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Folder Title:
NRMO [The National Regional Minorty Organization] A/PI [Asian and Pacific Islanders] T/A [Technichal Assistance] Needs

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The National Regional Minority Organization Community-Based Organization Technical Assistance Needs Assessment

Asian and Pacific Islander American Health Forum

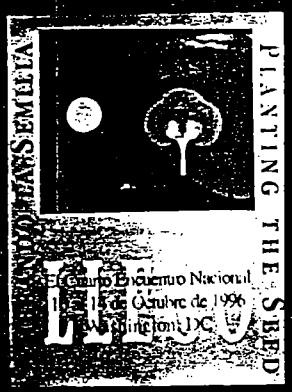
Inter Tribal Council of Arizona

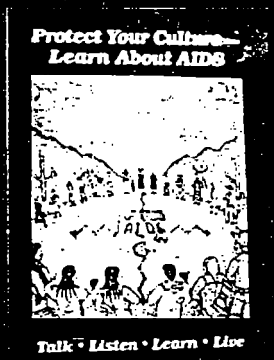
National Alumni AIDS Prevention Project

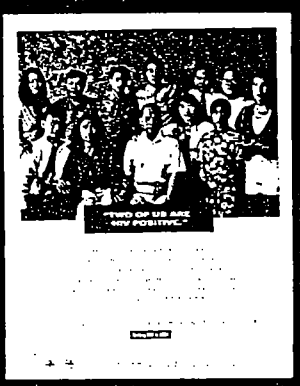
National Council of La Raza

National Latino Lesbian and Gay Organization

National Minority AIDS Council







Funding Provided by the Centers for Disease Control and Prevention, National Center for HIV/AIDS, STD and TB Prevention

ASIANS AND PACIFIC ISLANDERS AND HIV PREVENTION: TECHNICAL ASSISTANCE AND TRAINING NEEDS

Asian and Pacific Islander American **Health Forum**
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APIAHF
Asian & Pacific
Islander American
Health Forum

October 15, 1999

Todd Summers, Deputy Director
Office of National AIDS Policy
736 Jackson Place N.W.
Washington, D.C. 20503

Dear Todd:

Please find enclosed:

- a copy of the Asian and Pacific Islander chapter of the National/ Regional Minority Organization (NRMO) assessment of the technical assistance and training (TAT) needs of minority community-based organizations (CBOs) funded by the Centers for Disease Control and Prevention (CDC) and

- a copy of the final report by Ed Tepporn, one of the 1999 CDC Price Fellows, "Thinking Between the Coasts...How CDC Can Support HIV Prevention Efforts for Asians and Pacific Islanders in the Midwest".

Thank you for your continued interest in and support of the HIV prevention needs of Asians and Pacific Islanders. Please do not hesitate to contact me at phone 415/954-9951 or by e-mail at <ibau@apiahf.org> if you have any questions.

Sincerely,

Ignatius Bau

Ignatius Bau, J.D.
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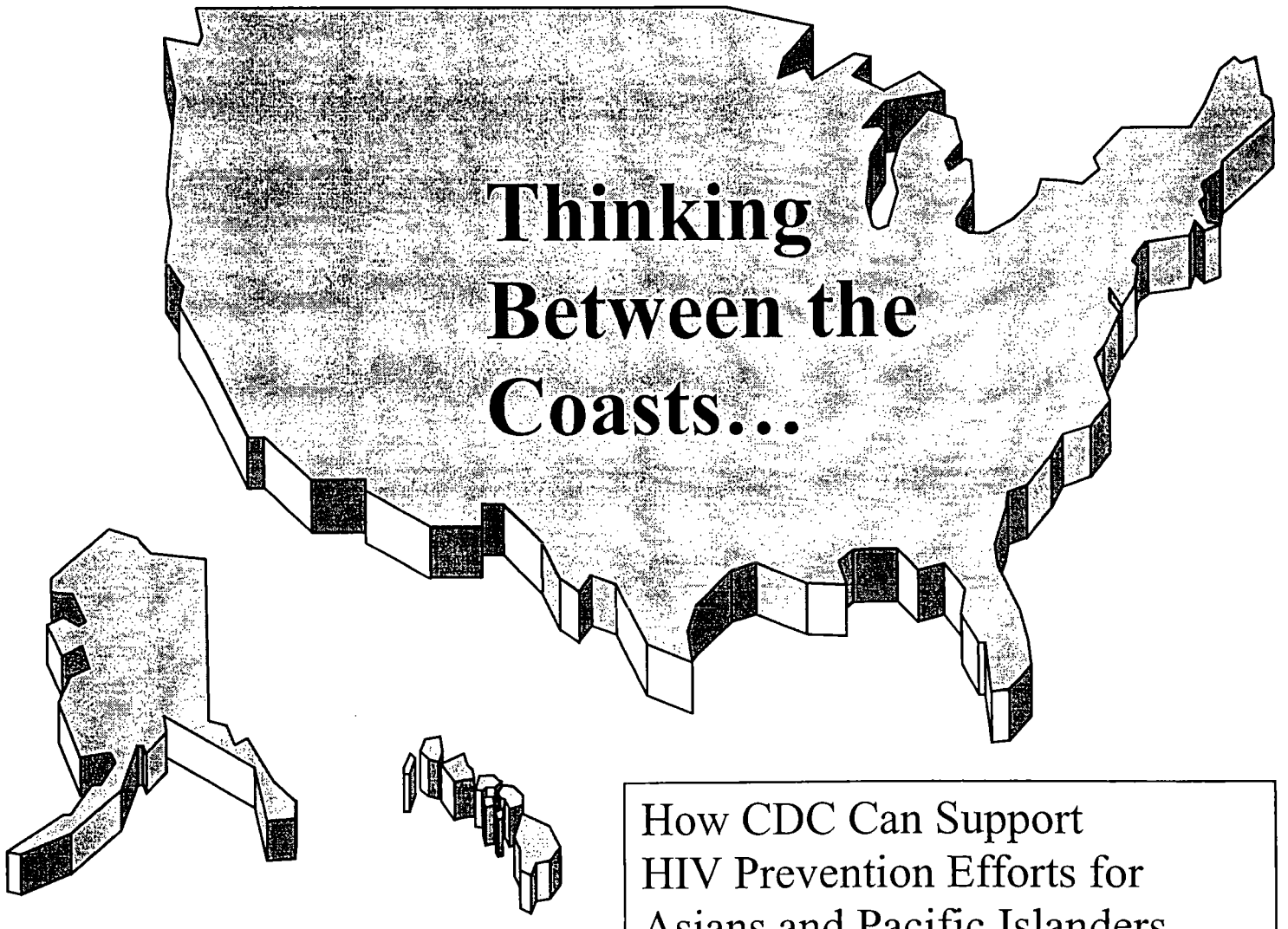

Thinking Between the Coasts...

How CDC Can Support HIV Prevention Efforts for Asians and Pacific Islanders in the Midwest

Ed Tepporn, Price Fellow
Director of Education, 1999
St. Louis Effort For AIDS
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PERSONAL BACKGROUND

For the past four years, I have worked as the Gay/Bisexual Outreach Coordinator for St. Louis Efforts For AIDS, one of the largest and oldest AIDS Service Organizations (ASO) in St. Louis, Missouri. I have also had the privilege of participating on the St. Louis Regional Planning Group and the Missouri Statewide HIV/STD Prevention Community Planning Group. I feel very strongly that both of these groups have had a beneficial impact in addressing many of the complicated HIV prevention needs and issues of individuals living in St. Louis and Missouri.

When I first became involved with these planning groups, I was concerned by the lack of attention paid to the Asian Pacific Islander (API) communities in regards to HIV prevention. I was told that according to the HIV/AIDS surveillance data, there were not a large number of API individuals who had been infected with HIV and were therefore not a high priority group.

There have been many non-API individuals in Missouri who have been supportive of my prevention efforts and my professional development. But one of the most empowering experiences I have had occurred when I attended a national conference and met other APIs who were working in the HIV prevention field. For the first time in my professional career, I felt like I was among a group of people who could absolutely relate to my experiences. I valued the opportunity to talk about challenges and best practices. I connected with other individuals who also felt the pressure of serving as the sole representative of a diverse set of languages, ethnicities, and cultures on various planning groups. Many of these individuals have been instrumental in providing me with peer support and technical assistance in my efforts to create a Gay, Lesbian, Bisexual, Transgendered (GBLT) API group in St. Louis. This group serves not only as a needed social support resource but also as a mechanism for reaching a group of individuals who were not being reached by traditional HIV prevention efforts.

In meeting and networking with these other API HIV service providers, however, I realized that the Midwest was and continues to be far behind our prevention partners on the East and West Coasts. Thus, when I was selected to be a Price Fellow, I wanted to explore how the Centers for Disease Control and Prevention (CDC) can continue to support and enhance efforts to target HIV prevention to APIs in the Midwest. By doing so, perhaps the impact of HIV on this population can be averted before it reaches the epidemic proportions we have seen in other groups.

The purpose of the Price Fellowship is to provide a two-way learning experience between the CDC and non-governmental organizations (NGOs). By conducting this particular project, I hope to provide exploratory, qualitative data and preliminary recommendations to the CDC about API HIV prevention in the Midwest, with a focus on the assets, challenges, and needs of current and potential API HIV providers and the national API TA/T providers in regards to training and technical assistance issues. The strength of this approach is that it is based on and attempts to capture rich data on personal experiences.

This project, however, is limited by a short project timeline which only allowed for a small number of organizations to be interviewed. Given the small sample size and non-randomized convenience sampling techniques, the results of this project are not meant to be representative of, nor generalizable to, the myriad of current and potential HIV prevention providers for API communities in the Midwest. Instead, this project hopefully emphasizes the need for CDC, community planning groups, AIDS Service Organizations, Community Based Organizations, and concerned individuals to more fully explore the HIV prevention needs of the API communities in the Midwest and the technical assistance and training (TA/T) needs of the organizations who are trying to serve them.

SHORT HISTORY

On June 7, 1999, President Bill Clinton issued Executive Order 13125 to improve the quality of life of Asian Americans and Pacific Islanders through increased participation in Federal programs where they may be underserved. Given the current funding levels for HIV prevention, organizations and community planning groups have tried to prioritize prevention funds so that they reach those communities hit hardest by the epidemic. In most jurisdictions, particularly in areas outside of the East and West Coasts, APIs do not constitute a significant percentage of new HIV infections. Yet, many geographic areas, such as Minnesota and Chicago, are experiencing rapid population growth in their API communities. Limited funding, if any, is set aside to target these communities with prevention programs. Combined with other cultural factors and barriers to health care resources, this results in the potential for a future wave of infections in the Asian and Pacific Islander communities not only in these locales but also across the country. It is important that CDC, community planning groups, and organizations nationwide address this underserved population in order for prevention efforts to be proactive as opposed to reactive.

Before Executive Order 13125 was issued, CDC had already recognized the increasing impact of HIV on API and other minority communities. The CDC established the National and Regional Minority Organizations (NRMO) Program in 1988. The program was designed to provide culturally competent and relevant TA/T to organizations that provide HIV prevention to racial/ethnic minority populations. Currently, the Asian and Pacific Islander American Health Forum (APIAHF) is the main provider of training and technical assistance to API community based organizations (CBOs) and State and local health departments through its Empowerment through Training and Technical Assistance (ETTA) Program. Working with seven partner agencies located in Los Angeles, Oakland, San Francisco, New York, Seattle, and Washington, D.C., the ETTA program provides TA/T to over 80 organizations.

According to a recent APIAHF study, "HIV prevention for APIs in the United States is focused mostly on the West Coast, Hawaii, and in a few states in the Northeast" (Chng, Sy, Choi, Bau, & Astudillo, 1998). Only a handful of HIV prevention programs targeted to API communities exist in the Midwest. This lack of programs is alarming, particularly when considering figures such as the 129% increase in new API Men Who Have Sex With Men (MSM) AIDS cases in the Midwest (Sullivan, 1995). In order to provide a comprehensive prevention effort, programs that target API MSM are needed, but so are programs geared towards API women, youth, substance users, and other risk groups.

METHODOLOGY

This project consisted of three separate phases that all occurred in the month of August 1999. During Phase I, I conducted informational interviews with fourteen individuals in various branches of CDC. These included the Behavioral Intervention Research Branch, Program Evaluation Research Branch, Training and Technical Support Systems Branch, Community Assistance, Planning, and National Partnerships Branch, Surveillance Branch, Epidemiology Branch, and the Prevention Services Research Branch. These individuals graciously provided their insight and experience as well as several documents on various CDC sponsored projects and evaluations. From these documents, I reviewed literature on current training, technical assistance, and capacity building research projects and evaluations sponsored by CDC.

Phase II consisted of face to face key informant interviews with individuals from two organizations that currently provide national technical assistance, specifically around API issues. For this phase, I interviewed a staff member of the Asian Pacific Islander American Health Forum (APIAHF), and two staff members of the National

Program of the Asian Pacific Islander Wellness Center (APIWC). The Asian Pacific Islander American Health Forum is a National Regional Minority Organization that receives funding from CDC to support the HIV prevention efforts of CBOs and health departments that serve Asians and Pacific Islanders. APIAHF's Empowerment through Training and Technical Assistance (ETTA) program coordinates a coalition of seven Asian community-based health and humans service agencies in San Francisco, Oakland, Los Angeles, Seattle, New York, and Washington, DC.

"We really try to use peer resources so that people share their experiences and expertise with one another."

The APIAHF's ETTA program provides technical assistance and training on a national basis. Their TA/T activities include the geographic areas that their partner agencies are located in and are supplemented with people from other areas such as Hawaii, Pacific Islands, the South, and the Midwest. The APIAHF coordinates a loose consortium of about 80 agencies and health departments and has regular contact with another additional 20 agencies. Currently, no efforts are specifically targeted to organizations in the Midwest but APIAHF has tried to include Midwestern programs and organizations in all of their national activities, including conferences and workshops.

One of these partner agencies is the Asian Pacific Islander Wellness Center (A&PIWC) which provides support to Asian AIDS organizations and gay API groups through its National HIV Prevention and Organizational Development Technical Assistance Program. In the past 4 years, the A&PIWC has worked with 47 groups. This includes 19 HIV/AIDS agencies, 25 community based gay Asian groups, and 3 other groups. Of these organizations, five are located in the Midwest.

"There have been many times when we are conducting a workshop or doing a training and people tell us in the evaluations that the TA was really useful. They tell us that they would like some way of taking the experience back to their agencies. While we have tried doing reports from conferences and workshops, it's hard for us to replicate that experience without doing it over and over again."

In Phase III, I conducted telephone interviews with staff members at organizations in the Midwest that currently or could potentially provide HIV prevention services to the API communities in their respective geographic areas. Given the short time constraints of this project, I realized that I could not conduct a complete research study, and had to limit my efforts to exploratory research. Thus, looking at the 1990 US Census data, I identified the seven largest cities in the Midwest that had populations over 250,000 that had the largest API populations. These cities were Chicago, IL; St. Paul, MN; Minneapolis, MN; Indianapolis, IN; Kansas City, MO; Cleveland, OH, and St. Louis, MO. I attempted to conduct a telephone interview with a staff member at one organization in each city. The organizations contacted included a city health department, an Asian community based organization, an Asian Mental Health organization, a non-minority based ASO, and a community planning group (CPG).

RESULTS

Interviews with Current API TA/T Providers

The following are a sampling of the questions conducted in the interviews and the corresponding annotated responses.

What were the most helpful aspects of the technical assistance that you provided?

- API specific
- Use peer resources so that people share their experiences and expertise with one another
- Networking opportunities
- Organizational development
- Development of HIV prevention programs through sharing of curricula and documentation

"The lack of stability and continued funding makes it difficult to bring those API organizations and individuals into our activities on a national basis."

What have been the three largest challenges (besides funding) in your efforts to provide TA/T to HIV API programs and organizations in the Midwest?

- Lack of groups in the Midwest
- Lack of stability and continued funding for programs in the Midwest that are API specific
- Lack of an organization in the Midwest that can serve as a hub for TA/T efforts
- Lack of surveillance data on APIs because states are not required to break out all racial/ethnic minority groups in surveillance data
- HIV may not be the sole focus of organizations and individuals in the Midwest
- The Midwest has different API populations compared to the East Coast and West Coast
- TA/T needs in the Midwest differ from TA/T needs on the West Coast

"If state and local health departments don't break out a separate API category, and then break down API into ethnic populations, then even though the data may show small numbers, community advocates will never be able to make the case that HIV prevention for APIs is needs. Especially if the data continues to be reported simply as 'other'."

What current assets/resources does your organization possess that could be used to address potential TA/T need in the Midwest?

- Written materials (i.e., brochures, curricula, research)
- Advocacy
- Individuals from the Midwest working in the program
- Networking opportunities

What additional assets/resources (besides funding) would your organization need to address potential TA/T needs in the Midwest?

- An organization to serve as a regional hub for TA/T efforts
- A network of state agencies or federally funded programs in the Midwest
- Staff positions to specifically handle networking
- Allies in health departments and community planning groups that would support API prevention needs, especially where APIs aren't represented
- States need to be require to break out all racial/ethnic minority groups

"National organizing is very expensive. We are trying to do regional work. The Pacific Region and the Northeast Region work. But the Midwest doesn't work. The biggest challenge is there hasn't been a lot of groups formed in the Midwest."

How important to TA/T efforts is peer support targeted to organizations providing HIV prevention to API communities?

"In our experience, peer support can be more important than the support we provide, especially at the program level."

"The disadvantage of peer support is the tremendous turnover in staff that takes place."

"It's very important...the problem is that many of the youth have not been in the HIV field that long. Therefore, they do not get to go to national conferences because higher ranking staff are sent to these conferences.

"It's really important for new staff, but may have a decreasing value for more experienced staff"

"It's not necessarily increased funding. It's building the capacity of API organizations to compete successfully for CDC Program Announcement 704 money."

Interviews with Current and Potential API HIV Prevention Providers

Of all the HIV Prevention providers contacted, only one (in Chicago) currently had funding for HIV prevention programs targeted to APIs. One of the organizations previously had funding, but lost it when their state community planning group reprioritized funding strictly by HIV/AIDS surveillance data.

"Any justification for funding has to follow the HIV/AIDS surveillance data and there is no data for the API community so it gets lost in the shuffle."

The following is a sampling of the interview questions and annotated responses.

What are the main assets/resources that your organization/program possesses that would support HIV prevention programs targeted to API communities?

Answers shared by two or more respondents include:

- Established trust in the API community
- Experience working with API populations

Other answers include:

- Some contractual monies available to bring in TA/T
- Experience developing culturally specific programming for other racial/ethnic communities
- Staff who are interested in providing HIV prevention to APIs
- Providing a wide array of services (one stop shopping)
- API are part of target population within MSM category for next year

"We hear opposition such as 'How can we justify doing HIV prevention in API communities when we have such high rates in the African American community?'"

What have been the three largest challenges (besides funding) in your efforts to provide HIV prevention to API communities?

Answers shared by two or more respondents include:

- Lack of available HIV/AIDS surveillance data on API individuals
- Lack of prioritization of HIV groups for prevention dollars
- Lack of staff or person power
- Lack of a community needs assessment of the API communities
- Lack of empowerment for interested staff
- Intense API community stigma around HIV and sexuality
- Lack of awareness/understanding of the need for funding for API HIV prevention

"In my city, Hepatitis is a bigger health risk than HIV in the API communities. It's a struggle to make funders realize the need for HIV prevention."

Other answers include:

- Tokenization of the one or two API individuals involved in HIV prevention in local group
- "Brain Drain" – once a person reaches a certain ability, they move out of the Midwest
- Buy-in from API community gatekeepers
- Lack of access to materials in API languages

"What it takes is a willingness on the part of recognized leaders in any specific community to step forward and say this is MY issue and OUR issue. We haven't seen that with the API communities (in my area)."

What types of technical assistance does your organization currently need to address these challenges?

"It's not just a matter of prevention. It's also racism, immigrationism, classism, psychosocial issues..."

Answers shared by two or more respondents include:

- Opportunities to network with other prevention providers to share ideas and best practices
- How to gain access to and support from local API communities
- Conducting needs assessment in API communities
- How to involve key leaders in local API communities

Other answers include:

- TA on API recruitment for community planning groups
- More cultural competency training for ASOs to appropriately address the diverse API communities

"The only way that we could get funding was through people of color grants. We were mandated to work as a team of men color as if we were one blanket population even though our communities have very different needs."

What types of technical assistance do you think your organization will need 2-3 years from now?

Answers shared by two or more respondents include:

- Diversity training for ASOs and community planning group

Other answers include:

- Developing a diverse funding base for API HIV prevention programs
- Developing effective partnerships and collaborations
- Designing culturally competent services for the diverse API communities
- Developing a culturally specific social marketing campaign
- PIR training so that newly recruited API members can be most effective in advocating for their communities
- Leadership development
- Community building and organizing for the API communities
- TA on providing outreach to specific API risk groups (ie API women at risk)

"Getting together very disparate communities to try to form critical mass sounds good in theory, but realistically has been challenging."

How important is peer support (the opportunity to network, share information, and learn from other prevention providers to your current efforts?

"It would be great to the degree that is can serve as a venue for comparing notes and resources for how to particularize HIV prevention programs for different API communities."

"I can't underestimate the amount of support and planting of seeds that has been offered to us...the most important thing was that we got the peer support we needed and that the national organizations mirrored the enthusiasm we had."

"As an organization that has received a lot of TA/T from different programs, one of the best things was to meet people who do similar work."

"They (API outreach workers) are very resilient people, but they are very underappreciated. They are paid very low salaries. Everybody thinks that they don't know what they are talking about."

"My TA provider dealt not only with organization and systemic problems, but also recognized the personal burnout issues. He served as a peer advocate and peer support."

"The two staff who were doing HIV prevention work were "an island" in and of itself in the whole Hmong community. It would be great if they could have peer support in the Hmong community in general. They used to attend and enjoy local API Network meetings but nobody has the funding to continue it."

"It's critical...towards the end, I could not identify with anyone in my area and I felt like 'I was the only one who gave a damn (about the API community'."

RECOMMENDATIONS

"In my city, we see a lot of Asian who use parallel health systems (alternative health care systems). Our concern is that these people are not getting into our (behavioral data collection) system."

In order to better address the HIV epidemic as it manifests among API communities in the Midwest, I recommend future attention to and action in the following areas:

1) HIV/AIDS Surveillance

Both TA/T providers and prevention providers indicated that it is difficult for them to assess the extent of the epidemic among API communities in their area because surveillance data for APIs are not separated out by race and is often lumped into an "other" category.

CDC should recommend that all states and directly funded cities collect expanded race/ethnicity data. In presenting this data graphically, the states and cities should use different scales, or graphs within graphs, to adequately portray trends for each of these race/ethnic groups.

2) Prioritization

"If we move in community planning away from strictly HIV/AIDS data based surveillance to 'community profiles', then that would be more inclusive of relevant population and sociodemographic data. Then, a stronger case could be made for prioritizing API communities due to rapid population growth, youth of the population, geographic concentration, and linguistic isolation."

When priority groups are determined solely by HIV/AIDS surveillance data, API communities often are not targeted for prevention program due to low numbers. This prioritization process, however, ignores the fact that API populations are continuing to grow rapidly, and many areas have developed localized, concentrations of API populations.

This exclusive focus on surveillance data also does not reflect the various barriers to accessing HIV prevention and services that are faced by many API individuals. Nor does it take into account cultural and linguistic issues that may put API individuals at higher risk for HIV.

While prioritization by surveillance data does ensure that community planning groups are able to respond to the epidemic by targeting high risk groups that have been heavily impacted, it does not allow community planning groups to prevent the epidemic in those communities which may be at high risk but have not experienced high numbers of HIV infection.

CDC should recommend that community planning groups collect and utilize information from needs assessment, resource inventory, and gap analysis of API communities in addition to HIV/AIDS epidata when prioritizing populations.

3) Community Planning

"There's a direct correlation between API population size and the HIV prevention efforts targeted to APIs."

From my past experience with the local and state community planning process, I have experienced firsthand the difficulty of achieving parity, inclusion, and representation. This is especially true in regards to Asians and Pacific Islanders. As the only API representative on the Missouri HIV/STD Prevention Community Planning Group, I am expected to represent the needs and issues of a group that according to the US Census is comprised of over 29 Asian and 19 Pacific Islander ethnic/national groups that speak an even greater number of languages and dialects.

In Missouri, the community planning group members conduct their own needs assessments in order to reserve as much of our limited funding as possible to community programs. As the only API community planning group member, am I expected to voluntarily conduct a needs assessment of the state's API population, a project that could easily fill the duties of at least full-time staff person?

CDC and other TA/T providers should develop/continue specific efforts to help CPGs achieve PIR in regards to API populations.

"We don't have a lot of money to go to national conferences so it (a network of API prevention providers) would be a great way to get support. It might also serve as a great place to recruit job candidates when hiring."

CDC and other TA/T providers should provide TA/T to community planning groups and API individuals and CBOs on cost and time effective methods for conducting comprehensive community needs assessment. These methods need to take into account the lack of API community infrastructure that is common in many Midwestern cities.

4) Peer Support

All of the API respondents indicated the extreme importance of peer support. They strongly valued the opportunity to learn and share information and tools with other HIV prevention providers. Unfortunately, this peer support often occurred only in the short context of attending a national conference. Many of the API staff cannot afford to attend national conferences, or are not the individuals chosen by their respective agencies to attend conferences.

"The internet can stratify organizations. Some people don't have internet access. Some of the organizations don't even have computers."

CDC should fund an API NRMO to specifically support efforts to provide their Midwest and other regional constituents with opportunities to network with each other through conferences and other methods such as institutes at national conferences, regional workshops, exchange programs, mentorship, national meetings, email discussion groups, etc.

These networking opportunities should be organized on a variety of different levels, for example: local, regional, national, ethnic-specific, risk group specific. This staff person could also develop a resource inventory of programs and organizations providing HIV prevention to the API communities. This process of developing this resource inventory may enhance current consortiums organized by the NRMOs and identify new organizations not already tapped into the existing TA/T structure.

5) Regional Technical Assistance and Training

"We see the value of more explicit peer support structures and relationships."

The respondents noted a significant gap in the prevention services targeted to the API communities in the Midwest as well as a parallel gap, due to various challenges, in the technical assistance available to the organizations that provide these prevention services.

CDC should make available TA/T funds specifically designated to enhancing the capacity of organizations to provide HIV prevention to API communities in the Midwest. A portion of these funds should be earmarked for infrastructure development and capacity building in order to allow at least one API community based organization in the Midwest to develop the capacity to serve as a regional hub for TA/T efforts on API HIV Prevention in the Midwest.

6) Further Assessment of Midwest TA/T Needs

"The current TA/T model is based on a request model...the ideal model is establishing an ongoing TA/T relationship with a group."

In conducting this project, I found that there are very few planning groups and organizations that are working to prevent HIV infections in the API communities. This is alarming in that by neglecting to provide even basic HIV awareness to these API communities, we may be paving the road for future waves of epidemics. Realizing that the short time I have had to conduct this project does not even scratch the surface of truly analyzing the capacities, challenges, and needs of organizations in the Midwest that provide HIV prevention to API communities, I recommend that:

CDC should further evaluate the current efforts, capacities, and TA/T needs of organizations in the Midwest that currently target or would like to target API communities. This assessment should encompass not only Asian ASOs and CBOs, but also health departments, CPGs, and non-minority ASOs and CBOs.

CONCLUSIONS

Although, limited by timing and sample constraints, this project indicates that gaps exist in regards to HIV prevention activities for APIs in the Midwest and TA/T efforts to support those activities. Future projects should include involve the creation of a thorough national resource inventory of HIV prevention efforts targeted to APIs. This should not be limited to the Midwest, but should include every state, territory, and city funded by CDC. Although this project was limited to metropolitan areas, future research should include urban, suburban, and rural areas. Because API AIDS organizations are not the only agencies that currently or potentially outreach to API communities, future efforts should include API health organizations, API gay groups, API cultural groups, API social groups, API professional groups, community planning groups, and non-minority ASOs and CBOs. All of these groups may become key partners for collaboration in efforts to address the API HIV epidemic. An assessment of the current capacity and resources of those organizations in regards to API HIV prevention is necessary along with an assessment of those organization's TA/T needs to strengthen competency and capacity.

Our country has witnessed the increasing impact of the HIV/AIDS epidemic in other minority communities that previously had low numbers of reported HIV/AIDS cases. Like the API communities, these communities also were not initially prioritized or funded for prevention efforts because of low numbers of HIV/AIDS cases. Like the API communities, these communities have cultural and access to health care barriers that can increase their risk for HIV infections. Given the current emphasis placed on evaluation of HIV prevention programs, let's make sure that we learn from our successes and our mistakes. We must apply the appropriate lessons learned to communities where we have yet to see large numbers of HIV/AIDS cases so that we can prevent the HIV epidemic from expanding farther than it already has.

References

Asians and Pacific Islanders and HIV/AIDS Surveillance. (June 1999). San Francisco, CA: Asian and Pacific Islander American Health Forum.

Asians and Pacific Islander and HIV Prevention: Technical Assistance and Training Needs. (March 1999). San Francisco, CA: Asian and Pacific Islander American Health Forum.

Bau I. Asians and Pacific Islander and HIV prevention community planning. AIDS Education and Prevention. (1998). 10 (Suppl.A): 77-93.

Chng CL, Sy FS, Choi ST, Bau I, and Astudillo R. Asian and Pacific Islander American HIV community based organizations: A nationwide survey. AIDS Education and Prevention. (1998). 10 (Suppl.A): 48-60.

Gentry D. The NRMO evaluation project: Year one final report. (April 1999). St. Louis University. Unpublished draft.

Myhre S and Scott K. The NRMO evaluation project: Draft report of year 2 study. (December 1998). St, Louis University. Unpublished draft.

NRMO community based organization technical assistance needs assessment: Executive summary. (1999). Atlanta, GA: Centers for Disease Control and Prevention.

Research Triangle Institute. Program Evaluation Technical Assistance Assessment. (July 1999). Atlanta, GA: Centers for Disease Control and Prevention.

Summary of activities. (August 1999). San Francisco, CA: Asian And Pacific Islander Wellness Center National HIV Prevention and Organizational Development Technical Assistance Program.

Sy FS, Chng CL, Choi ST, and Wong FY. Epidemiology of HIV and AIDS among Asian and Pacific Islander Americans. AIDS Education and Prevention. (1998). 10 (Suppl.A): 4-18.

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ASIANS AND PACIFIC ISLANDERS AND HIV PREVENTION: TECHNICAL ASSISTANCE AND TRAINING NEEDS

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Asian and Pacific Islander Chapter Summary

The Asian and Pacific Islander American Health Forum (APIAHF) conducted an assessment of the technical assistance and training (TA/T) needs of community-based organizations (CBOs) targeting Asians and Pacific Islanders with HIV prevention interventions. APIAHF is a National/Regional Minority Organization (NRMO) funded by the Centers for Disease Control and Prevention (CDC) through a six-year Cooperative Agreement to provide TA/T to CBOs and health departments on HIV prevention targeting Asians and Pacific Islanders. APIAHF's assessment was conducted in conjunction with the CDC and the five other NRMOs funded to conduct this national needs assessment. The CDC was particularly interested in assessing the TA/T needs of CBOs regarding epidemiology, behavioral and social science, biomedical research, program evaluation, HIV prevention community planning, collaboration, and organizational development. APIAHF's assessment also focused on the cultural and linguistic diversity among Asians and Pacific Islanders as well as some of the Asian and Pacific Islander populations at highest risk for HIV infection, including Asian and Pacific Islander gay and bisexual men and other men who have sex with men (MSM) and Asian and Pacific Islander youth, including young MSM and queer-identified youth.

APIAHF's assessment of the TA/T needs of Asian and Pacific Islander CBOs used multiple methodologies during a one-year period, August 1997 through August 1998. The methodologies included two surveys of 80 CBOs that target Asians and Pacific Islanders with HIV prevention interventions (with a total of 57 responding CBOs from 15 states, Washington DC, and Guam, for a 71% response rate to one or both surveys), a survey of 30 national, territorial, state, and local health departments and Health Ministries in jurisdictions with the highest numbers of Asian and Pacific Islander residents (with 24 responses for a 80% response rate), five regional focus groups with staff of HIV prevention programs targeting Asian and Pacific Islander gay and bisexual men (with 36 participants from 17 CBOs), eight local focus groups of Asian and Pacific Islander youth (with 80 participants under age 25 from six cities), and six key informant interviews with leaders of Asian and Pacific Islander gay groups from six cities.

The key findings from the needs assessment were:

HIV Prevention Programs for Asians and Pacific Islanders

Asian and Pacific Islander CBOs provide a diverse number of individual, group, and community-level HIV prevention interventions targeting diverse Asian and Pacific Islander populations by Asian and Pacific Islander ethnicities/national origins, Asian and Pacific Islander languages, and HIV-related risk behaviors.

About half of the HIV prevention programs targeting Asians and Pacific Islanders are located in California and Hawai'i and the majority are based in urban areas. The TA/T needs of CBOs where programs are geographically concentrated are different than those of CBOs where there may be less community, financial, political, and social support for HIV prevention interventions for Asians and Pacific Islanders.

There are significant gaps in the linguistic access to HIV testing and other HIV prevention programs for Asians and Pacific Islanders in many states with large numbers of Asian and Pacific Islander residents. Among the states with the highest number of Asian and Pacific Islander residents, there were significant gaps in the availability of HIV testing in Asian and Pacific Islander languages, information and materials in Asian and

Pacific Islander languages, and funding for Asian and Pacific Islander HIV prevention programs.

The unique TA/T needs of the six-United States affiliated Pacific jurisdictions must be included in the provision of TA/T to Asians and Pacific Islanders. Although there are few CBOs (or nongovernmental organizations) engaged in HIV prevention in the Pacific jurisdictions, culturally appropriate TA/T to the Health Ministries and health departments in the Pacific jurisdictions is critical to the success of HIV prevention efforts in the region.

Organizational Development Needs of Asian and Pacific Islander CBOs
Asian and Pacific Islander CBOs need TA/T on a diverse number of organizational development issues, including fundraising and resource development, strategic and long-term planning, volunteer program development, and collaboration.

HIV/AIDS Surveillance and Epidemiology
Asian and Pacific Islander CBOs need TA/T on improving HIV and AIDS surveillance data and in obtaining information about the HIV prevention needs of Asians and Pacific Islanders, especially among specific Asian and Pacific Islander ethnicities/national origin populations. The majority of the responding CBOs access and use available HIV and AIDS surveillance data about Asians and Pacific Islanders. However, the unavailability and inadequacy of data, especially data disaggregated by Asian and Pacific Islander ethnicities/national origins means that CBOs seeking to target Asians and Pacific Islanders for HIV prevention must utilize other sources of data to document the HIV prevention needs of Asian and Pacific Islander communities. For example, Asian and Pacific Islander CBOs could use TA/T to conduct their own community needs assessments to provide additional information to health departments, HIV prevention community planning groups, and funders about the HIV prevention needs of Asians and Pacific Islanders.

HIV Prevention Community Planning
Asian and Pacific Islander CBOs need TA/T on increasing their participation and effectiveness within HIV prevention community planning. Asian and Pacific Islander CBOs also need TA/T on how to effectively participate within the HIV prevention community planning process. Given the underrepresentation of Asians and Pacific Islanders in most HIV prevention community planning groups, the Asian and Pacific Islander members often face difficult challenges in ensuring that the HIV prevention needs of Asians and Pacific Islanders are included in the planning process and in the establishment of HIV prevention priorities. TA/T on parity, inclusion, and representation issues for Asians and Pacific Islanders within community planning is a high priority.

HIV Prevention Program Development and Program Evaluation
Asian and Pacific Islander CBOs need TA/T on developing and evaluating culturally appropriate HIV prevention interventions targeting Asians and Pacific Islanders at the highest risk for HIV infection. The majority of the responding CBOs target specific HIV risk behaviors among Asians and Pacific Islanders, often focusing on Asian and Pacific Islander gay and bisexual men and other men who have sex with men (MSM) and on Asian and Pacific Islander youth. Other programs focus on Asian and Pacific Islander women, Asian and Pacific Islander transgender persons, and Asian and Pacific Islander commercial sex workers. However, a few programs are less focused, seeking to target the Asian and Pacific Islander "community-at-large." Such programs are less likely to be effective or sustainable in the increasingly competitive world of HIV prevention priorities.

Asian and Pacific Islander CBOs also need TA/T in developing and evaluating culturally and linguistically appropriate HIV prevention interventions targeting specific Asian and Pacific Islander ethnicities/national origin populations. Effective HIV prevention interventions must be tailored for specific Asian and Pacific Islander ethnicities/national origin populations.

Given the inadequacy of HIV prevention materials in Asian and Pacific Islander languages, national coordination of the development and dissemination of Asian and Pacific Islander language HIV prevention materials is critical.

Asian and Pacific Islander gay and bisexual men's social, cultural, and political organizations need TA/T on organizational development, leadership development, and community-level HIV prevention interventions to build community capacity and impact community norms in support of effective HIV prevention interventions. Among Asians and Pacific Islanders, gay and bisexual men and other MSM remain the most impacted behavioral risk population for HIV infection, with 74% of the cumulative Asian and Pacific Islander male AIDS cases reported among MSM. Continued TA/T that builds organizational and individual capacities among Asian and Pacific Islander gay and bisexual men is vital.

Asian and Pacific Islander CBOs need TA/T on developing and evaluating the effectiveness of HIV prevention interventions targeting Asian and Pacific Islander youth, particularly interventions that involve parents and other family members and address the wholistic health and other needs of Asian and Pacific Islander youth.

Asian and Pacific Islander CBOs need TA/T on developing and evaluating the effectiveness of HIV prevention programs targeting Asian and Pacific Islander populations at risk for HIV infection, including Asian and Pacific Islander women, Asian and Pacific Islander transgender persons, Asian and Pacific Islander injection drug users (IDUs), and Asian and Pacific Islander commercial sex workers.

Asian and Pacific Islander CBOs need TA/T on developing culturally and linguistically appropriate group and community-level HIV prevention interventions. Most Asian and Pacific Islander CBOs conduct individual-level HIV prevention interventions. Coordinated multiple-level interventions may be more effective in impacting increased knowledge and behavior change to reduce HIV transmission among Asians and Pacific Islanders.

Asian and Pacific Islander CBOs need TA/T on improving the evaluation of their HIV prevention programs, especially in developing and using outcome evaluation measurements. Although almost all Asian and Pacific Islander CBOs do evaluate their HIV prevention programs, most use process evaluation measurements. Few HIV prevention programs utilize outcome and impact evaluation in their programs.

Behavioral and Social Science

Further development, evaluation, validation, and diffusion of culturally appropriate HIV prevention interventions for Asian and Pacific Islander populations, especially those targeting Asians and Pacific Islanders at highest risk for HIV infection, is needed. There has been almost no prevention science research or evaluation of HIV prevention programs for Asians and Pacific Islanders. Coordinated efforts to identify, develop, and evaluate effective HIV prevention interventions that are culturally and linguistically

appropriate for each Asian and Pacific Islander ethnicity/national origin population and each risk behavior group population are needed. Such basic research and evaluation is essential to strengthening HIV prevention programs.

Asian and Pacific Islander CBOs need TA/T to address the co-factors for HIV risk and the facilitators to HIV risk reduction that are most common among Asians and Pacific Islanders. Such co-factors may require the development of TA/T on issues of culture, identity, and other structural issues not currently part of TA/T on HIV prevention.

Asian and Pacific Islander CBOs continue to need opportunities to build collaborative relationships with researchers to jointly strengthen HIV prevention programs through the application of HIV prevention science.

Collaboration

Staff from Asian and Pacific Islander CBOs continue to need opportunities to network; share lessons learned, experiences, and expertise; and support one another in HIV prevention. National, regional, and local conferences, working groups, and other opportunities to convene are important TA/T activities for Asians and Pacific Islanders. More formal mentorship, leadership development, and staff exchange programs also should be developed to build the staff capacities of Asian and Pacific Islander CBOs.

Asian and Pacific Islander CBOs also continue to need opportunities to network; share lessons learned, experiences, and expertise; and support one another within specific Asian and Pacific Islander ethnicities/national origin populations. Such opportunities can improve the cultural competence and linguistic accessibility of HIV prevention programs for Asians and Pacific Islanders.

Asian and Pacific Islander CBOs need TA/T in exploring new models of collaboration and programmatic delivery of HIV prevention programs for Asians and Pacific Islanders. In an increasingly competitive funding environment, Asian and Pacific Islander HIV prevention programs will be challenged to explore and implement innovative collaborations with other Asian and Pacific Islander community institutions, other HIV prevention programs (especially in other communities of color), health departments, and funders to sustain their efforts in the future.

Technical Assistance and Training Providers and Formats

Asian and Pacific Islander CBOs need TA/T from a diverse number of TA/T providers, including the CDC, state and local health departments, NRMOs, other CBOs, and academic institutions. Each of these TA/T providers must provide TA/T appropriate to their particular knowledge, expertise, and TA/T skills. For example, it makes most sense for NRMOs to continue to focus their TA/T efforts on the unique cultural and linguistic barriers and facilitators to effective HIV prevention interventions within communities of color such as within the Asian and Pacific Islander communities. NRMOs also should continue to work to build and strengthen national, regional, and local collaborations and increase coordination among Asian and Pacific Islander CBOs. TA/T should continue to be made available in a diverse number of TA/T delivery methods, including conferences, training workshops, site visits, written information, and phone and e-mail contact.

Methods

APIAHF used multiple methodologies during a one-year period, August 1997 through August 1998, in its assessment of the TA/T needs of Asian and Pacific Islander CBOs.

The methodologies included two surveys of 80 CBOs that target Asians and Pacific Islanders with HIV prevention interventions (with a total of 57 responding CBOs from 15 states, Washington DC, and Guam, for a 71% response rate to one or both surveys), a survey of 30 national, territorial, state, and local health departments and Health Ministries in jurisdictions with the highest numbers of Asian and Pacific Islander residents (with 24 responses for a 80% response rate), five regional focus groups with staff of HIV prevention programs targeting Asian and Pacific Islander gay and bisexual men (with 36 participants from 17 CBOs), eight focus groups of Asian and Pacific Islander youth (with 80 participants under age 25 from six cities), and six key informant interviews with leaders of Asian and Pacific Islander gay groups from six cities.

In addition, APIAHF used information from several ongoing TA/T activities within its NRMO program, including national panels reviewing HIV prevention materials in ten Asian and Pacific Islander languages, a National Summit on Technology Transfer of HIV Prevention Interventions for Asian and Pacific Islander Men Who Have Sex with Men (March 1997), APIAHF's published analysis of HIV prevention plans and HIV prevention community planning groups from 40 jurisdictions (June 1998), the San Francisco International Summit on Filipinos and HIV/AIDS (July 1998), and a TA/T workshop for the Pacific jurisdictions (August 1998).

Two Surveys of CBOs
APIAHF conducted surveys in August 1997 and April 1998 of CBOs that target Asians and Pacific Islanders with HIV prevention interventions. Forty-nine of 80 CBOs responded to the August 1997 survey (61% response rate) and 47 of 80 CBOs responded to the April 1998 survey (59% response rate). A 48th response to the April 1998 survey was received after data entry had been completed and was not included in this analysis. The respondents were not identical; a total of 57 CBOs responded to one or both of the surveys (71% overall response rate).

The first survey was jointly developed by APIAHF and APIAHF's NRMO program TA/T consultants Francisco Sy, M.D., Dr.P.H., and Simon Choi, Ph.D., from the University of South Carolina School of Public Health, and Chwee Ly Chng, Ph.D., from the University of North Texas. The survey was originally compiled from several existing survey instruments and then modified after pilot testing for content validity by APIAHF and APIAHF NRMO program partner Asian and Pacific Islander Wellness Center. Among those who pilot-tested the survey were CBO staff on the planning committee for the 1997 Asian and Pacific Islander Institute at the United States Conference on AIDS. The first survey asked questions about organizational history and structure, target populations, HIV prevention interventions, HIV care services, program evaluation, technical assistance and training needs, HIV prevention community planning, and Ryan White CARE Act planning. The survey was sent by mail and fax in August, 1997 to 80 CBOs identified by APIAHF through its list of CBO and health department members of its National Asian and Pacific Islander Consortium on AIDS and STDs (NAPICAS), as well as other CBOs that APIAHF was aware of that currently provide or had provided in the past HIV/AIDS programs for Asians and Pacific Islanders. [A list of NAPICAS members is attached.] Telephone followup was conducted with non-responding CBOs after three weeks. Six responding CBOs were asked to complete the survey a second time to ensure reliability. [A copy of the August 1997 survey is attached.] Data entry and tabulations were conducted with in-kind assistance from the University of South Carolina School of Public Health.

The preliminary results of the first survey were presented at the APIAHF "Voices from the Community" national conference in San Francisco, California, and at the Asian and Pacific Islander Institute at the United States Conference on AIDS in Miami, Florida, both in September 1997. The final results were published in a special supplement to AIDS Education and Prevention (Chng, Sy, Choi, Bau, and Astudillo,1998). Results of the first survey also were presented at the American Public Health Association Annual Meeting in Indianapolis, Indiana, in November 1997 and at the American Psychological Association Miniconvention on HIV/AIDS in San Francisco, California, in August 1998.

The second survey included the eleven core questions and matrix of TA/T needs jointly developed and pilot tested by CDC and the NRMOs conducting this needs assessment. The core questions asked demographic information about the responding CBO and its HIV prevention programs. The matrix asked the CBOs to rank specified areas of potential TA/T by priority, identify specific TA/T needs, and identify preferred providers of such TA/T. APIAHF added questions about organizational history and structure, target populations, HIV prevention interventions, epidemiology, program evaluation, behavioral and social science, biomedical research, collaboration, HIV prevention community planning, and technical assistance and training needs. The survey was sent by mail and fax to the same 80 CBOs that received the first survey in August, 1997. Telephone followup with non-responding CBOs was conducted after three weeks. [A copy of the April 1998 survey is attached.] Data entry and tabulations were conducted by the CDC and APIAHF. The preliminary results of the second survey were presented at APIAHF's National Asian and Pacific Islander Summit on HIV/AIDS in San Diego, California, in September 1998 and at the Asian and Pacific Islander Institute at the United States Conference on AIDS in Dallas, Texas, in October 1998.

The responding CBOs to the two surveys were not identical. A total of 57 of the 80 CBOs responded to one or both of the surveys (71% overall response rate). The high number of responses to two surveys within an eight-month time period provides validation of the survey instruments and allows for a more comprehensive analysis of the data. APIAHF's ability to quickly report on the preliminary results of the surveys at national meetings of Asians and Pacific Islanders working on HIV/AIDS issues and to publish an analysis of the first survey results has increased the credibility of the needs assessment project among Asian and Pacific Islander CBOs and has provided the responding CBOs with data and information that they can immediately use in developing and evaluating their HIV/AIDS programs. The survey results also were used by APIAHF and its NRMO program partners in planning both APIAHF's National Asian and Pacific Islander Summit on HIV/AIDS in San Diego, California, in September 1998 and the Asian and Pacific Islander Institute at the United States Conference on AIDS in Dallas, Texas, in October 1998.

Focus Groups

Based on APIAHF's review of the epidemiology of HIV/AIDS in the Asian and Pacific Islander communities, its ongoing work in its NRMO program, and the preliminary results of the August 1997 CBO survey, APIAHF identified Asian and Pacific Islander gay and bisexual men and other MSM and Asian and Pacific Islander youth as the top target populations for HIV prevention within the Asian and Pacific Islander communities. Accordingly, APIAHF sought to focus on the HIV prevention needs of these two populations as part of this needs assessment. It was important to access these two target populations directly about their HIV prevention issues. APIAHF decided to use

both focus groups and key informant interviews to obtain information about HIV prevention among these populations.

During the period April through June 1998, APIAHF's NRMO program partner Asian and Pacific Islander Wellness Center conducted five focus groups with staff of HIV prevention programs targeting Asian and Pacific Islander gay and bisexual men and other MSM. Participants were identified by the Asian and Pacific Islander Wellness Center based on its work providing TA/T to CBOs on HIV prevention programs targeting Asian and Pacific Islander gay and bisexual men and other MSM. These focus groups were conducted in Philadelphia, Pennsylvania; Kaapa, Hawai'i; Honolulu, Hawai'i; San Francisco, California; and Los Angeles, California. A total of 36 individuals from 17 Asian and Pacific Islander gay and bisexual men's HIV prevention programs from New York, New York; Boston, Massachusetts; Philadelphia, Pennsylvania; Washington, DC; San Francisco, California; Oakland, California; San Jose, California; Los Angeles, California; San Diego, California; Honolulu, Hawai'i and Kapaa, Hawai'i participated in these focus groups. Written consent from all the focus group participants was obtained and each focus group followed a standard protocol of open-ended questions. [A copy of the protocol for the Asian and Pacific Islander gay and bisexual men's focus groups is attached.] Questions were asked about HIV prevention needs and issues among Asian and Pacific Islander gay and bisexual men and other MSM, program development, evaluation, and organizational development.

In addition, seven Asian and Pacific Islander youth-serving CBOs conducted eight focus groups with Asian and Pacific Islander youth under age 25 during July and August 1998. APIAHF identified these seven Asian and Pacific Islander CBOs through a national mailing to NAPICAS CBO members seeking assistance in conducting the focus groups. The Asian and Pacific Islander CBOs that recruited and conducted the focus groups were the Indochinese Community Center in Arlington, Virginia (n=9; Chinese, Vietnamese, Laotian; 6 males and 3 females; ages 15-24); AIDS Services for Asian Communities in Philadelphia, Pennsylvania (n=15; Cambodian, Thai, Indian, Singaporean, Taiwanese, Filipino and Vietnamese; 11 males and 4 females; ages 15-24; 11 self-identified as gay, lesbian, bisexual, transgender, queer or questioning; 6 self-identified as drug users; 2 self-identified as HIV+); Southeast Asian Mutual Assistance Associations Coalition in Philadelphia, Pennsylvania (n=10; Hmong and Cambodian; 7 males and 3 females; ages 9-12) and (n=7; Cambodian, Chinese, Korean; 4 males and 3 females; ages 15-23); Korean Youth Community Center in Los Angeles, California (n=18; Korean, Vietnamese, Taiwanese, and Filipino; 14 males, 4 females; ages 15-19); Asians and Pacific Islanders for Reproductive Health in Long Beach, California (n=9; 9 Cambodian females; ages 14-16); Life Foundation in Honolulu, Hawai'i (n=6; 6 Asian/multiracial males; ages 18-23; 6 self-identified as gay); and West Hawai'i AIDS Foundation in Kaapa, Hawai'i (n=6; part Hawaiian, Tahitian, Filipino; all males; ages 15-18). The Asian and Pacific Islander CBO's obtained written consent from each of the focus group participants and followed a standard protocol of open-ended questions. Different types of monetary and other incentives (movie tickets, etc.) were provided to the focus group participants. A total of 80 youth, 54 males and 26 females, participated in these focus groups. [A copy of the protocol for the Asian and Pacific Islander youth focus groups is attached.] Questions were asked about issues for Asian and Pacific Islander youth, trusted sources of information, information received about HIV, and ideas for effective HIV prevention programs for Asian and Pacific Islander youth.

Key Informant Surveys
In addition, APIAHF's NRMO program partner Asian and Pacific Islander Wellness Center conducted six key informant interviews with leaders of Asian and Pacific Islander gay men's groups in Los Angeles, California; San Francisco, California; Berkeley, California; Dallas, Texas; Seattle, Washington; and New York, New York, during August 1998. Key informants were identified through Asian and Pacific Islander Wellness Center's past TA/T work with each of these Asian and Pacific Islander gay men's groups. Interviews were conducted by telephone and followed a standard protocol of open-ended questions. Questions were asked about organizational development, TA/T received and needed, and capacity to engage in HIV prevention.

Survey of Health Departments and Health Ministries
APIAHF also surveyed the health departments in the 12 states and 12 local jurisdictions with the highest numbers of Asian and Pacific Islander residents, as well as the health departments and Health Ministries of the six United States-associated Pacific jurisdictions regarding HIV prevention programs targeting Asians and Pacific Islanders in their jurisdictions. Given the relatively small number of Asian and Pacific Islander CBOs involved in HIV prevention throughout the United States, it was important to assess the HIV prevention needs of Asian and Pacific Islander communities in geographic areas where there might not be an Asian and Pacific Islander CBO involved in HIV prevention. Twenty-four jurisdictions - 11 of the 12 state health departments, 8 of the 12 local health departments and 5 of the 6 Pacific jurisdictions - responded to the survey (80% response rate). [A copy of the health department survey and a chart with the responses summarized are attached.] Questions were asked about surveillance data, HIV testing and prevention programs for Asians and Pacific Islanders, services and materials available in Asian and Pacific Islander languages, and TA/T received on Asians and Pacific Islanders as a target population for HIV prevention.

Other Data Sources
APIAHF also utilized information for this needs assessment from several ongoing activities in its NRMO program. APIAHF partners with seven Asian and Pacific Islander CBOs in California, Washington, New York, and Virginia to provide TA/T to other NRMO partners and the Asian and Pacific Islander CBO and health department members of our National Asian and Pacific Islander Consortium on AIDS and STDs (NAPICAS). For example, in the fifth year of the NRMO program, 36 NAPICAS CBOs, 35 other CBOs, and 17 health departments received TA/T through the APIAHF NRMO program. Each of the NRMO partners receives funding from APIAHF through subcontracts to both provide and receive TA/T. Beginning in September 1998, APIAHF also received supplemental funding from the CDC to support the Asian and Pacific Islander Wellness Center's TA/T activities targeting Asian and Pacific Islander gay organizations and HIV prevention programs targeting Asian and Pacific Islander gay and bisexual men and other MSM. These activities by the Asian and Pacific Islander Wellness Center were funded in the past by the National Task Force on AIDS Prevention, a former NRMO targeting gay men of color.

APIAHF's NRMO program also conducts regional and national TA/T conferences (East Coast Regional Conference, 1995; West Coast Regional Conference, 1996; "Voices from the Community" Conference, 1997; and National Asian and Pacific Islander Summit on HIV/AIDS, 1998) and coordinates the annual Asian and Pacific Islander Institute at the United States Conference on AIDS (formerly the National Skills Building Conference). The NRMO program also convenes national working groups on HIV

prevention and cultural competence, HIV prevention community planning, Asian and Pacific Islander youth and HIV prevention, and Asian and Pacific Islander women and HIV prevention. During the past three years, APIAHF also has conducted ten national reviews of HIV prevention materials in Asian and Pacific Islander languages. These national panels identify priority needs for additional materials and develop glossaries of common terminology used in HIV prevention. These national language review panels have reviewed materials in Chinese, Tagalog, Vietnamese, Korean, Japanese, Cambodian, Thai, Hmong, Lao, and Samoan. These review panels are an important resource for identifying the HIV prevention issues and needs of specific Asian and Pacific Islander ethnicities/national origins.

In the area of behavioral and social science, APIAHF convened a National Summit on Technology Transfer of HIV Prevention Interventions for Asian and Pacific Islander Men Who Have Sex with Men in March 1997 (Bau, Lew, and Bao, 1998). One of the outcomes of the summit was collaboration by summit participants on a special supplement to AIDS Education and Prevention focusing on Asian and Pacific Islander MSM. Summit participants were the guest editors, authors, and reviewers for the special supplement. The special supplement included articles on epidemiology (Sy, et al., 1998), the August 1997 CBO survey (Chng, Sy, Choi, Bau, and Astudillo, 1998), and HIV prevention community planning (Bau, 1998). Another article critiqued common theories of health education and behavior change and proposed an "ecological" model of HIV prevention more appropriate for Asian and Pacific Islander communities (Choi, Yep, and Kumekawa, 1998). APIAHF's NRMO program partner Asian and Pacific Islander Wellness Center and APIAHF also convened two national meetings in January 1998 and September 1998 to deepen collaborations among researchers and CBOs and develop research strategies that would strengthen HIV prevention in Asian and Pacific Islander communities. These gatherings of Asian and Pacific Islander researchers and CBO staff have increased the Asian and Pacific Islander communities' understanding of the importance of behavioral and social science in HIV prevention.

APIAHF also has worked with the California Department of Health Services Office of AIDS and the CDC on improving the surveillance data collected and reported about Asians and Pacific Islanders and HIV/AIDS. For example, APIAHF and other Asian and Pacific Islander CBOs in California successfully advocated for the updating of California's epidemiogical information about California's communities of color ("Epidemiology of AIDS and HIV Among Racial/Ethnic Groups in California," California Department of Health Services, 1997). APIAHF currently is engaged in discussions with the CDC regarding a manuscript being prepared on Asians and Pacific Islanders and HIV/AIDS.

Finally, APIAHF's NRMO program maintains a National Asian and Pacific Islander HIV Resource Center; updates a bibliography on Asians and Pacific Islanders and HIV/AIDS; publishes a quarterly program newsletter, the *API HIV Forum,* that is disseminated to a mailing list of over 400 organizations and individuals; and maintains a closed, unmoderated electronic mailing list, *API-HIVinfo*, with over 120 subscribers.

Limitations in Methods

Although the use of multiple methodologies in this needs assessment allows for a multi-faceted assessment of the TA/T needs of Asian and Pacific Islander CBOs, there are several limitations to this assessment. First, the two CBO surveys were based on a convenience rather than random sample, selected from membership in APIAHF's

National Asian and Pacific Islander Consortium on AIDS and STDs (NAPICAS) and CBOs known through its NRMO program activities. Given APIAHF's working relationships with CBOs throughout the United States through its NRMO program, there is a high degree of confidence that all CBOs currently conducting HIV prevention programs targeting Asians and Pacific Islanders were included in this sample. The high response rate to the two surveys provides data on almost all of the CBOs known by APIAHF to be currently conducting HIV prevention interventions targeting Asians and Pacific Islanders. APIAHF focused its followup efforts among nonresponding CBOs on those CBOs known to have current HIV prevention programs. There were no significant gaps identifiable by geography or target populations. However, it is possible that other CBOs that conduct HIV prevention programs targeting Asians and Pacific Islanders are unknown to APIAHF and were not included in the sample. In addition, there was no comparison or analysis of responding CBOs with nonrespondents by geography, target population, or other factors. Thus, the results of the CBO surveys are neither exclusive nor inclusive of Asian and Pacific Islander CBOs engaged in HIV prevention.

Moreover, a significant percentage of the responding CBOs (23% of responding CBOs to the April 1998 CBO survey) did not identify Asians and Pacific Islanders as their *primary* target population for HIV prevention. Asians and Pacific Islanders may have been a secondary or lower priority target population at these CBOs. These CBOs were included in the sample because of that CBO's membership in NAPICAS or because of APIAHF's contacts with Asian and Pacific Islander staff members at that CBO. These CBOs also may not be reflected in the mapping of Asian and Pacific Islander CBOs conducted by the CDC, which used the primary target population to classify responding CBOs. [See CDC GIS map.] In addition, these responses were not segregated or analyzed in any comparative manner with the responding CBOs that did identify Asians and Pacific Islanders as their primary target population for HIV prevention.

The focus groups and key informant interviews also used convenience sampling methods. Participants in the Asian and Pacific Islander gay and bisexual men's focus groups were limited to the four geographic regions in which the focus groups were conducted (Northeast, Hawai'i, Northern California, and Southern California). Individuals from other geographic areas (e.g., Northwest, Midwest), where HIV prevention programs for Asian and Pacific Islander gay men exist, were not included in these focus groups. The analysis of the focus groups was compiled by APIAHF's NRMO program partner Asian and Pacific Islander Wellness Center staff who conducted the focus groups. Similarly, the six key informants were chosen by the Asian and Pacific Islander Wellness Center based on its working relationships with Asian and Pacific Islander gay and bisexual men's groups.

The Asian and Pacific Islander youth focus groups were conducted by the seven Asian and Pacific Islander youth-serving CBOs in six cities and recruitment was also done through convenience sampling rather than random sampling methods. Although the total number of youth participants (n=80) and the demographics of the participants provide a diverse sample, there was no attempt to quantify the commonality of any particular comments based on such demographics (age, gender, sexual orientation, ethnicity/national origin, immigration status, geography, etc.). In addition, the analysis for this needs assessment is based on the summaries of the focus groups provided by the staff of the Asian and Pacific Islander youth-serving CBOs who conducted the focus groups.

Background on Asians and Pacific Islanders

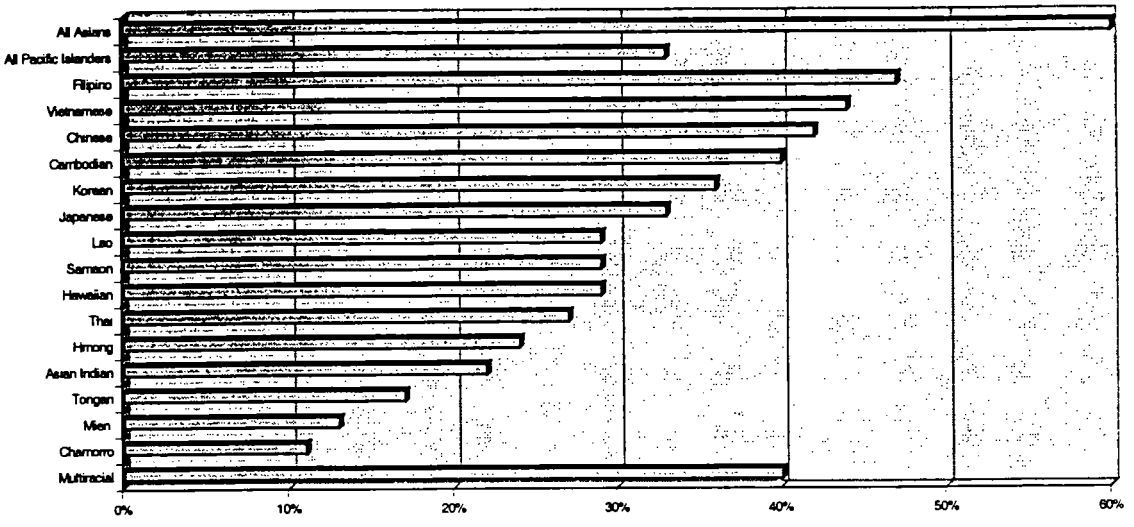
The Asian and Pacific Islander population is the fastest growing racial/ethnic population in the United States. From 1980 to 1990, the Asian and Pacific Islander population in the United States nearly doubled, from 3.7 million to 7.2 million, or from 1.6% to 2.9% of the total United States population. The 1990 United States Census reported a 95% growth in the Asian and Pacific Islander population since 1980, with increases of 102% for Chinese, 124% for Koreans, 818% for Cambodians, and 1,631% for Hmong. Recent projections are that the Asian and Pacific Islander population will increase to 12 million, or 4.4% of the United States population, by the Year 2020. According to 1990 Census categories, there are 29 Asian and 19 Pacific Islander ethnic/national groups included in the term "Asian and Pacific Islander." The Asian and Pacific Islander population is extremely heterogeneous, with dozens of distinct languages and cultures as well as histories. This diversity is particularly important for reaching immigrant Asians and Pacific Islanders who may not have been exposed to the HIV prevention messages now pervasive in the United States. The potential conflicting messages and norms faced by Asian and Pacific Islander immigrant youth are especially acute. Understanding, communicating about, and negotiating safer sex and drug use are difficult enough for youth; issues of acculturation and independence from family and community norms compound these issues for Asian and Pacific Islander immigrant youth.

At the same time, there are commonalities among Asians and Pacific Islanders that make it essential to target HIV prevention interventions that are specific and tailored to Asian and Pacific Islander communities. For example, strong cultural identification with family and community require HIV prevention interventions to consider group norms rather than focusing on individual knowledge and behaviors. Stigma and shame often mask issues within Asian and Pacific Islander communities. Asians and Pacific Islanders also often have beliefs about health and health-seeking or health-preserving behaviors that are more pragmatic, wholistic, or spiritual than Western health education and behavior change models.

HIV Prevention Issues for Specific Asian and Pacific Islander Ethnicities/ National Origin Populations

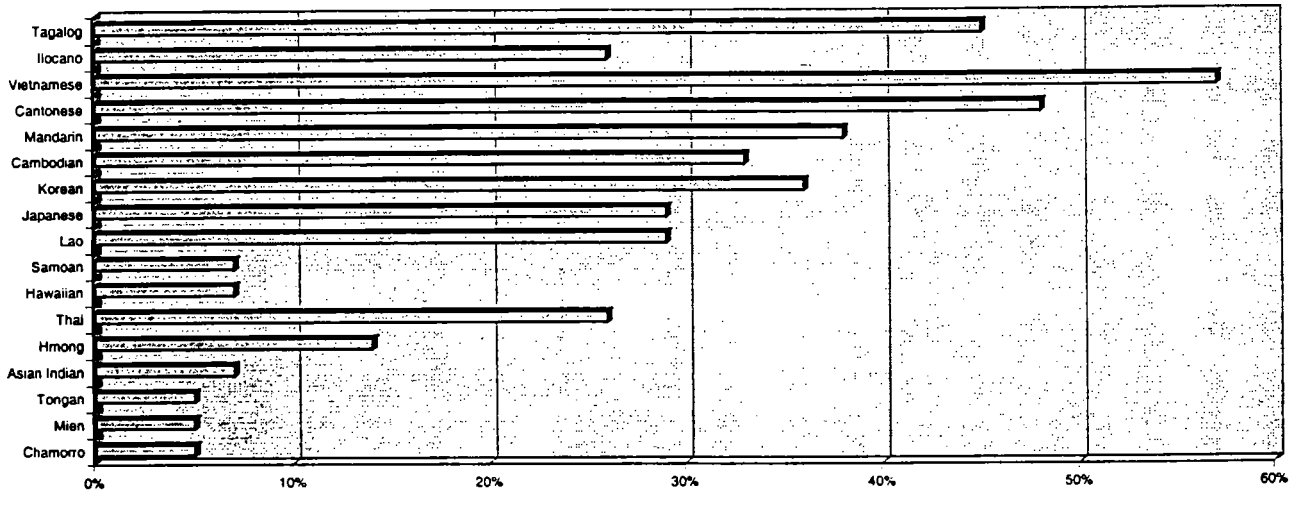
The CBOs responding to the August 1997 CBO survey reported targeting a diverse number of Asian and Pacific Islander ethnicities/national origin populations for HIV prevention. For example, while 60% of the responding CBOs reported targeting "all Asians" and 33% reported targeting "all Pacific Islanders," more CBOs reported targeting Filipino, Vietnamese, Chinese, Cambodian, Korean, and Japanese populations than other Asian and Pacific Islander populations. In an increasingly heterogeneous, multiracial society, it is also noteworthy that 40% of the responding CBOs included multiracial/biracial individuals within their target populations.

Responding CBOs Targeting Asian and Pacific Islander Ethnicities/National Origins (Source: August 1997 CBO Survey)



Similarly, the CBOs responding to the August 1997 survey reported using a diverse number of Asian and Pacific Islander languages in their HIV prevention programs, with Vietnamese the most common, followed by Cantonese (Chinese), Tagalog (Filipino), Mandarin (Chinese), Korean, Cambodian, Japanese, Lao, Ilocano (Filipino), and Thai. These responses are generally consistent with the primary languages of the Asian and Pacific Islander ethnicities/national origins populations primarily targeted by Asian and Pacific Islander CBOs.

Responding CBOs Using Asian and Pacific Islander Languages in HIV Prevention (Source: August 1997 CBO Survey)



There has been very little research conducted on the HIV prevention needs of specific Asian and Pacific Islander ethnicities/national origins. For example, several knowledge, attitudes, beliefs, and behaviors surveys conducted by the San Francisco Department of Public Health in 1990-1991 among Chinese, Filipino, Japanese, and Southeast Asian communities had significant methodological limitations that preclude their generalization.

A few other studies have focused on HIV prevention issues in the Vietnamese community in southern California (Carrier, Nguyen, and Su,1992; Gellert, Moore, Maxwell, Mai, and Higgins, 1994) and the Filipino community in northern California (Fairbank, Bergman, and Maullin, 1991).

Significant gaps in data exist in determining the impact of HIV/AIDS among Asian and Pacific Islander ethnicities/national origins. Only the Pacific jurisdictions, the states of Hawai'i and California and the cities of San Francisco, Los Angeles, and New York City regularly report HIV/AIDS surveillance data by API ethnicities/national origins (Sy, et al., 1998).

Filipinos

Based on the data available, Filipinos remain the most impacted by HIV/AIDS among Asian and Pacific Islander ethnicities/national origins (Proceedings of San Francisco International Summit on Filipinos and HIV/AIDS, 1998). For example, 32% of the reported AIDS cases among Asians and Pacific Islanders in California through May 1998 are Filipino (California Department of Health Services, 1998) and 54% of the reported AIDS cases among Asians and Pacific Islanders in San Diego county through June 1998 are Filipino (San Diego Department of Health Services, 1998).

The San Francisco International Summit on Filipinos and HIV/AIDS, co-sponsored by APIAHF and the San Francisco Mayor's Office, brought together 30 participants from the United States and the Philippines to examine HIV prevention and service programs for Filipinos. The participants reviewed the epidemiology of HIV/AIDS among Filipinos in key jurisdictions in the United States and the Philippines. The participants also described the types of HIV prevention programs and interventions that have been specifically developed for Filipinos. Finally, the participants identified the TA/T needs for HIV prevention programs targeting Filipinos. The summit participants concluded that Filipinos needed to participate more actively in their HIV prevention community planning groups; collect and disseminate all available HIV/AIDS surveillance data on Filipinos; share the experience and expertise of Filipinos involved in HIV prevention both in the United States and the Philippines through a more regular network; and utilize the potential linkages with Filipino families, churches, and businesses to support HIV prevention efforts. As a result of the summit, a Filipino AIDS Advocacy Network has formed. It held its first meeting after the National Asian and Pacific Islander Summit on HIV/AIDS in San Diego in September 1998. The network will remain an important method for collaboration, information, and resource sharing and support among HIV prevention programs for Filipinos. Such community-based efforts are vital for supporting and sustaining HIV prevention efforts in specific Asian and Pacific Islander communities.

Pacific Islanders

Six Pacific jurisdictions receive CDC funding for HIV prevention, including three United States flag territories (Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands) and three freely associated states (Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau). Although there are few CBOs (or nongovernmental organizations) involved in HIV prevention in these Pacific jurisdictions, it was important to include an assessment of the TA/T needs of these jurisdictions to provide a comprehensive assessment of the TA/T needs of Asians and Pacific Islanders regarding HIV prevention.

APIAHF conducted a workshop on Pacific Islanders and HIV prevention issues at the APIAHF "Voices from the Community" national conference in September 1997 in San Francisco, California. The participants in the workshop noted the significant differences between Asian and Pacific Islander cultures and among different Pacific Islanders. The participants emphasized working within the cultural norms of each Pacific jurisdiction, such as traditional tribal structures or contemporary religious institutions. As common in many cultures, there is a reluctance to discuss sex and sexuality directly in the Pacific. More indirect approaches to HIV prevention that emphasize health, family, and community can be more effective. There also was discussion about the challenges in recruiting and retaining Pacific Islanders living in the continental United States within HIV prevention programs. There was a good dialogue on the isolation and lack of social and other support for those who step forward to conduct HIV prevention in small communities such as Pacific Islander communities in the continental United States.

APIAHF also participated in affinity groups with Pacific Islanders at the HIV Prevention Community Planning Summit in May, 1998 in St. Louis, Missouri. As a result of initial discussions at the summit, APIAHF worked with the CDC, NRMO program partner Asian and Pacific Islander Wellness Center, and NRMO National Minority AIDS Council to plan and conduct a three-day TA/T workshop in Guam in August 1998. Over 35 participants from Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, and the Republic of Palau attended the TA/T workshop. Participants also included representatives from each of the state health departments in the Federated States of Micronesia (Ponhpei, Chuuk, Yap, and Kosrae states). The participants first reviewed the epidemiology of HIV/AIDS in the Pacific jurisdictions and the types of HIV prevention interventions currently being implemented. There was a consensus that HIV remained more a theoretical public health issue for many in the region because of the few cases of Pacific Islanders open about their HIV status. Although the numbers of reported HIV/AIDS cases are relatively low, there are several factors that emphasize the need for HIV prevention in the region: very young and sexually active populations, with some of the highest fertility rates in the world; significant migration within the region and between the region and Asia and the continental United States; rapidly expanding tourist industries, including commercial sex; and dramatic increases in foreign workers, especially from Asia. The participants also reviewed the behavioral and social science literature about effective HIV prevention interventions and applied those findings to key target populations in the Pacific: youth, MSM, women, IDUs, and commercial sex workers. The participants concluded that much of the research was not directly applicable to the unique cultural contexts of the Pacific but provided useful ideas for program development and evaluation. The participants also reviewed various methods of program evaluation and developed potential process and outcome objectives for some of their HIV prevention programs in the Pacific. The participants also received TA/T on HIV prevention community planning and on their continuation applications for CDC funding. At the conclusion of the TA/T workshop, the participants identified the need for continued TA/T on regional collaboration, HIV prevention program development, program evaluation, and HIV prevention community planning.

Comments from the participants in the TA/T workshop reflect the need for continued TA/T on HIV prevention specifically focused on the region:

> *Participants from the jurisdictions were able to share how programs are culturally appropriate and sensitive issues are addressed in HIV prevention.*

Culture is very much valued in my place. This will help me a lot in terms of how to do awareness and identification of risk populations.

It was a great opportunity for the Pacific Island jurisdictions to have engaged in a sharing of information and concerns on pressing issues. The networking was helpful.

Concern to address the region as a whole rather than separate is important.

Evaluation is extremely important and the session brought light to us, especially those who have difficulty evaluating programs.

Promoted awareness to address our issues as a region rather than separate islands will be important as funds do not increase over the next few years and as HIV infection increases among islanders.

Due to the historical and continuing relationships between each of the six Pacific jurisdictions and the United States, most residents speak English. Yet there are dozens of Pacific Islander languages spoken throughout the region that require Pacific Islander and Asian language access. Five of the six Pacific jurisdictions responded to our health department survey. These responses indicate that American Samoa, the Federated States of Micronesia, the Republic of Palau and the Republic of the Marshall Islands do provide HIV test counseling in Pacific Islander and Asian languages. American Samoa, Palau and the Marshall Islands have the capacity to answer calls to their centralized information and referral hotline in Pacific Islander and Asian languages. Guam, the Federated States of Micronesia, Palau and the Marshall Islands also disseminate HIV prevention materials in Pacific Islander and Asian languages. These responses also reinforce the importance of understanding and incorporating the unique linguistic needs of Asians and Pacific Islanders in any HIV prevention program.

Other Asian and Pacific Islander Ethnicities/National Origin Populations
APIAHF's national panels have reviewed HIV prevention materials in ten Asian and Pacific Islander languages and developed glossaries of common HIV prevention terminology in each of those ten languages. The panels have reviewed 39 Chinese, 18 Tagalog, 29 Vietnamese, 17 Korean, 21 Japanese, 19 Cambodian, 13 Thai, 4 Hmong, 13 Lao, and 7 Samoan materials. To date, APIAHF has reviewed 180.

There were several critical findings and recommendations made by all the review panels. First, there was a noticeable difference in the quality of materials written in the Asian and Pacific Islander languages and materials developed in English and then translated into one of the Asian and Pacific Islander languages. There was a strong and consistent recommendation to use focus groups convened from the target population to develop an original text for any future materials. Second, the review panels found an alarming number of errors in translation, as well as typographical and proofreading errors. These errors highlight the need for careful translation and proofreading. Many of the brochures were outdated, using old terms (e.g., ARC) or failed to mention new treatment options for individuals living with HIV. All the panelists also noted the need for consistent terms to be used in HIV prevention materials. The Asian and Pacific Islander language glossaries of common terms used in HIV prevention developed by each of the review panels should assist in establishing more consistency across new materials and

programs. Third, there were very few or no HIV prevention education materials targeting women, youth, IDUs, or transgender persons. Most of the brochures targeted the general Asian and Pacific Islander communities and may be ineffective in reaching these specific target populations. Fourth, the actual prevention education message differed widely among the materials, from messages of strict abstinence from all sexual activity to more "sex-positive" messages. Very few materials included instructions on proper condom use as a means of protection against HIV infection. Fifth, it was recommended that more materials be formatted for Asian and Pacific Islander cultures (e.g. Samoan, Hmong) that rely more on verbal rather than written communication (e.g. videos or graphically-oriented brochures). Finally, the review panels found few graphics and illustrations in the materials that were culturally appropriate and relevant to targeted Asian and Pacific Islander populations.

The national panels also provided guidance on the priority needs for HIV prevention in their respective Asian and Pacific Islander communities. For example, the Thai panelists identified a need to develop additional Thai materials for the following populations: men, mothers and children, youth, workers, and transgender persons. Initial concepts were developed for a youth brochure/video covering various issues of sex and social pressures; a brochure for men (inclusive of gay and bisexual men) encouraging condom use, testing, and increasing basic knowledge; and a brochure for women covering basic ob/gyn knowledge, reproductive health, as well as information about testing, perinatal transmission, and access to social support. The Hmong panelists identified a need to develop Hmong materials for adult males and for youth. Initial concepts were developed for adult males and youth, covering issues of drug and alcohol use, high risk sexual behavior, tattooing and acupuncture, as well as basic HIV information. Possible formats include audio cassette tapes, videos, brochures, and posters. The Lao panelists identified a need to develop Lao materials about testing, condom use, and HIV awareness/ sensitivity/compassion for the general community, the MSM population, and youth. Initial concepts were developed for a youth brochure discussing sexual decision-making, a brochure or poster targeting closeted gays and lesbians that offer support, and a video or brochure for parents to help them discuss HIV/AIDS with their children. The Samoan panelists identified a need for materials targeting youth, gay/bisexual men, women, those with lower literacy levels, and those who tattoo.

Similar suggestions for specific Asian and Pacific Islander language materials were made by the CBOs responding to the April 1988 survey. For example, the CBOs noted the need for specific materials targeting Asian and Pacific Islander MSM, youth, women, and heterosexual men. Other materials needed included specific materials for refugees, especially Southeast Asian refugees, and materials on HIV testing, drug use, and HIV treatment.

Health Department Programs and Services for Asians and Pacific Islanders

The responses by state and local health departments to the APIAHF survey provide important information about HIV prevention programs for Asians and Pacific Islanders. This information is especially important in areas where there are a large number of Asian and Pacific Islander residents but no CBOs specifically targeting Asians and Pacific Islanders for HIV prevention.

It is encouraging that many of the responding health departments do provide HIV test counseling in at least some Asian and Pacific Islander languages: Hawai'i, Washington, Illinois, New York, New Jersey, Massachusetts, Virginia, Seattle/King County, San

Francisco County, Los Angeles County, Orange County, San Diego County, and New York City. Some health departments reported bilingual staff capacity while others reported reliance on interpreters. However, the states of Minnesota, Texas, and Florida and the cities of Houston and Chicago do *not* provide HIV test counseling in any Asian or Pacific Islander languages. These gaps are vital to Asian and Pacific Islander access to HIV testing. The lack of language access is particularly critical in these geographic areas with high numbers of Asian and Pacific Islander residents. Many of these same health departments recognize the need for Asian and Pacific Islander language materials and public information campaigns.

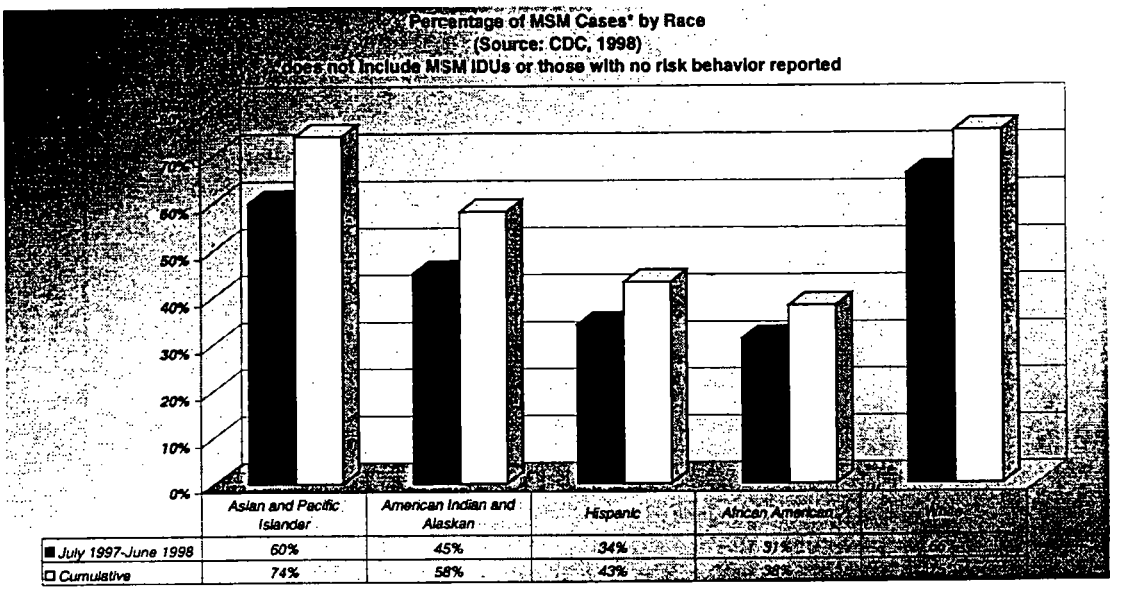
Only some of the responding health departments have the capacity to answer calls to their centralized information and referral services in Asian and Pacific Islander languages. Only Hawai'i, New Jersey, Seattle/King County, San Francisco County, Los Angeles County, San Diego County, and the city of Houston report such language capacity, although some do so through the AT&T Language Line Interpreter Services. (Although the state of California did not respond to the health department survey, there is a statewide AIDS information and referral hotline for Tagalog-speakers in California operated by the San Francisco AIDS Foundation.) The states of Washington, Colorado, Minnesota, Illinois, Texas, Florida, Virginia, Massachusetts, and New York and the cities of New York and Chicago do *not* have the capacity to answer calls on their centralized information and referral hotlines in any Asian or Pacific Islander languages. Moreover, only the Pacific jurisdictions, states of Minnesota and Colorado, the city of Los Angeles, and San Francisco and San Diego counties have conducted any HIV prevention public information campaigns in Asian or Pacific Islander languages.

More of the responding health departments, including the states of Hawai'i, Washington, Colorado, Minnesota, New York, Massachusetts, and Virginia and San Francisco County, Los Angeles County, and San Diego County disseminate Asian and Pacific Islander language HIV prevention materials. The states of Illinois, Texas, Florida, and New Jersey, the city of Chicago and Seattle-King County do *not*. The city of Houston responded that it is developing materials in Vietnamese and Chinese. The health department survey asked the respondents to include copies of the Asian and Pacific Islander language HIV prevention materials actually being disseminated. A review of the materials being disseminated demonstrate that the same materials are often used by many health departments and some of these materials were identified as out-of-date or inappropriate by APIAHF's national review panels. The responses by the health departments did not identify any new materials; all the materials had been reviewed by APIAHF's national review panels. At least one health department acknowledged that the Asian and Pacific Islander materials being disseminated were potentially outdated and specifically referenced APIAHF's national reviews as providing guidance for the development of new materials. The responses to the health department surveys reinforces the findings and recommendations of the APIAHF national review panels about the urgent need for the development of appropriate and targeted Asian and Pacific Islander language HIV prevention materials. This is an area of potential collaboration between the health departments, Asian and Pacific Islander CBOs, and the NRMO program.

Asians and Pacific Islanders at Risk for HIV

Asian and Pacific Islander Gay and Bisexual Men

Asian and Pacific Islander gay and bisexual men and other MSM continue to be disproportionately impacted by HIV/AIDS (Sy, et al., 1998). The CDC reports that 74% of cumulative reported AIDS cases among Asian and Pacific Islander male adults through June 1998 are reported among MSM (CDC, 1998). This is the highest percentage of MSM cases among the four communities of color.



The CDC has reported that the rate of increase in reported AIDS cases among Asian and Pacific Islander MSM between 1989 and 1994 was 55%, compared to 14% among white MSM (MMWR 44 (21):401-404, 1995). Similarly, the California HIV prevention community plan reported that the percentage increase of newly diagnosed AIDS cases among MSM and MSM IDUs between 1990 and 1993 was actually greatest (21.9%) among Asians and Pacific Islanders, compared to all racial/ethnic groups in California (California HIV Prevention Plan,1995). There have been only a few studies of the HIV seroprevalence rates, HIV risk behaviors, and attitudes toward HIV and AIDS among Asian and Pacific Islander MSM. Most of the studies were conducted in California (four in the San Francisco Bay Area, one in Los Angeles, and one in Orange County); the two other studies were conducted in the greater Boston area and Chicago. These studies have reported HIV seroprevalence rates between 1.4% and 27.8% (Nemoto, Wong, Ching, et al., 1998; Chng, 1998). Only a few studies have focused on specific Asian and Pacific Islander ethnicities/national origins and none are national in scope.

Like other gay men of color, Asian and Pacific Islander gay and bisexual men and other MSM must integrate their sexual identity within the cultural contexts of both racism and homophobia (Choi, Yep and Kumekawa, 1998; Choi, Salazar, Lew, and Coates, 1995). The participants in focus groups conducted among program staff for Asian and Pacific Islander gay and bisexual men's HIV prevention programs repeatedly emphasized the need to support healthy sexual identities in a manner that involves both a Western, psychosocial individualized "coming out" process and integrates one's family and community in a culturally appropriate manner. Asian gay leaders in Vancouver have named this dual process "facing out," incorporating the Asian concept of "saving face" - avoiding shame - and involving one's family and community rather than just individuals (Asian Society for the Intervention of AIDS, 1997).

There has only been one completed research project documenting the effectiveness of an HIV prevention intervention for Asian and Pacific Islander gay men (Choi, et al., 1996). The intervention involved a series of group workshops and resulted in reduction in HIV risk behaviors. This research and the national diffusion of the intervention was the case study used at the March 1997 National Summit for Technology Transfer of HIV Prevention Interventions for Asian and Pacific Islander Men Who Have Sex With Men (Bau, Lew, and Bao, 1998). The same researcher is currently engaged in a CDC-funded project examining HIV prevention interventions for Asian and Pacific Islander young gay men in Seattle, Washington, and San Diego, California. The project is in the formative research phase (Choi, Yep, and Kumekawa, 1998).

The focus group participants noted that many Asian and Pacific Islander immigrants who are not gay-identified MSM often do not access HIV prevention programs yet engage in anonymous sex or other sexual activities that do not facilitate assessment or communication of HIV risks. On the other hand, the participants in the focus groups reported high levels of general knowledge about HIV among Asian and Pacific Islander gay-identified men, accompanied by high levels of denial of personal risk. One focus group participant commented:

> *We did a very informal assessment of a local gay Asian and Pacific Islander group. One of the things we found out, much to my surprise, was that some of the apathy, or why Asian and Pacific Islander MSM don't practice safer sex, is that most Asians and Pacific Islanders don't know other Asians and Pacific Islanders who are positive. They just don't see it in their world.*

Another focus group participant also noted:

> *The media plays a big factor. All the state HIV/AIDS campaigns, there are no Asian and Pacific Islanders on the posters. There is this whole culture that excludes Asians and Pacific Islanders from HIV and AIDS campaigns and posters. These youth obviously think that HIV is not going to affect them and all the things these youth watch, like MTV, there is nothing about Asians and Pacific Islanders. Every population but Asians and Pacific Islanders.*

As noted in both the gay and bisexual men's and youth focus groups, some of these issues are less important for some Asian and Pacific Islander gay and bisexual youth as a generation of queer youth of all races establish a more open and fluid sense of both sexual and cultural identities. However, immigrant gay youth are particularly vulnerable to the tensions between cultures and emotions in developing and sustaining a healthy self-identity.

The focus groups conducted among program staff for Asian and Pacific Islander gay and bisexual HIV prevention programs also identified several critical TA/T needs. These needs included TA/T on reaching substance users, immigrant and monolingual populations, and non-gay-identified MSM. The participants also identified training on core issues of race, class, gender and sexual identity; community organizing; volunteer recruitment and retention; leadership development; and gaining support from the general Asian and Pacific Islander communities as TA/T needs.

On the other hand, the key informant interviews with leaders of Asian and Pacific Islander gay groups found that most Asian and Pacific Islander gay groups were either

not prepared or not interested in developing more formal HIV prevention programs as part of their gay groups or starting new AIDS service organizations. Most of these Asian and Pacific Islander gay groups recognize their responsibility to promote HIV prevention among their members and still incorporate HIV prevention into their meetings and activities; they simply do not view a formal HIV prevention program as their primary mission or organizational goal. Such organizations usually have strong personal and organizational relationships with the local Asian and Pacific Islander HIV prevention programs, often hosting HIV prevention programs, conducting fundraising activities, or providing volunteers. Many individual members of such Asian and Pacific Islander gay groups are either currently working as paid staff at existing AIDS service organizations or are actively involved as volunteers in local HIV prevention programs. Some serve as members of the boards of directors of the local Asian and Pacific Islander AIDS service organization. However, the organizational goals of these Asian and Pacific Islander gay groups are more focused on social, cultural, and political goals. If reaching Asian and Pacific Islander gay and bisexual men continues to be vital to the success of HIV prevention in the Asian and Pacific Islander communities, then continuing to support such community building is equally vital. These Asian and Pacific Islander gay groups can address the issues of identity, coming out, and social support that are critical to successful HIV prevention interventions for Asian and Pacific Islander gay and bisexual men. (Choi, Yep, and Kumekawa, 1998; Choi, Salazar, Lew, and Coates, 1995). They need TA/T on organizational development, planning, and leadership development. The key informants also emphasized that in-person provision of TA/T was very important and preferred rather than receiving manuals or TA/T by phone or e-mail. However defined, the role of these Asian and Pacific Islander gay groups will continue to be important in HIV prevention efforts among Asian and Pacific Islander gay men.

Finally, one of the recurring themes from the focus groups and key informant interviews among Asian and Pacific Islander gay men is the need for ongoing personal and professional support and leadership development. It is not surprising that many of these program staff are struggling with personal and professional issues of community leadership. They sometimes find themselves not only as paid HIV prevention staff and organizational leaders but also as individuals who are expected to assume greater and greater community and organizational responsibilities for management, fundraising, and planning, often without any formal training or background. They find themselves motivated by community-based activism, or "passion," but increasingly competing in an already well-established and entrenched "AIDS industry" which demands increasing professionalism, training, experience, and skills. Turnover, burnout, and interpersonal conflicts often result in cycles of reinventing and starting over. If Asian and Pacific Islander gay men are to continue as leaders and peer implementers of effective HIV prevention programs, these TA/T needs must be addressed.

Asian and Pacific Islander Youth

There has been some research about the HIV prevention needs of Asian and Pacific Islander youth. Several studies report that some Asian American youth, especially immigrant and refugee youth, had less knowledge about HIV than their peers (Horan and DiClemente, 1993; Strunin, 1991; Siegel and Lazarus, 1991; and DiClemente, Zorn, and Temoshok, 1987). However, other studies found that once heterosexual Chinese-American students became sexually active, their HIV risks were similar to their white peers (Hou and Basen-Engquist, 1997; Cochran, Mays, and Leung, 1991). Another study noted that Asian-American college students were more likely to use informal sources, such as friends and the media, for information about HIV/AIDS rather than

attend formal lectures or workshops (Goh, 1993). That study also noted that the levels of knowledge about HIV/AIDS among Asian students born in the United States was comparable to that found in other racial/ethnic groups while the knowledge of Asian students not born in the United States was less than their peers. Given the diversity among Asian and Pacific Islander youth by age, immigration status/acculturation, primary language, and culture, such limited studies cannot be generalized easily to all Asian and Pacific Islander youth.

The focus groups conducted by Asian and Pacific Islander youth-serving agencies among Asian and Pacific Islander youth for this needs assessment consistently found that HIV prevention was not the primary issue, or even the primary health issue, among Asian and Pacific Islander youth. Issues of acculturation, peer pressure, family relationships, education, and career were reported to be more important. While parents are often identified as the most important persons in the lives of Asian and Pacific Islander youth, parents are rarely the source of information about HIV. Asian and Pacific Islander youth are more likely to obtain information about HIV from school or friends. Many participants in the focus groups stated that they would not feel comfortable talking to their parents about sex or about HIV. One focus group participant said:

> *I get the impression that Asian families never talk about AIDS. Maybe they say only, "be careful." Speaking to your mother and father is hard. I wouldn't talk with an older brother or sister because they probably would think the way my parents do.*

This apparent contradiction and tension between Asian and Pacific Islander youth and their parents makes HIV prevention programs specifically targeted for Asian and Pacific Islander youth vital. At the same time, it is important to consider a role for Asian and Pacific Islander parents in HIV prevention given the importance of their roles in the lives of their children. If the community norms that now make it difficult for Asian and Pacific Islander youth to talk with their parents about sex and HIV can be addressed, HIV prevention can be facilitated throughout the Asian and Pacific Islander communities.

The Asian and Pacific Islander youth in the focus groups also reported that sex education in schools was often ineffective. Although they may be receiving information about HIV, the information is not presented in a relevant or applicable manner. For example, the youth suggested that written and other materials need to include images of Asians and Pacific Islanders and need to be inclusive of queer youth and youth still questioning their sexual orientation. The focus group of Asian and Pacific Islander young gay men emphasized the need for integrating sexual and cultural identities. The Asian and Pacific Islander youth in the focus groups suggested that Asian and Pacific Islander speakers or speakers directly affected by HIV, i.e., someone living with HIV or AIDS, would be the most effective sources of information about HIV prevention. The youth also suggested HIV prevention activities that were more wholistic, including the opportunity to explore and work on complex issues of self-esteem, communication, and family relationships.

Additional research is needed about the HIV prevention needs of Asian and Pacific Islander youth. The focus groups conducted for this needs assessment revealed a number of strong recommendations for both research and program development. Not surprisingly, the youth themselves had clear ideas and recommendations for the design of HIV prevention programs that they would consider effective. For many of the Asian

and Pacific Islander youth-serving CBOs who conducted the focus groups, these were some of the first community-based assessments of the HIV prevention needs of Asian and Pacific Islander youth they had participated in. These and other Asian and Pacific Islander CBOs will need ongoing TA/T to continue to work with Asian and Pacific Islander youth to develop, implement, and evaluate effective HIV prevention interventions for Asian and Pacific Islander youth.

Asian and Pacific Islander Women

Among the 61 Asian and Pacific Islander female adult AIDS cases reported to the CDC from July 1997 to June 1998, 33% did not have an exposure or risk category reported. The 18% of cumulative Asian and Pacific Islander female adult AIDS cases with no exposure or risk category reported remains the highest among all female adult racial/ethnic groups. Similarly, the number of Asian and Pacific Islander women who reported receipt of blood transfusions or blood components as their risk factor is the highest among all female adult racial/ethnic groups (17% cumulative). Of the reported exposure categories for Asian and Pacific Islander female adult AIDS cases from July 1997 to June 1998, 46% were women who have sex with men (47% cumulative) and 13% were IDUs (17% cumulative).

There only has been one published article on HIV prevention interventions for Asian or Pacific Islander women (Flaskerud and Nyamathi, 1988). That study found that the effectiveness of group counseling sessions for Vietnamese women depended in large measure on the cultural and linguistic appropriateness of the presentations. This absence of data about AIDS among Asian and Pacific Islander women makes understanding HIV risk and the development of effective HIV prevention programs for Asian and Pacific Islander women particularly challenging.

Asian and Pacific Islander Drug Users

While there has been some research conducted on drug use among Asians and Pacific Islanders, there has been little examination of the impact of drug use on HIV risk among Asians and Pacific Islanders (Gock and Ja, 1995). Recent studies in San Francisco among Chinese, Filipino and Vietnamese drug users have revealed differences in the primary drugs used and HIV risk behaviors among these Asian ethnic populations. For example, the Filipinos in the sample were more likely to inject drugs and to have sex partners who were IDUs. Filipinos in the study also were more likely to report having sex while on drugs (Nemoto, Aoki, Huang, et al., 1998). It will be important to continue to obtain information about drug use and HIV risk among Asians and Pacific Islanders. For example, several participants in the gay men's focus groups identified the need for better understanding of the relationship between drug use, especially crystal meth use, and HIV risk among Asian and Pacific Islander gay men.

Asian and Pacific Islander Transgender Persons

Thirteen percent of the 392 male-to-female and 7% of the 123 female-to-male transgender participants were Asian and Pacific Islander. Twenty-seven percent of the Asian and Pacific Islander male-to-female transgender participants were HIV+ (San Francisco Department of Public Health, 1999). Although data by racial/ethnic groups is not yet available, 35% of the total male-to-female participants were HIV+ and 2% of the female-to-male participants were HIV+ (San Francisco Department of Public Health, 1998). San Francisco is the only jurisdiction that explicitly includes transgender persons within its HIV prevention priorities. Like other Asian and Pacific Islander populations at

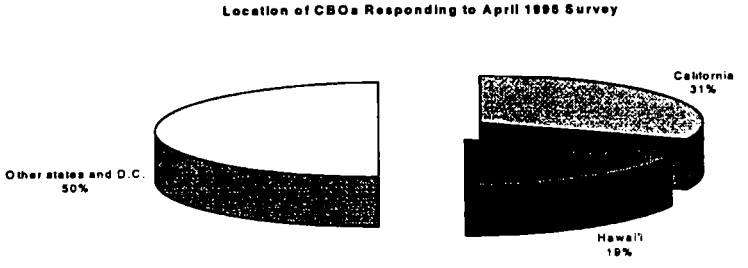
risk for HIV infection, more research and program development is needed for Asian and Pacific Islander transgender persons.

Asian and Pacific Islander Commercial Sex Workers
While there has been little research conducted on the HIV prevention needs of Asian and Pacific Islander commercial sex workers, there has been some research about HIV prevention among female and male commercial sex workers generally (Siegal, et al., 1992; McKeganey, 1994; and DeGraaf, et al., 1995). There also has been some research on the HIV prevention needs of commercial sex workers in Thailand (Morris, et al., 1995; Limanonda, et al., 1994), Singapore (Wong, et al., 1994), and Indonesia (Wirawan, et al., 1993). The HIV infection rate among female commercial sex workers in Thailand has been reported from 22% to 45% (McKeganey, 1994). Some Asian and Pacific Islander women are engaged in commercial sex at massage parlors in the United States. However, there has been little research documenting the HIV prevention needs of these women. Like many other Asian and Pacific Islander populations at risk for HIV infection, more research and program development is needed for Asian and Pacific Islander commercial sex workers.

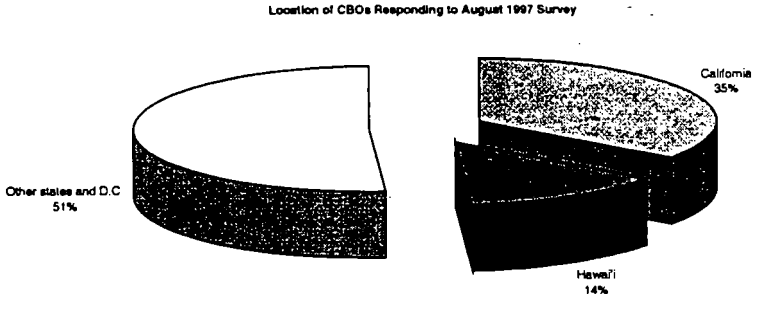
HIV Prevention Programs Among Asian and Pacific Islander CBOs
HIV prevention programs in the Asian and Pacific Islander communities have been diverse. A handful of Asian and Pacific Islander AIDS-specific organizations are well-established, especially in geographic areas with either higher incidence of HIV/AIDS or large Asian and Pacific Islander populations. Asian and Pacific Islander AIDS service organizations (ASOs) can be found today in San Francisco, California (Asian and Pacific Islander Wellness Center and Filipino Task Force on AIDS); Los Angeles, California (Asian Pacific AIDS Intervention Team); San Diego, California (Asian and Pacific Islander Community AIDS Project); New York, New York (Asian and Pacific Islander Coalition on HIV/AIDS); Boston, Massachusetts (Massachusetts Asian AIDS Prevention Project); Philadelphia, Pennsylvania (AIDS Services in Asian Communities); Chicago, Illinois (Asian American AIDS Services); Seattle, Washington (Asian Pacific AIDS Council) and Washington, DC (Asian and Pacific Islander Partnership for Health). Each of these organizations provide both HIV prevention programs and services for Asians and Pacific Islanders living with HIV and AIDS. The oldest of these organizations are the former Asian AIDS Project (which became part of the Asian and Pacific Islander Wellness Center through a merger with the Living Well Project (formerly the Gay Asian Pacific Alliance Community HIV Project) in 1997) in San Francisco and the Asian Pacific AIDS Intervention Team in Los Angeles, both of which began in 1987. The Filipino Task Force on AIDS remains the only Asian and Pacific Islander ethnic-specific AIDS organization; it was established in 1988. (APIAHF, Asian and Pacific Islander HIV/AIDS Timeline, September 1998).

In addition, numerous Asian and Pacific Islander health and social service agencies with long traditions of serving the Asian and Pacific Islander communities have maintained HIV prevention programs for many years, some as long as a decade. Many of these Asian and Pacific Islander CBOs serve a specific Asian and Pacific Islander ethnic/national origin community. Others are the only Asian and Pacific Islander CBO in their geographic area and serve all Asians and Pacific Islanders in their area. Despite years of HIV prevention work conducted by many of these Asian and Pacific Islander CBOs, HIV/AIDS program staff often have to continue to educate other staff, management, and boards of directors about the importance of HIV/AIDS issues at that

particular CBO. These HIV prevention programs are often only a small and underfunded program within a very large CBO and not a high priority for the CBO as a whole.

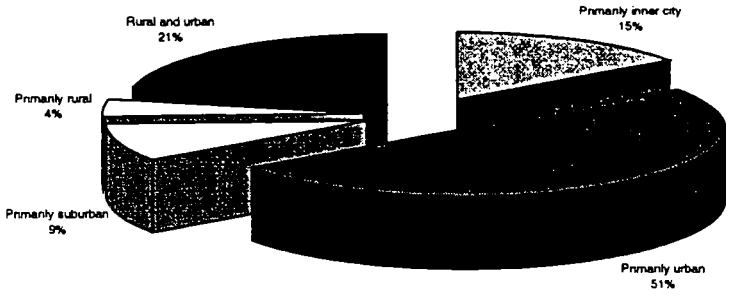


Thirty-five percent of the CBOs responding to the August 1997 survey were from California and 14% from Hawai'i. Other respondents were from Washington; Colorado; Minnesota; Illinois; Michigan; Missouri; Texas; Georgia; New York; Massachusetts; Pennsylvania; Virginia; and Washington, DC. Similarly, 31% of the respondents to the April 1998 survey were from California and 19% from Hawai'i. Other respondents were from Washington; Oregon; Colorado; Minnesota; Illinois; Michigan; Missouri; Texas; Georgia; New York; Massachusetts; Pennsylvania; Virginia; Washington, DC; and Guam. Thus, while TA/T activities for Asian and Pacific Islander CBOs are likely to be focused on California and Hawai'i, it is important for there to be national, regional, and local TA/T available to the Asian and Pacific Islander CBOs located in these other states.



Forty-nine percent of the CBOs responding to the April 1998 survey reported an urban area as their primary geographic service area, with another 15% reporting the inner city. Thus, a substantial majority of HIV prevention programs targeting Asians and Pacific Islanders are located in urban areas. Another 21% of the responding CBOs reported a mix of rural and urban areas as their service area. Only 8% reported a suburban service area and only 4% reported a rural service area. Thus, although the substantial majority of HIV prevention programs targeting Asians and Pacific Islanders are focused in urban areas, the distinct needs of programs and CBOs in rural areas should not be overlooked.

Geographic Service Area of Responding CBOs
(Source: April 1998 CBO Survey)



Seventy-seven percent of the respondents to the April 1998 survey primarily targeted Asians and Pacific Islanders for HIV prevention. Other responding CBOs had an Asian or Pacific Islander staff person that generally assumes responsibility for HIV prevention programs for the Asian and Pacific Islander populations in that area, even if not primarily or even formally targeted by that CBO's HIV prevention programs. These individuals often have to continue to educate their own institutions about the HIV prevention needs of Asians and Pacific Islanders at the same time they seek and build collaboration with Asian and Pacific Islander communities who might not be interested in HIV/AIDS issues. Continuing to support these Asian and Pacific Islander staff, working with their CBOs on issues of targeting, and increasing the cultural competency of these CBOs present distinct areas of needs for ongoing TA/T.

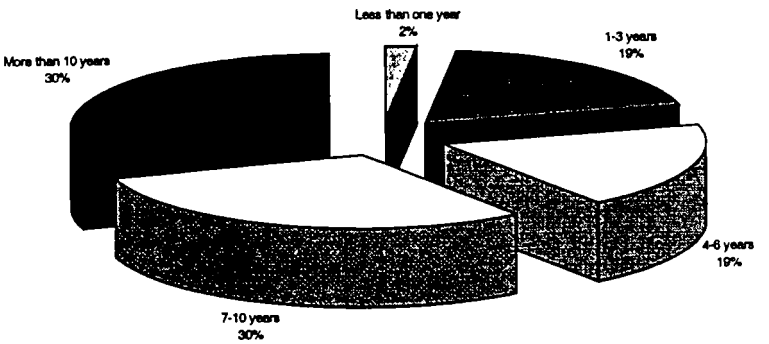
The CBOs in Hawai'i present a unique situation, in the only state where Asians and Pacific Islanders are the majority of the state population. There are at least ten CBOs in Hawai'i that provide HIV prevention programs. In addition, there also are at least two programs focused specifically on Native Hawaiians. For CBOs in Hawai'i, the issue is not whether the target population is Asian and Pacific Islander, but rather whether an individual identifies as "local." For example, the participants in the Asian and Pacific Islander gay and bisexual men's program focus groups reported that the majority of individuals reached at gay bars, at public sex environments, and in prison in Honolulu are Asian and Pacific Islander. However, there are different cultural issues raised depending on whether the individual identifies primarily as gay or more as a "local." For example, outreach to Asian and Pacific Islander men who are gay-identified has been difficult. Hawai'i also has many islands which are isolated and where confidentiality is difficult to maintain. Thus, the CBOs in Hawai'i also will continue to present distinct TA/T needs.

According to the April 1998 survey, a majority of the responding CBOs providing HIV prevention programs to Asians and Pacific Islanders today have been doing so for a relatively long time; 30% for 7-10 years and another 30% for more than 10 years. Only 2% (n=1) reported HIV prevention programs less than one year old. According to the August 1997 survey, the mean year for the beginning of the responding CBOs was 1990 (seven years old). This length of time that Asian and Pacific Islander CBOs have been

involved in HIV prevention is a community-wide asset, reflecting many years of institutional and individual staff experience and expertise in HIV prevention. This base of human resources should be utilized in any national TA/T efforts.

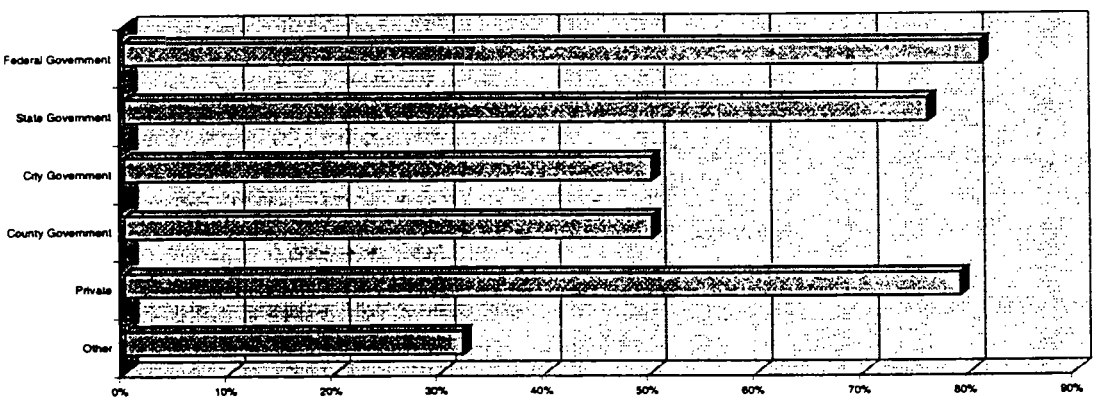
In the August 1997 survey, 52% of the responding CBOs had annual HIV prevention budgets less than $100,000. The others had annual HIV prevention budgets greater

Years Responding CBOs Have Povided HIV Pevention
(Source: April 1998 CBO Survey)



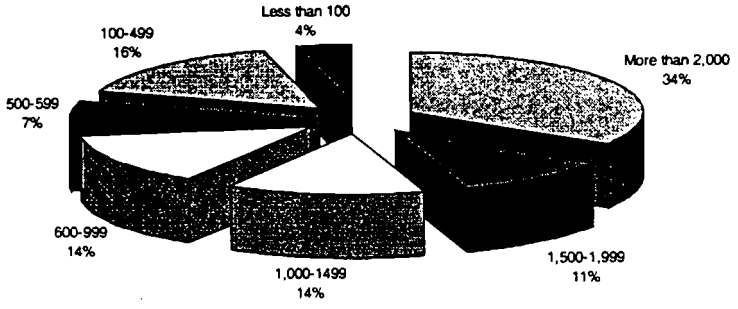
than $100,000. The relatively large number of responding CBOs with higher budgets may be due to the inclusion of larger CBOs whose primary target populations are not Asians and Pacific Islanders in the sample. Eighty-one percent of the responding CBOs reported receiving federal funding for HIV prevention, 76% reported receiving state funding, 50% reported receiving county funding, 50% reported receiving city funding, and 79% reported receiving private funding. While it is not surprising that the most common sources of funding for HIV prevention programs for Asians and Pacific Islanders are governmental, it is encouraging that such a substantial number of responding CBOs also reported private, nongovernmental funding. However, the survey did not ask questions about the mix of funding sources for HIV prevention among the responding CBOs. Such issues may be an important focus for TA/T on fundraising issues for Asian and Pacific Islander CBOs.

Sources of Funding for HIV Prevention Among Responding CBOs
(Source: April 1997 CBO Survey)



Significantly, in the April 1998 survey, 34% of the respondents (n=15) served more than 2,000 individuals in their HIV prevention programs in 1996 and another 13% (n=11) reported serving between 1,000 and 2,000.

Number of People Served by responding CBOs' HIV Prevention Programs
(Source: April 1998 CBO Survey)



According to the August 1997 survey, 34% of the responding CBOs had more than 121 hours a week (more than 3.5 FTE) of paid staff time dedicated to HIV prevention, another 34% had 41-120 hours a week (1 to 3.5 FTE), and 32% had less than 40 hours a week (less than 1 FTE). Twenty-six percent of the responding CBOs reported no active volunteers, 63% reported using 1-10 active volunteers in a typical week, and 13% reported using more than 10 active volunteers in a typical week. Given the competition for funds for HIV prevention and the limited paid staff sustainable by such funds, more TA/T on developing and maintaining volunteer programs may be valuable for Asian and Pacific Islander CBOs.

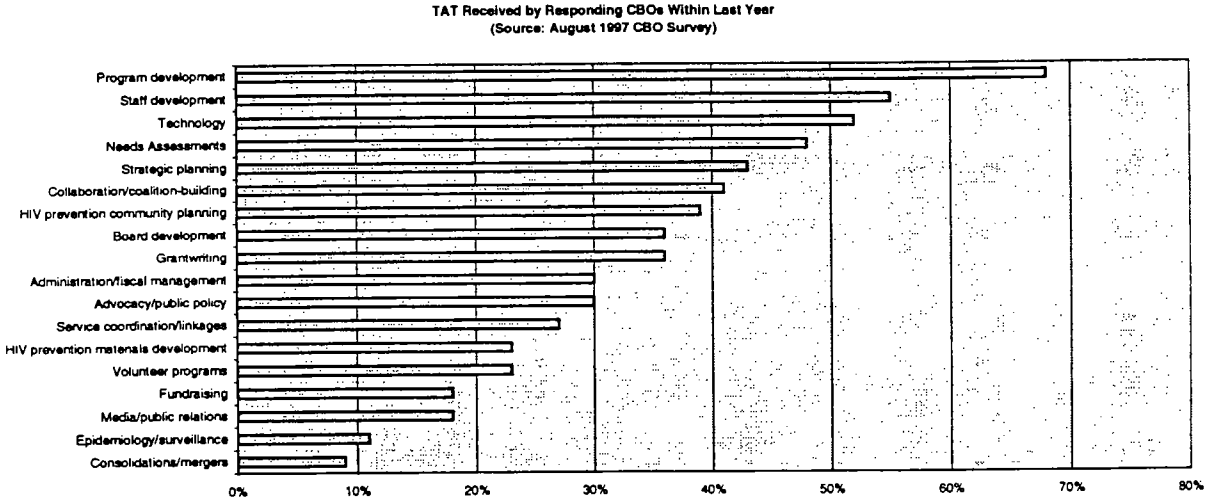
In terms of board of directors, 81% of the CBOs responding to the April 1998 survey had Asian board members and 23% had Pacific Islander board members. Moreover, 79% of the responding CBOs had more than one Asian board member and 15% had more than one Pacific Islander board member. This degree of representation of targeted populations on boards of directors is important for community accountability and credibility. The relatively high degree of representation of members of the target community on boards of directors reflects one of the strengths of Asian and Pacific Islander CBOs. However, the CBO surveys did not ask questions about board representation among risk behavior groups, i.e., gay and bisexual men, youth, etc. Such representation will be important for sustaining institutional support for HIV prevention programs at these Asian and Pacific Islander CBOs.

Technical Assistance and Training Needs of Asian and Pacific Islander CBOs
In terms of TA/T needs, most responding CBOs prioritized organizational development needs, from fundraising to strategic and long-term planning. Thirty-eight percent of the responding CBOs to the April 1988 survey ranked TA/T on organizational development as a high priority (n=18; mean=1.78, high priority=1, low priority=3). Sixty percent of the responding CBOs needed TA/T on understanding information on organizational development and 64% needed TA/T on using such information. The preferred providers of TA/T on organizational development were CBOs (36%) and NRMOs (24%).

In the August 1997 survey, the most important TA/T needs identified by the responding CBOs were fundraising, strategic planning, HIV prevention needs assessment, and HIV

prevention program evaluation. These TA/T priorities are consistent with the relative stability of Asian and Pacific Islander CBOs and the need to sustain and improve their existing HIV prevention programs rather than starting up new programs.

In contrast, when asked about the TA/T they actually received in the past year, 68% received TA/T on HIV prevention program development, 54% on HIV prevention program evaluation, 52% on staff development, 48% on technology, 43% on HIV prevention needs assessments, 43% on strategic planning, and 41% on collaboration and coalition building, while only 36% received TA/T on grantwriting and only 18% on fundraising. Only 11% reported receiving TA/T on epidemiology and surveillance. There does seem to be some lack of congruence between the TA/T prioritized by the responding CBOs and the TA/T they reported actually receiving. In improving the provision of TA/T to CBOs, it will be important to ensure that the types of TA/T prioritized by the CBOs are available and accessible.



Fifty-two percent of the responding CBOs reported receiving TA/T from local training centers, 46% from other local AIDS service organizations, 43% from state health departments, 37% from APIAHF, 25% from the National Minority AIDS Council, and 18% from Asian and Pacific Islander Wellness Center. Seventy-seven percent of the responding CBOs received TA/T from attending a training, 64% from attending training workshops and conferences, and 49% from newsletters and publications. Thus, the responding CBOs seem to access a variety of TA/T providers in a variety of TA/T delivery formats.

Among the areas of TA/T that the CDC was particularly interested in assessing, the CBOs responding to the April 1998 survey ranked TA/T on program evaluation the highest priority, followed by TA/T on behavioral and social science and then TA/T on organizational development.

TA/T Priorities Ranked by Responding CBOs
(Source: April 1998 CBO Survey)

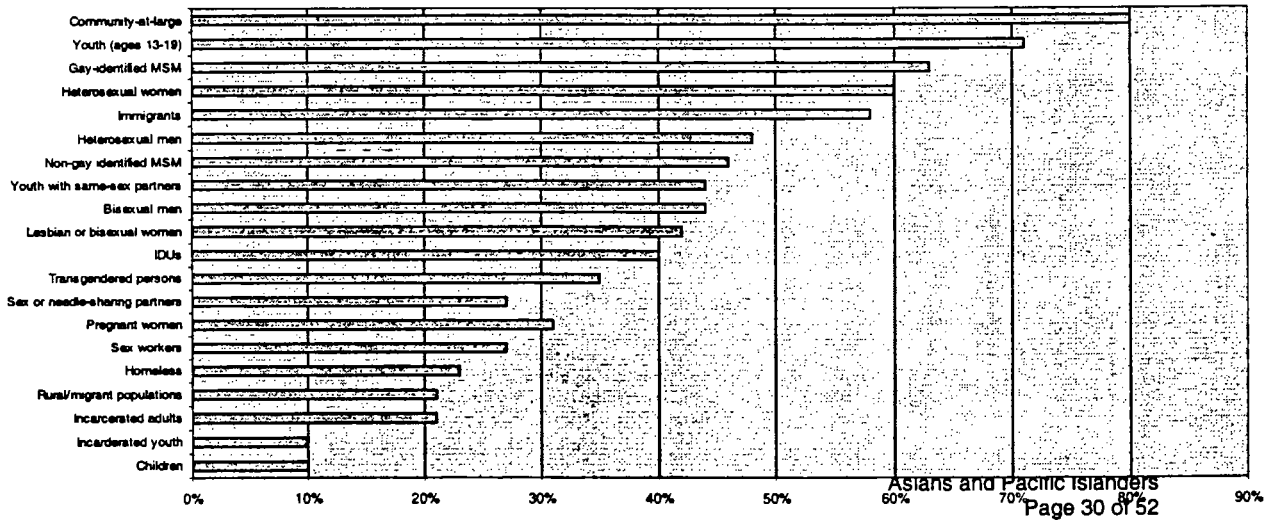
TA/T Issues	% of Responding CBOs Ranking as High Priority	Mean Priority Score (1=High, 3=Low)
Program Evaluation	45%	1.58
Behavioral and Social Science	40%	1.69
Organizational Development	38%	1.78
Epidemiology	30%	1.86
Community Planning	20%	2.06
Collaboration	19%	2.08
Biomedical Research	17%	2.23

In qualitative responses, the need for TA/T on fundraising and other types of TA/T on organizational development were prominent. The responding CBOs also identified very specific needs for TA/T to reach specific Asian and Pacific Islander populations, such as commercial sex workers or non-gay-identified MSM. It is also interesting that many of the TA/T needs identified involved the provision of TA/T to health departments and non-Asian and Pacific Islander organizations on cultural competency and diversity.

HIV Interventions in the Asian and Pacific Islander Communities

Most HIV prevention programs targeting Asians and Pacific Islanders focus on either Asian and Pacific Islander youth (including gay and queer youth) or Asian and Pacific Islander gay and bisexual men and other MSM. A few CBOs also have programs targeting Asian and Pacific Islander women, especially women commercial sex workers, and Asian and Pacific Islander transgender persons. Even fewer HIV prevention programs for Asian and Pacific Islander IDUs or incarcerated Asians and Pacific Islanders were identified. When asked to identify the populations targeted by their HIV prevention interventions, a large majority of the respondents to the April 1998 survey identified the community-at-large (88%, n=42). Specific populations targeted included youth (71%, n=34), gay-identified MSM (63%, n=30) and heterosexual women (60%, n=29). The populations least likely to be targeted were incarcerated youth (n=5) and children (n=5). It is not surprising that the responding CBOs identified their youth and MSM programs as their most successful HIV prevention programs. These responses were consistent with the responses to the August 1997 survey, where 64% of responding CBOs targeted all Asian and Pacific Islander communities, 62% targeted Asian and Pacific Islander gay men, and 62% targeted Asian and Pacific Islander youth.

Primary Target Populations for HIV Prevention Among Responding CBOs
(Source: April 1998 CBO Survey)



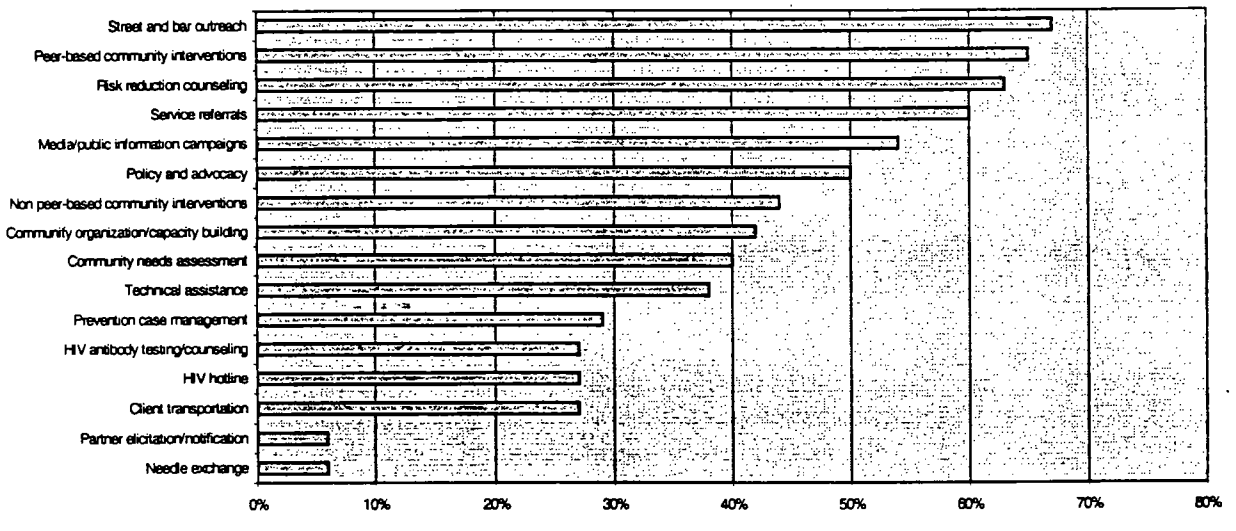
The most common types of HIV prevention interventions reported by the responding CBOs were individual-level outreach, education, and condom/educational materials distribution. Very often these interventions occur in the natural venues of the target population, such as bars, dance clubs, and schools. Many programs also conduct outreach at Asian and Pacific Islander community events such as community fairs. While some of these programs were characterized by the responding CBOs as risk reduction activities, very few have behavior change components.

Very few responding CBOs have ongoing programs with formal or structured group interventions. Many programs do engage in community-level interventions such as mass media advertising, production and distribution of posters, and other community visibility campaigns. However, few of these efforts are targeted or linked with group or individual-level interventions.

In the August 1997 survey, the three most important HIV prevention objectives reported by responding CBOs were to increase awareness of HIV, disseminate basic information about HIV transmission and risk reduction, and increase risk reduction and life skills. The most common contents of HIV prevention programs for individual-level interventions were to explain HIV transmission (100%), provide referrals for HIV testing (99%), demonstrate condom use (95%), and clarify perception of risk (95%). The most common contents of HIV prevention programs for community-level interventions were to change Asian and Pacific Islander community norms about high risk behaviors (63%) and conduct communitywide events with an HIV prevention focus (53%).

In the April 1998 survey, the most common types of interventions reported were street and bar outreach (67% of respondents, n=32), peer-based community interventions (65%, n=31), risk reduction counseling (63%, n=30), and service referrals (60%, n=29). The least common interventions were partner elicitation/notification (6%, n=3) and needle exchange (6%, n=3). Over half of the responding CBOs conducted media/public information campaigns (n=26). Significantly, 50% (n=24) reported that they engaged in policy and advocacy activities.

Types of HIV Prevention Interventions Among Responding CBOs
(Source: April 1998 CBO Survey)



However, when asked to identify their *primary* type of intervention conducted, 44% of the responding CBOs identified street and bar outreach (n=20), with an extremely wide diversity of other primary activities (next highest, n=4 for community organization and for capacity building). When asked to identify their *secondary* type of intervention, 21% identified risk reduction counseling (n=9) and 19% identified peer-based community interventions (n=8). Again, there was a wide diversity of other secondary activities (next highest, n=4 for both media/public information campaigns and for conducting community needs assessments). The most commonly identified *tertiary* type of intervention was peer-based community interventions (22%, n=9), followed by risk reduction counseling (n=5), non-peer-based community interventions (n=5), and media/public information campaigns (n=5).

When asked to identify co-factors for HIV risk among Asians and Pacific Islanders, the CBOs responding to the April 1998 survey listed the following:

- misconceptions/ignorance/stigma
- lack of self-esteem
- lack of social support
- issues of sexual identity
- lack of services in appropriate language
- lack of culturally competent services
- drug and alcohol use
- commercial sex
- violence
- gangs
- lack of access to health care
- immigration laws/fear of deportation
- welfare reform
- oppression (racism, sexism, homophobia)

While many of these co-factors are familiar within HIV prevention science, it is interesting that societal factors such as lack of access to health care, fear of immigration laws, and welfare reform also were identified as barriers to effective HIV prevention in the Asian and Pacific Islander communities. Few HIV prevention programs or TA/T programs address such factors.

The responding CBOs then listed the types of behavior changes that are needed among Asians and Pacific Islanders to reduce HIV risk:

- increased knowledge about HIV risk
- belief that Asians and Pacific Islanders are at risk
- open discussion of HIV
- availability of condoms/normalize condom use
- identifying and facilitating alternative behaviors
- communication with sexual partners
- access to testing
- access to drug treatment
- community support/mobilization
- leadership

In the August 1997 survey, 84% of the responding CBOs reported lack of government funds as one of the most important barriers to HIV prevention programs for Asians and Pacific Islanders, 77% reported denial of risk among targeted populations, 74% reported limited staff, 74% reported lack of private funding, 68% reported homophobia, and 63% reported lack of political representation and influence. Some of these barriers were confirmed by the responses to the health department surveys. When asked to specify the total dollars spent by their jurisdictions on HIV prevention targeting the Asian and Pacific Islander communities in our surveys of health departments, Texas, Florida, New Jersey, Houston, and Chicago identified no dollars ($0) for their Asian and Pacific Islander communities. At the same time, only the health departments in Hawai'i, Virginia, Colorado, Massachusetts, and Los Angeles have received TA/T on the HIV prevention needs of Asian and Pacific Islander communities. This lack of support for and understanding of the HIV prevention needs of Asians and Pacific Islanders by health departments is an important barrier to HIV prevention.

On the other hand, 62% of the responding CBOs reported increased coordination and collaboration among HIV providers, and 59% reported government funding for programs for target populations as the most important facilitators to HIV prevention programs for Asians and Pacific Islanders. Thus, TA/T that results in both increased collaboration among Asian and Pacific Islander CBOs as well as additional government funding for HIV prevention for Asians and Pacific Islanders are important priorities.

HIV/AIDS Surveillance and Epidemiology

The CDC reports 4,786 cumulative AIDS cases among Asians and Pacific Islanders as of June 1998, or 0.7% of all cases reported nationally (CDC, 1998). Four thousand two hundred and one of those cumulative reported Asian and Pacific Islander cases are among adult men, 540 among adult women and 45 are pediatric cases. From July 1997 through June 1998, there were 355 new Asian and Pacific Islander male adult cases reported, 61 new Asian and Pacific Islander female adult cases, and 4 new Asian and Pacific Islander pediatric cases. APIAHF's published analysis of the HIV/AIDS surveillance data in 40 HIV prevention community plans shows the percentage of reported Asian and Pacific Islander HIV or AIDS cases in state and local jurisdictions generally at 1-3%, with higher percentages in Hawai'i (nearly 27% of reported AIDS cases) and the six Pacific jurisdictions (nearly all reported AIDS cases) where Asians and Pacific Islanders are the majority of the local population.

The recently revised Office of Management and Budget (OMB) Statistical Policy Directive No. 15 (1998) requires that all federal government agencies and all other government agencies receiving federal funding collect and report data for each racial/ethnic group, including Asians and Pacific Islanders. The OMB directive also recommends further disaggregation of all data by each of Asian and Pacific Islander ethnicities/national origins used in the United States Census. Finally, beginning with Census 2000, data about Asians and Pacific Islanders will be collected and reported in two separate categories: "Asian Americans" and "Native Hawaiians and Other Pacific Islanders." This disaggregation of the "Asian and Pacific Islander" category is an acknowledgment of the diversity of the many populations now aggregated into a single racial/ethnic category. Similarly, the Council of State and Territorial Epidemiologists (CSTE)/ CDC *Suggested Guidelines for Developing an Epidemiological Profile for HIV Prevention Community Planning* (1995) recommends that information about all racial/ethnic minorities be included and discussed in epidemiological profiles for HIV prevention community planning and that "[a]n effort should be made to further

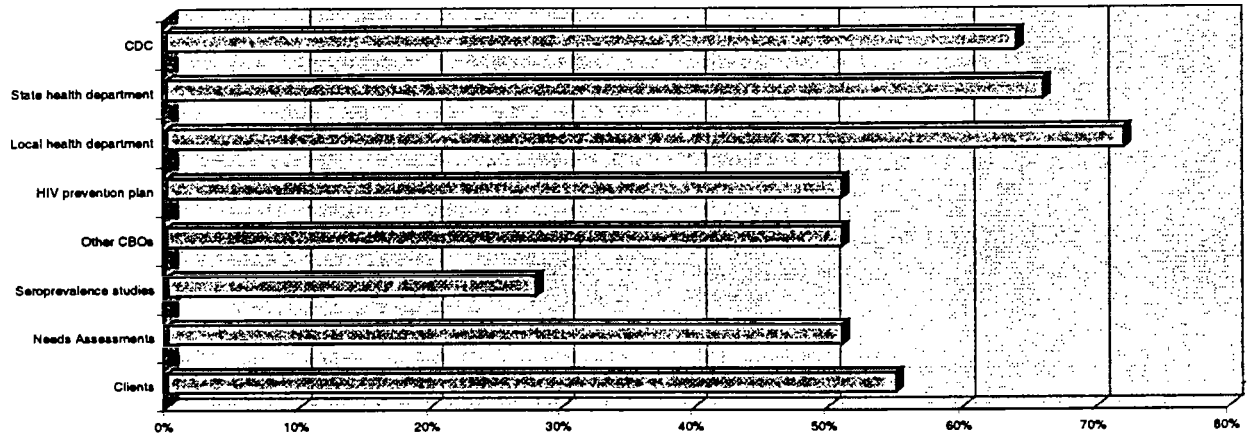
characterize by origin...the Asian/Pacific Islander population (e.g., Chinese, Filipino, Japanese, Korean, Pacific Islander)."

However, many state and local health departments still provide no HIV/AIDS data about Asians and Pacific Islanders. According to the surveys of health departments conducted for this needs assessment, Massachusetts, Florida, Virginia, Houston, and Chicago still include Asians and Pacific Islanders in an "other" category in their regularly published HIV/AIDS surveillance reports. Similarly, APIAHF's analysis of 40 HIV prevention community plans found that eight states (Delaware, Kansas, Maryland, Massachusetts, Michigan, New Jersey, Tennessee, Texas) and one city (Houston) provide no HIV/AIDS surveillance data about Asians and Pacific Islanders in their HIV prevention plans. (Bau, 1998). Incidentally, except in New Jersey, there are no Asian or Pacific Islander members on the community planning groups in those eight states and one city.

According to the surveys of the health departments, only California, Hawaii, San Francisco, Los Angeles, and New York City report HIV or AIDS surveillance data disaggregated by Asian and Pacific Islander ethnicities/national origins. In addition, with the exception of the Pacific jurisdictions, none of the HIV prevention plans include surveillance data disaggregated by Asian and Pacific Islander ethnicities/national origins, even where the state or local health department collects and reports that data. Moreover, almost none of the plans conducted any trend analysis of the existing HIV/AIDS data or made any projections about the future epidemiology of HIV/AIDS among Asians and Pacific Islanders.

Sixty-four percent of the CBOs responding to the April 1998 survey reported using surveillance data from the CDC, 66% from their state health department, and 72% from their local health department. It is encouraging that the responding CBOs seem to be accessing data from all three levels of government but using the data from their local health departments the most. Fifty-five percent of the responding CBOs also reported using their clients as sources of data. Only 51% reported using data from their HIV prevention community planning group.

Sources for HIV/AIDS Surveillance Data for Responding CBOs
(Source: April 1998 CBO Survey)



The responding CBOs were most likely to use the number of HIV/AIDS cases among their target population (81%), HIV/AIDS cases disaggregated by Asian and Pacific Islander ethnicities/national origins (75%), HIV/AIDS cases disaggregated by risk factors (75%), and changes and trends in HIV/AIDS cases (75%) in the development of their HIV prevention programs. It is significant that the overwhelming majority of the responding CBOs used data disaggregated by Asian and Pacific Islander ethnicities/national origins when so few jurisdictions provide such data. These CBOs recognize the importance of such disaggregated data so that HIV prevention programs can be appropriately targeted for specific Asian and Pacific Islander languages and cultures. However, it is likely that these CBOs that target Asians and Pacific Islanders are forced to use HIV/AIDS data from other areas of the country that is disaggregated by Asian and Pacific Islander ethnicities/national origins but may not be directly applicable to their own geographic area. This forces these CBOs to be more sophisticated in analyzing and explaining the epidemiology of HIV/AIDS in the Asian and Pacific Islander communities. It also is interesting that so many of the responding CBOs appreciated the need for data and analysis about changes and trends in HIV/AIDS cases when so few of the HIV prevention plans prepared by HIV prevention community planning groups include such trend analysis or data.

The HIV prevention community planning process requires that community planning groups construct comprehensive epidemiological profiles as the basis for identifying HIV prevention priorities. Unfortunately, most epidemiological profiles only include HIV/AIDS surveillance data and overlook other important data, including data about STDs, drug use, teen pregnancy (Bau, 1998). Other data about population growth, geographic concentration and isolation, and primary languages are also critical to constructing a comprehensive epidemiological profile for HIV prevention. Accordingly, there is a need for TA/T to state and local health departments and HIV prevention community planning groups on how to obtain and include other relevant data, including population growth and linguistic diversity, as part of a comprehensive epidemiological profile for HIV prevention community planning.

Epidemiology was ranked a high priority for TA/T by 30% of the responding CBOs in the April 1998 survey (n=14; mean=1.86, high priority=1, low priority=3). A majority of the responding CBOs (66%) reported needing TA/T on understanding epidemiology. In light of the challenges in obtaining relevant epidemiology data, it is surprising that only 47% of the responding CBOs reported needing TA/T on obtaining epidemiology information. However, the responding CBOs identified the need for TA/T "working with health departments to obtain additional surveillance data about our target populations" (64%), "working with community planning groups to improve their epidemiological profiles" (62%), "making projections of future AIDS/HIV cases" (57%), and "analyzing changes and trends in AIDS/HIV cases" (55%). The least reported need for TA/T were "obtaining existing surveillance data from the CDC" (36%) or "obtaining existing surveillance data from health departments" (36%). Again, the emphasis is not on obtaining existing data, which may be incomplete or inadequate, but on analysis of the data and working with health departments and HIV community planning groups to improve their data and their epidemiological profiles. The responding CBOs preferred receiving TA/T on epidemiology from the CDC (31%) and health departments (29%). Given the significant gaps in comprehensive epidemiological data about Asians and Pacific Islanders and HIV/AIDS, this is an important area of TA/T for Asian and Pacific Islander CBOs.

HIV Prevention Community Planning

APIAHF's analysis of forty HIV prevention community plans found that 16 of 34 community planning groups had no Asian or Pacific Islander members and seven other jurisdictions only had one Asian or Pacific Islander member (Bau, 1998). The forty plans reviewed included the plans from the fifteen states with the largest number of Asian and Pacific Islander residents as well as the six Pacific jurisdictions. It is extremely difficult for Asian and Pacific Islander communities to participate meaningfully in the community planning process where there is no parity, inclusion, or representation from the community. There seems to be some correlation between the absence of epidemiology data about Asians and Pacific Islanders in the HIV prevention community plan and the absence of Asian and Pacific Islander members on those community planning groups. It is not clear whether the absence of data is used to justify the absence of Asian and Pacific Islander representation or whether the absence of representation results in the absence of relevant data. The analysis also showed that Asians and Pacific Islanders were prioritized for HIV prevention only in the Pacific jurisdictions and Hawai'i. The CDC's revised guidance on HIV prevention community planning will present new challenges to the greater inclusion and participation of Asians and Pacific Islanders in HIV prevention community planning. For example, multi-year plans may create static priorities for HIV prevention that will continue to exclude Asians and Pacific Islanders.

In the August 1997 survey, 79% of the responding CBOs reported being highly involved or involved in their state or local HIV prevention community planning process. Nineteen responding CBOs reported that Asians and Pacific Islanders were included in the epidemiological profile of their state or local HIV prevention community plans and five CBOs reported that Asians and Pacific Islanders were not included. In the April 1998 survey, only 20% of the responding CBOs ranked TA/T on HIV prevention community planning as a high priority for TA/T (n=9; mean=2.06, high priority=1, low priority=3). Only 34% of the responding CBOs reported needing TA/T on obtaining information about HIV prevention community planning and only half (51%) reported needing TA/T on using information about community planning. CBOs were cited most frequently as the preferred provider of TA/T on community planning (30%).

In the CDC's recently revised guidance on HIV prevention community planning, greater emphasis is placed on conducting community needs assessments, an inventory of HIV prevention programs and resources, and a gap analysis. APIAHF's review of forty HIV prevention community plans revealed some more recent needs assessments conducted by health departments and HIV community planning groups. For example, the state of California has conducted extensive focus groups with Asians and Pacific Islanders about their HIV prevention needs. Both Los Angeles County and Pennsylvania have conducted key informant interviews of Asians and Pacific Islanders. The Rhode Island HIV community planning group conducted public forums to receive input about HIV prevention priorities (Bau, 1998). In response to the health department surveys conducted as part of this needs assessment, only 10 of the 24 (42%) responding health departments reported conducting assessments of the HIV prevention needs of Asians and Pacific Islanders in their jurisdiction. According to the April 1998 survey, over 60% of the responding CBOs did not conduct their own community needs assessments. TA/T on improving the assessment of the HIV prevention needs of Asians and Pacific Islanders can also be useful to state and local health departments and to HIV prevention community planning groups as well as CBOs.

Behavioral and Social Science

In the April 1998 survey, 78% of the responding CBOS reported that they used behavioral and social science in developing their HIV prevention programs. Forty percent of the responding CBOs to the April 1988 survey ranked TA/T on behavioral and social science as a high priority (n=19; mean=1.69, high priority=1, low priority=3). While less than half of the responding CBOs (49%) needed TA/T on obtaining information on behavioral and social science, 66% needed TA/T on using such information. The responding CBOs preferred such TA/T from universities (27%) and the CDC (24%), and then from CBOs (20%) and NRMOs (16%).

In identifying barriers to the use of behavioral and social science, 57% of the responding CBOs stated that "it is too expensive to obtain journals or attend conferences to get information," 45% stated that "available information is too theoretical and not presented in a format that would be useful for CBOs," and 45% stated that "the research we are aware of is inappropriate for the populations we serve." Interestingly, only 11% stated that they did not know where to look for behavioral and social science information. One focus group participant stated:

> *Theories are theory but the community is the reality of what we are trying to do. It doesn't necessarily translate.*

Not surprisingly, when asked what would facilitate their use of behavioral and social science, 77% of the responding CBOs stated "having research and data that are relevant and appropriate to my target populations," 68% stated "obtaining user-friendly guides on the use of behavioral and social science in the development of HIV prevention programs," 62% stated "obtaining user-friendly summaries of research reports," and 62% stated "having funding/resources to conduct our own studies and data collection." One focus group participant noted:

> *Before I even knew about the theories, I practiced it, but I knew that there was something missing. Now that I actually know it, I can use that to help me identify what is missing from programs.*

As part of its NRMO program, APIAHF maintains an updated bibliography of references on Asians and Pacific Islanders and HIV/AIDS. The responding CBOs seem to want more of these "user-friendly" summaries and guides. It is interestingly that only 11% of the responding CBOs reported that they did not know where to look for behavioral and social science information. Instead, the CBOs emphasized the need for more relevant research and information and even the funding and resources to conduct primary research themselves. Thus, it seems that it is equally if not more important to the responding CBOs that more behavioral and social science research be conducted which is focused on Asians and Pacific Islanders rather than accessing or using existing research that may not be relevant or applicable to Asian and Pacific Islander populations.

APIAHF and its NRMO program partner Asian and Pacific Islander Wellness Center also have convened four meetings (September 1995 in San Francisco, California; March 1997 in Sonoma, California; January 1998 in San Francisco, California; and September 1998 in San Diego, California) among Asian and Pacific Islander researchers and CBOs to develop and strengthen collaborations among researchers and CBOs and to facilitate the application of behavioral and social science to HIV prevention program development

and evaluation. The first of these meetings developed recommendations for research strategies and increasing the collaboration among researchers and CBOs (Asian and Pacific Islander Wellness Center, 1995).

The National Summit on Technology Transfer of HIV Prevention Interventions for Asian and Pacific Islander Men Who Have Sex With Men, in March 1997, critically examined the concept of "technology transfer" and concluded that a multidirectional process of "technology diffusion" is more appropriate for our communities (Bau, Lew, and Bao, 1998). The national summit also examined the barriers and facilitators to increased collaboration among researchers and CBOs. The participants recommended targeted funding for collaborative, community-based research; improved baseline surveillance and other data on Asians and Pacific Islanders, including data disaggregated by Asian and Pacific Islander ethnicities/national origins; involvement of the target population in the design, implementation, analysis and dissemination of the research; improved program evaluation by CBOs; assistance by researchers in "translating" and applying research findings; and ongoing partnerships between researchers and CBOs to design, implement, and evaluate appropriate community-based research on HIV prevention interventions. 32 of 36 (89%) participants responding to the written evaluation of the summit felt the need for similar or followup meetings in the future (Bau, Lew, and Bao, 1998).

The most recent of these meetings was held in San Diego, California, in September 1998 and emphasized the need to develop alternative, multidisciplinary theoretical models besides health education theories in behavioral science to help understand the HIV-related decisions that individuals, networks, and entire communities make in a culturally competent manner. There also was a recommendation to move away from a needs-based or deficit model and examine health-seeking beliefs and behaviors and other protective factors that might be based in one's culture or community. Such interventions would focus on existing individual and community assets instead of just needs. It is only with such models and such understanding that culturally competent HIV interventions will be developed, evaluated, and validated. It will be important to continue to convene these meetings to facilitate the development and application of behavioral and other social sciences to HIV prevention programs in the Asian and Pacific Islander communities.

Program Evaluation

In response to the question, "what other topics do you need TA/T on?" asked as part of the written evaluation of the National Asian and Pacific Islander Summit on HIV/AIDS in San Diego, California, in September 1998, a significant number of participants noted the need for TA/T on program evaluation. Examples of the comments of the participants included:

> *Evaluation of programs would have been most useful. How to properly evaluate a program. Most CBOs don't have the funding/time to do self-evaluation of programs. A model would have been useful.*
>
> *I think it would be more useful to have more "research," Ph.D.s, academics speak. Although it is useful to hear what our colleagues are experiencing, that can only take us so far, and tapping into the right resources, or getting to the solutions. For example: "Yes, evaluations are important, we need evaluations, we know what evaluations do, etc. It would be more useful if we actually had*

someone who has expertise in evaluation instruments, etc., who can teach us how to apply them for our needs – practical stuff!

Support in developing evaluation tools and source to review proposed/existing evaluation methods/tools and analyze the data.

We need "the perfect evaluation for your program."

In the August 1997 survey, 92% of the responding CBOs reported conducting some program evaluation of their HIV prevention programs. Specifically, 82% report the numbers of clients reached, 77% measure changes in knowledge through pre- and post-tests, and 66% use staff observations. Forty-five percent of the CBOs responding to the April 1998 ranked TA/T on program evaluation as a high priority for TA/T (n=21; mean=1.58, high priority=1, low priority=3). Specifically, 68% needed TA/T on understanding evaluation, 66% needed TA/T on using program evaluation information, and 55% needed TA/T on obtaining information about evaluation. CBOs (26%) and health departments (26%), and then NRMOs (19%) and the CDC (19%) were the preferred provider of TA/T on evaluation.

Among the focus group participants, the need for more creative and less burdensome methods for evaluation, for more realistic and targeted evaluations, and for analysis of evaluation data were cited as important to improving program evaluations. Even among those CBOs conducting evaluation, there are concerns about what the evaluations really mean. For example, one focus group participant commented:

The evaluations received from the people who attended were pretty positive but...the problem was that we were preaching to the chorus. These men had gone through numerous workshops. We failed in the sense that we did not get the people we thought should be going to these workshops. We promoted it heavily but we just did not get the result we wanted.

It is encouraging that such a substantial majority of the responding CBOs conduct at least process evaluation of their HIV prevention interventions. It will be important to provide TA/T on improving program evaluation, including outcome evaluation, in the future.

Biomedical Research

In response to the April 1998 survey, 83% of the responding CBOs reported that they used some biomedical research in their HIV prevention programs. The types of biomedical research most relevant were the role of STD treatment in HIV prevention (83%), how HIV is transmitted (81%), and how HIV affects the body (77%). The types of biomedical research least relevant to HIV prevention programs were post exposure prophylaxis (36%) and the gynecological manifestations of HIV disease (47%).

The responding CBOs listed "available information is too scientific and not presented in a format that would be useful for CBOs" (66%) and "we are not sure how to apply the biomedical research to our HIV prevention programs" (47%) as the two most common barriers to using biomedical research in the development of HIV prevention programs. They cited "having research and data that are relevant and appropriate to my target communities" (81%), "obtaining user-friendly summaries of research reports" (68%), and "obtaining user-friendly guides on the use of biomedical research in the development of

HIV prevention programs" (66%) as the most common facilitators to using biomedical research in HIV prevention. Only 17% of the responding CBOs ranked TA/T on biomedical research as a high priority (n=8; mean=2.23, high priority=1, low priority=3). While half of the responding CBOs (51%) needed TA/T on obtaining information on biomedical research, 57% needed TA/T on both understanding and using such information. Of those responding CBOs that expressed a preference for the type of provider of such TA/T, 30% preferred receiving such TA/T from the CDC and 26% from universities. Thus, CBOs do not generally prioritize biomedical research as a TA/T need. However, given the advances in HIV treatment and the availability of new testing technologies, such biomedical research will become increasingly important to CBOs.

Collaboration

In response to the April 1998 survey, CBOs reported that they were collaborating the most with other HIV/AIDS organizations (66%), HIV prevention community planning groups (60%), youth organizations (60%), gay/bisexual/lesbian organizations (57%), local health departments (55%), HIV testing centers (51%), women's organizations (45%), state health departments (40%), and community health clinics (40%). The responding CBOs were collaborating the least with labor unions (2%), Indian Health Services (2%), and managed care organizations (4%). It is encouraging that the responding CBOs recognize the importance of HIV community planning and have some working relationships with their local or state community planning groups. There also seem to be working relationships with local and state health departments. There also seem to be strong linkages with HIV testing centers, which would facilitate HIV testing by those at highest risk. Finally, it also is encouraging that the responding CBOs collaborate more with youth and gay/bisexual/lesbian organizations, given that Asian and Pacific Islander youth and Asian and Pacific Islander gay and bisexual men and other MSM were identified as the top target populations for the responding CBOs. It is not surprising that HIV prevention programs do not collaborate with managed care organizations. On the other hand, the responding CBOs do collaborate more with community health clinics (40%) than with hospitals (17%).

The responding CBOs listed "funders encourage collaboration" (32%), "past or current experiences of working together" (30%), "resources needed" (28%), and "personal relationships with staff from other organizations" (27%) as the most common facilitators of collaboration. It seems that there are both external and interpersonal motivations for collaboration. The external factors focus on the need for accessing resources, presumably funding. The interpersonal factors are based on personal working relationships that open the path to institutional collaboration.

On the other hand, the CBOs cited "competition/'turf' issues" (60%), "work with different target populations" (53%), and "other organizations do not want to collaborate" (49%) as the most common barriers to collaboration. According to the responding CBOs, sometimes other organizations are competitors but sometimes they simply do not identify with the same target populations.

The responding CBOs reported that "finding resources for collaborative projects" (60%), "improving information exchange and referrals" (55%), and "diversity/cultural competence training for other organizations/ institutions" would be the types of TA/T that would help overcome barriers to collaboration. Interestingly, the most common TA/T strategy identified is consistent with a funder or resource-driven motivation for collaboration. The responding CBOs also identified diversity/cultural competence

training as a TA/T strategy to overcome some of the competition and lack of knowledge or understanding about their target populations.

Only 19% of the responding CBOs to the April 1988 survey ranked TA/T on collaboration as a high priority (n=9; mean=2.08, high priority=1, low priority=3). Less than half of the responding CBOs (45%) needed TA/T on understanding information on collaboration. The responding CBOs already had identified increased coordination and collaboration with other CBOs as a facilitator to more effective HIV prevention efforts in the Asian and Pacific Islander communities. Based on the responses to these questions about collaboration, there already is a high degree of such collaboration. Accordingly, collaboration was not ranked as a high TA/T priority. Among the responding CBOs, the preferred providers of TA/T on collaboration were CBOs (38%) and NRMOs (25%). However, only 36% (n=17) of the responding CBOs identified existing collaborations with NRMOs.

APIAHF's NRMO program promotes collaboration and provides TA/T in support of collaboration in several ways. First, APIAHF's NRMO program has maintained a partnership with seven CBOs in six key cities: Asian and Pacific Islander Wellness Center in San Francisco, California; Asian Health Services in Oakland, California; Asian Pacific AIDS Intervention Team and Search to Involve Pilipino Americans in Los Angeles, California; Asian Pacific AIDS Council in Seattle, Washington; Asian and Pacific Islander Coalition on HIV and AIDS in New York, New York; and Indochinese Community Center in Arlington, Virginia. APIAHF's partners provide TA/T to CBOs and health departments in their local areas, promoting collaboration at the local and regional level. Its partners also are instrumental in providing leadership to local coalitions such as the Asian and Pacific Islander Caucus on HIV and AIDS and the Southern California Filipino Task Force on AIDS in Los Angeles, California; Hana Like in Alameda County, California; the Asian AIDS Education Team in Seattle, Washington; the Asian and Pacific Islander HIV/AIDS Leadership Network in New York, New York; and the Southeast Asian Health Coalition in Washington, DC. APIAHF also has facilitated strategic planning for both the Cultural Competency Core Group in Hawai'i and the Asian and Pacific Islander Caucus on HIV and AIDS in Los Angeles, California. APIAHF's recent provision of TA/T to the Pacific jurisdictions also enhanced the collaboration among the health departments and Health Ministries in the Pacific. These local and regional efforts to improve the coordination of HIV prevention programs for Asians and Pacific Islanders are vital to sustaining such programs.

Second, APIAHF's National Asian and Pacific Islander Consortium on HIV/AIDS (NAPICAS) includes over 70 CBO and health department members from 14 states; Washington, DC; and Guam. APIAHF keeps the members of NAPICAS regularly updated on its programs and regularly convenes as many members as possible at regional and national TA/T conferences, such as the National Asian and Pacific Islander Summit on HIV/AIDS, attended by over 120 participants from 43 CBOs in 14 states and Washington, DC. Such gatherings facilitate information and resource sharing as well as peer support for Asians and Pacific Islanders involved in HIV prevention. Evaluations and other comments from participants at these TA/T conferences consistently emphasize the importance of such peer networking and support in addition to the benefits of the content of the TA/T received. For example, participants at the National Asian and Pacific Islander Summit on HIV/AIDS in San Diego, California, in September 1998, noted in their written evaluations:

Sometimes the usefulness is not just about information sharing/networking. In relation to support, recommitment to the work and burnout prevention, this conference was excellent.

Very empowering and supportive. Impressive.

My first time to be with all Asians at a conference. I find it very empowering and enlightening. Keep up the good work.

I'm very glad to attend this summit. And it also helps me to understand the different needs of Asians and Pacific Islanders in different areas of the United States.

Good to network with others. During breaks, followup sharing about specific program design and evaluation was useful and entertaining.

Finally, a national working group convened by APIAHF has developed a model curriculum for cultural competency trainings for Asian and Pacific Islander HIV prevention programs. The model is a self-assessment tool to evaluate an organization's cultural competency in the areas of access, bilingual/bicultural staffing, program content, decisionmaking, evaluation, and feedback for each target population. An organization can develop both short and long-term workplans and objectives to increase its cultural competency. The premise of the model is that cultural competency cannot be achieved after simplistic TA/T or with superficial changes but requires a long-term institutional commitment to become increasingly more responsive and accountable to one's clients and constituents. The model has been presented to the CDC and at the National Skills Building Conference (1996), the HIV Prevention Community Planning Summit (1998), and the joint midyear conference of the Society for Public Health Education and the Association of State and Territorial Directors of Health Promotion and Public Health Education (1998). It will be published next year as a practice note in the Journal of Public Health Education. This model can be a useful tool to facilitate collaboration between Asian and Pacific Islander CBOs and other CBOs, health departments, and other organizations involved in HIV prevention.

Conclusions

HIV Prevention Programs for Asians and Pacific Islanders

Asian and Pacific Islander CBOs provide a diverse number of individual, group and community-level HIV prevention interventions targeting diverse Asian and Pacific Islander populations by Asian and Pacific Islander ethnicities/national origins, Asian and Pacific Islander languages, and HIV-related risk behaviors. About half of the HIV prevention programs targeting Asians and Pacific Islanders are located in California and Hawai'i and the majority are based in urban areas. The TA/T needs of CBOs where programs are geographically concentrated are different than those of CBOs where there may be less community, financial, political, and social support for HIV prevention interventions for Asians and Pacific Islanders. The unique TA/T needs of the six-United States affiliated Pacific jurisdictions must be included in the provision of TA/T to Asians and Pacific Islanders. Although there are few CBOs (or nongovernmental organizations) engaged in HIV prevention in the Pacific jurisdictions, culturally appropriate TA/T to the Health Ministries and health departments in the Pacific jurisdictions is critical to the success of HIV prevention efforts in the region.

There are significant gaps in the linguistic access to HIV testing and other HIV prevention programs for Asians and Pacific Islanders in many states with large numbers of Asian and Pacific Islander residents. Among the states with the highest number of Asian and Pacific Islander residents, there were significant gaps in the availability of HIV testing in Asian and Pacific Islander languages, information and materials in Asian and Pacific Islander languages, and funding for Asian and Pacific Islander HIV prevention programs.

Organizational Development Needs of Asian and Pacific Islander CBOs
Asian and Pacific Islander CBOs need TA/T on a diverse number of organizational development issues, including fundraising and resource development, strategic and long-term planning, volunteer program development, and collaboration.

HIV/AIDS Surveillance and Epidemiology
Asian and Pacific Islander CBOs need TA/T on improving HIV and AIDS surveillance data and in obtaining information about the HIV prevention needs of Asians and Pacific Islanders, especially among specific Asian and Pacific Islander ethnicities/national origin populations. The majority of the responding CBOs access and use available HIV and AIDS surveillance data about Asians and Pacific Islanders. However, the unavailability and inadequacy of data, especially data disaggregated by Asian and Pacific Islander ethnicities/national origins means that CBOs seeking to target Asians and Pacific Islanders for HIV prevention must utilize other sources of data to document the HIV prevention needs of Asian and Pacific Islander communities. For example, Asian and Pacific Islander CBOs could use TA/T to conduct their own community needs assessments to provide additional information to health departments, HIV prevention community planning groups, and funders about the HIV prevention needs of Asians and Pacific Islanders.

HIV Prevention Community Planning
Asian and Pacific Islander CBOs need TA/T on increasing their participation and effectiveness within HIV prevention community planning. Asian and Pacific Islander CBOs also need TA/T on how to effectively participate within the HIV prevention community planning process. Given the underrepresentation of Asians and Pacific Islanders in most HIV prevention community planning groups, the Asian and Pacific Islander members often face difficult challenges in ensuring that the HIV prevention needs of Asians and Pacific Islanders are included in the planning process and in the establishment of HIV prevention priorities. TA/T on parity, inclusion, and representation issues for Asians and Pacific Islanders within community planning is a high priority.

HIV Prevention Program Development and Program Evaluation
Asian and Pacific Islander CBOs need TA/T on developing and evaluating culturally appropriate HIV prevention interventions targeting Asians and Pacific Islanders at the highest risk for HIV infection. The majority of the responding CBOs target specific HIV risk behaviors among Asians and Pacific Islanders, often focusing on Asian and Pacific Islander gay and bisexual men and other men who have sex with men (MSM) and on Asian and Pacific Islander youth. Other programs focus on Asian and Pacific Islander women, Asian and Pacific Islander transgender persons, and Asian and Pacific Islander commercial sex workers. However, a few programs are less focused, seeking to target the Asian and Pacific Islander "community-at-large." Such programs are less likely to be effective or sustainable in the increasingly competitive world of HIV prevention priorities.

Asian and Pacific Islander CBOs also need TA/T in developing and evaluating culturally and linguistically appropriate HIV prevention interventions targeting specific Asian and Pacific Islander ethnicities/national origin populations. Effective HIV prevention interventions must be tailored for specific Asian and Pacific Islander ethnicities/national origin populations. Given the inadequacy of HIV prevention materials in Asian and Pacific Islander languages, national coordination of the development and dissemination of Asian and Pacific Islander language HIV prevention materials is critical.

Asian and Pacific Islander gay and bisexual men's social, cultural, and political organizations need TA/T on organizational development, leadership development, and community-level HIV prevention interventions to build community capacity and impact community norms in support of effective HIV prevention interventions. Among Asians and Pacific Islanders, gay and bisexual men and other MSM remain the most impacted behavioral risk population for HIV infection, with 75% of the cumulative Asian and Pacific Islander male AIDS cases reported among MSM. Continued TA/T that builds organizational and individual capacities among Asian and Pacific Islander gay and bisexual men is vital.

Asian and Pacific Islander CBOs need TA/T on developing and evaluating the effectiveness of HIV prevention interventions targeting Asian and Pacific Islander youth, particularly interventions that involve parents and other family members and address the wholistic health and other needs of Asian and Pacific Islander youth. Asian and Pacific Islander CBOs need TA/T on developing and evaluating the effectiveness of HIV prevention programs targeting Asian and Pacific Islander populations at risk for HIV infection, including Asian and Pacific Islander women, Asian and Pacific Islander transgender persons, Asian and Pacific Islander injection drug users (IDUs), and Asian and Pacific Islander commercial sex workers.

Asian and Pacific Islander CBOs need TA/T on developing culturally and linguistically appropriate group and community-level HIV prevention interventions. Most Asian and Pacific Islander CBOs conduct individual-level HIV prevention interventions. Coordinated multiple-level interventions may be more effective in impacting increased knowledge and behavior change to reduce HIV transmission among Asians and Pacific Islanders.

Asian and Pacific Islander CBOs need TA/T on improving the evaluation of their HIV prevention programs, especially in developing and using outcome evaluation measurements. Although almost all Asian and Pacific Islander CBOs do evaluate their HIV prevention programs, most use process evaluation measurements. Few HIV prevention programs utilize outcome and impact evaluation in their programs.

Behavioral and Social Science

Further development, evaluation, validation, and diffusion of culturally appropriate HIV prevention interventions for Asian and Pacific Islander populations, especially those targeting Asians and Pacific Islanders at highest risk for HIV infection, is needed. There has been almost no prevention science research or evaluation of HIV prevention programs for Asians and Pacific Islanders. Coordinated efforts to identify, develop, and evaluate effective HIV prevention interventions that are culturally and linguistically appropriate for each Asian and Pacific Islander ethnicity/national origin population and each risk behavior group population are needed. Such basic research and evaluation is essential to strengthening HIV prevention programs. Asian and Pacific Islander CBOs

continue to need opportunities to build collaborative relationships with researchers to jointly strengthen HIV prevention programs through the application of HIV prevention science.

Asian and Pacific Islander CBOs need TA/T to address the co-factors for HIV risk and the facilitators to HIV risk reduction that are most common among Asians and Pacific Islanders. Such co-factors may require the development of TA/T on issues of culture, identity and other structural issues not currently part of TA/T on HIV prevention.

Collaboration
Staff from Asian and Pacific Islander CBOs continue to need opportunities to network; share lessons learned, experiences, and expertise; and support one another in HIV prevention. National, regional, and local conferences; working groups; and other opportunities to convene are important TA/T activities for Asians and Pacific Islanders. More formal mentorship, leadership development, and staff exchange programs also should be developed to build the staff capacities of Asian and Pacific Islander CBOs.

Asian and Pacific Islander CBOs also continue to need opportunities to network; share lessons learned, experiences, and expertise; and support one another within specific Asian and Pacific Islander ethnicities/national origin populations. Such opportunities can improve the cultural competence and linguistic accessibility of HIV prevention programs for Asians and Pacific Islanders.

Asian and Pacific Islander CBOs need TA/T in exploring new models of collaboration and programmatic delivery of HIV prevention programs for Asians and Pacific Islanders. In an increasingly competitive funding environment, Asian and Pacific Islander HIV prevention programs will be challenged to explore and implement innovative collaborations with other Asian and Pacific Islander community institutions, other HIV prevention programs (especially in other communities of color), health departments, and funders to sustain their efforts in the future.

Technical Assistance and Training Providers and Formats
Asian and Pacific Islander CBOs need TA/T from a diverse number of TA/T providers, including the CDC, state and local health departments, NRMOs, other CBOs, and academic institutions. Each of these TA/T providers must provide TA/T appropriate to their particular knowledge, expertise, and TA/T skills. For example, it makes most sense for NRMOs to continue to focus their TA/T efforts on the unique cultural and linguistic barriers and facilitators to effective HIV prevention interventions within communities of color such as within the Asian and Pacific Islander communities. NRMOs also should continue to work to build and strengthen national, regional, and local collaborations and increase coordination among Asian and Pacific Islander CBOs.

TA/T should continue to be made available in a diverse number of TA/T delivery methods, including conferences, training workshops, site visits, written information, and phone and e-mail contact.

Recommendations
Organizational Development
1. Asian and Pacific Islander CBOs should continue to be provided TA/T on a diverse number of organizational development issues, including fundraising and resource

development, strategic and long-term planning, volunteer program development, and collaboration.

2. Organizational development TA/T should continue to be provided to existing and emerging Asian and Pacific Islander gay and bisexual men's organizations; such TA/T should be focused on building overall community infrastructure and individual leadership development to support and sustain HIV prevention either directly or indirectly among Asian and Pacific Islander gay and bisexual men.

HIV/AIDS Surveillance and Epidemiology

3. The CDC should ensure that the CDC and that state and local health departments follow OMB Statistical Policy Directive No. 15 and Council of State and Territorial Epidemiologists (CSTE)/CDC guidelines for collecting and reporting data by race/ethnicity, including data disaggregated by Asian and Pacific Islander ethnicities/national origins; the CDC and CSTE should provide TA/T to state and local health departments and HIV prevention community planning groups to ensure compliance with these guidelines.

4. The CDC and other TA/T providers should provide TA/T to state and local health departments and HIV prevention community planning groups on how to obtain and include other relevant data about Asians and Pacific Islanders, including population growth and linguistic diversity, as part of a comprehensive epidemiological profile for HIV prevention community planning.

5. The CDC and other TA/T providers should provide TA/T to state and local health departments and HIV prevention community planning groups on how to conduct trend analysis about HIV and AIDS and other relevant data and on how to make projections about HIV and AIDS cases and other relevant data as part of a comprehensive epidemiological profile for HIV prevention community planning.

HIV Prevention Community Planning

6. There should be a national mechanism established and funded to provide orientation, mentoring, and support to Asian and Pacific Islander members of community planning groups as part of the TA/T provided for community planning.

7. Asians and Pacific Islanders should be provided TA/T on issues of parity, representation, and inclusion so that they can more effectively participate in the HIV prevention community planning process.

8. The CDC and other TA/T providers should provide TA/T to Asian and Pacific Islander CBOs and to HIV prevention community planning groups on effective methods for conducting comprehensive community needs assessments, including surveys, focus groups, key informant interviews, and community forums.

Program Development and Program Evaluation

9. TA/T providers should provide TA/T on program development and program evaluation of culturally and linguistically appropriate HIV prevention interventions for Asians and Pacific Islanders, especially for Asian and Pacific Islander gay and bisexual men and other MSM, Asian and Pacific Islander youth, Asian and Pacific Islander women, Asian and Pacific Islander IDUs, Asian and Pacific Islander

transgender persons, Asian and Pacific Islander commercial sex workers, and other Asians and Pacific Islanders at highest risk for HIV infection.

10. TA/T providers should provide TA/T on program development and program evaluation of culturally and linguistically appropriate HIV prevention interventions for specific Asian and Pacific Islander ethnicities/national origins; such TA/T should focus on the unique cultural and linguistic factors that both pose barriers as well as facilitate effective HIV prevention interventions among that specific ethnicity/national origin population.

11. There should be a nationally coordinated and funded effort to review, develop, and disseminate culturally appropriate HIV prevention materials in Asian and Pacific Islander languages; the development of such materials must be done in Asian and Pacific Islander languages by members of that linguistic and cultural community rather than through translation of existing English language materials.

12. TA/T should be provided to state and local health departments on the importance of linguistic access to HIV testing and other HIV prevention programs for Asians and Pacific Islanders and the importance of Asian and Pacific Islander language HIV prevention materials.

13. Specific TA/T on HIV prevention should be provided to the six Pacific jurisdictions that is culturally appropriate for the region.

14. TA/T should be provided to Asian and Pacific Islander CBOs on improving the evaluation of their HIV prevention programs, especially in developing and using outcome evaluation measurements.

15. TA/T providers should provide TA/T to Asian and Pacific Islander CBOs on developing culturally appropriate group and community-level HIV prevention interventions.

Behavioral and Social Science and Biomedical Research

16. Resources should be provided to both researchers and CBOs to collaboratively develop behavioral and social science research that will evaluate, validate, and diffuse effective HIV prevention interventions for Asians and Pacific Islanders. Resources also should be provided for researchers and CBOs to collaboratively address the co-factors for HIV risk and the facilitators to HIV risk reduction that are most common among Asians and Pacific Islanders.

17. TA/T providers should provide information on behavioral and social science to Asian and Pacific Islander CBOs in a user-friendly format.

18. There should continue to be efforts to facilitate increased collaboration among Asian and Pacific Islander researchers and Asian and Pacific Islander CBOs.

19. TA/T providers should provide information on biomedical research to Asian and Pacific Islander CBOs in a user-friendly format.

Collaboration

20. TA/T providers should provide TA/T on collaboration, especially on innovative models for programmatic and organizational reorganization of HIV prevention programs within Asian and Pacific Islander communities and within communities of color. Such TA/T should examine the impact of collaboration on community support, budgets, revenues, and programmatic effectiveness.

21. TA/T providers should develop leadership development, mentoring, peer exchange, and support programs for Asians and Pacific Islanders working on HIV prevention.

Technical Assistance and Training Providers and Formats

22. There should continue to be a diverse network of national, regional, and local TA/T providers available to Asian and Pacific Islander CBOs, including NRMOS, other CBOs, the CDC, health departments, and academic institutions. TA/T should continue to be made available in a diverse number of TA/T delivery methods, including conferences, training workshops, site visits, written information, and phone and e-mail contact.

References

Asian and Pacific Islander HIV/AIDS Timeline. (September 1998). San Francisco, CA: Asian and Pacific Islander American Health Forum.

Bau I. Asians and Pacific Islanders and HIV prevention community planning. AIDS Education and Prevention. (1998). 10 (Suppl.A): 77-93.

Bau I, Lew S, and Bao D. Strengthening HIV prevention through technology diffusion (1998). San Francisco, CA: Asian and Pacific Islander American Health Forum.

Carrier J, Nguyen B, and Su S. (1992). Vietnamese American sexual behaviors and HIV infection. Journal of Sex Research. 29:547-560.

Centers for Disease Control and Prevention. (1998). HIV/AIDS Surveillance Report. 10(1):16, 18.

Chng CL, Sy FS, Choi ST, Bau I, and Astudillo R. Asian and Pacific Islander American HIV community-based organizations: A nationwide survey. AIDS Education and Prevention. (1998). 10 (Suppl.A): 48-60.

Chng, CL. Providing culturally competent HIV prevention programs for Asian/Pacific Islander Americans in the United States. (1998). (Unpublished manuscript).

Choi K, Coates TJ, Catania JA, Lew S, and Chow P. (1995). High HIV risk among gay Asian and Pacific Islander men in San Francisco. [Letter to the editor]. AIDS. 9:306-307.

Choi K, Salazar N, Lew S, and Coates TJ. (1995). AIDS risk, dual identity, and community response among gay Asian and Pacific Islander men in the United States. In GM Herek and B Green, eds. AIDS, Identity, and Community: The HIV Epidemic and Lesbians and Gay Men. 115-134. Thousand Oaks, CA: Sage Publications.

Choi K, Lew S, Vittinghoff JA, Catania JA, Barrett DC, and Coates TJ. (1996). The efficacy of brief group counseling in HIV risk reduction among homosexual Asian and Pacific Islander men. AIDS. 10:81-87.

Choi K, Yep GA, and Kumekawa E. HIV prevention among Asian and Pacific Islander American men who have sex with men: A critical review of theoretical models and directions for future research. AIDS Education and Prevention. (1998). 10 (Suppl.A): 19-30.

Cochran SD, Mays VM, and Leung L. Sexual practices of heterosexual Asian American young adults: Implications for risk of HIV infection. Archives of Sexual Behavior. (1991). 20(4):381-391.

Cultural Competency Resources for HIV Prevention Programs for Asians and Pacific Islanders. (March 1998). San Francisco, CA: Asian and Pacific Islander American Health Forum.

DeGraaf R, Vanwesenbeeck I, van Zessen G, and Straver CJ. (1995). Alcohol and drug use in heterosexual and homosexual prostitution, and its relation to protection behavior. AIDS Care. 7(1): 35-47.

DiClemente RJ , Zorn J, and Temoshok L. (1987). The association of gender, ethnicity, and length of residence in the Bay Area to adolescents' knowledge and attitudes about acquired immunodeficiency syndrome. Journal of Applied Social Psychology. 17:216-230.

Epidemiology of AIDS and HIV Among Racial Ethnic Communities in California. (1997). Sacramento, CA. California Department of Health Services Office of AIDS.

Fairbank, Bregman and Maullin, Inc. A survey of AIDS knowledge, attitudes and behaviors in San Francisco's American Indian, Filipino and Latino gay and bisexual male communities. (1991).

Flaskerud JH and Nyamanthi AM. An AIDS education program for Vietnamese women. New York State Journal of Medicine. (1988). 88:632-637.

Gellert GA, Moore DF, Maxwell RM, Mai KK, and Higgins KV. Targeted HIV seroprevalence among Vietnamese in southern California. Genitourin Medicine. (1994). 70: 265-267.

Gellert GA, Maxwell RM, Higgins KV, Mai KK, Lowery R, and Doll L. HIV/AIDS knowledge and high risk sexual practices among southern Vietnamese. Genitourin Medicine. (1995). 71: 216-223.

Gock TS and Ja DY. (1995). Providing substance abuse treatment to Asian Pacific clients. In O Amulerli-Marshall, ed. Substance Abuse Treatment in the Era of AIDS. Vol. 2: 223-249. Rocville, MD: Center for Substance Abuse Treatment.

Goh D. (1993). Effects of HIV/AIDS information on attitudes toward AIDS: A cross-ethnic comparison of college students. Journal of Psychology. 127(6):611-618.

Horan PF and DiClemente RJ. HIV knowledge, communication, and risk behaviors among white, Chinese and Filipino-American adolescents in a high prevalence AIDS epicenter: A comparative analysis. Ethnicity and Disease. (1993). 3(2):97-105.

Hou SI and Basen-Engquist L. Human immunodeficiency virus risk behavior among white and Asian/Pacific Islander high school students in the United States: Does culture make a difference? Journal of Adolescent Health. (1997). 20(1):68-74.

Limanonda B, van Griensven GJP, Chongvatana N, and Tirasawat P. (1994). Condom use and risk factors for HIV-1 infection among female commercial sex workers in Thailand. [Letter]. American Journal of Public Health. 84(12): 2026-2027.

McKeganey NP. (1994). Prostitution and HIV: What do we know and where might research be targeted in the future? AIDS. 8(9):1215-1226.

Morris M, Pramualratana A, Podhisita C, and Wawer MJ. (1995). Interventions for sexually active, heterosexual women in the United States. In RJ DiClemente and JL Peterson, eds. Preventing AIDS: Theories and Methods of Behavioral Interventions. 243-265. New York, NY: Plenum Press.

Nemoto T, Wong FY, Ching A, Chng CL, Bouey P, Hendrickson M, and Sember RE. HIV seroprevalence, risk behaviors, and cognitive factors among Asian and Pacific Islander American men who have sex with men. AIDS Education and Prevention. (1998). 10 (Suppl.A): 31-47.

Nemoto T, Aoki B, Huang K, Morris A, Le M, and Nguyen H. HIV risk behaviors among Asian drug users in San Francisco. (1998). (Under review by AIDS Education and Prevention).

Proceedings of the San Francisco International Summit on Filipinos and HIV/AIDS. (July 1998). San Francisco, CA: Filipino Task Force on AIDS.

San Francisco Department of Public Health. (1999). The transgender community health project: Descriptive results.

Siegal D and Lazarus N. (1991). AIDS knowledge, attitudes, and behavior among inner city, junior high school students. Journal of School Health. 61:160-165.

Siegal HA, Carlson RG, and Falck RS. (1992). HIV infection/serostatus outside epicenters: A comparison among injection drug users in high and low seroprevalence areas. In BS Brown and GM Bescher, eds. Handbook on Risk of AIDS: Injection Drug Users and Sexual Partners. 38-71. Westport, CT: Greenwood Press.

Strunin L. (1991). Adolescents' perceptions of risk for HIV infection: Implications for future research. Social Sciences Medicine. 32: 221-228.

Summary Recommendations for Research and Public Policy from Research Agenda Meeting. (1995). San Francisco, CA: Asian and Pacific Islander Wellness Center.

Sy FS, Chng CL, Choi ST, and Wong FY. Epidemiology of HIV and AIDs among Asian and Pacific Islander Americans. AIDS Education and Prevention. (1998). 10 (Suppl.A): 4-18.

Wirawan DN, Fajans P, and Ford K. (1993). AIDS and STDs: Risk behavior patterns among female sex workers in Bali, Indonesia. AIDS Care. 5(3):289-303.

Wong ML, Archibald CA, Chan R, Goh A, Tan TC, and Go CL. (1994). Condom use negotiation among sex workers in Singapore: Findings from quantitative research. Health Education Research. 9: 57-67.

Attachments

1. Members of the National Asian and Pacific Islander Consortium on AIDS and STDs (NAPICAS)

2. August 1997 CBO Survey

3. April 1998 CBO Survey

4. Protocol for Asian and Pacific Islander Gay and Bisexual Men's Focus Groups

5. Protocol for Asian and Pacific Islander Youth Focus Groups

6. Protocol for Asian and Pacific Islander Key Informant Interviews

7. April 1998 Health Department Survey

8. Responses to April 1998 Health Department Surveys