

SUMMER 2003

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Sexual Health of Asian American/Pacific Islander (AAPI) Men Who Have Sex With Men (MSM) in the United States: A Conceptual Model

By **Chwee Lye Chng, PhD,**
University of North Texas

Theoretical models in the past designed to explain risk behaviors have often ignored social, relational, and cultural behavioral factors, viewing these forces as independent variables, without recognizing that they might be interactive or reciprocal. We know that unsafe behaviors are rarely the direct product of merely a deficit of knowledge, motivation, or skill, but instead can have layered meanings within a given complex personal and social-cultural context. Our proposed model (Chng et al., 2002) is based on the premise that Asian American/Pacific Islander (AAPI) men having sex with men (MSM) in the United States typically develop their sense of self in a social-cultural environment marked by triple oppression—racism, homophobia, and immigrant status. We propose a conceptual model to understand sexual health among AAPI MSM as a product of a dynamic cultural process potentially involving multiple generations and moving through different “impact domains.” In this paper, sexual health is the integration of the physical, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication, and love.

Our model first locates the process in the home country (Impact Domain One), with its prevailing cultural norms—including sexual mores, sexual attitudes (shame or stigma), sexual behavior, and drug use. Secondly, these norms, beliefs, and practices will be modified by the migration/immigration



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experience (Impact Domain Two), which for some segments (especially Vietnamese and Cambodian refugees) may include severe trauma and the endurance of prolonged hardships. Although many Pacific Islanders are native to their lands and not “immigrants” in the traditional sense, when they migrate to the mainland, they may experience similar barriers that Asian Americans face, and in that context and to that extent, this model will be applicable to them. Thirdly, these norms, beliefs, and practices will be continually influenced by the process of acculturation (Impact Domain Three), as these AAPIs try to adjust to life in the United States.

An important subset of the third domain is the “generation” factor. Conceivably, the effect of Domains One and Two will be less

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From the Program Director's Desk

E. Duane Wilkerson, MPH,MDiv

I am very pleased to offer you this edition of *The Linkage*. This edition is dedicated to HIV-prevention and planning efforts for the Asian American and Pacific Islander (API) communities in the United States and U.S. territories. As you will read in these articles, the API community is immensely vast, heterogeneous, and often misunderstood. Although government demographers and many in the public health community often use the term "API" as if it referred to a single

community, the term actually incorporates more than 40 different ethnicities and more than 100 languages and dialects (see Prescott Chow's article). The challenges inherent in meeting the HIV-prevention and planning needs for these many distinct populations are enormous.

The authors who have contributed to this edition are national leaders in API communities. Their expertise includes HIV-prevention community planning, conducting interventions, research, and providing technical assistance (TA) or capacity building for prevention and planning. Their perspectives, insights, and recommendations on what it means to provide TA to an API community are extremely helpful and relevant for us. I want to thank each of them for their willingness to share their wisdom and knowledge with us in this newsletter.

I had the pleasure of meeting most of the contributors to this edition of *The Linkage* at the Asian and Pacific Islander Summit on HIV/AIDS Research (A&PI SHARE) in Oakland, CA, last November. The conference was a great success, with more than 300 registered participants from across the United States and U.S. territories. A&PI SHARE was the first-ever national forum for API researchers, health care and service providers, and consumers to examine jointly these issues and the current state of research. The summit had four goals:

1. Promote API-specific research in care, treatment, and prevention within a global context;
2. Enhance the exchange of technical and cultural competence between researchers and service providers to serve effectively APIs living with HIV;



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3. Support the development and application of new technologies and interventions for the prevention and care of HIV disease among APIs; and

4. Increase the participation of APIs living with HIV in the development and adaptation of research and services.

I am pleased to report that the BSSV Program completed a successful basic training for 21 BSSVs this June. Attending the training were CDC project officers from the Prevention Program Branch (PPB), CDC researchers from the Capacity Building Branch (CBB), and our program officer from the Academy for Educational Development (AED).

This year marks the beginning of our collaboration with CDC's Diffusion of Effective Behavioral Interventions (DEBI) initiative. One of the goals of DEBI is to train CBOs across the country in how to implement selected interventions with demonstrated effectiveness in producing behavioral changes related to HIV risk. Part of this effort includes matching CBOs with BSSVs who will act as coaches to CBO staff involved with implementing the selected interventions. Trainings for these interventions will begin this year.

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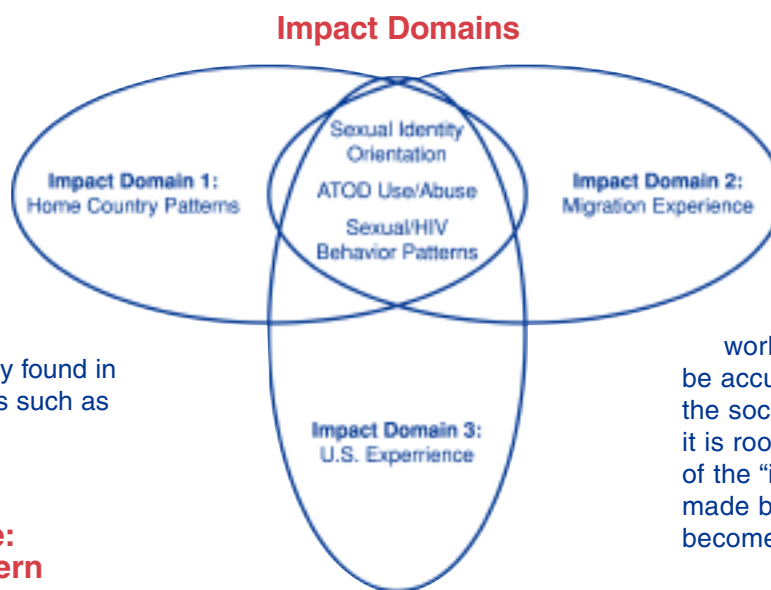
significant for those who were either very young at the time of immigration or are born in the United States. The effects of the first two domains (cultural norms of home country and the effects of migration/immigration) on individuals may also vary by the degree to which a particular immigrant community remains socially and culturally insulated (e.g., through language, social networks, cultural practices, economic participation) vis-à-vis the surrounding mainstream community and the larger influences of “American cultural practices and norms” (e.g., social norms, gender roles, and behavior codes commonly found in key socializing institutions such as schools, courts, and mass media).

**Impact Domain One:
Home Country Pattern**

Talking about illness (e.g., HIV) is taboo in many Asian cultures and avoided at all cost. For example, the Chinese words for three and four are homophones for birth and death, respectively. Hence, many customs include groupings of three items and avoid groupings of four. The Japanese share the avoidance of “four” because the word for four, “shi,” is also a homophone for death.

Because sexual issues are rarely discussed openly in homes, schools, or community, many young AAPI adults have minimal experience or skills in coping with relationships, sex, and sexuality issues in later life. This lack of experience can lead many to feel socially awkward (Lai, 1998). For example, candid public discussion about sexual issues is not easy with AAPI men, especially when

non-Asians are also present. Additionally, the cultural need to avoid interpersonal conflict in highly hierarchical systems, such as among Chinese and Japanese, can endorse silence over open dialog about sexuality. For some AAPI MSM, sometimes protecting their partners from uncomfortable feelings takes precedence over protecting themselves from risks of HIV.



Gay AAPI men have a difficult time in their own communities because of the continual denial of their existence; there is a prevailing belief that homosexuality is an indication of the “decline and evil of Western civilization” (Ruan, 1991). Because the family is such a powerful social unit, AAPI MSM often have to choose between perpetuating their family name through marriage or seeking personal satisfaction through same-sex relationships. The conflicts between ethnic and sexual identities might hinder safer-sex behaviors (Chng & Geliga, 2000). For example, whereas China decriminalized homosexuality in 1997 and removed it from a list of mental illnesses in 2001, the norm in the Chinese gay community is to get married, have

children, and pass as heterosexual at work, but frequent gay establishments afterwards (Ruan, 1991). This growing underground community of partly closeted, partly liberated, and sexually active gay males with dual identities can present unique challenges to HIV prevention. Sexuality for these men, often married with wives and children, finds expression in anonymous, sexual encounters with other men. Messages

tailored for “gay men” will not necessarily resonate with them. Although research has shown that difficulties in coming out as gay men and a lack of social support are predictors of high-risk behaviors (Catania, Coates, & Stall, 1991), within the AAPI immigrant world, individual behavior cannot be accurately understood apart from the social-cultural structures in which it is rooted. Seen in this light, many of the “irrational” sexual choices made by AAPI MSM immigrants become more understandable.

**Impact Domain Two:
Migration Experience**

Migration, in essence, is a dynamic, time-dependent process of discontinuity and transition, where an individual moves from a familiar world to an unknown, confusing, distressing, but sometimes rewarding, life in a new country (Sabatier, 1996). It involves a loss of the cultural environment of the home country and an attempt at integrating sociocultural constructs and values of the new host country (Chng & Geliga, 2000; Haour-Knipe & Rector, 1996). It is important to clarify that being an immigrant, in and of itself, is not a risk factor for HIV. It is the circumstances encountered and the activities undertaken during the

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migration process that are risk factors. In our study (Chng & Geliga, 2000), we found that of those AAPI MSM born overseas, the ones who had lived longer in the United States were less likely to engage in unprotected anal sex. For many immigrants, time spent in the United States is positively correlated to acculturation levels and exposure to HIV-prevention information in gay culture.

AAPI migrants have other concerns, such as legal, housing, and employment problems, far more pressing than a seemingly distant threat of AIDS (Haour-Knipe & Rector, 1996; Sabatier, 1996). Health may not be a first priority, and an effective HIV intervention may have to widen its scope in order to be acceptable to this population. Forced to work in low-paying service industry jobs that rarely provide health insurance, many AAPI MSM immigrants may overlook serious HIV-related illnesses until they reach later stages of the disease, then rush to the hospital for emergency treatment. Until then, many are unaware that they are HIV positive or have full-blown AIDS. Many illegal immigrants avoid HIV testing or medical care, fearing that a positive HIV result will ruin any chance they have of gaining legal residency.

Undocumented HIV-positive immigrants often fear returning to their native countries where potentially life-saving therapies are rare and where they are more likely to face discrimination. Instead, they risk deportation by going underground. In addition, AAPI MSM immigrants without marketable skills attempting to escape extreme poverty may resort to trading sex for goods, services, and cash. Because of language, culture, and power disparities, many AAPI MSM, particularly newly arrived immigrants, are unaccustomed to

initiating sexual discussions or negotiating safety with their partners (Yoshikawa et al., 1999).

**Impact Domain Three:
U.S. Experience**

Significant stressors are created by the acculturation process to life in the United States, regardless of migration experiences (Takeuchi & Young, 1994; Wong et al., 2002). The acculturation process may include significant changes in social status, challenges to traditional gender roles, and the effects of coping with racism and homophobia. Acknowledging its limitations, to facilitate understanding of acculturation with AAPI MSM, we use the Fung taxonomy of three distinct groups (1994). The first group consists of AAPI-identified and gay-identified men; it is usually the least closeted and most politically involved, and, not surprisingly, the most responsive to mainstream HIV prevention.

The third group, the most closeted and hardest to reach, refers to AAPI men who are not gay-identified and live and work in their ethnic community.

The second group, men who are gay but not AAPI-identified, makes up the largest of these three groups, and is most diversified. They experience cultural ambivalence, having to choose between the values of their ethnic community and the values of the predominantly White gay culture. The majority choose “gay White values” and associating exclusively with White men, rejecting everything that is AAPI. This might be the phenomenon of White identification in the AAPI MSM community described by some researchers (Choi et al., 1995; Wat, 2002).

The third group, the most closeted and hardest to reach, refers to AAPI men who are not gay-identified and live and work in their ethnic community. They are limited in their ability to move freely in the gay community because of their immigration status, language, and cultural barriers. These individuals are most likely to participate, if they participate at all, in social clubs organized by White men who want to meet AAPI men, such as Pacific Friends, Asians and Friends, and Long Yang Club. This is the group that most accurately reflects the definition and characteristics of AAPI MSM, as they seldom perceive themselves as gay (Yoshikawa et al., 1999; Wong et al., 2002).

Conclusion

Behavioral and social scientists are encouraged to explore the following issues when working with AAPI MSM: Xenophobia and stigmatization of immigrants, impact of legislation on access to prevention and mental health services, and perceptions of stigma/shame related to HIV and homosexuality/bisexuality in AAPI subgroups. In the course of providing technical assistance, scientists should also consider including assessment items related to current immigration status of respondents, length of time in the United States, health coverage and access to health care, and whether respondents are HIV tested or not.

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The first intervention selected for transfer through the DEBI initiative is called VOICES/VOCES (O'Donnell, O'Donnell, San Doval, Duran, & Labes, 1998). This is a group-level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Participants, grouped by gender and ethnicity, view an English or Spanish video on HIV-risk behaviors and condom use and take part in facilitated discussions. Six volunteers attended this training with me in Boston in May.

I want to announce the formation of the BSSV Advisory Committee.

The second intervention disseminated through the DEBI initiative is PROMISE (Fishbein, Higgins, Rietmeijer, & Wolitski, 1999). This is a community-level intervention based on several behavior change theories. A community identification process is conducted, role model stories are written from target population interviews. These stories are distributed along with other risk-reduction materials to help people move toward safer sex or risk-reduction practices. The intervention can be adapted for various population groups (e.g., IDUs, MSM, sex workers, or high-risk youth). The PROMISE training is scheduled for September this year. We have 30 volunteers who have signed up for this training.

Some of you know that I traveled to Sub-Saharan Africa last November. I was in Botswana and Lesotho for a short period of time. The occasion and opportunity came

through one of our volunteers, Dr. Donna Champeau, professor at Oregon State University, Department of Public Health. Dr. Champeau and her colleagues have a U.S. State Department grant to do some needs assessment and program development work in public health, including HIV prevention, in these two countries. They were interested in the BSSV technical assistance model, particularly to what extent the model would work in these countries. Needless to say, the experience was incomparable. It was overwhelming, beautiful, tragic, and hopeful all rolled into 9 packed days. I barely got my feet wet in this international experience but hope that it is only the beginning of an ongoing effort to expand the BSSV Program model to new horizons.

Finally, I want to announce the formation of the BSSV Advisory Committee. This committee will represent the volunteers and serve as advisors to the BSSV Program. The committee members will meet quarterly and consist of six BSSVs representing different disciplines. I am pleased to introduce to you the first six BSSVs selected to be on the committee: David Baranov from Rochester, NY; Nancy Brown from Palo Alto, CA; Kimberly Coleman from Washington, DC; Ann O'Connell from Storrs, CT; Francisco Javier Parga from Bayamon, Puerto Rico; and Scott Rhodes from Chapel Hill, NC. The term for each member serving on the committee will be 2 years. They will meet with the BSSV staff four times a year—three times in conference calls and once a year in a face-to-face meeting. The first face-to-face meeting was held in April at the APA offices in Washington, DC. ▼

Addressing HIV/AIDS Among Asian and Pacific Islander Populations: CDC's Capacity-Building Assistance Program

By Bryan Kim, MPH,
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Sociodemographics

According to the 2000 census, Asian and Pacific Islanders (APIs) are the fastest growing ethnic population in the United States. In 1980, the population of APIs stood at 3.7 million, representing 1.6% of the population in the United States. In 2000, the population of APIs in the United States more than doubled, representing 3.6% of the population at 10,242,998. There are more than 100 languages and dialects spoken by Asian and Pacific Islanders in the United States (2000 United States Census Bureau). States where the majority of Asian and Pacific Islanders reside are California, New York, Texas, Hawaii, Illinois, Washington, Florida, Virginia, Massachusetts, and Maryland. Approximately 7,530,900 APIs reside in those 10 states, comprising 74% of the total U.S. API population.

HIV/AIDS Among Asian and Pacific Islanders in the United States

As of December 2001, the cumulative total of all reported AIDS cases among APIs in the United States was 6,157. Approximately 87% of those cases were among men, and 13% among women. Of the total number of cumulative AIDS cases

among API men, 44% were between the ages of 30-39. For API women, 36% of the total number of cumulative AIDS cases were among those between the ages of 30-39.

Approximately 71% of all API male cumulative adult/adolescent AIDS cases through 2001 occurred under the exposure category of men who have sex with men (MSM). For API adult/adolescent females, 49% of cumulative AIDS cases were reported under the exposure category of heterosexual contact.

Among the 39 states and territories with confidential HIV infection reporting through December 2001, the number of API HIV infection cases reported was 852. This number includes only those individuals reported with HIV infection who have not developed AIDS. Approximately 75% of those cases were among API men, with 47% of the men in the age range of 25-34 (CDC, HIV/AIDS Surveillance Report, 2001).

CDC's HIV/AIDS Capacity-Building Assistance (CBA) Program

What is Asian and Pacific Islander (API) capacity-building assistance?

In order to address the HIV/AIDS epidemic among Asian and Pacific Islander populations, the Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention (DHAP) provides funding to four national capacity-building assistance (CBA) providers serving API populations. These providers address the capacity-building needs of community-based organizations and other stakeholders working with Asian and Pacific Islander populations. Capacity-building



Bryan Kim

assistance focuses on increasing core competencies that are essential to increasing the effectiveness and sustainability of HIV prevention activities within an organization or community. The CBA providers contribute to the quality, quantity, or cost effectiveness of intervention activities and/or sustainability of the infrastructural systems that support these activities. In light of this, the API CBA strategy is composed of four priority areas:

Priority Area 1: To improve the capacity of community-based organizations to develop and sustain organizational infrastructures that support the delivery of effective HIV-prevention-service interventions for the API community.

Examples of Priority Area 1 services include:

- Training materials development
- Organizational assessment
- Fiscal Management

Priority Area 2: To improve the capacity of community-based organizations to design, develop, implement, and evaluate effective HIV prevention interventions for APIs whose behavior places them at risk for acquiring or transmitting HIV and other STDs.

Examples of Priority Area 2 services include:

- Service integration
- Effective health communication message development

- Intervention adaptation or replication
- Priority setting for interventions and target populations
- Population-based needs assessment
- Collaboration with researchers
- Curriculum development

Priority Area 3: To improve the capacity of API community stakeholders, including CDC-funded community-based organizations, to build and strengthen community infrastructure for HIV prevention.

Examples of Priority Area 3 services include:

- Community leadership development
- Network development
- Policy development and analysis

Priority Area 4: To improve the capacity of API community-based organizations, community members, and other HIV prevention stakeholders to effectively participate in the HIV prevention community planning process.

Examples of Priority Area 4 services include:

- Use of parity, inclusion, and representation in the community planning process
- Use of data for decision making
- Public speaking and persuasion

What is the foundation for the API CBA strategy?

The foundation for the API CBA strategy is based on the recognition that:

- The involvement and participation of API communities is critical to reducing HIV infection.
- Local consultants are more likely to be knowledgeable about the

local epidemic, culture, and effective interventions.

- Intervention effectiveness is the cornerstone of HIV prevention.

Who is the target audience for CBA services?

The primary audiences for receiving CBA services are CDC-funded community-based organizations, health departments, and projects that serve API populations as well as API community stakeholders in geographical areas with a high prevalence of HIV/AIDS. However, indirectly and non-CDC-funded API organizations may also inquire about CBA services.

How do people access CBA services?

CDC-funded community-based organizations interested in receiving assistance should directly contact their CDC project officer or call (404) 639-5230. Indirectly funded capacity-building organizations (CBOs) (funded through the health department) can directly contact their local and or state health department to inquire about these services. Non-CDC-funded community-based organizations and community stakeholders can contact one of the CBA providers directly to inquire about these services (see information below).

Who are the CBA providers serving APIs?

Asian and Pacific Islander American Health Forum (APIAHF)
 942 Market Street, Suite 200
 San Francisco, CA 94102
 Phone: (415) 954-9970
 Web site: www.apiahf.org

- Funded for Priority Areas 1 (subcontract), 2, 3, and 4

Asian and Pacific Islander Wellness Center (APIWC)
 730 Polk Street
 San Francisco, CA 94102
 Phone: (415) 292-3420

Web site: www.apiwc.org

- Funded for Priority Areas 3 and 4

National Minority AIDS Council (NMAC)

1931 13th Street
 Washington, DC 20009-4432
 Phone: (202) 234-5120
 Web site: www.nmac.org

- Funded for Priority Area 1

PROCEED, Inc.

1126 Dickinson Street
 Elizabeth, NJ 07201
 Phone: (908) 351-7727
 Web site: www.proceedinc.com

- Funded for Priority Area 1

How is the Behavioral and Social Science Volunteer (BSSV) Program related to the CBA strategy?

The BSSV Program's national network of psychologists, sociologists, anthropologists, and public health experts provides technical assistance and services that are consistent with those under Priority Area 2. The primary responsibility of the CBA providers is to provide CBA services to CBOs that are directly funded by CDC. The BSSV Program has shifted its primary focus to CBOs that are funded by their state or local health departments (indirectly funded by CDC). However, both CBA providers and the BSSV Program can provide TA to either group of CBOs.

In an effort to coordinate these efforts and avoid duplication, the CDC CBA coordinator decides whether a CBA provider or the BSSV Program should respond to a request. This is not something the volunteers with the BSSV Program need to be concerned with. This decision is made before the BSSV Program staff contacts the volunteer. The BSSV Program has provided assistance to CBA providers, and it is excited about future collaborative opportunities. ▼

Providing Service to Asian Americans and Pacific Islanders: An Asian Capacity-Building Assistance (CBA) Perspective

By Prescott Chow,
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Background

Asian Americans and Pacific Islanders (AA&PIs) are extremely diverse, comprising more than 40 different ethnicities that speak over 100 languages and dialects. AA&PIs include Chamorro, Chinese, Filipinos, Koreans, Lao, Hawaiians, Hmong, Indians, Japanese, Samoan, Thai, Tongan, and Vietnamese, among others. The U.S. Census projects that by the year 2005, AA&PIs will comprise more than 4% of the total U.S. population, with native born AA&PIs comprising 40% and foreign born AA&PIs comprising 60% of that 4%.

AA&PIs are just as susceptible to HIV/AIDS as are other racial or ethnic groups. Although the number of reported AIDS cases among Asian Americans and Pacific Islanders remains small, lack of detailed HIV surveillance, underreporting, and misclassification often mask the true impact of the HIV epidemic on AA&PIs.

Asian Americans and Pacific Islanders are often stereotyped as the “model minority” in health, education, and economic status. AA&PIs, however, are often underserved in health care. In fact, AA&PIs have higher rates of many preventable diseases that are cofactors for HIV infection, such as tuberculosis and Hepatitis B.

Asian and Pacific Islander American Health Forum

The Asian and Pacific Islander American Health Forum (APIAHF) is

a national minority organization dedicated to promoting policy, program, and research efforts to improve the health and well-being of AA&PI communities in the United States and U.S.-affiliated jurisdictions. APIAHF advocates on health issues of significance to AA&PI communities, promotes community-based capacity building and training, conducts research, disseminates information, and convenes regional and national conferences on AA&PI health. APIAHF was founded in 1986 to address the health status and access disparities among Asian Americans and Pacific Islanders. APIAHF approaches activities with the philosophy of coalition building and developing capacity within local Asian and Pacific Islander communities.

The API HIV Capacity-Building Assistance Program

The APIAHF HIV project, funded through the Centers for Disease Control and Prevention (CDC) and the Office of Minority Health (OMH), seeks to increase the programmatic and organizational capacities of community-based organizations (CBOs) and health departments that provide HIV prevention interventions to AA&PI populations in the United States and its jurisdictions. This national program, known as the API HIV Capacity-Building Assistance Program (API HIV CBA Program), works with five regional partners. These partners are the Asian and Pacific Islander Coalition on HIV/AIDS in New York, NY; Asian Health Coalition of Illinois in Chicago, IL; Asian and Pacific Islander Wellness Center in San Francisco, CA; Asian Pacific AIDS Intervention Team in Los



Prescott Chow

Angeles, CA; and Maui AIDS Foundation in Wailuku, HI.

The API HIV CBA Program provides capacity building in program development, community mobilization, HIV-prevention community planning, organizational development, and new technology.

In addition to its regional partner agencies, APIAHF also collaborates with other HIV/AIDS minority CBA providers. These include the National Minority AIDS Council (NMAC), PROCEED, National Native American AIDS Prevention Center (NNAAPC), National Alliance of State and Territorial AIDS Directors (NASTAD), National Youth Advocacy Coalition (NYAC), U.S. Mexico Border Health Association, Association of Asian Pacific Community Health Organizations (AAPCHO), and the API Institute on Domestic Violence. Collaborative projects include joint CBA workshops and trainings, AA&PI CBO outreach, special AA&PI focus newsletter contributions, assessment tools development, and community mobilization efforts.

Who We Work With

APIAHF works primarily with community-based organizations and health departments whose HIV-prevention programs serve AA&PI

communities and other AA&PI community stakeholders and community planning groups in the United States and U.S. jurisdictions. APIAHF also works closely with behavioral and social science researchers, minority graduate students, and federal agency representatives that are interested in this area. APIAHF approaches activities with the philosophy of peer-to-peer assistance, coalition building, and developing capacity within local Asian and Pacific Islander communities on local, regional, and national levels.

Peer-to-Peer Assistance

Our program values the contributions and perspectives that CBO staff, community stakeholders, community planning members, CBA providers, researchers, health department staff, and federal agency representatives can provide to work toward addressing HIV in AA&PI communities. Participants are treated as peers and colleagues. Workshops, trainings, meetings, and conferences usually include a mix of participants from all of these areas. Together, participants address issues and develop and implement solutions and action plans. This approach has created a strong AA&PI pool of expertise as well as a sense of collective purpose and collegiality. This approach also supports networking and collaboration between individuals who may not usually work together.

In addition, participants may address ongoing and on-demand CBA requests with this approach. Primarily, CBA providers fulfill requests; however, CBO requesters may learn and gain additional valuable knowledge from colleagues in the field. Innovative assistance includes CBO staff roundtable discussions on specific program areas and staff-shadowing opportunities.

Local, Regional, and National Focus

The program utilizes a combination of locally, regionally, and nationally focused objectives and activities. This comprehensive, multilevel approach supports the national objectives and activities and keeps them grounded in local and regional issues. This also supports the program's continued efforts to provide leadership development opportunities for AA&PIs working in HIV/AIDS.

Highlights of CBA Work

APIAHF and its partner agencies have convened or helped convene more than 25 conferences, trainings, network meetings, and other capacity-building assistance activities in the past 5 years. Examples of these include:

- Asian and Pacific Islander Institute/Community Planning Leadership Summit—Los Angeles 2000, Houston 2001, Chicago 2002
- Pacific Islander Jurisdictions AIDS Action Group Planning and Development Meeting—Honolulu 2001, Houston 2001, San Francisco 2001, Atlanta 2002
- Prevention for Positives National Meeting—San Francisco 2002
- Asian and Pacific Islander Institute U.S. Conference on AIDS—Dallas 1998, Denver 1999, Atlanta 2000, Miami 2001, Anaheim 2002
- HIV+ Asian & Pacific Islanders
- National Asian and Pacific Islander Youth Working Group (Ongoing)
- Asian and Pacific Islander Women's HIV/AIDS National Network (Ongoing)
- National Asian and Pacific Islander Transgender HIV Network (Ongoing)

- Asian & Pacific Islanders Living With HIV Leadership Development Working Group (Ongoing)

Lessons Learned

Complexity of Communities

One size does not fit all—the diversity of AA&PI communities is often unrecognized by many non-AA&PIs. One extreme example is the combination of Asians with Pacific Islanders into the term *AA&PI*. Lumped together into one community, the nuances of each community are lost. While there are some broad generalities that can be made about the AA&PI community in the United States, it would be more accurate to discuss the different AA&PI communities by ethnicity, geography, and socioeconomic status.

Complexity of CBO Environments

CBOs are constantly challenged with ever-changing levels of resources and capacities. Staff turnover, funding concerns, and community mobilization barriers are common issues for all CBOs. Having capacity is not a static state, but a fluid one. Once achieved, it is mistakenly assumed that an organization will always have capacity. For example, organizations that are stable, capable, and effective in their provision of services can lose this capacity from staff turnover of key personnel in the program, a loss or ending of funding that supported the work, internal and external forces, etc. For AA&PI organizations working in HIV, stigma around the disease and related issues of sex, sexuality, and drug use add to the challenges in providing effective, sustained interventions. Because of the myth that the disease does not affect AA&PI communities, many AA&PI HIV organizations also lack the financial resources that mainstream HIV

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Recruiting Asians and Pacific Islanders to Your CPG

By Edward Tepporn,
Program Coordinator,
Asian and Pacific Islander
American Health Forum

Of the 50 states, 6 cities, and 5 U.S. territories that convene HIV-prevention community planning groups (CPG), at least 36 do not have Asians and Pacific Islanders serving on their CPG (based on year 2000 membership grids). I've asked several CPG members around the country why there were no Asians and Pacific Islanders (A&PIs) serving on their CPG. Responses usually fell into the following three categories:

- We don't have a significant A&PI population in our area.
- We're not sure how to recruit A&PIs.
- We don't have many A&PI HIV/AIDS cases compared to other groups.

To reflect the growing A&PI population in the United States, more CPGs have begun to actively recruit A&PIs as members. Below are a few questions that you may find helpful to consider should you specifically target A&PIs for recruitment onto your CPG.

1. Who are we targeting to recruit?

The term *A&PIs* encompasses a broad diversity of Asian ethnicities and at least 19 different Pacific Islander ethnicities, each with its own unique history, culture, and value system. No individual A&PI should be expected to represent the entire A&PI population. Thus, it may be helpful to examine census data to figure

out what the largest A&PI ethnic communities in your area are and try to recruit individuals from those particular communities. (It would be preferable to examine HIV/AIDS surveillance data, but most states don't break down this data by A&PI ethnicity.)

2. Where are we going to recruit A&PIs?

Some areas of the country have programs or AIDS service organizations that specifically target Asian and Pacific Islander communities. Their staff and volunteers represent a potential pool of new A&PI CPG members. But perhaps there are no such organizations in your area. Here are a couple of other A&PI-specific and ethnic-specific groups where you may find A&PIs who are interested in serving on your CPG:

- Health organizations
- Immigrant/refugee organizations
- Gay A&PI groups
- High school student groups
- College student groups
- Cultural groups
- Civic groups
- Social groups
- Religious organizations

3. Why do we think a certain person would make a good A&PI CPG member?

So you've found a person in one of these A&PI groups who has expressed interest in joining your CPG. Keep in mind that simply being A&PI does not automatically make a person the perfect CPG candidate. Some potential qualities to look for when recruiting potential A&PI CPG members (especially if a person is expected to represent A&PI communities) include:



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- Knowledge of A&PI cultures and issues and contacts within A&PI communities
- Knowledge/contacts with other cultures/issues/communities (for example MSM, women at risk, youth, IDU)
- Some degree of comfort with talking about HIV/AIDS, sexuality, sexual orientation, and/or gender issues
- Ability to contribute to the overall CPG planning process

4. What are some of the potential barriers to recruitment?

According to CPG membership grids included in each state's and jurisdiction's cooperative agreement with CDC, only 67 A&PIs were participating in CPGs during 2000. This included 27 members from Guam and Hawaii, where A&PIs constitute a majority of the population. A few of the barriers that may account for such a low number of A&PI CPG members include:

CPG meeting schedule

Many CPG meetings still take place during weekday business hours. For those CPG members and potential CPG members who don't work for the health department or for community-based organizations, this is a major barrier to participation. Many A&PI (and non-A&PI) community members are unable to take the time off from their jobs to attend the multiple CPG meetings that occur throughout the year.

A&PI cultural value of nonconfrontation

A generalized theme among many A&PI cultures is the avoidance of confrontation. Think about your last few CPG meetings. Were there any fairly contentious moments? Did anyone raise his or her voice during the meeting? Some A&PIs (and non-A&PIs) may be uncomfortable with heated discussions that may arise during CPG meetings (often when the agenda items include budget discussions). How does this affect A&PIs' parity inclusion and representation? How can your CPG adjust its bylaws, procedures, or overall CPG culture to accommodate the differing communication styles and differing levels of comfort with confrontation in your CPG?

Lack of A&PI prioritization

As previously mentioned, one rationale that some CPGs may use to justify the lack of A&PIs on their CPGs is that the number of A&PI HIV infections is low in comparison to the numbers in other racial populations. However, it may be interesting to look at surrogate markers (such as STD surveillance data, teen pregnancy rates, etc.) for A&PI populations. Also, current HIV/AIDS data is collected from health departments, hospitals, and doctors. If there has never been HIV/AIDS prevention specifically targeted to the A&PI communities in your area, then how likely is it that your average A&PI community members would know how HIV is

transmitted, be aware of their potential self-risk for HIV, be aware of the HIV-testing options available in their area, and be motivated enough to refer themselves for HIV testing? Even if they were motivated to walk in for an HIV test, how culturally and/or linguistically competent is that service provider (especially in regard to A&PIs who are recent immigrants or who do not speak English as their native language)?

In summary, we must consider whether or not our current HIV/AIDS surveillance data reflects the true epidemic in our A&PI communities. If it does not, still our census data clearly shows that A&PI populations are growing in most areas of the country. As these communities become larger, it becomes even more important for us to involve them in community health efforts, such as our HIV-prevention CPGs. If our HIV/AIDS surveillance data is accurate, then there may not be as many cases of HIV/AIDS in A&PI communities as compared to other racial groups. But this does not mean that A&PIs should be excluded from our HIV-prevention CPGs. After all, isn't the entire point of HIV prevention to PREVENT the disease from reaching epidemic proportions? Perhaps it is time that we made a more concerted effort to recruit A&PIs.

If your HIV-prevention community planning group would like to access CDC-funded capacity-building assistance services to increase Asian and Pacific Islander participation, then please contact either Lina Sheth at the Asian and Pacific Islander Wellness Center at (415) 292-3420, extension 320, lina@apiwellness.org; or Prescott Chow at the Asian and Pacific Islander American Health Forum at (415) 954-9970, pchow@apiahf.org. ▼

HIV Community Planning in the Pacific Island of Guam, USA

By **Randall L. Workman, PhD**,
*Professor of Sociology and
Community Development,
Guam Cooperative Extension,
University of Guam*

The Pacific Island of Guam is facing an intensified urgency for HIV/AIDS community planning that must begin to employ a comprehensive approach, one that addresses the continuum of services from prevention of HIV to the care of people and communities affected by HIV/AIDS in the Pacific Island nations and territories region affiliated with the United States.

With only 210 square miles (about 7 x 30 miles) and a 2000 census population of 154,000, the Pacific Island of Guam has the entire arc of Asia within a 2-3-hour plane flight. Travel is easy from Korea, Japan, Taiwan, Hong Kong, the Philippines, Thailand, and Australia, but it's more than 9,000 miles to Washington, DC, and Guam's administrating power, the United States. Even Hawaii is 6-7-hours' flying time. In Guam, one of Asia's holiday paradise destinations, tourism dominates the private economy, while the government and military are the major employers. Location is a factor for Guam, which has one of the highest rates of HIV infection in the Pacific Basin. (Comparable incidence rates in 1998 were: Guam, 27.4 per 100,000; New Caledonia, 23.2; French Polynesia, 20.8; Australia, 31.2.)

Guam is also a hub for the remote islands in the western Pacific Ocean, the U.S. affiliated islands of Micronesia. This Pacific Island region, an ocean area larger than the continental United States, has a population of only about 300,000 on 200+ islands that have a total landmass about the size of the

smallest U.S. state, Rhode Island. While the district center islands have transportation and telecommunications services, isolation has limited the extent to which local public health and primary care services have developed any capacity to handle HIV/AIDS.

It hasn't been an issue until recently. For years, HIV/AIDS had been restricted to the military/tourist islands of Guam and the Commonwealth of the Northern Mariana. But next to Guam, the island state of Chuuk, Federated States of Micronesia, has exploded in the last 3 years from zero indigenous HIV infections to 2 infections to 22 infections.

As a practicing sociologist with the Cooperative Extension Community Development Program at the University of Guam for the past 24 years, I have specialized in applied research and planning for health and human service programs in the Pacific Islands. The only local professional organization when I first arrived was the Guam Association of Social Workers, which became my linkage to public agencies and community associations where I could practice behavioral and social science. It set the course of my career, in which I am a university extension resource available to work with the island's full range of health programs, from infectious diseases to chronic health problems, and from physical health to mental health.

Thus, in 1988, I was an advisor to the Guam Department of Public Health and Social Services (DPHSS) when its staff conducted an HIV/AIDS knowledge, attitudes, and beliefs study that was modified from versions by the National Center for Health Statistics. This had limited utility for program planning and led the Guam DPHSS to fund the university extension service to con-



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duct a more targeted needs assessment study. The study design obtained availability samples and surveyed persons from defined high-risk groups (i.e., men who have sex with sex men, sex industry workers, intravenous drug users, persons with multiple partners, etc.). Working with the STD/HIV prevention program at the Guam DPHSS, we have conducted this study design twice, first in 1989-1990 and again in 1995-1996. Because of recent concerns about needs within the island's sex industry, we did a secondary analysis of the 1996 data with new street interviews. This report has a spin-off online publication.*

Guam has had an HIV-prevention community planning (CPG) process since 1994, and most of my involvement over the years has simply been as the social science member of Guam's CPG. Guam's CPG process is different (as I understand the descriptions explained to me) from that in most states and in designated metropolitan urban areas of the U.S. mainland. Like all the U.S. affiliated Pacific Island jurisdictions, Guam's prevention and primary care services are predominately government based and delivered.

Addressing this condition, Vince Crisostomo, executive director of Guam's Coral Life Foundation, has worked with the other Pacific Islands to form a regional nongovernmental organization (NGO)—Pacific Island Jurisdictions AIDS Advocates Group (PIJAAG)—to mobilize the region's CPGs and persons living with HIV/AIDS as a single voice speaking with the U.S. government. Guam is the only island in Micronesia that has evolved NGOs, and only in recent years has the Guam DPHSS begun to privatize HIV/AIDS services by outsourcing grants to NGOs.

Providing technical advice on organizational sustainability to community-based nongovernmental AIDS organizations has also been one of my behavioral/social science role activities. In 1991, Arrow was Guam's first nonprofit organization. It published a local newsletter (1992-1997); conducted public advocacy on AIDS issues; and carried out direct volunteer service work, such as providing care baskets to people living with HIV/AIDS. The organization disbanded as a formal organization in 1997. The Coral Life Foundation was organized in 1993 with a close working involvement of the Guam DPHSS; volunteer liaisons to Guam's business community; and volunteer liaisons to Guam's gay, lesbian, and transgender communities. This NGO is still active. Other specific groups have also organized over the years, such as Gays and Lesbians of Guam (1994-1995), which also published a local newsletter. Perhaps of greatest importance to current issues was Paloa'an Plus, a support group organized by five HIV+ Pacific Island women to advocate against the lack of primary health care services to meet the needs of persons living with HIV/AIDS.

Paloa'an Plus ("Paloa'an" is the Chamorro word for women) has weakened as members have progressed in the disease, but their cause has finally begun to be

addressed by Guam's service provider network. The Ryan White CARE Act Needs Assessment Advisory Council was formed in June 2002 as part of a project supported by HRSA Ryan White CARE Act Title III funding to engage community involvement in the assessment of need and development of a planned system of care mobilizing primary health care services. Again, I'm engaged in a social science needs assessment, but one now expanding the issue to development of a comprehensive continuum of services, ranging from prevention of HIV to the care of people and communities affected by HIV/AIDS.

Even so, in a small insular community where everybody knows and sees everybody else, confidentiality is nearly impossible.

A major aim of this study concerns how HIV/AIDS cases are counted by the CDC. This issue can be assigned a dollar value by the gain or loss of federal funds for HIV/AIDS allocated to states and territories, based upon such counts. This may not be a problem for U.S. states and cities, but for small, isolated areas like the Pacific Islands—it is. Guam can't meet the minimum counts required by federal agencies to receive funds. Guam actually had its first confirmed HIV-positive test in 1984, but since the island lacked the public health lab facilities, the case was sent to Hawaii. Following official policy, the case was recorded there, so Guam's count record began in 1985, when federal assistance established lab testing on the island. Even so, in a small insular community where everybody knows and sees everybody else, confidentiality is nearly impossible. Guam's CPG members are

personally aware that many people have tested off-island in Hawaii or the United States or in Asia and the Philippines. However, Guam's federal grant applications lack statistical data to verify the numbers of persons actually in need and struggling to access available, but underfunded services.

Working in the islands, I have experienced the need for several major role functions needed of behavioral and social scientists in the CPG process. Two forces have always pressured me—forces that bestow value upon what scientists do. One force is the governing power with federal funds to make projects possible, and the other is the consumers and patients of community health systems who need accountable health care and prevention services. On one side the social scientist is a technical specialist collecting the data documentation required by federal funding agencies to get money. On another side, the social scientist is a learning partner with and teacher for the people in a community who are working to solve a health problem affecting themselves, their partners, families, and friends. These two forces are pressuring Guam with an intensified urgency for HIV/AIDS community planning that must begin to employ a comprehensive approach, one that addresses the continuum of services from prevention of HIV to the care of people and communities affected by HIV/AIDS in the region of Pacific Island nations and territories affiliated with the United States.

* Workman, R. L., Pinhey, T. K., & Hill, A. L. (2001, June). Promoting HIV testing among Guam sex workers: Problems in paradise. *Research for Sex Workers* [Serial online] No. 4, 10-12. Available from: URL: <http://www.med.vu.nl/hcc>. ▼

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agencies may access.

Complexity of CBA Provision

Needs of CBOs do not always fit neatly into one CBA area or another. For example, a request for AA&PI youth HIV-prevention program development assistance may also require assistance in organizational development (Does the program fit into the agency's mission and vision? Does the agency have the capacity to sustain a youth program?), community mobilization (How can the organization work with the local community to support and lead HIV-prevention efforts? What coalition work can help support HIV prevention, and who are the community gatekeepers that need to be involved in this project?), and HIV-prevention community planning (What are the local jurisdiction's HIV prevention priorities? What are ways the agency can work with the CPG to ensure AA&PI youth can participate in the planning process?). One request may actually be many needs.

Relationship Building, Trust, and Cultural Competency

Many CBOs have experienced less-than-wonderful interactions with some scientists (e.g., researchers) that have created a level of distrust and animosity toward the scientific community in general. Ongoing relationships that are respectful and mutually beneficial need to be cultivated and nourished for trust to be established/reestablished between CBOs and behavioral/social scientists. Cultural competence, defined as a set of behaviors, attitudes, and policies that enables effective work in cross-cultural situations, needs to be prioritized.

Tips for Behavioral and Social Scientists

As future opportunities arise for collaboration between behavioral and

social scientists (BSSV) and capacity-building assistance (CBA) groups who serve AA&PI community-based organizations (CBOs), it is important that BSSVs remain flexible because chaos can happen amid the challenging realities of CBO environments. BSSVs may find that CBAs request assistance for a CBO that has a variety of needs, such as requiring needs-assessment instruments, infusion of theory into programs, goals and objectives reviews, and evaluation designs. Like other technical assistance with CBOs, this may mean building a long-term ongoing relationship with the CBO. In addition, working with some AA&PIs may mean having regular meetings with CBO staff, which can foster support and sustain enthusiasm and commitment to the process. The BSSV should recognize that CBO staff may have differing familiarity, experience, and expertise with behavioral science terms and theories. The BSSV should respect the organizational values, policies, and protocols of the CBO. The BSSV should acknowledge both CBO experience and scientific expertise and take time to learn as much as possible about the CBO prior to providing scientific expertise. In this light, the BSSV has skills that are very important, but even more important is that the BSSV offer appropriate skills when needed or requested by the CBO. This will help make a working relationship with the CBO a win-win opportunity of learning



Check Out Our Website at
www.apa.org/pi/aids/bssv.html

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Conference Call With

CHWEE LYE CHNG, PhD

**Scheduled for
September 12, 2003**

Take part in a conference call with **Chwee Lye Chng, PhD**, University of North Texas.

**Host Name: BSSV Program
Date: September 12, 2003
Time: 3:00-4:00 p.m. (EST)
Participant Passcode: 700102
Participants, call: 866-524-7423**

UPCOMING CONFERENCES

August 25-27, 2003

CDC Conference on STD/HIV Prevention and the Internet, Omni Shoreham Hotel, Washington, DC. For more information and abstract submission deadlines visit the Web site at www.cdc.gov.

September 12-13, 2003

The African American Leadership Conference on HIV/AIDS, "Taking It to the Streets," Lexington, KY. Sponsored by the Kentucky Department for Public Health (KDPH). For more information, please contact Ramonda Yocum at (800) 420-7431 or at Ramonda.Yocum@mail.state.ky.us.

September 18-21, 2003

The United States Conference on AIDS (USCA), New Orleans, LA. Sponsored by the National Minority AIDS Council (NMAC). For more information and abstract submission deadlines, please visit <http://www.nmac.org/conferences/USCA2003/default.htm> or contact NMAC's Conferences and Meeting Services Department at (202) 483-6622.



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