



**California Collaborations in HIV Prevention Research
Dissemination Project**

8
MODULE 8

**Asian and Pacific Islander MSM
HIV Prevention Evaluation Study**

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California Collaborations in HIV Prevention Research: Dissemination Project

INTRODUCTION TO THE DISSEMINATION PROJECT

To support community-based research efforts in California, the State Office of AIDS (OA) and the Universitywide AIDS Research Program (UARP) joined forces in 1998 to provide funding for HIV/AIDS community research collaborations. This program is built upon the collaborative research endeavors initiated by UARP in 1995 and community-based research efforts sponsored by OA. The UARP-OA initiative fosters partnerships among researchers, community-based AIDS service organizations, and local health departments. As a coordinated response to a statewide public health need, it:

- Provides support for evidence-based planning, design, delivery, and evaluation of prevention interventions
- Builds community research capacity
- Disseminates information on HIV/AIDS prevention interventions

UARP and OA have jointly funded 26 community collaborative HIV/AIDS prevention intervention projects. The *California Collaborations in HIV Prevention Research: Dissemination Project* is designed to disseminate information on these research projects and other resources developed through a range of UARP-OA initiatives. All of these materials serve as resources to be used by local health departments, community-based organizations, and research organizations in support of their work in HIV/AIDS prevention and evidence-based planning.

The *Dissemination Project* Module series is organized into three sections: Behavioral Risk Research, Intervention Outcome Research, and Translation Research. The Behavioral Risk Research modules describe projects that focus on the context of the delivery of interventions; these modules do not evaluate prevention intervention effectiveness. The Intervention Outcome Research modules provide project findings on the effectiveness of specific interventions (available 2004). The Translation Research modules provide guidelines developed for translation of science-based interventions for use by community service organizations (available 2005).

The *Dissemination Project's* Research Summary series is composed of systematic reviews of HIV/AIDS prevention interventions among peoples of color throughout the United States. The first of these publications, an analysis of HIV/AIDS prevention interventions, focuses on heterosexual African

Americans (available 2004). Additional reviews of Hispanics/Latinos and MSM are forthcoming (2004–2005). These reviews were developed prior to the completion of the UARP-OA-funded community collaborative projects and thus do not include those California prevention interventions.

GUIDANCE FOR INTERVENTION MODULES

This guidance provides general background and direction on use for the UARP-OA intervention modules. The audience for the modules includes program planners and coordinators, policy and resource allocation bodies, and researchers and evaluators working in the field of HIV prevention.

The guidance is divided into the following sections:

- **Overview** of literature on community collaborative research and issues for adapting and using evidence-based interventions and evaluations in community settings
- **Brief descriptions** of the intervention modules, the various methodological approaches used to evaluate research, and the use of findings
- **Guidelines** for using the modules

Collaborative Research and Adaptation of Evidence-based Interventions— Current Challenges

One of the critical issues community-based organizations (CBOs) face is the question of how they can best make use of tested interventions with the populations they serve. While resources are available for implementing interventions that have been shown to be effective with certain populations,¹ little guidance is available on systematic processes for adapting, translating, using, or evaluating these interventions in community settings. Thus, CBOs face challenges in three broad areas when considering the use of an existing intervention: accessing information on interventions, finding an appropriate intervention, and tailoring the intervention to their own needs, organizational setting, and client population.

1. Centers for Disease Control, “Compendium of HIV Prevention Interventions with Evidence of Effectiveness,” in *HIV/AIDS Prevention Research Synthesis Project*, Atlanta: CDC, March 1999.

Accessing Information on Interventions

How does a CBO wanting to implement a tested intervention begin? How do they access information on interventions?

Easily accessible information and details on tested interventions with related evaluation materials are not always widely available. Thus, in most cases, CBOs rely on information from CBO and public health networks, rather than academic sources.²

An alternative strategy is becoming available. Although the process of translating research-based interventions has yet to be studied systematically, the CDC and a network of researchers participating in the Replicating Effective Programs (REP) project have been involved in disseminating research-based interventions and supporting this dissemination with a technical assistance support system based on a train-the-trainers model.³ This approach⁴ relies on CBOs identifying and adhering to the core elements of interventions that report significant behavior change outcomes, while tailoring key characteristics to fit the unique needs and context of their client population.⁵

Matching the Intervention to the Organization and Population

What are the key issues that organizations consider when deciding on the adoption and/or adaptation of an intervention? A handful of studies identify these points: contextual issues, key characteristics, and features specific to organizations.

Contextual factors that affect the delivery and selection of interventions by CBOs and local health departments include structural or external conditions; cultural norms; client factors; organizational mission, structure, and operations; staffing resources; and the program's relevance, utility, and effectiveness for meeting the needs of populations.

Community organizations base their assessments of the appropriateness of an intervention on a number of key characteristics:⁶

- Degree of compatibility with organizational philosophy about HIV prevention
- Perceived relevance to local culture
- Evidence to support its use
- Feasibility of implementing the intervention
- Ability to fill existing service gaps

Also essential to this decision-making process are organizational commitment and positive attitudes toward the intervention, as well as the availability of technical assistance and other resources to support implementation.

Adapting and Translating Interventions

How does a CBO choose an intervention, and once the choice is made, adapt it? As mentioned above, community organiza-

tions often gravitate to interventions that are accessible and *known* in the local network of providers. However, interventions almost always require some type of tailoring to fit the organization and its constituency. A variety of strategies are employed to enhance cultural appropriateness, including:⁷

- **Peripheral strategies**, such as packaging that focuses on a certain “look” identified as appealing to certain populations
- **Evidential strategies**, use of evidence of the effectiveness of an intervention
- **Linguistic strategies**, translation of the language used in an intervention for a particular population
- **Constituent-involving strategies**, incorporation of the experiences of community members into the intervention
- **Sociocultural strategies**, placement of the intervention within a broad context of health and life issues for a community

Community Collaborative Research— Intervention Outcome Modules

Community collaborative research addresses the issues of replication, adaptation, and use of evidence-based interventions by partnering research scientists and community providers and by ensuring that research, evaluation, and intervention approaches are realistic and grounded in the real world of community organizations working with populations greatly affected by the epidemic.⁸ The field of collaborative research facilitates adaptation, development, implementation, and testing of interventions. Use of related materials specifically tailored for populations is a continuing part of this work.

2. H. Barton-Villagrana et al., “Peer Relationships Among Community-based Organizations (CBOs) Providing HIV Prevention Services,” *Journal of Primary Prevention* (forthcoming).

3. M. Neumann and E. Sogolow, “Replicating Effective Programs: HIV/AIDS Prevention Technology Transfer,” *AIDS Education and Prevention* 12, supp. A (2000): 35–48.

4. See E. M. Roger, *Diffusion of Innovations*, 4th ed., New York: Free Press, 1995.

5. J. Kelly et al., “Transfer of Research-based HIV Prevention Interventions to Community Service Providers: Fidelity and Adaptation,” *AIDS Education and Prevention* 12, supp. A (2000): 87–98.

6. R. Miller, “Innovation in HIV Prevention: Organizational and Intervention Characteristics Affecting Program Adoption,” *American Journal of Community Psychology* 29, no. 4 (2001): 621–47.

7. M. W. Kreuter et al., “Achieving Cultural Appropriateness in Health Promotion Programs: Targeted and Tailored Approaches,” *Health Education & Behavior* 30, no. 2 (2003): 133–46.

8. See K. H. Stanstad et al. (eds.), “Collaborative Community Research: Partnerships Between Research and Practice,” *Health Education & Behavior* 26, no. 2 (1999).

How UARP-OA Collaborative Projects and Intervention Modules Address Current Challenges

UARP-OA collaborative projects are designed to ensure that equal partnerships between academics and community organizations drive the testing and implementation of interventions in community settings. One of the key goals of the *Dissemination Project* is to make materials from evaluation research available to a range of stakeholders: community-based organizations, researchers, and public health providers. The projects presented in the modules represent investigators' work, often in pilot phase, in evaluation and intervention outcome research.

In these modules, projects include outcome research on interventions serving people of color, IDU, youth, women, MSM, and people with HIV. As in previously distributed modules, details are provided on the research project, including key findings and collaborative research strategies. The instruments, resource tools, and other sample materials developed to support delivery of the interventions are also included.

The studies presented in these modules are important not simply because of their findings in terms of behavior change or increased knowledge about HIV prevention, but also because of their strategies for placing evaluation and intervention in the context of real community settings (e.g., CBOs providing services) and tailoring them to the actual lives they serve. These collaborative strategies inform the evaluation findings, and in many ways they offer a deeper and more complex perspective on service delivery and evaluation than any one set of outcome findings could provide.

Organizations will need to make their own determinations about the appropriateness of the interventions, using the considerations outlined in the preceding section. Applicability will vary depending on the methodological approach and findings from the intervention.

How the Interventions Included in the Modules Have Been Tested—And What This Tells Us

Evaluation research can be charted along a continuum—from initial research on populations to short-term and long-term outcomes of the intervention. Due to their differing purposes and contexts, the UARP-OA evaluation projects include a range of approaches that spans this continuum. The following paragraphs provide an overview of evaluation approaches represented in specific modules and identify how data from various evaluation approaches can be used by stakeholders for intervention design and delivery.

Formative evaluation (behavioral risk and context assessment) is used to collect data on consumer populations to ensure that an intervention is targeted to specific behaviors and specific psychological, social, and cultural contexts. Formative data may be used to improve implementation, solve unanticipated problems, and make sure participants are progressing toward desired outcomes. *See:*

- Module 1: *HIV/AIDS Behavioral Risk Research on African American Gay, Bisexual, and MSM*
- Module 2: *The Los Angeles Transgender Health Study*
- Module 3: *Youth Drug Injectors, Needle Exchange Use, and HIV Risk in San Francisco and Santa Cruz*
- Module 5: *HIV Prevention Outreach Programs in Santa Barbara*
- Module 6: *HIV/AIDS Prevention Intervention Among Urban, At-Risk African Americans*
- Module 8: *Asian and Pacific Islander MSM HIV Prevention Evaluation Study*

Process evaluation (intervention implementation) is used to measure the implementation of an intervention in terms of fidelity to core elements, appropriate targeting, and implementation procedures. It describes the components of the intervention, who it is reaching, and how it is implemented. Process data are often used to make sure the intervention is being implemented as planned and is reaching intended populations successfully. *All the modules report on process data.*

Outcome monitoring (pre- and post-intervention measurement, no control) is used to measure short-term outcomes when control groups are not available or ethical. It is limited in its ability to attribute changes to an intervention, but that can be mitigated somewhat through time-series data collection. Outcome monitoring can be a useful early test for an intervention being implemented at a new site or within a new population. Depending on the number of study participants, this approach can reveal that short-term changes may have taken place, although not necessarily that they are due to the intervention. *See:*

- Upcoming modules focusing on outcome evaluation: Interventions with IDU women and with MSM and people of color, and a study to help understand HIV testing among young adults

Outcome evaluation (quasi-experimental design, nonrandomized control groups) is used to measure short-term outcomes and attribute outcomes to an intervention, in cases where randomization is not feasible. Depending on the number of study participants, this approach can reveal that short-term changes are likely to have occurred as a result of the intervention. *See:*

- Module 6: *HIV/AIDS Prevention Intervention Among Urban, At-Risk African Americans*
- Module 7: *Teen Parents HIV Prevention Programs, Los Angeles*
- Module 8: *Asian and Pacific Islander MSM HIV Prevention Evaluation Study*
- Upcoming modules focusing on outcome evaluation: Interventions for African American youth and Latino MSM, and an intervention delivered at youth drop-in centers

Outcome research (experimental design, randomized control groups) is used to measure short-term outcomes and attribute outcomes to an intervention. The control group(s) is randomized in terms of population or site, controlling for the influence of variables unrelated to the intervention. Depending on the number of study participants, this approach can reveal short-term changes as a result of the intervention. *See:*

- Upcoming modules on available outcome research projects: an enhanced HIV counseling-and-testing multi-infection intervention designed for high-risk communities, and a small-group intervention for IDUs

What We Can Learn from the UARP-OA Collaborative Intervention Research Projects

All the intervention projects tell us about outcome monitoring in community settings, collaborations among multiple partners, tailoring and implementation of interventions, documentation of the process of implementation, consumer responses to interventions, and consumer populations in California. In some cases, the effectiveness of the intervention is assessed.

Guidelines on Use of Modules

Purpose

The intervention modules are intended to support and provide a supplemental mechanism for evidence-based planning, design, implementation, and evaluation for intervention services through the use of UARP-OA-funded community collaborative research, including behavioral risk assessments, intervention outcomes, and translation research.

Using the Modules

While best practices for adaptation/translation of tested interventions have yet to be firmly established, the following describes generally the process and practice of using modules and supporting materials for intervention work.

Assessing a Module's Relevance to Your Organization

Step 1: Assess your organization, population, and environmental context, outstanding needs, and available resources with respect to the use of evidence-based prevention and evaluation.

Step 2: Review available intervention and evaluation strategies, findings, and tools in modules, and determine the general fit with or responsiveness to your organization's needs, context, and target population.

Step 3: Based on the results of steps 1 and 2, determine how relevant intervention or evaluation materials and strategies could best be tailored for use by your organization for the populations you intend to serve.

Adapting and Adopting Strategies, Findings, and Materials to Your Organization

Select the components of intervention or evaluation strategies and the materials that speak to specific issues and situations facing your organization, population, and intervention needs. For example, it may be possible to select parts of an evaluation tool that answer questions you have about an intervention or population. Or there may be components of an overall intervention approach that provide relevant support for your work. Also keep in mind that evaluation findings are linked to core elements, so eliminating them could impair the effectiveness of the intervention.

- **Behavioral risk findings** can be used to guide program planning and intervention delivery.
- **Intervention findings and materials** can be used for design and delivery of interventions.
- **Tested interventions** can be adapted for implementation in local settings. Maintaining fidelity to core elements is fundamental, although key characteristics should be tailored to local context and population.
- **Research protocols and instruments** can support targeted data collection on local populations and intervention effectiveness, either in their original form or after adaptation to the individual context.
- **Training materials** can support training on delivery of interventions and implementation of program evaluation—again, either as provided or in customized form.
- **Tested interventions and existing interventions** can be linked to provide evidence-based support for existing interventions.



Asian and Pacific Islander MSM HIV Prevention Evaluation Study

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Lina Sheth, Asian and Pacific Islander Wellness Center

Module in a Nutshell

- Sexual behavioral findings for young and HIV+ API MSM
- Recommendations for community-based evaluation research
- Curriculum specific to API MSM youth
- Curriculum specific to HIV+ API MSM
- Implementation challenges
- Use of focus group discussions

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PURPOSE OF MODULE 8

Module 8 presents findings and supporting materials from a culturally specific HIV prevention intervention targeting a high-risk population of Asian and Pacific Islander (API) men who have sex with men (MSM) in California. Tooru Nemoto, Center for AIDS Prevention Studies (CAPS), UCSF; and Daniel Bao, Asian and Pacific Islander Wellness Center (A&PI Wellness Center), were co-principal investigators for the project. Lina Sheth took over as co-PI during the third year of the project.

Culturally sensitive and ethnic group-specific materials were developed for use with the target population. The collaboration team comprised service providers, researchers, and volunteers who identify as part of California’s API community. This enhanced the development of research protocols and communication with the target population.

RESEARCH PROJECT

The project was devised to address the lack of formative evaluated HIV prevention/education programs targeting API MSM. Through collaboration between A&PI Wellness Center and CAPS, this project expanded and evaluated an existing intervention designed to increase culturally specific protective factors against HIV infection and transmission. Subjects for the intervention were drawn from two high-risk API MSM groups: youth and HIV positives.¹

Summary and Purpose

Background

According to the U.S. Census Bureau,² the Asian and Pacific Islander population increased by about one-third between 1990 and 2000. Mirroring this increase is a rise in the number of AIDS cases among APIs.³ Centers for Disease Control and Prevention (CDC) statistics reveal that as of 2001, 5,922 AIDS cases had been diagnosed in APIs, with 72% of those in men who have sex with men (MSM).⁴ In San Francisco, where APIs make up a much larger percentage of the population than nationally (35% as opposed to about 4%),² the same proportion of MSM AIDS cases appears (73%).⁵

Despite the continued vulnerability of API MSM to HIV infection, almost no validated interventions targeting this group exist.⁸ Yet one study did demonstrate the effectiveness of a program that was culturally specific to API MSM.⁹ The intervention—a one-session, small-group workshop—aimed to provide safer sex education, enhance safer sex behaviors,

and increase social support and ethnic identity esteem. Compared to a non-treatment control group, participants reported increased knowledge and reduced anxiety about AIDS, fewer sex partners, and less unprotected anal sex.⁹

The prevention evaluation study described in this module was designed to address the shortfall in interventions targeting API MSM. It grew out of A&PI Wellness Center’s existing weekend retreat program, which had previously been tested and appeared to be culturally appropriate for the API MSM groups it served—youth and HIV-positive individuals. However, its effectiveness in changing HIV risk behaviors had yet to be formally evaluated.^{1,8}

Goal and Objectives

Research has demonstrated that high levels of unprotected sex continue to exist among MSM in general and in HIV-positive men, and there is evidence to suggest that this may be especially the case with MSM of color.¹⁰ Combined with rising percentages of HIV infection among non-whites, this argues for interventions tailored to specific at-risk populations. According to a recent meta-analysis,¹¹ “The goal for HIV intervention programs targeting specific risk groups should be to develop culturally sensitive and ethnic group-specific strategies for combating the spread of HIV.”¹⁰ This study took up that challenge.

The study’s goal was to implement and evaluate HIV prevention programs targeting two API MSM groups: (1) HIV-positive and (2) HIV-negative between the ages of 18 and 24. The objectives of the study were threefold:

- To conduct focus groups to identify culturally specific protective factors against HIV infection and transmission
- To develop the intervention methodology and curricula specific to HIV-positive API MSM and API MSM youth
- To evaluate the effectiveness of the intervention program and test the theoretical model

Research Methods

This section describes the study’s research protocol, target population, eligibility and recruitment, training, and data collection, including the tools used in these processes (see the appendices). A description of the interventions follows this section.

Social support networks may play an effective role in influencing health-related behaviors.¹

Research Focus and Protocol

A variety of cultural factors contribute to the HIV vulnerability of API MSM, including family expectations about marriage and children, and taboos on discussing sexual topics such as homosexuality and HIV. Perceptions of homophobia and

*The number of reported cases may not accurately reflect actual AIDS cases in the API community. Many states that report AIDS data to the CDC do not break out APIs as a separate category.⁶ In addition, rates of HIV testing among API individuals are low in general.⁷

racism may also prevent API MSM from seeking prevention services.¹⁰ The focus of the study was to design and implement interventions that take into account these cultural expectations and prohibitions. The need for cultural appropriateness was a determining factor in the design of the study itself as well as in the content and delivery of the intervention.

Using established theories and based on their experience with the target groups, the research team chose three protective factors that they hypothesized could reduce HIV risk behaviors:⁸

- Enhanced cultural and gay identity and sense of pride
- Norms that favor safer sex and drug use
- Supportive social networks

Baseline, post-intervention, and follow-up instruments (Appendices A and B) were used to gather data for program evaluation by monitoring changes in the above three areas as well as in HIV-related behaviors.⁸

Outreach

To recruit potential subjects, outreach workers used methods such as flyers (Appendix C) posted at gay-identified venues, full-page advertisements in magazines targeting gay Asian and Pacific Islanders, and e-mail messages sent to gay-themed distribution lists, as well as personal referrals.¹⁰ Different approaches were employed for the two types of participants:¹²

API-X (youth)

- E-mail to listservs and other existing mailing lists.
- Online chat rooms.
- Special events, such as poetry readings and sports-oriented picnics.
- Ongoing contact with gay/queer API student groups and lesbian-gay-bisexual and ethnic studies classes.
- Direct recruiting of friends by A&PI Wellness Center volunteers.
- Flyers and other outreach at dance clubs, bookstores, a queer youth clinic, community events, local queer youth conferences, etc.
- Outreach at non-research-focused youth and MSM-targeted A&PI Wellness Center programs.
- Case managers gave information about the research to clients.
- Information was distributed to other California-based API AIDS service organizations.

In addition, later on in the project, participants from previous retreats who recruited two new participants were invited to attend a retreat as volunteer support staff.

API-Plus (HIV-positive)

- Presentations at AIDS service organizations and other community-based organizations (CBOs).
- America Online chat room for HIV-positive APIs.

- Flyers were distributed on the street at sex clubs and other public sex environments; CBOs; street fairs including the Tenderloin's Tet Festival; health-related venues including primary care facilities, public health clinics, and pharmacies specializing in HIV medications.
- Direct outreach at A&PI Wellness Center's and San Francisco General Hospital's on-site clinics.

Recruitment

Several recruitment challenges arose. The stringent eligibility criteria (see sidebar) often excluded people who would otherwise have been referred by a friend or partner.⁸ This was a particular problem with youth recruitment, as some people did not want to participate if their friends could not come along, and their friends were often women or non-APIs.

The study methodology called for a three-month recruitment period prior to each retreat. Potential participants in the youth retreat, however, found it difficult to commit that far in advance. They would often not confirm until the week of the retreat or would cancel at the last minute.¹²

Different issues arose with recruiting HIV-positive participants, primarily involving language and culture. The concept of research studies in general was unfamiliar to many of A&PI Wellness Center's existing clients, and the researchers had expected to draw from that pool for participants.¹² Together, these challenges slowed and complicated recruitment efforts throughout the duration of the project. Eventually, a host of outreach and recruitment strategies (see Outreach, above) proved successful, although numbers still fell substantially short of initial expectations.⁸ The need for confidentiality prevented the outreach workers from directly contacting HIV-positive clients unless this could be done through the client's case manager.

Eligibility and Screening

Because of the cultural focus of the study, participation was strictly limited to API MSM (see Eligibility Criteria sidebar). Additional criteria also applied to each of the two interventions.

Those interested in participating filled out a contact card (Appendix D), giving only their first name and telephone number. Research assistants then contacted potential participants and verified their eligibility.

Eligibility Criteria

- Male Asian or Pacific Islander (self-identified)
- Gay, bisexual, or MSM (self-identified)
- 18 or older
- Reside or work in California
- Able to communicate in English
- Not previously enrolled in HIV prevention program at A&PI Wellness Center

Incentives

- For intervention participants, the retreat itself (lodging and meals) was considered compensation.
- Comparison group participants received \$30 for completing the baseline survey.
- All participants received \$30 for completing the follow-up survey.

Enrollment

Once they were screened and found eligible, subjects were assigned to the appropriate intervention group based on their age and HIV status. They were given copies of a consent form (Appendix E), and a research assistant read them the text of the form explaining the study's objectives and procedures, answered any questions, and obtained their signatures. Participants were given a choice of attending the next upcoming retreat or

the following one. Those who were eligible for the study but chose not to attend a retreat were invited to complete the baseline survey and a follow-up survey in three months (see Appendix A). These participants served as the comparison (control) groups.

Confidentiality and Risks

The research assistant also collected participants' contact information for the three-month follow-up portion of the study. This contact information, existing confidentiality agreements with HIV-positive clients, and the data collection instruments themselves necessitated measures to ensure participants' privacy. Completed questionnaires were identified only by code number. The log book that keyed those numbers to participants' names was kept in a locked filing cabinet and was maintained by and accessible only to the project director and the principal investigators (PIs). Completed instruments were kept in a separate cabinet accessible only to the PIs, project director, and research assistants.

The nature of the interventions—the detailed questionnaires, group discussions, and activities—meant there was a possibility some people might become uncomfortable or upset. Consequently, they were told that they could discontinue participation in the study at any time.

Training

A&PI Wellness Center staff facilitated the interventions, often with the assistance of peer volunteers. Peer volunteers were members of the target community, and their hiring and training was an important part of the intervention. Having individuals from within the target groups involved as research assistants and facilitators increased community representation in the project and improved the effectiveness of the intervention:⁸

- Young API MSM and HIV-positive API MSM participants were more likely to trust and were more receptive to facilitators they could identify with.

- Peer staff were also able to access “hidden” parts of the community, such as closeted MSM or recent immigrants, and this was crucial for recruitment.
- These staff members were often aware of challenges or flaws in the study design that were invisible to researchers (see the Value of Pilot Testing sidebar). For example, peer staff pointed out problems associated with lengthy measurement instruments.

The employment of peer-based staff required supporting resources and policies. For instance, since these staff were not formally trained medical or mental health professionals, having someone to whom they could immediately take questions and issues as they arose was necessary for both their clients and themselves.

The Value of Pilot Testing

The API-X and API-Plus intervention study underwent significant changes between its original conception and implementation. As originally designed, the study was to include six different conditions (three each for youth and HIV-positive subjects), in order to compare A&PI Wellness Center's existing weekend retreats with interventions that used the same curricula but delivered it over eight weeks in a series of two-hour workshops. (The third condition was a comparison group for each population; they would simply complete the survey instruments at baseline and three months later.) Participants were to have been randomly assigned to one of the groups once they had been screened and found eligible. This methodology was suggested by the principal investigator and other CAPS researchers as a way to enhance the study's scientific rigor.

After pilot-testing this design for two months with the API-X population, the A&PI Wellness Center-CAPS team discovered an insurmountable obstacle: “Participants were not willing to be assigned to the control or eight-session workshop conditions. Those who expressed interest in participating unvaryingly preferred the retreat condition.”⁸ In addition, randomly assigning participants to the comparison condition posed the ethical dilemma for A&PI Wellness Center of denying services to a portion of their clients.

As a result, the team decided to eliminate the random assignment to conditions and to abandon the eight-week workshop series in favor of an expanded number of weekend retreats.

Policies that clearly stated staff members' roles, boundaries, and responsibilities related to services also proved essential, particularly with regard to balancing A&PI Wellness Center's standards with the scientific standards of the university researchers. For example, because the interventions took place during weekend retreats at remote locations, policies were necessary to define the distinction between work and personal time, professional and personal roles (in interactions with participants), and the extent of staff members' responsibilities to participants.⁸

Data Collection

Data collection strategies included individual interviews and two series of focus groups—one before the intervention design was finalized, and another while the interventions were in process—as well as the surveys completed by participants in the intervention and comparison groups.

Initial Focus Groups

To ensure that the interventions would be culturally appropriate, a series of three initial focus groups were held, with a total of 22 API MSM participating in the groups. The groups roughly mirrored the target populations for the interventions, with young adults composing two groups and HIV-positive men the other. Most focus group participants had already participated in other activities at A&PI Wellness Center.

Each group was led by two facilitators who used a series of open-ended questions (Appendix F) to explore the social conditions and types of personal experience that surround HIV risk behaviors among API MSM. Specifically, participants were asked to:¹⁰

- Name their three most important concerns
- Discuss the communities they identified with
- Describe how HIV had affected their lives
- Identify their HIV care or prevention service needs

Each focus group took three hours, including breaks. Before beginning, all participants provided informed consent (see Appendix E). At the end of the session, participants were reimbursed for their time and given written information on HIV and STD testing, HIV/AIDS service agencies, and other social service agencies with API-specific programs.

Audiotapes of the groups were transcribed verbatim and then read independently by two individuals, who developed a list of themes with the goal of identifying factors contributing

to HIV risk for API MSM. These data were then used to refine the intervention content and develop the survey instruments.

Follow-up Focus Groups and Interviews

Additional focus groups, made up of 16 young API MSM participants, were conducted near the end of the study. To understand some of the recruitment and implementation challenges that had arisen during the intervention study, moderators again asked a series of open-ended questions (Appendix G). The first three topics were the same as in the first round of focus groups, while the fourth asked participants to identify barriers and motivators to using HIV prevention services.¹⁰

Ten individual interviews (Appendix H) with service providers and key stakeholders in the API MSM community were used to collect additional data on these same subjects. (See Implementation Challenges and Solutions, later in this module.)

Surveys

The research team created survey instruments that reflected the areas of concern that emerged from the initial round of focus groups (see sidebar). Standard measures of depression,¹³ self-esteem,¹⁴ and community involvement¹⁵ were also used. A different survey was tailored to each of the target populations—youth and HIV-positive. For example, the youth survey included questions on coming out and the young gay scene, while the HIV-positive version included items about treatment and health disclosure.⁸

Intervention participants from both populations self-administered the pre-intervention baseline survey (see Appendix A) prior to the weekend retreat. These instruments, which took about 45–60 minutes to complete, included questions about perceptions of community and social support, acculturation levels, strength of ethnic and sexual identity, and self-esteem and depression. They also collected data on demographic characteristics and sexual behavior.

At the end of the retreat, participants self-administered the post-intervention survey (see Appendix B), which took about 30 minutes to complete.

Three months after the retreat, participants received by mail the follow-up survey (the same questionnaire as that completed at baseline; see Appendix A) along with a cover

“Holding focus groups within agencies can generate new program ideas for service providers and empower clients to feel ownership and investment in the programs they help shape.”¹⁰

Areas of Concern for API MSM

- Dual-identity status (API and gay)
- Coming out and/or HIV disclosure
- Relationships and dating
- Substance use and sexual behavior
- Risk perception and risk-reduction strategies
- HIV-related health care and social services

letter (Appendix I) containing instructions, a reminder about the cash incentive, and a postage-paid return envelope. The data thus acquired allowed the research team to evaluate the intervention in terms of its long-term effectiveness.*

In addition, comparison groups composed of API MSM who met the criteria for participation but did not wish to attend a retreat, completed both the baseline and three-month follow-up surveys (see Appendix A), thus providing control data for the intervention evaluation.

The Interventions

Two different interventions were implemented and tested in the course of the study. The Asian & Pacific Islander Escape (API-X) targeted HIV-negative API MSM from 18 to 24 years old. The API-Plus program was for HIV-positive API MSM 18 and up. A total of 54 youth participated in the API-X interventions, and 40 HIV-positive men took part in API-Plus.

Retreat Format

Each intervention consisted of a 16-hour culturally specific HIV prevention workshop delivered during a weekend, out-of-town retreat.[†] Interventions were facilitated by A&PI Wellness Center staff members, often with the assistance of a peer volunteer. The retreat format included van transportation to a scenic location, lodging, and all meals (participants were responsible for cleanup). A variety of teaching methods were employed, including individual, small-group, and full-group exercises; writing, art, and role-playing activities; as well as group discussion.

Curricula

Curriculum content (Appendices J and K) was based in part on qualitative data from the series of focus groups conducted prior to the interventions. Using the themes uncovered in those groups, the interventions were structured around five conceptual areas of intervention necessary to effectively reach the API MSM target population:¹⁶

- Ethnic and sexual identity
- HIV and STD risk perception

- Sexual behaviors while under the influence of drugs or alcohol
- Health care for HIV-positive people
- HIV social services

Although similar in structure, the two interventions had somewhat different focuses (see the Intervention Topics sidebar).

RESEARCH FINDINGS

Key results from the survey instruments are shown on pages 8 and 9. Table 1 shows demographic data for the two intervention types. Table 2 has information about sexual behaviors for both groups. Tables 3 and 4 compare baseline versus follow-up data for the API-X and API-Plus groups, respectively.

Findings from the two series of focus groups and interviews also provided important information about the target populations. These findings are summarized below.

Focus Group Findings

Qualitative data from the focus groups are summarized below. The data highlight API MSM's perceptions of their particular vulnerabilities for HIV.^{‡10}

Ethnic and Sexual Identity

I would like to see people who have HIV, how they're living, how they're coping with it, especially API people.
—Focus group participant

- All participants expressed that they struggled to meld their gay and API identities.
- Gay men encounter homophobia in the API community, and derogatory stereotypes of APIs exist in the gay community.
- For HIV-positive API gay men, disclosing their HIV status to other APIs, including family, causes heightened shame and isolation.
- Several participants compensated for the preceding factors by associating only with other gay APIs.

Intervention Topics

API-X

- Building community networks
- Increasing HIV knowledge
- Changing attitudes toward safer sex
- Discussing STDs and risk behavior

API-Plus

- Devising HIV-disclosure strategies
- Maintaining and building relationships
- Integrating HIV status into one's identity
- Discussing treatment issues

*Attrition rates for the follow-up survey were greater than expected. In some cases, the survey itself may have contributed: some participants found it too long and the language used too technical. However, the greater difficulty was with younger participants, who often moved out of the area during the three-month period between the retreat and follow-up.
[†]Because the intervention occurred away from A&PI Wellness Center's premises, participants were required to sign a liability waiver and to provide emergency contact information.

[‡]A more detailed version of these findings was presented by Tooru Nemoto at the 18th Annual AIDS Investigators' Meeting and 4th Annual Conference on AIDS Research in California (Los Angeles, February 16, 2001), in a presentation entitled "HIV Prevention Interventions Targeting Asian-Pacific Islander MSM."

KEY RESULTS

Table 1 Sociodemographic Data

	Youth N = 54	HIV+ N = 40
Age		
Average	22	40
Range	18–24	22–65
Sexual orientation		
Gay	76%	78%
Queer	11%	5%
Bisexual	0%	5%
Other MSM	13%	13%
Education		
Less than high school	1%	12%
High school, GED, or technical school	17%	8%
Some college	44%	43%
Undergraduate degree or higher	37%	32%
Nativity		
U.S. born	41%	20%
Foreign born	56%	80%
Ethnicity		
Filipino	36%	41%
Chinese	26%	15%
Vietnamese	10%	0%
Other ^a	26%	44%

^a Includes Burmese, Cambodian, Native Hawaiian, Indian, Japanese, Laotian, Malaysian, and Thai

Table 2 Sexual Behaviors at Baseline

	Youth N = 54	HIV+ N = 40
Sex partners		
Median number of male sex partners (lifetime)	10 ^a	
Median number of partners past 3 months	2	2.7
Have regular partner	44%	69%
Lifetime sexual behavior		
Insertive anal sex (ever)	70%	50%
Unprotected ^b	68%	70%
Under substance influence ^b	39%	
Receptive anal sex (ever)	69%	61%
Unprotected ^b	78%	56%
Under substance influence ^b	43%	

^a Range = 0–90

^b Percentage of those who engaged in the primary behavior

Note: Because the data collection instruments were tailored to each of the two groups, not all questions were asked of both.

Table 3 Youth Sexual Behaviors at Three Months

	Baseline N = 54	Follow-up N = 15
Had insertive anal sex	41%	42%
Unprotected ^a	59%	60%
Under substance influence ^a	27%	20%
Had receptive anal sex	46%	67%
Unprotected ^a	64%	37%
Under substance influence ^a	24%	25%
STD diagnosis	18%	27%
Communication with regular sex partner^b		
Never/almost never discuss safer sex	38%	29%
Never/almost never discuss condom use	42%	29%
Never/almost never discuss monogamy	33%	21%
Partner has sex with others	17%	14%
Never ask about partner's HIV status	21%	7%

^a Percentage of those who engaged in the primary behavior

^b Percentage of those with regular partner; N = 24 at baseline, 10 at follow-up.

Table 4 HIV+ Sexual Behaviors at Three Months

	Baseline N = 40	Follow-up N = 26
Had insertive anal sex	52%	55%
Unprotected ^a	73%	55%
Had receptive anal sex	67%	65%
Unprotected ^a	57%	54%
Under substance influence ^a	23%	4%
STD diagnosis	40%	20%
Communication with regular sex partner^b		
Never/almost never discuss safer sex	45%	25%
Never/almost never discuss condom use	45%	25%
Never/almost never discuss monogamy	55%	23%
Partner has sex with others	25%	19%
Did not ask about partner's HIV status	30%	6%

^a Percentage of those who engaged in the primary behavior

^b Percentage of those with regular partner; N = 28 at baseline, 16 at follow-up.

Sexual Behaviors and Substance Use

- The groups displayed high levels of HIV knowledge, yet some related engaging in unsafe sex.
- HIV-positive participants expressed fear of both infecting partners and disclosing their HIV status to potential partners.
- Use of alcohol, marijuana, and methamphetamines, as well as other substances, is common, especially among youth.
- Many participants stated that they used substances to lower sexual inhibitions. Others said they isolate themselves when high or drunk.

“Fearing rejection, some HIV-positive participants ... did not disclose their HIV to casual partners.”¹⁰

HIV and STD Risk Perception

A lot of STDs are way more infectious than HIV. . . . STDs need to be a priority in young, gay Asian men’s lives because it’s so neglected.

—Focus group participant

- Youth participants perceived a greater risk of STD infection than of HIV infection.*
- HIV-positive participants perceived nearly the same degree of risk for both HIV and STDs. In both cases, this was lower than the perceived risk expressed by youth participants.*
- Youth lack knowledge about STD symptoms and methods of transmission.
- Many expressed uncertainty about the HIV risk of oral sex.
- HIV-positive participants questioned their vulnerability to reinfection.

Gaps in HIV Social Services for API MSM¹²

- Program curricula need to be sensitive to those who may have just recently come out as gay or HIV+.
- HIV+ men need groups where they can discuss issues such as nutrition, treatment, HIV prevention, and sex—not just being API and gay.

IMPLEMENTATION CHALLENGES AND SOLUTIONS

In the second series of focus groups with young API MSM and one-on-one interviews with community service providers working with this population, the research team explored challenges to implementation of HIV intervention programs targeting API MSM. Suggestions for overcoming these challenges also emerged. The following sections summarize these suggestions.¹⁷

Diversity

It wasn’t until I joined a couple of support groups that I started realizing there is diversity out there. There are queer people of every color, who have very different interests. —Focus group participant

API MSM are not a homogeneous group, so agencies must broaden their scope of outreach activities to reach this diverse community:

- Participants identify with multiple groups, and identities are often based on geography, level of acculturation, education, age, ethnicity, and other factors.
- Participants seek to interact with people from diverse communities outside the API community.

Information Overload

Life is not risk-free, so why focus on that one aspect, on HIV and sex, when that’s just one part of your life? —Focus group participant

HIV prevention “exhaustion” is an important challenge for services that target the MSM community, particularly younger men:

- The gay community feels saturated with HIV information.
- Many men do not feel that HIV awareness and risk reduction is a priority in their lives.
- HIV prevention messages are perceived as patronizing, because they offer few options besides the 100% condom rule.

Personal Priorities

Identifying myself as queer and having all these other queer API youth, it really helped a lot. It boosted my morale and self-esteem and how I should face things now. —Focus group participant

Time constraints prevent enrollment in highly demanding multisession interventions. Responsibilities with work, school, friends, and family leave little extra time for lengthy interventions.

*Focus group participants rated their perceived risk on a scale of 1–10. Mean ratings for the youth groups were 3.76 for HIV risk (infection or reinfection) and 5.16 for STD risk. Means for the HIV-positive group were 2.96 for HIV and 2.67 for STDs.

For young API MSM, other life issues receive higher priority than HIV, including:

- Coming out as gay to self and family
- Making friends and dating
- School and career goals

Social Content

I think it comes to a certain point when all the information, all the workshops, in a way they're secondary. They're just tools they use to help you recognize who you are and how you interact with a group. —Focus group participant

Most men stated they would respond more positively to socially oriented programs, such as:

- Social networking with other API MSM
- Programs that build self-acceptance
- Venues for developing friendships and dating opportunities
- Learning more about different career opportunities

COLLABORATION

The collaborative partnership at the core of this study emerged from discussions between HIV prevention researchers at the Center for AIDS Prevention Studies at UCSF and program directors and staff at the Asian and Pacific Islander Wellness Center.*

Each partner brought its individual expertise to the project. The CAPS/UCSF team contributed experience in design and evaluation of health interventions, as well as scientific and theoretical knowledge of health behavior change. A&PI Wellness Center brought its strong history and reputation for providing culturally sensitive services to the API community. In the process of collaborating, each organization gained knowledge in the other's areas of strength. A&PI Wellness Center staff learned about research design and methodology and program evaluation; researchers learned about the agency's mission, services, and program methods, and they gained a deeper understanding of the important questions to ask.⁸

The collaborators and the process they followed in working together are described further in the sections that follow.

Collaborative Partners

Asian and Pacific Islander Wellness Center

Established in 1987, A&PI Wellness Center is the oldest and most comprehensive nonprofit organization in North America targeting API communities around sexual health and HIV. The agency's mission is to educate, support, empower, and advocate for API communities—particularly APIs living with, or at-risk for, HIV/AIDS. Now in its 17th year, A&PI Wellness Center is regarded as an anchor institution delivering an in-

tegrated mix of HIV prevention, testing, care, research, and capacity-building programs. Its services are offered free of charge in 20 languages. The HIV Care Services department offers HIV treatment case management, mental health counseling, on-site primary medical care and psychiatric consultation, client and treatment advocacy, and individual and group support for APIs living with HIV/AIDS. The Health Education Department reaches more than 15,000 APIs annually through multilevel and multilingual health promotion programming, which includes on-site and mobile HIV testing, needle exchange, volunteer and leadership development opportunities, workshops and support groups, community organizing and outreach, magnet community events, social marketing, and web-based outreach. The Research and Technical Assistance department has provided HIV prevention capacity-building assistance to 55 organizations and 17 health departments and health ministries across the United States and Pacific jurisdictions. Research and Technical Assistance also operates the bilingual (English and Spanish) California Statewide Treatment Education Program (CSTEP), which provides training on HIV treatment for non-medical service providers working in communities of color.

In addition to working with UCSF/CAPS, A&PI Wellness Center has extensive experience in partnership with federal agencies, including NIH, CDC, HRSA, and OMH, and state and city departments of public health. The agency has had representation on the President's Advisory Council on HIV/AIDS and hosted the first-ever API Research Summit on HIV/AIDS.

Daniel Bao, associate director, Research and Technical Assistance, was co-principal investigator on this project, with Vince Cristostomo serving as project director for the first half of the project term. In the last half of the project, Lina Sheth became the new director of Research and Technical Assistance and co-PI on the project, with Javid Syed serving as project director.[†]

Center for AIDS Prevention Studies (CAPS), UCSF

The Center for AIDS Prevention Studies was established in 1986 to promote collaboration and multidisciplinary research on the prevention of HIV infection and disease. CAPS is part of the UCSF Department of Medicine and collaborates with the Department of Epidemiology and Statistics, the Division of Medical Ethics, the Institute for Health Policy, and the Divisions of Behavioral Sciences and Behavioral Pediatrics, as well as numerous San Francisco Bay Area institutions outside the university. Through these partnerships, CAPS links more

*CAPS/UCSF and A&PI Wellness Center had collaborated on an earlier intervention study targeting API MSM in San Francisco. The study evaluated a brief counseling workshop developed by A&PI Wellness Center.¹

[†]This project was supported by API staff, including Alberto Vajrabukka, Ofelia Virtucio, Huy Le, and Mazdak Mazarei.

Lessons Learned⁸

- Analysis and/or pilot testing can provide invaluable information about the appropriateness or feasibility of a project prior to launching a full-scale intervention.
- Survey instruments, particularly when self-administered by non-native English speakers, should avoid clinical terminology and excessive lengthiness. Translation services may also be needed.
- When responsibilities are divided between organizations, care must be taken to keep all parties fully informed about all activities related to the project.
- Peer-based staff are a vital asset to culturally appropriate interventions, and their front-line position makes them vulnerable to burnout. Proper reward and support mechanisms are recommended, as well as ongoing supervision and clear policies on project protocol.
- Staff turnover at CBOs is inevitably higher than at research institutions. To avoid related problems, all project activities need to be thoroughly documented.

than 200 investigators with expertise in epidemiology, behavioral medicine, biostatistics, biomedical and other sciences, survey research, substance abuse, ethics, public health, international health, and health policy research and analysis.

Tooru Nemoto, CAPS, was co-principal investigator on the project. Don Operario was project coordinator, and Toho Soma was project assistant.*

Processes and Key Components of Collaboration

Project responsibilities were divided according to the organizations' unique strengths. A&PI Wellness Center assumed most of the responsibility for community and client relations, including outreach and recruitment; conducting the interventions; ensuring community-appropriate research design, questions, and research implementation; and keeping track of participants for follow-up.[†] CAPS staff were responsible for such tasks as formalizing the research protocol; developing survey instruments; and maintaining, analyzing, and writing up the results of the data. Shared tasks included fa-

cilitating focus groups, analysis of focus group findings, development of the curricula, and administrative duties.⁸

Key to the successful collaborative relationship of the two organizations were a number of existing conditions:⁸

- Equal power in the collaboration, due to both partners (CAPS and A&PI Wellness Center) having been given direct funding
- A nonhierarchical relationship
- Commitment to placing the community's needs above their own respective interests
- Critical introspection and self-reflection
- Flexibility and openness to new ideas for research or service
- Monthly ongoing communication and meetings to update and jointly solve any problem issues as they arose

These conditions provided the foundation for the collaborative process summarized on page 13.

CONCLUSION

This collaborative research project between A&PI Wellness Center and the Center for AIDS Prevention Studies produced useful findings from focus group discussions and interviews. The resulting themes generated from these conversations were used in curriculum development and improvement. One key finding was the importance of acknowledging the roles of cultural, ethnic, and sexual identity in the development and implementation of HIV prevention programs targeting API MSM.

The researchers emphasize that these findings may not be generalizable to larger samples or to similar populations outside of California or the San Francisco Bay Area. The sample in this research project was acculturated API who spoke English. Most participants had graduated from high school, and all resided in the state of California, with its diverse sexual and cultural communities.

This project had implementation challenges, including that of HIV prevention exhaustion (e.g., the gay community feels saturated with HIV prevention messages); that retreats demand large time commitments and participants' time constraints caused impediments in enrollment; and that community members have social issues they perceive as more significant than HIV prevention.

Each of the collaborative partners has had long-term experience in HIV prevention. Of particular importance to this research was the vital asset of peer-based staff, the nonhierarchical relationship between the two organizations, and flexibility for changes in services and research protocol.

*CAPS project support staff included Terence Ng.

[†]A&PI Wellness Center is also supporting broad dissemination of the findings to API stakeholders.

Recommendations for Community-Collaborative Intervention Research

Stage 1: Pre-project Collaboration

- Convene a team of potential collaborators to discuss the health needs of your target population:
 - Describe your team's shared long-term vision related to the population's health need.
 - Define and agree upon a concrete research question.
- Identify the objectives of each collaborating party:
 - State your experience working with the target population or research topic.
 - Acknowledge your professional agendas and goals.
 - Discuss overlap and potential conflicts associated with having distinct agendas.
 - Discuss philosophies toward community-based work and implementing scientifically sound studies.
- Have an intervention research plan that is scientifically valid and community conscious:
 - Use evidence-based theory and methods as a foundation for your intervention research.
- Divide responsibilities among team members (e.g., grant writing, community outreach):
 - Hire and train members from the target community.
 - Create an organizational structure for the project; define specific project roles and responsibilities for all team members as well as each agency's overall goals and objectives.

Stage 2: Formative Research

- Use focus groups, interviews with community stakeholders, and ethnographic analysis to identify cultural factors related to intervention procedures.
- Assess the feasibility and cultural sensitivity of your intervention:
 - Pilot test all curricula, surveys, recruitment methods.
 - Make all necessary revisions based on formative research and pilot testing.
 - Communicate any changes with funding agency.

- Conduct ongoing in-service workshops on research methods, ethics, client services, etc.
- Prepare a protocol for providing referrals for participant issues that arise during the intervention (e.g., participants might need job training, substance abuse treatment, immigration/naturalization or other legal counsel).

Stage 3: Conducting the Intervention

- Meet regularly to update team members on all project activities.
- Document recruitment and intervention activities—what works and what does not; successes and challenges, etc.
- Provide appropriate support, supervision, and mentoring to front-line staff.
- Refer participants to necessary social and health services on a case-by-case basis.

Stage 4: Evaluation and Dissemination

- Involve non-research collaborators in data analysis through discussion of emerging findings.
- Consider cultural underpinnings of findings to “think outside the box.”
- Share findings with target community and CBO colleagues.
- Strategize on how to continue providing intervention services to the target population after project funding is complete.

Source: D. Operario, T. Nemoto, T. Ng, J. Syed, and M. Mazarei, “HIV Interventions for the Asian Pacific Islander MSM Community: Seeking Best Practices for Community-Collaborative Research,” in *University and CBO Collaborations to Build Capacity*, special issue of *AIDS Education and Prevention* (forthcoming 2004).

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