Data is a constant part of your daily decision-making process. From scouring the sales ads in the newspaper when you are looking to replace the coffeemaker that finally gave out after 15 years, to scanning the Top 10 box office receipts when deciding which movie you want to blow $10 on (or $20 if a soda and tub of popcorn are included), data is used everyday.

In the context of HIV prevention community planning, data is often elevated to the highest of the highest pedestals. In particular, the numbers and charts found in a jurisdiction’s epidemiologic profile often take on great importance, especially when community planning groups make decisions on HIV prevention priorities or when care councils are determining their funding formularies.

Some of you are probably thinking to yourselves, "Of course these decisions should be based on scientific data." Guess what? I agree with you [in fact the Centers for Disease Control and Prevention’s (CDC) Guidance for community planning states that CPGs were created with the intent of improving the scientific basis of programs]. Finding and using HIV/AIDS data to inform HIV prevention decision-making, however, often becomes a tad challenging for Asian and Pacific Islander communities. Here are a few reasons why:

- Too often we focus on the raw numbers and our eyes gravitate towards the biggest ones. This often leaves communities with smaller populations such as Native Americans, Alaskan Natives, Asians, Native Hawaiians and Pacific Islanders out of the prioritization process for funding, even when there may be evidence of an emerging epidemic.

- In most jurisdictions, there is insufficient data related to HIV/AIDS in Asian and Pacific Islander communities. This includes behavioral surveillance that would potentially help us identify what is putting specific Asian and Pacific Islander communities at high risk for HIV/AIDS.

- Few health departments provide HIV/AIDS data broken out by Asian and Pacific Islander ethnicity. Actually, the majority of health departments consistently lump data for Asians and Pacific Islanders in with other racial/ethnic groups (most often with Native American communities.)

Despite these challenges, Asian and Pacific Islander advocates must continue to be strategic in how we use existing data to make the case for funding for HIV prevention programs in our communities. Here are a few tips on how to most effectively use the data we have.

continued on page 3
"HIV MATTERS" is the theme for the 3rd annual Asian and Pacific Islander HIV/AIDS Awareness Day on May 19, 2007. APIAHF will be joining the collective effort to address HIV/AIDS stigma and to stir up action, support and inspiration in the fight against HIV/AIDS. We will be doing this by co-sponsoring a Congressional briefing in Washington D.C. on Asian American and Pacific Islander health focusing on domestic violence, diabetes and hepatitis B and HIV. We will also be co-convening the Asian and Pacific Islander Institute at the HIV Prevention Leadership Summit in New Orleans focusing on current HIV/AIDS data advocacy and research efforts.

Data matters to policymakers, funders, donors and community members, especially evidenced-based research that shows detailed data about the impact of HIV in our communities. Data advocacy - the call for improved data collection and reporting of HIV/AIDS among Asians and Pacific Islanders - is a core part of APIAHF’s advocacy efforts, capacity building assistance services, and leadership development trainings.

In this issue of HIV Forum, you will find strategies, lessons learned and resources that you can put into your advocacy ‘tool box’ in order to turn data into action, and action into concrete results and long-lasting collaborations. The concern with gaps in data and research is common across all communities of color, immigrant and refugee communities, and poor communities. This common issue can also be a common cause since accurate and up-to-date data matters to communities at-risk for HIV/AIDS.

At the same time that we are advocating for improved data from health departments, federal agencies, and community planning groups, we must also strategically use the data and research findings already available to us. There is data generated from assessments conducted by community based organizations, from existing research studies, and from alternative sources that help us paint a larger picture of the socioeconomic factors that shape HIV risk and healthcare access. I encourage you to make HIV matter by strengthening your data advocacy skills and widening your resources in order to build and sustain culturally and linguistically competent HIV/AIDS services in the Asian and Pacific Islander community.

Looking for HIV/AIDS statistics on Asian American, Native Hawaiian and Pacific Islander communities can often feel like searching for a needle in a haystack if you don’t know where to start. To make things a little easier, APIAHF has created this list of landmarks to help guide your path.

Ask your local health department. Although many health departments don’t break out specific Asian American, Native Hawaiian and Pacific Islander HIV/AIDS data in their reports, this data exists if you just know who to ask. Don’t be afraid to make a call or request a meeting with your local epidemiologist. You can request a report on the areas that you need. Sometimes you need to do is be persistent and keep asking.

Become familiar with national HIV/AIDS surveillance reports. The latest reports by the CDC about the extent of HIV/AIDS in Asian American, Native Hawaiian and Pacific Islander communities don’t include data from states that have recently switched over to names-based HIV case reporting. Unfortunately, several of these states, like New York and California, have sizable Asian American, Native Hawaiian and Pacific Islander populations which are not included in these findings. Nevertheless, these studies provide a good start in allowing advocates to track incidence and prevalence trends over time (see cover article). Typing in “National Asian American, Native Hawaiian and Pacific Islander HIV/AIDS Surveillance Reports” on your search engine will lead you to some of the numbers you seek.

Track down local research studies. To supplement limited national surveillance data and state/local health department data, look to research done in local communities to help paint a fuller picture of the HIV/AIDS prevention needs. If there is no published research about Asian American, Native Hawaiian, and Pacific Islander populations in your area, find a study done in a region that comes as close as possible to matching your own region in terms of influencing factors such as size and demographics. In many cases, you can use findings from these studies to make a case for your advocacy efforts.

Think outside the box. Don’t limit yourself to looking at only HIV/AIDS surveillance data. Census information provides a wealth of information about factors such as English language proficiency and socioeconomic status which can have an impact on access to HIV prevention and care services. In addition, you can use Census data to map Asian American, Native Hawaiian and Pacific Islander populations in your community and compare this information to the location of HIV testing sites for further information about access to services. To search for Census information on Asian American, Native Hawaiian and Pacific Islander populations, visit us at www.apiahf.org or go directly to www.census.gov.

Don’t recreate the wheel. Before you go on a mad search to find all the published literature on Asian American, Native Hawaiian and Pacific Islander HIV/AIDS data on your own, start by asking folks who have been down that road before. Look for prepared literature reviews (you can find a lot of sources at the APIAHF website) or find people whose job it is to prepare it for you. Call the Office of Minority Health’s Resource Center at 1.800.444.6472 or contact Henry Ocampo at hocampo@omhrc.gov for assistance in conducting a literature review.

Happy searching! For more information about any of the above suggestions, contact Mazdak Mazarei at APIAHF (mmazarei@apiahf.org or 415.568.3329).
{PUTTING DATA INTO ACTION}

Continued from front page

Estimated numbers of cases of HIV/AIDS, 2001 - 2004
35 areas with confidential name-based HIV infection reporting

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2004</th>
<th>PERCENT CHANGE</th>
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</thead>
<tbody>
<tr>
<td>Asian and Pacific Islander</td>
<td>279</td>
<td>394</td>
<td>41% increase</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>171</td>
<td>208</td>
<td>22% increase</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7174</td>
<td>6970</td>
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</tr>
<tr>
<td>Black, not Hispanic</td>
<td>21556</td>
<td>19206</td>
<td>11% decrease</td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>11242</td>
<td>11806</td>
<td>5% decrease</td>
</tr>
</tbody>
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935 areas with confidential name-based HIV infection reporting

The transformation in how HIV/AIDS data on Asians and Pacific Islanders is collected and interpreted will not occur overnight. As advocates for Asian and Pacific Islander communities, we cannot get discouraged and must take heart in the small wins we can achieve by using the tactics previously described. Remember that we are all important pieces of a larger movement. Together, we can affect a collective change to improve data for Asians and Pacific Islanders that will subsequently provide the justification for prioritizing prevention efforts for the communities we serve.

For those interested in getting involved in community planning, APIAHF and its regional partners will be offering Asian and Pacific Islander FACES (Fostering Advocacy and Community Empowerment Skills) trainings across the country to help orientate Asians and Pacific Islanders to the community planning process. Contact Mazdak Mazarei at 415.568.3329 or mmazarei@apiahf.org for more information.
Females of Arabic Descent
Living with HIV/AIDS in Michigan by Mode of Transmission, as of 1/1/06 (N=43)

- 60% MSM (26)
- 19% unknown (8)
- 7% IDU (3)
- 5% MSM/IDU (2)
- 5% heterosexual (2)
- 5% blood receptions (2)

Enhance health and well-being of the population
Community meeting addressed questions of identity and cultural differences
Community members are encouraged to use their own language and traditions

- BENJAMIN IGNALINO, California

I am fortunate to have a CPG and epidemiologist that understands the importance of being sensitive to a detailed ethnic breakdown. I don’t think that it started that way though. Having a fairly large number of Asians and Pacific Islanders in San Diego is great. There just wasn’t enough of us on boards or involved directly in HIV prevention programming that made those important statements. So my strategy for getting epidemiological data and CPG’s to talk about Asian and Pacific Islander issues as related to health and HIV is to bring those from the community that have an investment in the topic and make ready a space for them at the table.

Each time you get a chance to tell them about Asians and Pacific Islanders, tell them. I don’t wait for opportunities, but instead I make them. For example, our epidemiologist concurred that the data is not significant, but nonetheless, was provided. What is significant was the manner in which it was presented - with caveats and more importantly by an Asian and Pacific Islander. This way, significant changes in the incidences and prevalence can be emphasized.

Additionally, I have during the last couple of months began providing Asian and Pacific Islander epidemiological data to the HIV Planning Council, the Ryan White Planning group for HIV treatment and care. The importance being that we need to integrate prevention and care that allows for a broader audience receiving the same epidemiological information, thus conveying the need to place special emphasis in addressing the Asian and Pacific Islander community.

Lastly, promote a special "data day" dedicated to addressing emerging populations (and I don’t mean behavior) and redefining racial/ethnic minorities. Place emphasis on addressing epidemiological data specified to Asians and Pacific Islanders and the importance in addressing the emergence of HIV/AIDS in sub-populations of the Asian and Pacific Islander community.

- GREG HUANG-CRUZ, New York City

Arab Community Center for Economic and Social Services

Opened in 1971, ACCESS is the largest Arab American human services agency in the U.S. The Arab American population in the greater Detroit, Michigan area is the largest Arab community in North America and the second largest outside the Middle East.

ACCESS COMMUNITY HEALTH & RESEARCH CENTER

- Opened in 1985, it is the most comprehensive Arab American community-based health and mental health center in North America.
- Dedicated to providing accessible, affordable and holistic health services with programs encompassing outreach, education, preventive services, health care services, supportive medical services, research and advocacy.
- Provides HIV/AIDS education, counseling, testing and referrals.

HIV/AIDS & STD PREVENTION PROGRAM

The overall goal of the HIV/AIDS and STD prevention program is to increase the knowledge of the Arab American community about HIV/AIDS and knowing their HIV status. The backbone of the program is outreach.

Program Goals:
- To develop a campaign to address stigma surrounding HIV/AIDS
- To foster awareness in the religious community in order to find ways to work together to prevent an epidemic in the Arab American community

For more information about ACCESS’s HIV Program, visit www.accesscommunity.org or contact Chris Ayoub Ramazzotti at cayoub@accesscommunity.org 313.216.2253.

MEETING COMMUNITY NEEDS: Making Inroads Into Southwest Asian/Middle Eastern Communities

Even though the Federal Government classifies our populations differently, APIAHF’s HIV Program includes all people living in the United States and the U.S.-affiliated jurisdictions who trace their heritage to the lands of Asia, Hawai’i and the Pacific Islands as part of our constituency. This includes people of Southwest Asian (commonly referred to as Middle Eastern) descent, of whom Arabs are a subset. We seek to remain inclusive and responsive to all our diverse communities in how we are named, recognizing that notions of identity are complicated and carry complex political, social and familial meanings. That being said, to quote a former colleague Javid Syed, we strive "to make inroads into the [Southwest Asian/Middle Eastern] community in a way that actually meets the community’s needs and doesn’t feel like we’re imposing an identity onto them... [Our] goal is not necessarily to make people feel like they need to give up an identity to become part of another identity, but to see whether there are strategic political resources and cultural reasons why people need to come together to make the lives of their communities more sustainable and have better access to services."
In each issue of *HIV Forum*, Asian and Pacific Islander members of community planning groups are interviewed. Through these interviews, we hope to share with you stories of inspiration, courage and leadership.

In this issue, we interviewed Chris Ayoub Ramazzotti who currently serves on the Michigan HIV/AIDS Council, and is one of the only Arab community planning group members in the entire country.

APIAHF: There aren’t many people of Middle Eastern descent on CPGs nationwide. Can you tell our readers a bit about how you came to represent the HIV prevention needs of the Arab community on Michigan’s community planning group? What were your initial hopes about joining?

Since there is no national HIV/AIDS data collected for Arab-Americans, I had the hope that serving on the Michigan CPG would start a dialogue not only for the people in Michigan, but nationally for other community planning groups to recognize the importance of including Arab Americans.

APIAHF: What advice or suggestions would you give to other Asian and Pacific Islander or Middle Eastern CPG members?

The most important thing you can remember about community planning groups is to draw from the experience of the other members in making connections and let them know that who you are and what you’re doing speaks directly to the experiences of your community.

APIAHF: What have you found to be the most challenging about your experiences on your CPG?

The most challenging thing is to be the voice for such a large and diverse community. The challenge is to represent everyone’s interests with just one voice.

APIAHF: What have you found to be the most rewarding part of being on your CPG?

The most rewarding thing is being able to draw on such a diverse and large pool of experience in HIV prevention and public health. Developing relationships with other providers, like through the Asian and Pacific Islander Fostering Advocacy and Community Empowerment Skills (API FACES) trainings, and the health department is invaluable to us as we move our program forward. We draw on those contacts and their experiences every day.

APIAHF: Asian and Pacific Islander HIV advocates often speak about their frustration with the lack of quality data that meaningfully illustrates the impact of HIV/AIDS in their communities. What strategies have you used to address this barrier in Michigan?

The most important thing you can do to address those issues is to continue to work with your state health department and show them the importance of your community’s voice. In Michigan we have worked closely with the health department and they have included Arab Americans in all epidemiological data collected. This is something that every minority community has to deal with, and building relationships and working closely with your health department is the best solution. A lot of community based organizations look at the health department as working against them when really the health department can be your best ally.
ased in 1996, the Asian Health Coalition of Illinois (AHCI) is a non-profit, community-based organization (CBO) whose mission is to improve the health and well being of Asians and Pacific Islanders in Illinois through advocacy, technical assistance, public education and community-based research. AHCI’s founders include CBOs, health care providers, public health officials and research institutions committed to furthering a health agenda that addresses cultural and linguistic barriers to health faced by Asian and Pacific Islander communities, in addition to the need for better data collection and a stronger advocacy voice for Asians and Pacific Islanders in the health arena.

AHCI has five mighty full time staff members, three of whom spearhead the agency’s HIV collaboration with the Asian & Pacific Islander American Health Forum. The valiant leader, Executive Director Dr. Hong Liu, has more than 13 years of experience working with communities to improve Asian and Pacific Islander health. Dr. Hong Liu eats oatmeal, fruit and soy milk for lunch everyday which keeps the doctor away. Matthew Magee has worked with HIV and infectious disease epidemiology for seven years, including a few stints in Latin America, India and Europe. Mr. Magee tries not to place pens behind his ear so that others don’t catch on to his nerdy numbering ways. Mona Artani recently earned her MPH in Chicago and has extensive leadership experience with health advocacy and women’s health issues. Ms. Artani cooks a mean chicken 65 and frequently wins AHCI’s nomination for best dressed.

Current programs at AHCI include many collaborative partnerships with CBOs at the local and regional level. For example, AHCI has existing collaborations with Asian and Pacific Islander CBOs to screen for hepatitis B, reduce HIV stigma and collect health statistics that are disaggregated by Asian and Pacific Islander ethnicity. The hepatitis B screening program partners with more than ten CBOs across metropolitan Chicago and has offered nearly 2,000 screenings in the past six years. A recent assessment project to collect local-level health statistics has been successful at generating community support for developing individualized prevention strategies for Chicago’s Chinese, Vietnamese, and Cambodian neighborhoods.

At the regional level, AHCI partners with APIAHF and A&PI Wellness Center as the Mid-East Capacity Building Assistance (CBA) Provider for the National HIV CBA Program. This program engages AHCI with multiple organizations throughout the Mideast and Midwestern US. Additionally, AHCI is a partner on the Illinois Strategic Prevention Framework, assisting with the formation of a comprehensive network of organizations to address substance abuse across the state. AHCI is also an active member of the National Hepatitis B Task Force Focus on Asian and Pacific Islander Americans.

Located in the Uptown neighborhood of Chicago, AHCI is a regional and local leader in establishing innovative programs to reduce health disparities in diverse Asian and Pacific Islander communities.

For more information about AHCI or its HIV capacity building programs, please contact Matthew Magee at 773. 878.0569, matt@asianhealth.org or Mona Artani at 773.878.0761, mona@asianhealth.org.
HISTORY OF THE BILLS
The Minority Health Improvement and Health Disparity Elimination Act (S. 4024) was introduced during the last session of Congress, in September 2006, by former Senator Frist (R-Tennessee) and Senator Kennedy (D-Massachusetts). The bill was developed in a bipartisan fashion with input from a diverse group of advocates including APIAHF and our partner organization Association of Asian Pacific Community Health Organizations (AAPCHO). S. 4024 reauthorized the Office of Minority Health, the National Center for Health and Health Disparities at the National Institutes of Health (NIH), and health professions training programs in the Health Resources and Services Administration (HRSA). The bill also required collection of data on race, ethnicity and primary language; established an internet clearinghouse for providers on cultural competency and communication; and established grants to improve outreach, participation and enrollment for available healthcare programs. In this session, Kennedy and a Republican cosponsor will reintroduce a very similar bill in Spring 2007. The Senate Health, Education, Labor and Pensions (HELP) committee has jurisdiction over this bill.

In the House, the Health Equity and Justice Act (HR 6275) was also introduced in September 2006 by Representative Donna Christensen (D-US Virgin Islands). The bill was developed by the Tri-Caucus, which consists of the Congressional Black Caucus, the Congressional Hispanic Caucus and the Congressional Asian Pacific American Caucus. APIAHF, AAPCHO and many other national minority organizations provided input. The bill covered much of the same ground as the S. 4024. In addition, the bill established an advisory committee on language access as well as grants for demonstration programs to improve language access. The Caucuses anticipate introducing a new bill in May 2007 that will likely have to be referred to several committees, including the Committee on Energy and Commerce and the Committee on Ways and Means, before it comes for a vote before the full House.

The last minority health improvement bill to be enacted was the Minority Health and Health Disparities Research and Education Act (P.L. 106-525) in November 2000. Sponsored by Kennedy and the minority caucuses, it elevated the NIH Office of Minority Health to the National Center for Minority Health and Health Disparities.

UPDATE ON THE RYAN WHITE CARE ACT
The Ryan White HIV/AIDS Treatment Act which provides funding for HIV/AIDS care, support services and treatment was re-authorized on December 9, 2006, after more than two years of extensive negotiations led by a bipartisan House and Senate working group and community advocates. The Act was reauthorized for only three years instead of the traditional five years, with the intention of giving Congress and the AIDS advocacy community time to address ongoing concerns over insufficient resources and changes to funding formulas and HIV/AIDS case reporting.

While there are many provisions that remain problematic, there are a few sections of the new Act that positively impact Asians, Pacific Islanders and immigrants. Maintained in the final compromise version of the bill were codification of the Minority AIDS Initiative; the inclusion of linguistic services as a support service; the maintenance of hold harmless provisions (3 years); and the stabilization of funding levels (no less than 95% of Fiscal Year '06 levels) in urban areas to preserve current infrastructures of care. Ryan White HIV/AIDS Treatment Act services including treatment under the AIDS Drug Assistance Program (ADAP) are still accessible for the uninsured, underinsured and undocumented.

The final version of the Ryan White HIV/AIDS Treatment Act also included the US-affiliated Pacific Island jurisdictions (American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, and Republic of Palau) as eligible to receive Ryan White funding. Due to an oversight in previous reauthorizations, five of the six Pacific Island jurisdictions were omitted in the definition of "state" which resulted in a shutdown from funding.

HRSA AND THE MINORITY AIDS INITIATIVE
After the Ryan White CARE Act was reauthorized, Health Resources and Services Administration (HRSA) moved quickly to translate the law into new funding guidelines. It has been a mixed bag of bad news and somewhat good news, since many current grantees anticipated changes to funding allocations and had concerns about whether HRSA would allow time for this transition.

The somewhat good news: Title I and Title II grantees received a much needed waiver on the 75/25 rule in fiscal year 2007. The waiver exempts grantees from having to spend 75% of their budget on core medical services and instead be able to continue using these resources for interpretation and translation, housing, and transportation.

The bad news: While the codification of the Minority AIDS Initiative (MAI) in the Act was a success, the administration of the funding has put a lot of minority services and organizations in peril. In their decision to make the MAI funding competitive, HRSA announced a funding gap of a minimum of 5 months (March 1 - August 1), forcing grantees to either cut or stop services if they do not have alternative funding sources. Previously, MAI grants were divided among all eligible metropolitan areas and states according to a formula based on their proportion of racial and ethnic minority AIDS cases.

In addition to the funding gap, HRSA intends to make MAI funding, which is allocated for mainly capacity building assistance services, to comply with the 75/25 rule. This inconsistency is still being negotiated with HRSA, policymakers and community advocates.

The Tri-Caucus responded with a letter to the Administration voicing their concerns with the unintended consequences of the changes to the MAI funding. The Tri-Caucus letter urged the Administration to continue distributing Minority AIDS Initiative funds based on the methodology in the 2000 CARE Act until HRSA has made the final changes, or to make the grant year for MAI effective March 1, 2007, not when HRSA chooses to issue notices of grant awards in August or September 2007. This will allow programs to use alternative funding sources (such as formula funds) in anticipation of being able to reimburse those alternative sources with MAI monies once they become available. As of May 2007, 2 months into the MAI funding gap, HRSA and the Administration have not responded to these requests.
At 8:45 am on my way to one of the MATH study’s community research sites to observe a test during the pilot phase of the study, I received a call from Mark Molina, HIV program coordinator for Asian Americans for Community Involvement (AACI) in San Jose, CA. It seems that while Mark was preparing for the participant of the study to show up, he discovered that the MATH study server was down. The server is housed at Georgetown University (GU) from where sites like AACI can download the study protocol and survey. I immediately placed a call to staff at GU in hopes that the problem could be fixed as soon as possible.

**PROTOCOL.** When everything is running smoothly, study data inputted by the seven research sites is instantly accessible through the server to the principal investigators. In this way, disaggregated data can be easily organized for analysis, HIV rapid testing technology at each site can be monitored quickly and any gaps in data quality can be addressed immediately. Unfortunately, the incident at AACI that morning was not an isolated one, as a couple of other sites have had the same experience. Eventually, the server was up and running so that when the study participant arrived, the rest of the session went smoothly. Understandably though, issues like these led the researchers to re-think the process.

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**Background:** The Men of Asia and Pacific Testing for HIV (MATH) study is a five-year, national research consortium that aims to collect behavioral and epidemiological data on 2000 Asian and Pacific Islander men who have sex with men (MSM) at 7 community-based research sites in 5 metropolitan areas. The MATH Study is designed to collect data about HIV/AIDS prevalence, HIV behavioral risk, and community service infrastructure in Asian and Pacific Islander communities. Dr. Frank Wong, PhD of Georgetown University and Dr. Tri Do, MD, MPH of University of California, San Francisco are the Principal Investigators. APIAHF is the convener of the MATH consortium, sits on the scientific team, participates in decision-making processes, and provides additional capacity building assistance to all research sites.

This article is part of a series of updates about the MATH study’s progress focused on the challenges and rewards of conducting community-based participatory research.
SURVEY. Overall, the challenge for each site is to maximize the limited amount of time allocated for the study which includes administering the electronic survey. While there is a necessity to the length of the survey as it includes questions on demographics and risk factors, being a self-administered survey, the speed of its completion is highly contingent upon the computer literacy of the participant. Thus, despite a projected completion time of one hour, some participants have spent much more time completing the survey, and any glitches in the technology only exacerbate the problem. In trying to solve this challenge, the MATH study consortium began looking at the possibility of trimming down the length and transferring the survey into a paper version.

PAPER. Considering all the technical challenges, the scientific team decided to change the protocol and survey into a paper version after discovering major glitches in the computer hardware of the laptops provided to the research sites - glitches that would be costly to fix. According to GU, transferring the protocol and the survey to a paper version would be more cost-efficient. Needless to say, without computer technology, data will take longer to compile and analyze.

With this major change, the scientific team is working with great care to keep data quality at its optimum level by looking at the different aspects of the study structure. While the survey and some parts of the study will perform well with a paper survey instrument, some parts of it will need a better system which the scientific team is looking to create. For instance, monitoring quality assurance in terms of HIV rapid testing will require tighter oversight.

At AACI that day, after the study participant left, it was already past 3:00pm. While the session did go smoothly, the participant took more time than anticipated to complete the survey. By the time it was all done, Mark missed a meeting and I almost missed my train back to San Francisco.

But this is the reason why studies are pilot tested - to see how things roll out, what works well and what can be done better. As the MATH study progresses along its timeline, the study is now at its critical point, moving past the pilot phase and into the data collection phase. While it is disappointing that the computer technology did not prove to be a good fit, it is best to learn these lessons sooner rather than later. As they say, the study must go on.
GEM P. DAUS, MA, is the Senior Policy Associate at APIAHF. Since joining APIAHF in 2000, Gem has led advocacy efforts to increase access to quality healthcare, research and the involvement of communities in advocating for their own health and well-being. Gem has testified at Congressional briefings, federal advisory committees and the Institute of Medicine. Gem received the National Leadership Award from the NYU Center for the Study of Asian American Health and the Healthcare Hero Award by the Congressional Black Caucus, Hispanic Caucus, Native American Caucus and Asian and Pacific American Caucus.

Prior to APIAHF, Gem worked at the National Minority AIDS Council (NMAC), providing training and technical assistance to AIDS service organizations and state HIV prevention planning groups throughout the U.S. He also served as president of the Asian and Pacific Islander Partnership for Health, a local health promotion and advocacy organization.

DEEANA JANG, JD, is the Policy Director for APIAHF. Based at the Washington, DC office, Ms. Jang returned to APIAHF in April 2007 after working as a Senior Policy Analyst at the Center for Law and Social Policy. From 1996-2000, she worked on California and federal health policy issues at APIAHF. Deeana was also a legal services attorney for many years representing low-income families in domestic violence, immigration, school discipline and housing issues at San Francisco Neighborhood Legal Assistance Foundation, Asian Law Alliance and the Asian Law Caucus. She serves on the Advisory Committees of the Asian and Pacific Islander Institute on Domestic Violence and the National Network to End Violence against Immigrant Women. She is a co-founder of the Asian Women’s Shelter, one of the first battered women’s shelters in the country to address the needs of Asian immigrant women and their children. She is a former chair of the board of the National Immigration Project and also served on the board of the Northern California Coalition for Immigrant and Refugee Rights. Ms. Jang is currently serving on the board of the National Asian Pacific American Women’s Forum. She received her BA from Oberlin College and her JD from King Hall School of Law at UC Davis.
Mona Bormet, MPH, CHES, is the Healthy Asian American and Pacific Islander Policy (HAAPI) Fellow in the DC office. Mona previously served as a fellow in the Office of Congresswoman Lois Capps, in which she honed her health policy skills on the federal level. Mona received her Masters of Public Health (MPH) from the University of Minnesota, School of Public Health. During her time in Minnesota, Mona served as a Research Assistant for the Minnesota Asian/American Health Coalition (MA/AHC) and interned for the State Council on Asian Pacific Minnesotans (CAPM). During the summer of 2005, Mona interned at the Centers for Disease Control and Prevention (CDC), Cardiovascular Health Branch (CHB). She also spent two weeks in Baton Rouge, Louisiana assisting the American Red Cross and United States Public Health Service with disease surveillance in Hurricane Katrina/Rita relief efforts. For fun, Mona recently went skydiving, she loves to hike, play volleyball, and is looking forward to traveling to Rwanda with her church this summer.

Linda M. Choi, MPH, is the Policy Coordinator. At APIAHF, her work is focused on research, policy advocacy and providing technical assistance in the realm of cultural competency, census data, and media work for community-based organizations. She received her Masters of Public Health (MPH), and post baccalaureate certificate in medical anthropology from the University of Arizona.

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is the Healthy Asian American and Pacific Islander Policy (HAAPI) Fellow in the DC office. Mona previously served as a fellow in the Office of Congresswoman Lois Capps, in which she honed her health policy skills on the federal level. Mona received her Masters of Public Health (MPH) from the University of Minnesota, School of Public Health. During her time in Minnesota, Mona served as a Research Assistant for the Minnesota Asian/American Health Coalition (MA/AHC) and interned for the State Council on Asian Pacific Minnesotans (CAPM). During the summer of 2005, Mona interned at the Centers for Disease Control and Prevention (CDC), Cardiovascular Health Branch (CHB). She also spent two weeks in Baton Rouge, Louisiana assisting the American Red Cross and United States Public Health Service with disease surveillance in Hurricane Katrina/Rita relief efforts. For fun, Mona recently went skydiving, she loves to hike, play volleyball, and is looking forward to traveling to Rwanda with her church this summer.

SuHaila Khan, MD, PhD, is the Community Capacity Program Director, focusing on the Health Through Action program supported by W.K. Kellogg Foundation. She is a public health physician and health economist with over ten years experience in evaluation and research of health service delivery strategies in Asia, Africa, Latin America and in the U.S. She has extensive experience working in non-profits and on projects funded by United States Agency for International Development (USAID), United Nations International Children’s Emergency Fund (UNICEF), and World Health Organization (WHO).

Marguerite Ro, DrPH, is the Deputy Director of APIAHF. Formerly an Assistant Professor at Columbia University, she held appointments in the College of Dental Medicine, the Mailman School of Public Health and the Center for Community Health Partnerships. Dr. Ro spent the last several years working with underserved communities across the U.S. on improving access to healthcare through policy improvements and systems changes, primarily as the Senior Health Policy Analyst for the W.K. Kellogg Community Voices Initiative. Dr. Ro has conducted program management and evaluation for the American Legacy Foundation and the Community Health Foundation of Western and Central New York. She has authored numerous publications on issues including AA and NHPI health, community health workers, men’s health, mental health and oral health. Dr. Ro received her Masters and Doctorate from the Johns Hopkins School of Hygiene and Public Health. She is also a mother of a precocious but adorable daughter, Carmelita.

Health Through Action - Community Partnerships Grant Program is designed to promote and support vibrant and active community collaboratives through strengthened capacity to conduct effective health programming, policy, and advocacy geared at reducing and eliminating health and healthcare disparities of Asian American, Native Hawaiian and Pacific Islander children, individuals and families.

As part of its overall capacity building effort, Health through Action aims to develop a Native Hawaiian and Pacific Islander health agenda. The program has also created the Health Braintrust, a gathering of researchers, representatives of advocacy groups and policy makers from state and federal agencies to address the data needs of Asian American, Native Hawaiian and Pacific Islander communities.

Expanding healthcare access, increasing research and improving data collection, and increasing investment in community-based health promotion programs.

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Linda M. Choi, MPH, is the Policy Coordinator. At APIAHF, her work is focused on research, policy advocacy and providing technical assistance in the realm of cultural competency, census data, and media work for community-based organizations. She received her Masters of Public Health (MPH), and post baccalaureate certificate in medical anthropology from the University of Arizona.

Mona Bormet, MPH, CHES, is the Healthy Asian American and Pacific Islander Policy (HAAPI) Fellow in the DC office. Mona previously served as a fellow in the Office of Congresswoman Lois Capps, in which she honed her health policy skills on the federal level. Mona received her Masters of Public Health (MPH) from the University of Minnesota, School of Public Health. During her time in Minnesota, Mona served as a Research Assistant for the Minnesota Asian/American Health Coalition (MA/AHC) and interned for the State Council on Asian Pacific Minnesotans (CAPM). During the summer of 2005, Mona interned at the Centers for Disease Control and Prevention (CDC), Cardiovascular Health Branch (CHB). She also spent two weeks in Baton Rouge, Louisiana assisting the American Red Cross and United States Public Health Service with disease surveillance in Hurricane Katrina/Rita relief efforts. For fun, Mona recently went skydiving, she loves to hike, play volleyball, and is looking forward to traveling to Rwanda with her church this summer.

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announcements from APIAHF

OFFICE MANAGER
Responsible for managing and performing office administration and support activities to support the achievement of APIAHF’s mission and objectives. Specifically, this position is responsible for planning, developing and implementing administrative services systems including office management, travel arrangements, office space utilization and administrative support for the San Francisco, CA and Washington, DC offices.

CONSULTANTS
We are constantly on the lookout for professionals with expertise in organizational development, executive coaching, strategic planning and fund development.

If you are interested in any of these opportunities or for a full job description, please send an e-mail to hr@apiahf.org.

Join Our Family!

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San Francisco, CA 94108