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Learning from HIV/AIDS among Asian Americans and Pacific Islanders (AAPIs)

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Abstract

Health crises have become a significant threat to the well-being and quality of life of California's residents, with SARS and avian influenza the most obvious recent examples of such threats. The State of California has engaged in significant efforts at the state and local levels to devise plans and strategies to address emerging health threats, including rapid spread of infectious disease and bioterrorism; however, there remain significant gaps, particularly concerning the rapidity and effectiveness of communication to California's growing immigrant population. We argue that enhancing community-based organization (CBO) capacity to address health crises such as potential pandemics is a necessary yet overlooked component. This article uses capacity building regarding HIV/AIDS prevention in the Asian American and Pacific Islander (AAPI) communities in Southern California as a new model of emergency preparedness, one that leverages the untapped resources in CBOs.

Gaps in California State Response to Health Crises

The State of California has engaged in significant efforts at the state and local levels to devise plans and strategies to address emerging health threats, including rapid spread of infectious disease and bioterrorism; however, while these efforts are necessary and potentially effective, there remain significant gaps, particularly concerning the rapidity and effectiveness of communication to California's growing immigrant population. Reaching California's immigrant population is particularly critical during health

emergencies because they constitute a significant part of the state's population. According to the Public Policy Institute of California:

> California has not only more immigrants but also a greater proportion of immigrants than any other state in the nation. More than one-fourth of all Californians are foreign born, and over 30 percent of these immigrants are estimated to be undocumented.[1]

Many of these immigrants are linguistically isolated and consequently need language- and culturally-specific and appropriate messages and messengers with respect to health crises and emergency preparedness. These populations therefore constitute a significant focus of any comprehensive statewide effort that aims to improve emergency preparedness. Much research and policy concerning immigrants and health crises have centered on health disparities, which have been primarily addressed through federal efforts and programs. But while federal programs such as REACH 2010, through the Centers for Disease Control and Prevention (CDC), have done much to focus policy attention on the role that community-based organizations may play in reducing health disparities and improving health outcomes, there has been less attention paid by state policymakers and legislators, in California and other states, to understanding the ways that nongovernmental organizations might play a critical role in a comprehensive emergency health management plan. There have been past efforts to provide multilanguage information to households and communities in California concerning potential health crises, such as the Governor's Office of Emergency Services (OES) public service announcements concerning avian influenza in English, Spanish, and Cantonese. However, there is much work to be done to ensure that emerging health crises are addressed in ways that reach linguistically isolated and low literacy populations, many of whom are unfamiliar with and distrustful of formal medical services and government agencies at multiple scales.

Therefore, the aim of this paper is to provide a culturally sensitive model whereby state legislators and policy makers can understand, enhance, and leverage the capacity of community-based organizations, especially those based in immigrant and impoverished communities, to address health emergencies, and in so doing, to become part of the ongoing effort to synchronize and coordinate federal, state, county, and municipal efforts at data col-

lection, information dissemination, and medical care access and delivery. This policy paper outlines the ways in which HIV/AIDS prevention in the Asian American and Pacific Islander (AAPI) communities in Southern California point to a new model of emergency preparedness, one that leverages the untapped resources in community-based organizations to disseminate accurate, trusted, and rapid information to immigrant populations throughout the state of California. This model complements rather than replaces current efforts at statewide coordination of emergency planning and implementation, and offers a way for understanding the assets of community-based organizations in the wider health emergency planning effort in California and other states with large immigrant communities. HIV/AIDS prevention among Asian American and Pacific Islander community-based organizations is used as a case study to provide illustrations, lessons, and best practices models about how to expand and leverage community resources to enable legislators and policymakers to stabilize, sustain, and draw on these frontline resources in the case of a statewide health emergency.

The paper proceeds in the following manner. First, to provide examples of current and recent health crises that critically affect Asian American and Pacific Islander communities in California, two highly infectious and emerging diseases, SARS and avian influenza, are described. Next, a brief overview is provided of current approaches to emergency preparedness in California, especially focused on health crises and emergencies (though much of this debate tends to focus on bioterrorism rather than highly infectious diseases). The paper then turns to background on HIV/AIDS prevention in Asian American and Pacific Islander communities, and an example of rapid response to sexually transmitted disease in Los Angeles, and how these experiences provide important lessons in terms of the gaps in conventional approaches to preparedness. The paper then provides a model of capacity building for highly technical and dynamic health crises (of which SARS and avian influenza are examples), using HIV/AIDS prevention by Asian American and Pacific Islander community-based organizations as a case study. Though HIV/AIDS does not represent a health condition with potentially rapid infectious qualities such as SARS and avian influenza, HIV/AIDS does share characteristics with SARS and avian influenza such as population misinformation and lack of knowledge, and potential high levels of fear and stigmatization.

The paper concludes with policy recommendations given this new model, indicating ways that legislators and policy makers can best enhance and leverage the capacity of community-based organizations to help address health emergencies statewide.

Examples of Rapid Health Emergencies
in California: SARS and Avian Influenza

Though much health policy and research has focused on bioterrorism (e.g. Gerberding et al., 2001), public health crises have increasingly emerged as vital challenges to public emergency preparedness. SARS and avian influenza are two particularly important potential pandemics that have tested government capacity to deal with rapidly emerging health crises. These two potential pandemics are particularly important for California as many of the state's immigrant population groups came from countries associated with emergence and outbreaks of these two conditions, and there is much travel by California residents between California and Asian nations.

SARS (severe acute respiratory syndrome) was first identified in Hong Kong, China, and Vietnam with the World Health Organization sending out a worldwide alert in early 2003 (Booth et al., 2003). SARS has since been diagnosed across the globe. Perhaps part of the challenge of identifying and managing SARS is that the symptoms consist of headache/fever, diarrhea, and cough, which may be misinterpreted by those infected as something less virulent (such as a cold or less severe influenza) (Booth et al., 2003).[2] The important lessons from the SARS experience is that though SARS has largely disappeared from the public consciousness, and is described as "moderately transmissible" (Riley et al., 2003), what is clear from this pandemic is that international travel, lack of information in the community, and misdiagnosis can have potentially large-scale negative impacts on population health.

Avian influenza has yet to see widespread human-to-human transmission. Up to this point, transmission of the avian influenza A (H5N1) virus has been largely confined to infected poultry and people who had close contact with these domestic bird species, though there have been isolated examples of possible human-to-human transmission. Research on avian influenza indicates that the disease can affect all domestic bird species, and also will likely affect feral birds depending on contact between domestic and wild

bird species (Alexander, 2000). Avian influenza is not a new disease, however, the "highly pathogenic" H5N1 in early 2004 infected an estimated forty-four persons in eight Asian countries, with thirty-two dying (Ungchusak et al., 2005; Hien et al., 2004).[3] There are potentially severe impacts on California's population if avian influenza is not quickly and accurately recognized by households and medical service providers.[4]

These two recent and highly contagious diseases point to a need to clarify how best to educate and inform individuals, households, and communities, particularly those in communities that might be exposed to SARS or avian influenza (or other highly contagious infectious diseases).

Emergency Health Preparedness in California

Concerns about bioterrorism, rapid disease infections, natural disasters, and other issues have led states to look to varying approaches to improve and enhance emergency preparedness. The State of California has multiple individuals and agencies responsible for addressing natural disasters, health emergencies, and most recently, (bio)terrorism (Bea et al., 2004). A recent report, however, indicates that California is one of four states to receive the lowest score nationwide in terms of emergency preparedness for disease, disaster, and bioterrorism; the other low-rated states are Iowa, Maryland, and New Jersey (the states receiving the highest score in this report are Oklahoma and Kansas) (Cubanski et al., 2002; Trust for America's Health, 2006).[5]

In an attempt to systematize public health response to emergencies, the federal government, through the CDC, provided grant support to researchers to develop a model emergency health powers act that could be used by states across the country to deal with health crises associated with bioterrorism and highly infectious disease (Gostin et al., 2002). This model act was created in part to counteract the incremental nature of legislative and legal response to diseases as they emerged. Instead, the model act was aimed at addressing vastly different health codes across the fifty states, fragmentation in public health policies within states, and the lack of required planning for such health emergencies. As of 2003, twenty states and the District of Columbia had enacted parts of this model act.[6] Critics of this approach argued that this model act allowed the state to "take" private property (including firearms), quaran-

tine populations including those living with HIV / AIDS, and vaccinate without permission.

Based on this model, California Assemblyman Keith Richman introduced AB 1763 in January 2002, called the Emergency Health Powers Act, which would have added a Division to California's Health and Safety Code. The bill provided for, among other powers, state-mandated new duties for reporting by health care providers, coroners, medical examiners, and local law enforcement agencies, the ability to declare a state of public health emergency by the Governor, which would activate state, local, and other disaster emergency plans, and perhaps, most controversially, authorize public health authorities during a declared state of public emergency to medically examine, test, vaccinate, and treat individuals for infectious disease even without these individuals' consent, and allow the Governor to use private property.[7] The bill encountered opposition from advocacy groups from the left and right; the ACLU argued that the AB 1763 minimized checks and balances, provided too broad emergency authority, and did not provide privacy protection. Assemblyman Richman amended the bill in April 2002, to focus on creating a Public Health Emergency Powers Commission. The Assembly Committee on Health approved this amended bill, 13-1; however, the bill was "later held under submission in the Appropriations Committee."[8]

Assemblyman Richman introduced another Emergency Health Powers Act bill in January 2003 (AB 206),[9] without some of the more controversial elements from the previous bill (e.g., authority to vaccinate individuals). This bill or an amended version was supported by the Health Officers Association of California (HOAC), Kaiser Permanente, and the California Optometric Association. This bill engaged opposition by various individuals and groups, such as the California State Association of Counties (CSAC), County Health Executives Association of California (CHEAC), Child and Family Protection Association of California (CFPAC), Association of American Physicians and Surgeons, Inc., City and County of San Francisco, and the American Civil Liberties Union (ACLU). Among the arguments in opposition were that existing laws were adequate to address the issues raised in the bill, and that the bill provided for inappropriate police powers and Governor authority. AB 206 died in committee in February 2004.

Since such debates, there has not been a lack of legislation enacted to address emergency health management in the State

of California. In 2006, for example, state legislation was passed to increase coordination among agencies, improve data sharing, and enhance preparedness plans.[10] Currently, there are efforts to improve the effectiveness of the Governor's Office of Emergency Services (OES) by developing a plan that assesses the state's medical service system in terms of its "surge capacity" (that is, its ability to cope with a large increase in patients and individuals needing care following a disaster),[11] and a recent California Department of Health Services (DHS) plan for dealing with a potential influenza pandemic (California Department of Health Services, 2006).

California's state governmental bureaucracy faces many institutional obstacles in working to design and implement a state-wide rapid emergency health response. OES regions are large and diverse, for example, the southern region consists of such diverse counties as Los Angeles, Mono, San Luis Obispo, and Imperial among others, representing distinct needs for information, different types of local and county governance structures, and varying characteristics concerning possible outbreaks and potential public health response. Another example is that while the recent California DHS plan for pandemic influenza highlights the need for enhanced public health agency capacity for coordination, outreach, testing, and diagnosis, effective implementation will also largely depend on the ability of organizations to disseminate trustworthy, credible, and rapid information and suggested actions to a very diverse and multilingual population. The plan refers to these challenges, but implementing such a plan will require the active participation of community-based and other civil service organizations based in local neighborhoods. Emergency preparedness requires the connection between public agencies and a primarily untapped resource available especially in immigrant communities for rapid response, that is, community-based organizations, that will enable culturally appropriate and cost-effective means.

Community Based Organizations as Rapid First Responders: Lessons from HIV/AIDS Prevention and Sexually Transmitted Disease Response

One principal component of emergency preparedness at the federal level concerning bioterrorism and health crises involves "enhanced communications" (Rotz et al., 2002). Community-based organizations, in contrast to federal, state, county, and mu-

nicipal agencies, work more directly in and with individuals and households, many represent hard-to-reach communities, act as opinion leaders, have built networks of information (both in terms of collection and dissemination), and perhaps most importantly, participate in local communities of trust.

HIV/AIDS prevention in immigrant communities provides important lessons for how legislators, policy makers, and stakeholders may leverage community resources to rapidly respond to politically charged and stigmatized conditions, such as SARS and avian influenza. For example, the Asian American and Pacific Islander population is the fastest growing and one of the most diverse minority populations in California; it encompasses forty-three different ethnic groups and more than 100 different languages. According to the 2000 Census, about 35.1 percent of Asian households are linguistically isolated in Los Angeles County, compared to only 15.2 percent in the general population. Though AIDS case rates for AAPI populations in the U.S. remain low compared to other communities of color, the numbers are steadily rising.

The barriers to HIV/AIDS prevention and care among AAPIs are significant.

❖ Stigma, racism, homophobia, shame, and linguistic isolation result in a lack of language-specific programs, reduced access to healthcare, avoidance of HIV testing, and delay of care until later stages of HIV/AIDS among AAPIs (Takahashi, 1997).

❖ Cultural norms and taboos limit public discussion about sexual practices, and risk behaviors such as drug use and disclosure of homosexuality and drug use are associated with shame, loss of face, and stigma (Nemoto et al., 2003).

❖ The fear of deportation if found to be infected with HIV prevents many immigrants from seeking information or HIV testing (Kahle et al., 2005). To complicate matters further, AAPI immigrants fear denial of permanent residency due to HIV positive status and lack health coverage.

❖ Distrust of physicians, and more general mistrust of social institutions outside local communities because of societal fears concerning global terrorism and epidemics (e.g., SARS and most recently avian influenza) severely limit access to current and reliable information and services (Takahashi and Magalong, 2007).

Cultural and linguistic diversity serves as a major barrier for this population because intervention strategies must address the

cultural and linguistic differences among ethnic groups in order to effectively prevent or treat illnesses and disease. Likewise, AAPIs seeking medical help and information must often negotiate unfamiliar medical systems, agencies for which they have developed limited trust, and settings where staff do not speak their languages (Nemoto et al., 2003). For this immigrant population then, which is largely distrustful, unaware, and linguistically isolated from formal public health and medical service providers, community-based organizations may be the best organizational conduit for rapid response to hard-to-reach individuals and groups (Yoshikawa et al., 2003).

One study of rapid response to an infectious syphilis outbreak in Los Angeles from December 1999 to September 2000 provides insight into how such a system might be designed and its potential effectiveness (see Table 1 below) (Chen et al., 2002). This "multifaceted response" was used in March 2000 to address an outbreak of infectious syphilis among men who have sex with men (MSM), who were deemed to be at highest risk and constituted the target population for this rapid response effort. Though the authors caution that a scientific assessment was not made of the impact of this plan and response, they do believe that this approach resulted in "a faster decline in the outbreak than would have been expected." Using this system, eighty-nine early syphilis cases among MSM were identified and treated, and twenty-one of the partners, roommates, or friends of these eighty-nine MSM were "preventatively treated" (six were diagnosed were early syphilis). The following steps were used to establish that an outbreak had occurred, to rapidly disseminate information, training, and testing services, and to activate coordinated surveillance activities.

This study highlights the high degree of coordination and roles for local, county, state, and federal agencies necessary in identifying an outbreak, in rapid surveillance and monitoring, and adequate resources for outreach, testing, diagnosis, and treatment. One of the critical components of this approach, however, that has largely been missing from ongoing debates concerning health emergencies is the role of community-based organizations and local venues in effectively addressing, in a rapid way, public health crises. But, one of the issues here remains the uneven and at times tenuous state of community-based organizations in their efforts to continue to provide high quality services to their constituents. It is to this issue that the paper now turns.

Table 1. Local Outbreak Plan[1] and Sample Multifaceted Response

Component	Activity Plan	Sample Response of Infectious syphilis outbreak
Provider awareness	Weekly e-mail updates; monthly newsletter; press release, media coverage; STD training sessions	HIV/AIDS early intervention providers (EIPs) identified 40% of the 89 early syphilis cases, private clinicians & HMOs (26%), STD clinics (10%), & STD program case managers, mobile van screenings, & screenings at correctional facilities (24%). Letters & press releases about the outbreak were distributed to health providers.
Community-based organization recruitment & participation	Education of affected & nonaffected communities; community forums; service planning area meetings; implementation of screening	Three community-based organizations (CBOs) were recruited to assist in containment efforts & establish awareness of outbreak. Stakeholders were provided training on current guidelines for testing, diagnosis, & treatment.
Media campaign	Initial press release; print advertising & media; radio advertising; Internet advertising	A $450,000 media campaign was designed & implemented with input from the County STD program, & six CBOs. The varied products used were in English & Spanish.
Community outreach: education & screening	Social & recreational sites; public health facilities; community centers; street-based sites; mobile van	Screening was conducted at 65 sites during 80 different events, resulting in 6000 syphilis tests. Mobile van screening was conducted at 24 sites.
Correctional facility	Targeted testing; screening for STDs; treatment; education & counseling	Screening & a single dose treatment were provided to self-identified MSM inmates; 811 inmates were screened for syphilis.
Enhanced active surveillance & rapid evaluation	Reactor grid suspension; screening; case management; social networking clustering; weekly case analysis; epidemiologic analysis; communication-needs assessment	Enhanced active surveillance with "suspension of the reactor grid, intensified case management, & targeted efforts toward MSM populations;" "a daily outbreak update & weekly case analysis" were instituted. Most individual cases were interviewed & treatment was available for each patient & their social networks. Rapid evaluation included daily outbreak update & weekly case analysis.
Interagency collaboration	Intensified interstate communication control records; integrated services with local programs; investigation by state & CDC officers	Interagency collaboration included public agencies & CBOs, with "143 rapid outbreak response partners from 20 public & 30 private organizations" to coordinate outreach & surveillance activities.

CDC=Centers for Disease Control and Prevention (Atlanta, GA); STD=sexually transmitted disease

1. Adapted from Table 1, Chen, James L., Dulmini Kodagoda, A. Michael Lawrence, and Peter R. Kerndt. 2002. "Rapid Public Health Interventions in Response to an Outbreak of Syphilis in Los Angeles." *Sexually Transmitted Diseases* 29(5): 277-284.

Expanding Capacity for Highly Technical, Dynamic
Health Crisis Response: Lessons from HIV/AIDS
Prevention Capacity Building among AAPI Organizations

Similarly, researchers have long advocated improving and
expanding the capacity of community-based organizations in di-
verse minority populations for HIV/AIDS prevention as the criti-
cal component in reducing HIV transmission (Kelly et al., 2000;
Myrick et al., 2005; Ramos et al., 2006). In the context of these myr-
iad challenges, the ways that organizational capacity can be ex-
panded in culturally appropriate ways for HIV/AIDS prevention
have important lessons for how community resources might be
leveraged for quickly responding to potential health emergencies
(Takahashi and Smutny, 1998). Organizations participating in such
capacity building programs have indicated greater leadership,
more potential to interact with media outlets, and greater ability
to design and implement culturally appropriate HIV prevention
programs (Sheth et al., 2007).

Organizational capacity can be defined as the degree to which
organizations address problems to attain specified goals. There
are internal and external organizational factors that determine or-
ganizational capacity, both in terms of current abilities and orga-
nizational gaps, especially resources (funding, information, etc.),
relationships (including agency networks and trust with program
participants), and leadership. One study reviewed the scholarly
literature and found four basic approaches to capacity building
in health: top-down, bottom-up, partnerships, and community
organizing (Table 2). Each of these approaches had distinct foci,
strategies, and measures to indicate effectiveness.

The ability of community-based organizations (CBOs) to
provide culturally effective and appropriate HIV/AIDS preven-
tion programs requires several elements. First, CBOs must be able
to convey complex information to at-risk populations who have a
wide array of sometimes conflicting needs (Altman, 2003). HIV/
AIDS remains highly stigmatized, creating a complex set of cul-
tural and societal obstacles within which prevention must be ef-
fectively designed (Takahashi, 1998; Valdisseri, 2005). At a simple
level, culturally appropriate HIV/AIDS prevention may include
multiethnic staff with multilingual skills, but effective strategies
should also include sensitivity to diverse backgrounds, and gain-

Table 2. Capacity Building Approaches[1]

Approach	Focus	Strategies	Measures
Top-down	Procedural change	Organizational change, develop organizational infrastructure	Changes in policy, resource allocation
Bottom-up	Staff training	Build staff expertise	Development of skills, workforce
Partnerships	Organizational relationships	Build partnerships, coalitions, alliances	Collaborative activities, network density
Community organizing	Participation & mobilization	Empowerment, expand community participation	Community ownership & involvement

1 Beth R. Crisp, Hal Swerissen, and Stephen J. Duckett. 2000. "Four Approaches to Capacity Building in Health: Consequences for Measurement and Accountability." *Health Promotion International* 15(2).
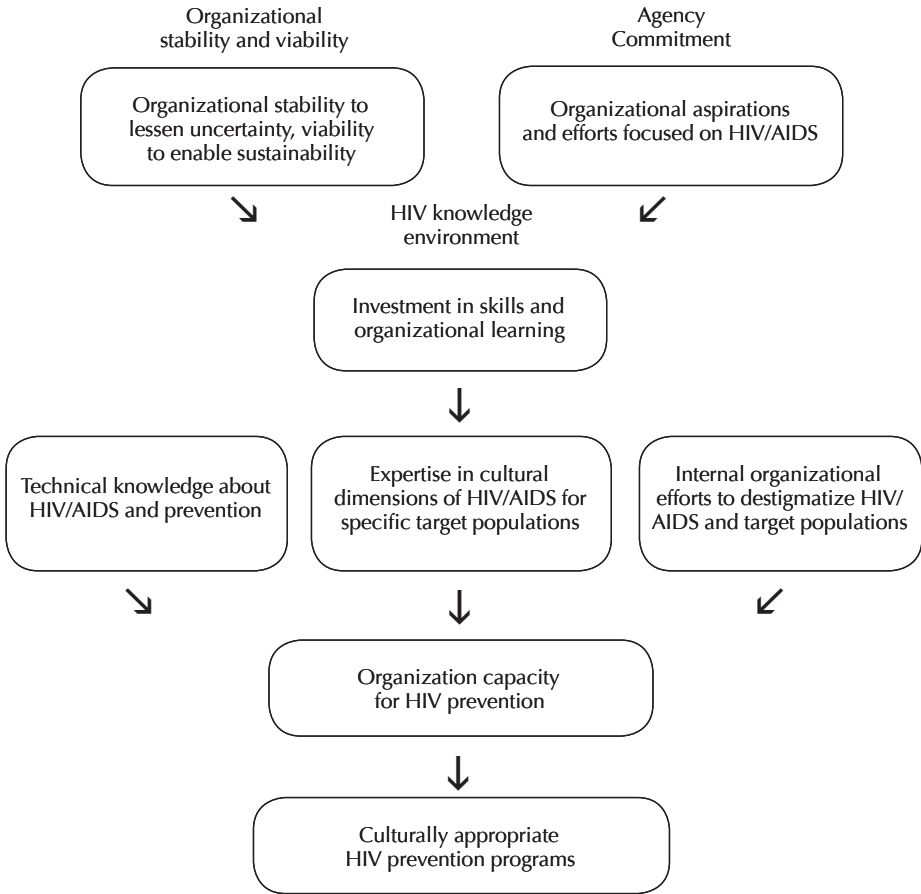
ing trust of groups distrustful of public agencies and medical service providers (Takahashi et al., 2001).

One model of capacity building for AAPI community-based organizations providing HIV/AIDS prevention consists of three basic components: organizational stability and viability, organizational commitment to HIV/AIDS issues, and HIV knowledge environments (Figure 1) (Takahashi et al., 2007). The first component, organizational stability and viability, refers to both the ability of an organization to sustain itself with reasonable expectations about funding levels, staff, policy mandates, and target population needs, but also the ability to adapt programs to accommodate changing conditions. With the high turnover typically associated with CBO staff because of generally low wage levels, CBO organizational stability is quite difficult. Gaining new funding sources, diversified target populations, and more partnerships, that is, more organizational viability, however, may work at cross purposes with goals of organizational stability, which aims at steady state conditions and expectations for minimal organizational change (Takahashi and Smutny, 2002). In terms of emergency preparedness, volatility in CBO expansion and decline define a complex and dynamic organizational environment for emergency health planning and implementation.

The second component, organizational commitment to HIV/AIDS issues, means that organizational leadership, mission, and vision must be tied to HIV/AIDS prevention. In other words, HIV/AIDS prevention must be a vital element in an organization's mission, strategic planning, and regular programs and services. Without organizational commitment, organizational stability/viability will likely not result in ongoing investment in enhancing knowledge environments. In terms of emergency preparedness, CBO mission, vision, and organizational planning must dovetail in clear ways with broader health emergency planning goals and objectives. Without this clear organizational overlap in mission, goals, and objectives, partnerships and coordination will be fragile.

The third component consists of knowledge environments. Particularly for highly complex and newly emerging infectious diseases, the ability for CBOs to understand and apply new and often technical information is critical to the ability to provide culturally appropriate HIV/AIDS prevention programs, and in turn, for participating in emergency preparedness planning and implementation. Knowledge environments are defined by: (1) information collection from both inside and outside the CBO; (2) ability to access technical knowledge, and if knowledge is not available within the CBO, the ability to access experts; and (3) having both redundancy within CBOs ("cross-functioning") and diverse skills so that mutual understanding is possible within CBOs (because mutual understanding can lead to innovation when the CBO is faced with new problems) (Cohen and Levinthal, 1990). For CBO capacity to engage in culturally appropriate and effective HIV/AIDS prevention, three subcomponents are important: technical knowledge about HIV transmission and prevention; understanding about cultural norms and community issues that define HIV/AIDS in target populations, and how to overcome or leverage these norms and issues; and organizational commitment to reduce stigma toward HIV/AIDS within the CBO. In terms of emergency preparedness, knowledge environments would require the ability to understand and access technical information concerning health emergencies, along with the ability to understand and overcome community and cultural norms preventing or obstructing individual, household, and community behaviors that impede health emergency planning and implementation.

Figure 1. Model for AAPI CBO Capacity Building[1]

Organizational
stability and viability

Agency
Commitment

Organizational stability to
lessen uncertainty, viability
to enable sustainability

Organizational aspirations
and efforts focused on HIV/AIDS

↘   HIV knowledge
environment   ↙

Investment in skills and
organizational learning

↓

Technical knowledge about
HIV/AIDS and prevention

Expertise in cultural
dimensions of HIV/AIDS for
specific target populations

Internal organizational
efforts to destigmatize HIV/
AIDS and target populations

↘   ↓   ↙

Organization capacity
for HIV prevention

↓

Culturally appropriate
HIV prevention programs

1. Takahashi, et al., 2007.

Recommendations for CBOs

To expand CBO capacity for culturally appropriate and effective health emergency planning and implementation, technical assistance can be effectively used to enhance any of these components, using top-down, bottom-up, partnerships, and community organizing approaches described previously. CBO organizational viability may be enhanced through technical assistance to CBO directors by focusing on improving knowledge of strategic planning and fundraising (top-down), while technical assistance may also improve CBO organizational stability by increasing staff expertise (bottom-up). Technical assistance might provide tools to CBOs for coalition expansion to bridge to public health and medical service providers (partnerships), and models for mobilizing residents and target populations engaging in emergency health planning (community organizing). However, without capacity building across all three of the basic CBO capacity building components simultaneously, sustaining culturally appropriate programs is unlikely.

One study indicated that over a three-year period, AAPI organizations targeted for increasing capacity in HIV/AIDS prevention experienced improvements in organizational viability (financial management, external relations, and strategic management) (Takahashi et al, 2007). However, during the same period, many of these CBOs experienced large increases in staff and Board membership (which reduced organizational stability). The changes in CBO organizational capacity across many areas meant, perhaps not surprisingly, that the CBOs wanted different skills as their capacities changed—for example, at the end of the three-year program, several participants wanted more strategic planning assistance, and skills to incorporate program evaluation into program design. Thus, technical assistance focused on viability/growth (e.g. fundraising, strategic management) may be useful to most organizations, while assistance with stability and streamlining (e.g., program evaluation) may be most useful to organizations that have reached a critical level of sustainable capacity. In any case, what is clear is that organizational development will need to be taken into account when trying to expand CBO capacity to participate in health emergency planning and program implementation.

Policy Recommendations

Legislators and policymakers focused on health emergency planning and implementation for the State of California need to broaden the scope of emergency health planning, policy design, and program implementation to respond to the rapid growth of California's immigrant population, many of whom are linguistically isolated, distrustful of public agencies and medical service providers, and hard-to-reach. Statewide efforts to plan and rapidly response to health crises and emergencies will do little if all affected individuals, households, and communities are not informed and educated in a timely and effective manner.

This policy paper has argued that to design effective statewide health emergency policies, plans, and programs, legislators and policymakers must centrally incorporate community-based organizations (CBOs). However, to ensure that CBOs are active and effective participants in this process, the following lessons from capacity building among Asian American and Pacific Islander CBOs in HIV/AIDS prevention are especially important (Takahashi et al., 2007):

> (1) culturally appropriate CBO capacity building for health emergency planning and implementation must address CBO stability/viability, organizational commitment, and knowledge environments at the same time;

> (2) CBO capacity can be expanded in a relatively short period of time, even in a context of severe budget challenges and organizational turbulence;

> (3) knowledge environments can be affected by process as well as content—workshops and one-on-one contacts are useful for conveying information and developing skills, but in addition, communication can be effectively enhanced through processes that include organizations with distinct missions that provide substantive opportunities for interaction;[14]

> (4) as CBO capacity increases, viability/stability and knowledge environments will change, meaning that different types of technical assistance will be needed depending on organizational developmental stage and needs.

The California State Legislature and Governor's Office should mandate not only that CBOs be included in statewide planning for health crises and emergencies, but based on the results reported in

this paper, policy makers and state agencies should devise mechanisms that expand CBO capacity, particularly those CBOs based in linguistically isolated, immigrant communities, to be active participants in statewide health emergency planning and rapid response.

❖ Initial steps: Working with already existing coalitions or working groups of CBOs working on HIV/AIDS, tuberculosis, hepatitis, and other infectious conditions is a cost effective means of disseminating information and building trust between state agencies and CBOs. Initial steps should include outreach by state health agencies responsible for statewide health emergency planning and response to these existing coalitions and working groups, development of a database of CBOs for information dissemination, and convening of statewide discussions on current and existing emergency health policies with these CBOs for information exchange and relationship building.

❖ Expanding knowledge environments: State agencies responsible for health emergency planning and response should provide technical assistance to CBOs in understanding state agency organizational practices and procedures, translating scientific and medical information about emerging statewide health crises, and developing skills in communicating with state agencies and policy makers. Providing such assistance through credible organizations (such as existing coalitions or working groups of CBOs) is necessary to overcome suspicion and lack of trust within immigrant communities of government and law enforcement agencies. Both one-on-one interactions (state agency representatives and CBO staff) and group sessions (state agency representatives and multiple CBOs) are effective means for information dissemination and knowledge building.

❖ Ensuring organizational stability: Policy makers and state agencies must recognize that CBOs must be provided financial support to enable their long-term participation in statewide health emergency planning and rapid response. CBOs providing services to linguistically isolated, immigrant communities face a myriad of pressures and are generally underfunded. For long-term participation by CBOs in statewide emergency health planning and response, CBO viability and stability is a necessary prerequisite.

Centrally incorporating CBOs in health emergency planning and program implementation will ensure that hard-to-reach individuals, households, and communities will be informed and edu-

cated in a timely manner, and in so doing, will provide the best opportunity for the State of California, and other states across the nation, to maintain population health and safety.

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Notes

1. See the Public Policy Institute of California website <http://www.ppic.org/main/policyarea.asp?i=18;> (accessed 2 March 2007).

2. One large challenge for tracking the transmission of SARS was "history of contact exposure," especially as this was a new disease and not widely recognized as having severe outcomes, including death. In Toronto, Canada, the "outbreak" began with an elderly couple that had traveled to Hong Kong from Canada, staying in a hotel in Hong Kong that later was identified as having a "cluster" of hotel guests who were later diagnosed with SARS; this couple returned to Toronto, Canada, where two days later, the elderly woman became ill and died a few weeks later. One of her family members went to a local Toronto hospital, which became "the epicenter" for the outbreak (Booth et al., 2003). The Centers for Disease Control and Prevention (CDC) in 2003 defined exposure to SARS as consisting of the following criteria: having close contact with someone who possibly or probably had SARS, traveling to Hong Kong, China, Vietnam, Singapore, or Taiwan, or visiting a hospital setting where SARS was being treated (Booth et al., 2003).

3. This study showed that avian influenza is transmissible via close contact between people, where a family cluster of H5N1 in Thailand was studied. The so-called "index patient" was a young girl, who came to a clinic with a fever, sore throat, and cough; she was admitted to a hospital five days later with a 101.3 F temperature; the next day, she was transferred to a provincial hospital and died the same day. Analyzing genetic samples from the index patient, her mother (who also died), and the index patient's aunt (who survived), the researchers concluded that the H5N1 virus was probably transmitted from the index patient to her mother and aunt during close contact during the young girl's illness.

4. Avian influenza was recently detected in poultry in Great Britain according to an article in the San Francisco Chronicle newspaper

online in February 2007; See See D'arcy Doran, "H5N1 Bird Flu Virus Confirmed in England," SF Gate. 3 February 2007, available online at http://www.sfgate.com/cgi-bin/article.cgi?file=/news/archive/2007/02/03/international/i080341S66.DTL.

5. A 2002 issue brief prepared for a roundtable indicated that California's health infrastructure was inadequate to address threats of bioterrorism (see Cubanski et al., 2002).

6 See California State Senate. Assembly Committee on Health. *Emergency Health Powers Act*. 29 April 2003. The text of this bill is available online at <http://info.sen.ca.gov/pub/03-04/bill/asm/ab_0201-0250/ab_206_cfa_20030430_101627_asm_comm.html> (accessed 3 March 2007).

7. http://www.assembly.ca.gov/acs/acsframeset2text.htm; accessed 2 March 2007.

8. *Emergency Health Powers Act*.

9. *Emergency Health Powers Act*.

10. See California Office of Emergency Management Services. Legislative Affairs Section. Emergency Management Legislation: 2007 Session. <http://www.oes.ca.gov/Operational/OESHome.nsf/Content/2A0D7FB2049B816188256B7B00278393?OpenDocument> (accessed 2 March 2007).

11. See <http://www.dhs.ca.gov/epo/surge/>; (accessed 2 March 2007).

12. Crisp, et al., 2000.

13. Takahashi, et al., 2007.

14. In similar ways that AB 632 introduced by Assemblymember Judy Chu in 2005 (approved by the Assembly, but later vetoed by Governor Schwarzenegger; re-introduced and approved in 2006 as AB 1015) enacts "management boards" to address community management issues related to released sex offenders, including state and local government agencies and nongovernmental organizations, we argue that building capacity for emergency preparedness among CBOs will require regularized face-to-face communication by public agencies and local community groups.

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Lois M. Takahashi has published numerous articles and two books on her research interests, which include access to social services for populations in need, the NIMBY (Not In My Back Yard) syndrome, and community participation and environmental governance in Southeast Asian cities.

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