

ELIMINATING DISPARITIES IN HIV DISEASE: COMMUNITY MOBILIZATION TO PREVENT HIV TRANSMISSION AMONG BLACK AND HISPANIC YOUNG ADULTS IN BROWARD COUNTY, FLORIDA

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A coalition led by public health professionals adopted the PRECEDE-PROCEED model for community planning and health promotion to eliminate local disparities in HIV disease. Discussion groups and other formative evaluation activities conducted during the first year of the project maximized input from community members and community-based organizations. Twelve of 53 ZIP-code areas, which accounted for 73% of reported AIDS cases among Black and Hispanic young adults (18 to 39 years) from 1994 through 1999, were selected as the primary sites for intervention. Horizontal outreach to residents, vertical outreach to stakeholders and gatekeepers, strategic communications, and capacity building and infrastructure development, were chosen as the most promising activities to promote behavioral and social change. Results from baseline computer-assisted telephone-interview (CATI) surveys completed with 2,011 community residents in 2001, and first-year follow-up interviews with 2,381 in 2002, indicated that: awareness of program efforts had increased from 5.4% in 2001 to 6.7% in 2002; recognition of the extent of the HIV/AIDS problem had increased from 27.5% in 2001 to 35.3% in 2002; and participation in HIV-prevention efforts had increased significantly. Interventions are reaching the target audience, informing young adults of the risks of HIV infection, and encouraging them to take ownership and action. (*Ethn Dis.* 2004;14[suppl 1]: S1-110–S1-118)

Key Words: African Continental Ancestry Group, Community Health Planning, Cultural Diversity, Ethnic Groups, Health Disparities, Hispanic Americans, HIV Prevention, Minority Groups, Social Behavior

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INTRODUCTION

Sexually transmitted diseases (STDs) have disproportionately affected African-American and other minority populations in the United States for generations.¹ When public health programs were introduced early in the 20th century, venereal disease control strategies included the establishment of public clinics and treatment centers, where everyone could receive medical care without cost.² Over the past 100 years, researchers have examined how conditions of social class, poverty, and racial discrimination have contributed to the excessive morbidity and mortality experienced by African-American and other minority populations,³ but few programs have been introduced to eliminate long-standing racial and ethnic disparities in STD rates.

Healthy People 2010 is a national initiative designed to improve the health and welfare of all Americans.⁴ Efforts focus on attaining 2 goals: 1) increasing the number of years that people enjoy healthy lives; and 2) eliminating racial and ethnic disparities, especially with respect to 6 diseases. One of the 6 diseases, acquired immune deficiency syndrome (AIDS), results from infection with human immunodeficiency virus (HIV), and HIV is often sexually transmitted.⁵

Comprehensive HIV-prevention programs in the United States recognize the importance of mobilizing communities to respond to the unique characteristics of local epidemics.⁶ Community mobilization can only succeed if members of a community become aware of a problem, participate in collective ac-

tion to define, understand, and address the problem, and take responsibility for solving the problem.⁷ Although the Centers for Disease Control and Prevention (CDC): 1) had advocated a Planned Approach To Community Health (PATCH) since the early 1980s⁸; 2) began to require state and local health departments to conduct community planning for HIV prevention in 1994⁹; and 3) was responsible for implementing Racial and Ethnic Approaches to Community Health (REACH) as part of the Healthy People 2010 initiative, we are not aware of any other published report from any agency that used PATCH or the Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation (PRECEDE)/Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development (PROCEED) model for health promotion¹⁰ to plan, implement, and evaluate a primary HIV-prevention program for any community in the United States.^{11–13}

The PRECEDE/PROCEED model seems to be particularly well suited for primary HIV-prevention at the community level, because it attempts to maximize the participation of community members in the planning process, examines the predisposing, reinforcing, and enabling factors associated with behaviors epidemiologically linked to transmission, and encompasses the policy, regulatory, and organizational issues that can facilitate or impede both program implementation, and the abilities of individuals to change their behaviors.¹⁴ Formative evaluations must be

conducted to discover and describe the critical variables that drive local epidemics.¹⁵ Summative (process, impact, and outcome) evaluations must be conducted to determine whether the interventions selected by local planning groups are being delivered in such a way as to bring about changes as intended.¹⁶

In Broward County, Florida, a coalition was formed in 1999 to address the problem of racial and ethnic disparities in HIV disease. The coalition was established by faculty members in the Department of Public Health at Florida International University (FIU), a predominantly minority institution of higher education, and included members of the 3 major community-based organizations (CBOs) serving the African-American, Haitian and Caribbean Islander, and Hispanic communities, respectively. The coalition decided to adopt the PRECEDE/PROCEED model, and to apply the principles of community mobilization to reach its goal. This report describes the development, implementation, and evaluation of a community action plan designed to prevent the sexual transmission of HIV among young adults (18–39 years old) of African-American, Hispanic, or Caribbean/Haitian ancestry.

METHODS

Formative evaluations conducted during the first year of our project included the secondary analysis of available data, discussion groups with residents of areas targeted for change, telephone interviews with gatekeepers, and “windshield surveys” to identify possible places in the community to intervene. Summative evaluations included baseline and follow-up computer-assisted telephone-interview (CATI) surveys of eligible residents, to determine whether they were being exposed to interventions, and responding to them appropriately. Procedures used to carry out these research tasks were presented to,

and approved by, the University Research Council, an institutional review board (IRB), before implementation.

Formative Evaluations

The AIDS case reports for Broward County from 1994 through 1999 were obtained from the State of Florida Department of Health (DOH), Bureau of HIV/AIDS. Characteristics of individuals reported to have been diagnosed with AIDS included age, gender, race, ethnicity, mode of transmission, place of birth, and ZIP code of residency. Frequency distributions and cross tabulations were generated to compare the attributes of African Americans (born in the United States), Haitians and other Afro-Caribbean Islanders, and Hispanic Americans, recently reported with AIDS. Geographic Information Systems (GIS) software was also used to help identify communities and locate neighborhoods with elevated levels of HIV disease.

Discussion groups led by 2 or more graduate students from FIU, with at least one staff representative from a collaborating CBO, were set up to explore the predisposing, reinforcing, and enabling factors that could be contributing to sexual risk-taking, and the spread of HIV and other STD. Each group sought 6–12 participants. Eight groups were to be formed with African-American adults, 8 with Haitian and other Afro-Caribbean adults, and 8 with Hispanic adults, living in various areas of the county with high reported rates of AIDS incidence. A semi-structured questionnaire and standardized procedures were developed to facilitate discussions. To the extent possible, students were matched with group members by cultural heritage and language spoken. All discussions with African-American community members were in English, but most discussions with Haitian community members were conducted in Creole, and most discussions with Hispanic community members were conducted in Spanish.

Telephone interviews were conducted with stakeholders, community gatekeepers, and influential persons in Broward County, to identify predisposing, reinforcing, and enabling factors related to HIV infection, and to examine the policy, regulatory, and organizational issues that could help or hinder implementation of our community action plan. All CBOs, and the Broward County Health Department, were asked to nominate up to 15 people from their respective communities who were regarded as leaders, especially in the realm of important health problems, such as HIV/AIDS. These individuals were then telephoned by a graduate student from FIU, told about the reason for the call, and invited to respond to a few questions. A semi-structured questionnaire and standardized procedures were developed to elicit responses. Data from the discussion groups and telephone interviews were analyzed to assess needs, and used to design interventions to address the conditions which seemed to be contributing to the spread of HIV in communities targeted for change.

To help the coalition appreciate and understand the social, cultural, and physical environments where HIV was being transmitted, and where interventions would have to be introduced, public health graduate students conducted rapid ethnographic assessments.¹⁷ Students could choose a community to investigate by driving around in their private cars to see where people gathered, and then getting out of the car (if they felt safe and comfortable) to engage in participant observation. These “windshield surveys” of communities were regarded by the coalition as a useful source of information for developing interventions and identifying places where interventions could be carried out.

Impact Evaluation

Baseline and follow-up CATI surveys were conducted in 2001 and 2002 to determine the immediate impact of interventions on young adults who lived

Table 1. Demographic characteristics of discussion group participants

Discussion Group Participants	# N=166	%
Race/ethnicity		
African-American	55	33.1%
Caribbean/Haitian		
Caribbean Islander of African ancestry	24	14.6%
Haitian/Haitian-American	7	4.2%
Hispanic/Hispanic-American	57	34.3%
Other/unknown	23	13.9%
Age (years)		
18–24	29	17.5%
25–31	47	28.3%
32–39	49	29.5%
Other/unknown	41	24.7%
Gender		
Female	92	55.4%
Male	74	44.6%

in communities targeted for change. A procedure was developed by the Institute for Public Opinion Research (IPOR) at FIU to call telephone numbers listed for residences in the ZIP-code areas of interest, screen respondents for eligibility, and enroll a member of the household who was African-American, Caribbean Islander of African ancestry, Haitian, or Hispanic, and between the ages of 18 and 39 years. The IPOR staff of trained interviewers included men and women who could speak Creole and Spanish, in addition to English.

Gift certificates in the amount of \$10, and referrals on questions about personal or family health problems, were offered to all participants. Follow-up interviews were to be scheduled with as many first-year participants as IPOR staff could contact one year later. Other eligible residents in the community who had not been enrolled in the baseline survey replaced those lost to follow-up. To assess changes at follow-up, *P* values were computed, using a 2-sample test of difference between proportions.

RESULTS

Formative evaluations to develop a community action plan were carried out

from October 1999 through July 2000. The plan for community mobilization was written and reviewed in summer 2000, and then revised based on the comments and recommendations of reviewers, CBO representatives, and community members. Impact evaluations commenced with the implementation of the program plan in spring 2001.

Formative Evaluations

During the first year planning phase, the coalition reviewed and analyzed available demographic, epidemiologic, programmatic, and social survey data to

identify seriously affected areas of Broward County, and earlier efforts to introduce HIV-prevention and related services. Analysis of these data indicated that 73.3% of recently reported (1994–1999) cases of AIDS among minority young adults (18–39 years old) were concentrated in 12 of 53 ZIP-code areas. Most of these 12 ZIP-code areas straddled Interstate highway 95 (I-95): 4 contiguous ZIP-code areas were in the north, 4 in the center, and 4 in the south. Two thirds of the county’s impoverished population lived in these areas. Human immunodeficiency virus (HIV)-prevention efforts had been conducted in these communities, but were sporadic, along with their funding.

A total of 166 community members participated in 18 discussion groups. Participants in discussion group sessions were fairly evenly divided by gender, age group, and the major populations of interest (Table 1). Sessions were held in diverse settings: 2 were held outside Caribbean nightclubs on Saturday nights between 11:30 PM and 2:00 AM, 2 within low-income housing complexes, one in a park with young women waiting for young men to finish playing basketball, and another with young men shortly after they finished playing basketball. One session was held in a hair-styling salon, another in a barbershop, and yet another

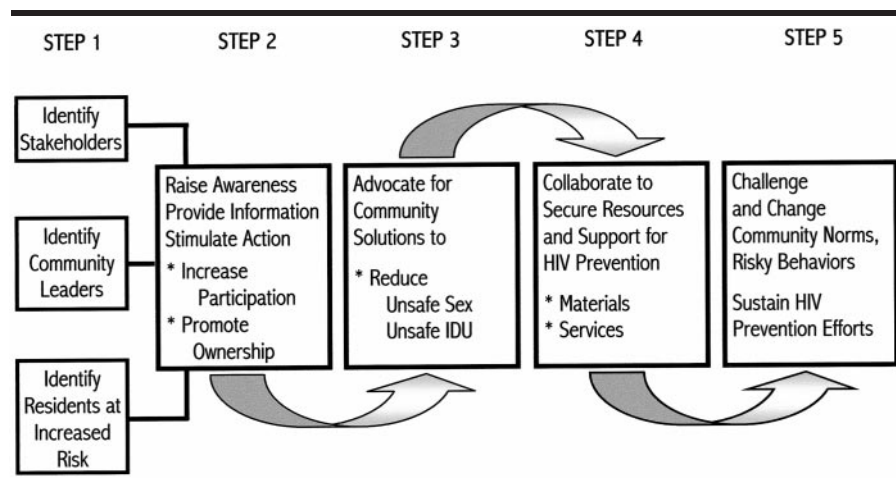


Fig 1. Community action plan logic model

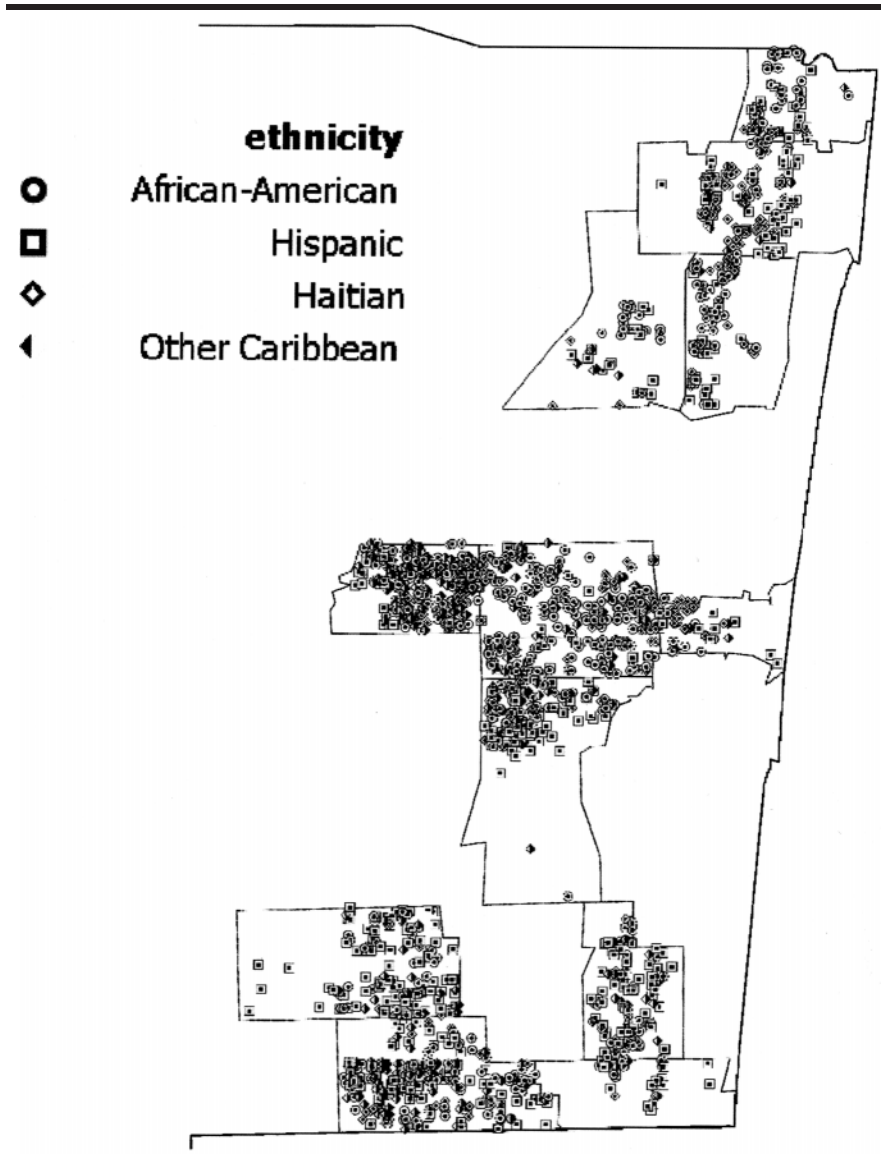


Fig 2. Residential distribution of participants in CATI survey 2001

er was conducted with an HIV-support group.

"Respect," "spirituality," and "love" (in its many different forms) emerged as the most important values community members used to guide decisions, but there was considerable variation among groups. Beliefs about AIDS also varied, but there seemed to be consensus among residents that a continuing, visible presence of informed outreach workers, and a steady stream of reliable information, were urgently needed by young adults living within targeted ar-

reas. "It's a community problem," one respondent said, "not an individual one."

Telephone surveys with 46 stakeholders, gatekeepers, and minority community leaders were completed in spring 2000. By and large, comments from these influential individuals supported findings from the discussion groups, stressing the need for a constant stream of accurate HIV-prevention messages delivered by culturally competent persons, and for catchy HIV-educational campaigns that could be sustained until

the AIDS epidemic was contained. "We are tired of people from outside our community coming in here and promising things," said one respondent, "just like politicians do, and then leaving us alone to rely on our own resources until another election comes along."

Rapid ethnographic assessments on weekdays and weekends identified commercial areas, libraries and other public buildings, shopping malls, supermarkets, grocery stores, pharmacies, restaurants, bars, clubs, barber shops, beauty salons, car washes, laundromats, parks, and other places in residential neighborhoods where people gathered and could be approached. People seen in and around these establishments were described in detail, as illustrated in the example below:

When I drove around the neighborhood on Saturday afternoon, car washes seemed to be one of the most popular places for young males. They were cleaning their cars, so that they looked good for Saturday night. While they waited for their cars to be cleaned, they sat and hung out with their friends. As with bars, beauty salons, and barber shops, car washes provide appropriate conditions for an intervention: people wait and talk. Furthermore, intervening while young people are preparing for Saturday night dates seems more than appropriate.

Community Action Plan

Information gathered during rapid ethnographic assessments converged with findings from secondary analyses of available HIV/AIDS morbidity and other data, observations made during discussion group sessions, and telephone interviews with stakeholders, gatekeepers, and other influential community members. Interventions would have to be designed and delivered to raise awareness of the HIV/AIDS problem in diverse communities, to provide technically accurate and culturally competent information, and to stimulate action to increase participation in primary prevention efforts and promote local ownership of the HIV/AIDS problem. Once this was accomplished, community members might be able to advocate ef-

Table 2. Characteristics of CATI survey respondents, 2001 and 2002

CATI Survey Participants	2001		2002	
	# N=2011	%	# N=2381	%
<i>Sociodemographic characteristics</i>				
<i>Race/ethnicity</i>				
African-American	695	34.6%	847	35.6%
Caribbean Islander of African ancestry	404	20.1%	446	18.7%
Haitian/Haitian-American	392	19.5%	387	16.3%
Hispanic-Hispanic-American	520	25.9%	701	29.4%
<i>Age (years)</i>				
18–24	656	32.6%	759	31.9%
25–29	405	20.1%	469	19.7%
30–34	439	21.8%	509	21.4%
35–39	511	25.4%	644	27.0%
<i>Gender</i>				
Female	1299	64.6%	1522	63.9%
Male	712	35.4%	859	36.1%
<i>Marital status</i>				
Single	843	41.9%	1018	42.8%
Married	776	38.6%	951	39.9%
Widowed	10	0.5%	10	0.4%
Divorced	84	4.2%	102	4.3%
Separated	44	2.2%	52	2.2%
Never married	204	10.1%	216	9.1%
Other	43	2.1%	31	1.3%
<i>Education</i>				
Grade school	80	4.0%	51	2.1%
Some high school	334	16.6%	302	12.7%
High school graduate	641	31.9%	758	31.8%
Some college	534	26.6%	713	29.9%
College graduate	325	16.2%	459	19.3%
Graduate degree	87	4.3%	89	3.7%
<i>Income (annual)</i>				
Under \$10,000	191	9.5%	201	8.4%
\$10,000–\$19,999	363	18.1%	365	15.3%
\$20,000–\$29,999	409	20.3%	411	17.3%
\$30,000–\$49,999	399	19.8%	475	19.9%
\$50,000–\$79,999	191	9.5%	265	11.1%
\$80,000 or more	70	3.5%	115	4.8%
Don't know/no response	388	19.3%	549	23.1%
<i>Residence</i>				
Single family home	1073	53.4%	1426	59.9%
Duplex	104	5.2%	121	5.1%
Condominium	142	7.1%	196	8.2%
Apartment	639	31.8%	581	24.4%
Mobile home	12	0.6%	19	1.5%
Other	37	1.8%	35	1.5%
<i>Property</i>				
Own	975	48.5%	1326	55.7%
Rent	1019	50.7%	1019	42.8%
Other	13	0.6%	31	1.3%
<i>Health characteristics</i>				
<i>Current status</i>				
Excellent	741	36.8%	919	38.6%
Good	996	49.5%	1158	48.6%
Fair	224	11.1%	253	10.6%
Poor	44	2.2%	46	1.9%

Table 2. Continued

CATI Survey Participants	2001		2002	
	# N=2011	%	# N=2381	%
Insurance/medical coverage				
Yes	1289	64.1%	1597	67.1%
No	717	35.7%	774	32.5%
Ever tested for diabetes				
Yes	1117	55.5%	1461	61.4%
No	856	42.6%	888	37.3%
Received results of diabetes test				
Yes	819	40.7%	1159	48.7%
Yes, with comment	247	12.3%	246	10.3%
No	49	2.4%	52	2.2%
N.A. (or no response/don't know)	896	44.6%	924	38.8%
Ever tested for drug abuse				
Yes	853	42.4%	1115	46.8%
No	1150	57.2%	1254	52.7%
Received results of drug test				
Yes	618	30.7%	874	36.7%
Yes, with comment	199	9.9%	163	6.8%
No	36	1.7%	72	3.0%
N.A. (or no response/don't know)	1158	57.6%	1266	53.2%
Ever tested for gonorrhea				
Yes	800	39.8%	1069	44.9%
No	1133	56.3%	1224	51.4%
Received results of gonorrhea test				
Yes	617	30.7%	890	37.4%
Yes, with comment	171	8.5%	156	6.6%
No	10	0.5%	17	0.7%
N.A. (or no response/don't know)	1213	60.3%	1312	55.2%
Ever tested for HIV/AIDS				
Yes	1444	71.8%	1811	76.1%
No	560	27.8%	557	23.4%
Received results of HIV-antibody test				
Yes	1108	55.1%	1503	63.1%
Yes, with comment of positive result	33	1.6%	10	0.4%
Yes, with (other) comment	276	13.7%	260	10.9%
No	27	1.3%	37	1.5%
N.A. (or no response/don't know)	567	28.2%	570	23.9%

fectively for community solutions to reduce unsafe sex and needle use, collaborate effectively to secure resources and support for local HIV-prevention activities, and challenge and change community norms and risky behaviors associated with HIV transmission (Figure 1). Four activities were determined by the coalition as essential to carrying out the 5-step strategy for community mobilization: 1) horizontal outreach to residents, especially those at high risk of

infection; 2) vertical outreach to gatekeepers, business owners and operators, and others in the community who could support and sustain HIV-prevention efforts; 3) strategic communications; and 4) CBO capacity building, and countywide infrastructure development, to ensure the public's health.

Impact Evaluation

To determine whether interventions were reaching targeted audiences, and

influencing perceptions of the AIDS problem and related behaviors in phase 2, CATI survey data were systematically collected from 2,011 community residents, 18 to 39 years old, in 2001, and from 2,381 residents in 2002. Over 70,000 telephone numbers had to be called in 2001 to find more than 2,000 eligible respondents and enroll them in the baseline survey. Participants from each of the 4 major racial and ethnic minority communities of interest in

Table 3. Impact of interventions on target populations

Variable	African-American		Caribbean		Haitian		Hispanic	
	2001 N=695	2002 N=847	2001 N=404	2002 N=446	2001 N=392	2002 (N=387	2001 N=520	2002 N=701
Ever tested for HIV/AIDS								
Yes	81.2%	82.2%	76.0%	71.5%	59.9%	67.2%	65.0%	76.5%
No	18.6%	17.6%	23.5%	28.0%	39.3%	32.0%	35.0%	22.7%
					<i>P</i> = .035		<i>P</i> < .001	
Heard about REACH 2010								
Yes	6.2%	8.0%	5.4%	7.8%	3.8%	4.4%	5.4%	5.7%
No	93.5%	91.4%	94.1%	91.0%	94.9%	94.6%	94.0%	94.0%
Acted to solve AIDS problem								
Yes	7.2%	10.2%	3.5%	8.1%	4.8%	6.2%	3.7%	4.7%
No	92.8%	89.8%	96.5%	91.9%	95.2%	93.8%	96.3%	95.3%
	<i>P</i> = .041		<i>P</i> = .004					

Broward County were recruited from each of the 12 ZIP-code areas in which interventions were being introduced, but residential clustering was notable in several areas (Figure 2).

Of the 2,011 participants interviewed in 2001, 571 (28.4%) were contacted and enrolled again in 2002. Sociodemographic characteristics of the 2 samples were similar, but participants in the follow-up survey were slightly older, better educated, wealthier, and more likely to own a home than to rent an apartment (Table 2). Respondents were more likely to report being tested for antibody to HIV than for diabetes, illegal substances, or gonorrhea, and the proportion that reported being tested for antibody to HIV increased from 71.8% in 2001, to 76.1% in 2002 (*P* < .001). Although not asked directly, thirty-three residents (1.6%) in 2001 mentioned that they had received a positive test result for HIV antibody; 10 respondents (0.4%) in 2002 volunteered that they had tested positive.

The overall increase in HIV-antibody testing was attributable to increases only among Haitian and Hispanic residents (Table 3). Awareness of coalition activities increased from 5.4% in 2001, to 6.7% in 2002 (*P* = .06). Recognition of the extent of the HIV/AIDS problem increased from 27.5% in 2001, to 35.3% in 2002 (*P* < .001). Overall

participation in community HIV-prevention efforts increased from 5.1% in 2001, to 7.5% in 2002 (*P* < .001), with African Americans and Caribbean Islanders most likely to report taking action in the past year to try to address the AIDS epidemic in Broward County (Table 3).

DISCUSSION

The CDC initiated HIV-prevention community planning in December 1993 to promote “culturally competent and scientifically sound HIV prevention services that specifically address unique community needs.”¹⁸ The community planning initiative was designed to create partnerships “between the health department administering funds and representatives of the communities for whom the services are intended.” In addition, CDC proclaimed, “the community planning process embraces the notion that the behavioral and social sciences must play a critical role in the development, implementation, and evaluation of HIV-prevention programs within a community.”

To help communities assess needs and develop scientifically sound services for HIV prevention, CDC staff members reviewed the HIV/AIDS literature, identified key characteristics of success-

ful programs, and concluded, “The preponderance of the empirical evidence reviewed showed that behaviorally based HIV-prevention programs have a favorable impact on behavioral outcomes in specific populations, especially when delivered with sufficient resources, intensity, and cultural competency.”¹⁹ Subsequent reports have evaluated the planning process,²⁰ priority setting,²¹ and funding allocations,²² but we could find no report of an agency describing culturally competent and scientifically sound services to address unique community needs for HIV prevention by drawing from the social sciences to develop, implement, and evaluate a program plan.

Community-planning groups may be hindered by the need to cover broad geographic areas and encompass many diverse communities in their planning efforts. The “essential components,” “necessary elements,” “logistical requirements,” and “roles and responsibilities,” defined in the community planning “guidance” may restrict what members are allowed to do. Additionally, limitations of time and resources may impede, not only the creation of HIV prevention programs that are based in sound behavioral science, but also the publication of program results.

Our coalition was established through a partnership between an aca-

demic department of public health and 3 community-based organizations serving major racial and ethnic minority populations. We used principles of community mobilization and the PRECEDE/PROCEED model to guide the development, implementation, and evaluation of our community action plan. Our cooperative agreement with CDC prohibited the coalition from using any portion of our award to duplicate or supplant services in Broward County that already received federal support. Therefore, we designed our program to supplement and enhance efforts of the Broward Community Planning Partnership (BCPP). The BCPP is the authorized community-planning group for Florida Area 10 (Broward County) that oversees counseling and testing, referral, partner notification, and other primarily biomedical and individual-level services carried out by the health department, their grantees, and their contractors.

Our coalition conducted formative evaluations to identify culturally appropriate and scientifically sound interventions by following the processes and procedures suggested by the PRECEDE/PROCEED model. We were not required to comply with the dictates of the HIV Prevention Community Planning Guidance. We benefited from the services of graduate students (many of whom lived in the communities we sought to serve) pursuing master of public health degrees. Graduate students provided the labor required to analyze available data, conduct discussion groups, interview stakeholders and gatekeepers, and complete windshield surveys and related ethnographic assessments of neighborhoods experiencing high rates of HIV disease, and related social and economic problems.

By analyzing available data, we were able to: 1) pinpoint areas where racial and ethnic minority populations were experiencing high rates of AIDS; 2) reduce the service area for our intervention project from 53 ZIP-code areas to 12; and 3) determine that young adults

between the ages of 18 and 39 years should be the primary target for our interventions. Through our conversations with community residents in discussion groups, and with influential members of Broward County in telephone calls, we discovered that the services needed to stimulate community mobilization and promote HIV prevention had been offered in the past, but were insufficient in intensity and scope to bring about the changes needed to stop HIV transmission. Windshield surveys and informal discussions with people encountered on the street, at the car wash, and other popular gathering places, helped the coalition decide where, when, and how outreach should be conducted to contact those who might benefit from the constant stream of informative messages that we were told was so critically needed by the communities we sought to serve.

Community building begins when residents with common interests or complaints come together, form coalitions, and generate collective power through commitment, participation, and collaboration.²³ Evidence collected during the initial phase of formative research, and impact evaluation of the first 2 years of implementation, indicated that while young adults in the 12 ZIP-code areas targeted for change had serious concerns and recognized the shortcomings of earlier efforts to address the HIV problem in their communities, few had come together to take ownership of the local problem. Therefore, the logic model developed by the coalition to stimulate action may take longer, and require a much greater commitment of resources, to implement than we originally anticipated.

The challenges that lie ahead are formidable and familiar.²⁴⁻²⁵ Solutions have been suggested,²⁶⁻²⁸ and now, with the support of CDC, are being pursued. With the expectation that "sufficient resources, intensity, and cultural competency" will continue to be provided until we can demonstrate that our mission

has been accomplished, we intend to eliminate centuries-old disparities in suffering from STDs.

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