A RESEARCH-BASED TOOL FOR IDENTIFYING AND STRENGTHENING CULTURALLY COMPETENT AND EVALUATION-READY HIV/AIDS PREVENTION PROGRAMS

Patricia Vinh-Thomas, Megan M. Bunch, and Josefina J. Card

Recent literature on racial disparities in HIV/AIDS and effective HIV/AIDS health service delivery efforts has underscored the importance of cultural sensitivity, relevance and competence in reducing such disparities and providing effective health service delivery. Less work has been done on the role of cultural competence in the delivery of effective HIV/AIDS prevention programs, perhaps because few such prevention programs aimed at minority populations have to date been demonstrated as effective. This article surveys the various ways that the concept of cultural competence has been studied, extends the concept to the field of HIV/AIDS prevention, and presents a simple-to-use instrument that operationalizes the concept for use with HIV/AIDS prevention programs. The article also explores the idea of evaluation readiness among HIV/AIDS prevention programs in the hope of eventually enlarging the pool of minority-focused HIV/AIDS programs demonstrated as effective. The resultant tool can serve as a research-based framework that: (a) serves as a cost-effective way to select promising programs—especially promising minority-focused programs—for rigorous outcome evaluation; (b) advances the field of HIV/AIDS prevention research by providing a conceptual framework for studying the relationship between cultural competence and program effectiveness; and (c) serves as a framework for building capacity in HIV/AIDS prevention programs, pointing to ways in which such programs can be strengthened.

Since the onset of the AIDS epidemic in the early 1980s, racial and ethnic minority populations have been disproportionately affected by HIV/AIDS. Today, minorities represent the majority of new AIDS cases as well as the majority of Americans living with AIDS (Henry J. Kaiser Family Foundation, 2001). Although a growing number of HIV/AIDS prevention efforts over the past 20 years have been shown to be effective, “prevention’s successes have not been as evident among the populations now at
greatest risk, particularly people of color...” (Centers for Disease Control and Prevention, 2001).

Much is written in the literature about the complex and often politically explosive relationship between race, culture and HIV risk (Bok & Morales, 2001; Hernandez & Smith, 1991; Rivara & Finberg, 2001; Zenilman, Shahmanesh, & Winter, 2001). Although many HIV/AIDS prevention programs are often targeted to racial populations, it is important to acknowledge that race is socially constructed and heavily influenced by underlying cultural and socioeconomic conditions, such as poverty, discrimination, and underemployment, many of which are associated with “high risk” behaviors. For this reason, prevention efforts must be designed and implemented in a culturally competent manner, focusing on a multitude of factors affecting an individual’s risk of infection, including sociocultural factors that influence behavior (Hernandez & Smith, 1991; Rivara & Finberg, 2001; and Zenilman et al., 2001). In fact, although the majority of the literature on cultural competence refers to the delivery of health care services, the recent literature on racial disparities in HIV/AIDS and effective HIV/AIDS prevention programs makes reference to the importance of cultural sensitivity, cultural relevance, and/or cultural competence in the delivery of prevention services and care (Auerbach & Coates, 2000; Bok & Morales, 2001; Cohen & Goode, 1999; Hernandez & Smith, 1991; McCormick et al., 2000; Rao & Svenkerud, 1998; Stevenson & White, 1994). Given the interplay between culture and behavior, many researchers (e.g., Davis, 1997) write about the relationship between cultural competence in program design and delivery, and better health outcomes.

There is wide agreement among researchers, practitioners, and organizations about the importance of cultural competence, although the definitions of the concept have varied widely (Blue, 2000; Brach & Fraser, 2000; Bureau of Health Professions, 2000; Campinha-Bacote, 1999; Cross, Bazron, Dennis, & Isaacs, 1989; Fortier, Convissor, & Pacheco, 1999; Like, 2000). We surveyed the literature on this topic, synthesizing existing perspectives into a singular definition of cultural competence as “a set of congruent behaviors, attitudes, and policies—including a consideration for linguistic, socioeconomic, and functional concerns that influence behavior (Like, Steiner, & Rubel, 1996) that come together in a system, agency, or among professionals, thus: (1) enabling that system, agency, or those professionals to work effectively with the target population (Cross et al., 1989, and (2) resulting in services that are accepted by the target population (Dana, Behn, & Gonwa 1992).”

Because culture shapes and influences the way people think about gender, sexuality, health, and illness (Campinha-Bacote, 1999; Ortiz-Torres, Serrano-Garcia, & Torres-Burgos, 2000; Woloshin, Bickell, Schwartz, & Gany, 1995), a program’s ability to deliver services in a culturally competent manner has serious implications for access to and quality of prevention services and care (Bok & Morales, 2001; Brach & Fraser, 2000; Cohen & Goode, 1999; Coye & Alvarez, 1999; Davis, 1997; Fortier et al., 1999; Friedman, 1994; Goode, Sockalingam, Brown, & Jones, 2000; Ginzberg & Ostow 1991; King, Sims, & Osher 2000; Like et al., 1996; Perkins, 1998). For example, a practitioner’s inability to communicate with and access the beliefs of clients/participants compromises his or her capacity to meet client needs. Many researchers argue that current prevention methods often fail to address the cultural and social contexts of their target populations (Bok & Morales, 2001; Diaz & Ayala, 2001; McCormick et al., 2000). Stevenson and White (1994) conducted a pilot study with 29 administrators and counselors from AIDS-related community-based organizations across the nation, asking the question: What are the top five hurdles to providing
AIDS education in the African American, Hispanic, and Asian communities? The respondents identified linguistic differences and the lack of cultural sensitivity (e.g., culturally irrelevant teaching/educational materials in prevention interventions) among the top barriers. On a pragmatic level, researchers argue that the failure to consider the social and cultural ecology of a community will bring about program failure, due to poor utilization (Hernandez & Smith, 1991; Stevenson & White, 1994).

DEVELOPING A RESEARCH-BASED TOOL MEASURING CULTURAL COMPETENCE

Table 1 presents a summary of various ways that researchers have conceptualized cultural competence. Our search of the literature resulted in the identification and creation of 20 research-based indicators of cultural competence. In Table 1 we have grouped the indicators according to their applicability to various activities of an HIV/AIDS prevention program’s life cycle: program development, program implementation, program sustainability, and program validation. Development refers to activities included in the conceptualization and design of a program, implementation to activities necessary to the administration and operation of the program, sustainability to the program’s ability to maintain itself fiscally and institutionally, and validation to various forms of support for the program.

We wanted to develop a research-based tool that could be used to identify existing, culturally competent HIV/AIDS prevention programs as well as help all HIV/AIDS prevention programs diagnose areas of strength and weakness relative to cultural competence. To accomplish this goal, we developed a scoring system for each cultural competence indicator in Table 1 in the form of a simple, three-level performance continuum with criteria representing minimal (inadequate), sufficient, and high achievement of the indicator’s requirements, respectively. We are now developing training resources and an associated training program aimed at helping HIV/AIDS prevention programs use the tool to assess their level of cultural competence as well as strengthen themselves in areas of weakness relative to cultural competence. In developing the training resources, we are using our 20 cultural competence indicators as the guiding framework, fleshing them out further via lengthy telephone interviews with HIV/AIDS practitioners and researchers. The end result will be a set of user-friendly resources comprising checklists and step-by-step protocols to help practitioners through each of the steps necessary in developing, implementing, and/or augmenting a culturally competent HIV/AIDS prevention program. Examples of these steps include conducting a needs-and-assets assessment, hiring and training representative staff, identifying and involving community leaders in program development and implementation, and attending to the sociolinguistic needs of the target population.

AUGMENTING THE TOOL WITH INDICATORS OF EVALUATION READINESS

Virtually all of the literature on effective HIV/AIDS prevention programs focuses on programs that have been designed from the start in collaboration with researchers who are able to bring to the table the funding, expertise, and resources necessary to design and implement an evaluable program (adequate sample sizes, a cooperative “standard of care” program able to serve as the control or comparison group, sufficient resources to collect data from both treatment and control groups over the evaluation research period).
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Literature Sources</th>
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<tr>
<td><strong>Program Development</strong></td>
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<tr>
<td>Adoption or development of definition of cultural and linguistic competence</td>
<td>Beadle de Palomo &amp; Anderson, 2000; Blue, 2000; Child Welfare League of America, 1993; Cohen &amp; Goode, 1999; Cross et al., 1989; Davis, 1997; Fortier et al., 1999; King, et al., 2000</td>
</tr>
<tr>
<td>Ability to assess the target population's needs</td>
<td>Chin, 2000; Cross et al., 1989; Georgetown University Child Development Center, 2000; U.S. Conference of Mayors, 1993</td>
</tr>
<tr>
<td>Mechanisms and structures to identify cultural, linguistic, and socio–economic issues among target population</td>
<td>Beadle de Palomo &amp; Anderson, 2000; Blue, 2000; Campinha-Bacote, 1999; Child Welfare League of America, 1993; Chin, 2000; Cohen &amp; Goode, 1999; Cross et al., 1989; Dana et al., 1992; Georgetown University Child Development Center, 2000; Janz et al., 1996; King, et al., 2000; Like et al., 1996; McCormick et al., 2000; Rao &amp; Svenkerud, 1996;</td>
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<tr>
<td>Mechanisms and structures to identify resources, leaders of, influential members of, and individuals who know about and are respected by, the target population and the broader community to involve in program development and implementation</td>
<td>Cross et al., 1989</td>
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<tr>
<td>Significant involvement of leaders of, influential members of, and individuals who know about and are respected by, the target population and the broader community and in the development of program</td>
<td>Beadle de Palomo &amp; Anderson, 2000; Brach &amp; Fraser, 2000; Chin, 2000; Cohen &amp; Goode, 1999; Cross et al., 1989; Dana et al., 1992; Davis, 1997; Fortier et al., 1999; King, Sims &amp; Osher, 2000; Like et al., 1996; McCormick et al., 2000; Munoz &amp; Sanchez, 1996; Rao &amp; Svenkerud, 1996;</td>
</tr>
<tr>
<td>Ability to tailor program to target population</td>
<td>Beadle de Palomo &amp; Anderson, 2000; Child Welfare League of America, 1993; Cross et al., 1989; Georgetown University Child Development Center, 2000; Janz et al., 1996; Kahan &amp; Goodstadt, 2001; Rao &amp; Svenkerud, 1998;</td>
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<tr>
<td><strong>Program Implementation</strong></td>
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<tr>
<td>Recruitment, retention of qualified, culturally competent and representative staff</td>
<td>Brach &amp; Fraser, 2000; Child Welfare League of America, 1993; Chin, 2000; Cohen &amp; Goode, 1999; Cross et al., 1989; Dana et al., 1992; Davis, 1997; Georgetown University Child Development Center, 2000; Munoz &amp; Sanchez, 1996</td>
</tr>
<tr>
<td>Staff representation of target population at various levels of program</td>
<td>Child Welfare League of America, 1993; Cross et al., 1989; Davis, 1997; Munoz &amp; Sanchez, 1996; Rao &amp; Svenkerud, 1998; Conference of Mayors, 1993</td>
</tr>
<tr>
<td>Support for improving/increasing staff attitudes, behaviors, knowledge and skills relevant to serving target population, including awareness of diversity within target population, especially if staff are not representative of target population</td>
<td>Brach &amp; Fraser, 2000; Child Welfare League of America, 1993; Chin, 2000; Cohen &amp; Goode, 1999; Cross et al., 1989; Dana et al., 1992; Davis, 1997; Georgetown University Child Development Center, 2000; Fortier et al., 1999; Like et al., 1996; Munoz &amp; Sanchez, 1996; Rao &amp; Svenkerud, 1998;</td>
</tr>
<tr>
<td>Significant involvement of leaders of, influential members of, and individuals who know about and are respected by, the target population and the broader community in the implementation of program</td>
<td>Beadle de Palomo &amp; Anderson, 2000; Chin, 2000; Cohen &amp; Goode, 1999; Cross et al., 1989; Dana et al., 1992; Davis, 1997; Fortier et al., 1999; Like et al., 1996; McCormick et al., 2000; Rao &amp; Svenkerud, 1998;</td>
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<tr>
<td>Ability to conduct outreach to and raise public awareness in target population</td>
<td>Munoz &amp; Sanchez, 1996</td>
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<tr>
<td>Ability to address potential logistical barriers to accessing program</td>
<td>Brach &amp; Fraser, 2000; Cross et al., 1989; Fortier et al., 1999; Like et al., 1996; McCormick et al., 2000; Munoz &amp; Sanchez, 1996; New York State Office of Mental Health, 1997; Conference of Mayors, 1993</td>
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<tr>
<td>Program Sustainability</td>
<td>Ability to document program and communicate the value of the program to a variety of audiences</td>
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<tr>
<td></td>
<td>Beadle de Palomo &amp; Anderson, 2000; McCormick et al., 2000</td>
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<tr>
<th>Program Validation</th>
<th>Evidence of participant satisfaction with, interest in, or enthusiasm for program</th>
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<tbody>
<tr>
<td></td>
<td>Beadle de Palomo &amp; Anderson, 2000; Chin, 2000; Cross et al., 1989; Dana et al., 1992; Davis, 1997; Kahan &amp; Goodstadt, 2001; Lucke et al., 2001; McMurtry &amp; Hudson, 2000; Munoz &amp; Sanchez, 1996; New York State Office of Mental Health, 1997</td>
</tr>
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| Evidence of support for program among general members of community | Beadle de Palomo & Anderson, 2000; Brach & Fraser, 2000; Cohen & Goode, 1999; Dana et al., 1992; Janz et al., 1996; Kahan & Goodstadt, 2001; Munoz & Sanchez, 1996 |

| Evidence of staff enthusiasm, endorsement for program | Cross et al., 1989; Kahan & Goodstadt, 2001; Lucke, Donald, Dover, & Raphael, 2001 |

| Evidence of support for program among other organizations, agencies also serving target population and broader community | Child Welfare League of America, 1993; Kahan & Goodstadt, 2001; Munoz & Sanchez, 1996; U.S. Conference of Mayors, 1993 |
In our own previous work, we have used this literature on effective programs to establish the HIV/AIDS Prevention Program Archive (HAPPA), a collection of 11 program packages or “replication kits” containing everything needed to replicate and re-evaluate intervention programs deemed effective by an independent scientist expert panel in preventing HIV/AIDS or its risk-related behavioral antecedents in at least one subgroup of adults in the U.S. (Card, 2001; Card, Benner, Feinstein, & Shields, 2001).

In establishing HAPPA, we found a dearth of proven-effective HIV/AIDS prevention programs targeted at racial and ethnic minorities (“minority-focused programs”), despite the overrepresentation of minorities in the U.S. HIV-infected population. We sought to correct this imbalance by taking proactive steps to identify promising (possibly effective) minority-focused HIV/AIDS prevention programs and then evaluate these programs. Our approach was to start with the universe of HIV/AIDS prevention programs already in existence in communities across the nation. These programs have funding levels much smaller than the levels associated with the proven-effective programs in HAPPA because they have “bubbled up” to meet specific needs in specific communities, instead of being theoretically driven interventions created from the start in collaboration with researchers and their major evaluation-related funding.

We felt that there were potential gems out there that could be shown to be “effective” if only evaluation funding and expertise were brought to the table. In this manner we sought to bridge the disconnect between research and practice by an innovative traversing of the research-to-practice feedback loop. Instead of going from research to practice as we did with HAPPA (and as almost all journal articles on the topic do), we sought to go from practice to research, beginning with programs already in existence in communities. Our hope was to augment the literature with primary research on minority-focused, community-based programs, which might influence future research and programming.

In short, rather than beginning with programs that were designed in collaboration with researchers and implemented with evaluation in mind, we began with programs that were already in existence and had not yet been evaluated (either because of their specificity toward targeted populations or because of resource constraints). Given the realities of limited funding, we knew that we could not evaluate all existing programs in scientific fashion. We needed to focus our evaluation efforts in systematic, cost-effective, science-based fashion. We needed to identify HIV/AIDS minority-focused prevention programs that (a) were culturally competent, (b) incorporated best practices in their intervention protocol, and (c) were “evaluation-ready” on infrastructure indicators such as program stability, sustainability and support.

Accordingly, we searched the literature for additional indicators of program strength and evaluation-readiness to add to our cultural competence tool. Our literature search added 13 research-based indicators to our list (Table 2).

Recall that the indicators in Table 1 reflected the activities and characteristics identified in the research literature as essential to the provision of culturally competent services. The indicators in Table 2 highlight the attributes most germane to a program’s ability to identify, measure, evaluate, and document progress toward positive outcomes. Generally speaking, the indicators of Table 1 demonstrate how program success hinges upon public/external involvement, perception, and satisfaction whereas the indicators of Table 2 list elements crucial to program existence and survival that can be implemented internally. For example, with respect to program sustainability, Table 1’s indicator refers to a program’s ability to articulate its benefit to external audiences (including the target population), in part demonstrating its flexi-
## TABLE 2. Program Strength and Evaluation Readiness Indicators

<table>
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<tr>
<th>Indicator</th>
<th>Literature Sources</th>
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<tr>
<td><strong>Program Development</strong></td>
<td></td>
</tr>
<tr>
<td>Written statement of program goals and objectives</td>
<td>Chin, 2000; Coyke, Bonich, &amp; Turner, 1991; Cross et al., 1989; Kahan &amp; Goodstadt, 2001; Lucke et al., 2001; Peterson, 1998</td>
</tr>
<tr>
<td>Existence of written, logically consistent program model or program rationale that anticipates an evaluation plan</td>
<td>Card, Brindis, Peterson, &amp; Diego, 2001; Peterson, 1998</td>
</tr>
<tr>
<td>Existence of a written plan of implementation describing nature, sequence, timing, and duration of activities and services</td>
<td>Peterson, 1998; Card, Benner et al., 2001a</td>
</tr>
<tr>
<td>Use of findings in literature regarding programs that work</td>
<td>Dana et al., 1992; Kahan &amp; Goodstadt, 2001</td>
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<tr>
<td><strong>Program Implementation</strong></td>
<td></td>
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<tr>
<td>Evidence that most program participants stay with program until it is completed</td>
<td>Peterson, 1998; Sedivy, 2000</td>
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<tr>
<td>Sufficient resources</td>
<td>Peterson, 1998; Sedivy, 2000</td>
</tr>
<tr>
<td>Existence of infrastructure to collect information and track program participants</td>
<td>Cross et al., 1989; Peterson, 1998</td>
</tr>
<tr>
<td>Ability to integrate program with existing services, both internally and externally</td>
<td>Sedivy, 2000</td>
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<tr>
<td><strong>Program Sustainability</strong></td>
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<tr>
<td>Ability to stabilize program for at least a year</td>
<td>Peterson, 1998; Sedivy, 2000</td>
</tr>
<tr>
<td>Evidence of long-term commitment by parent organization/institution to support and institutionalize the program</td>
<td>Sedivy, 2000</td>
</tr>
<tr>
<td>Multi-year support for program from outside source(s)</td>
<td>Peterson, 1998; Sedivy, 2000</td>
</tr>
<tr>
<td><strong>Program Validation</strong></td>
<td></td>
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<tr>
<td>Evidence of intended program effect</td>
<td>Card, Benner, 2001; Peterson, 1998</td>
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<tr>
<td>Independent replication of program at another site</td>
<td>Kahan &amp; Goodstadt, 2001; Peterson, 1998</td>
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</table>
bility and adaptability with communication whereas Table 2’s indicators point internally to a program’s longevity, institutionalization, and fiscal strength. Another example of how the two tables provide different lenses and perspectives on programs involves the program validation indicators: In Table 1, a program achieves validation through the support and endorsement of various populations whereas Table 2’s operationalization of program success involves achieving outcomes and replication. The indicators listed in Table 1 and Table 2 are not intended to be thought of as mutually exclusive to either cultural competence or evaluation readiness. Rather, we present the indicators in their respective tables as a way to organize, in a cursory manner, the wide range of “ideal-program” indicators supported by the literature.

Just as we did for the 20 indicators in Table 1, we developed a scoring system for each of the 13 indicators in Table 2 in the form of a simple, three-level performance continuum with criteria representing minimal (inadequate), sufficient, and high achievement of the indicator’s requirements, respectively. The resultant tool for guiding our search of evaluation-worthy programs is provided in the appendix. Because the performance criteria for each indicator are based on characteristics of an ideal program, HIV/AIDS prevention programs should not be expected to “pass” (achieve criterion level 2 or 3) all of the indicators in order to be deemed “promising” or “evaluation ready.” Rather, the hope is that prevention programs will demonstrate a broad level of strength on indicators spanning all four activities of program development, program implementation, program sustainability, and program validation before an investment is made in a rigorous evaluation of their effectiveness in preventing HIV/AIDS or changing its sexual and drug-related risk behavior antecedents. Programs found wanting on one or more indicators could focus on increasing their scores on the indicator in a variety of ways, such as improving staff training, investing in the infrastructure required for the indicator, and other relevant means of raising performance (see our earlier discussion of the training resources we are developing to accompany the tool).

USING THE FRAMEWORK AND TOOL TO IDENTIFY EVALUATION-READY HIV/AIDS PREVENTION PROGRAMS

To identify the most promising, but as yet unevaluated, minority-focused HIV/AIDS prevention programs in the country, we used the tool in the appendix to assess existing minority-focused HIV/AIDS prevention programs and to cull from existing programs those we could label as promising and ready for a more rigorous outcome evaluation.

IDENTIFYING MINORITY-FOCUSED HIV/AIDS PREVENTION PROGRAMS

Through a comprehensive search for programs based on (a) findings from the research literature, (b) recommendations and referrals from funding agencies and organizations at federal, state, and local levels, and (c) recommendations and referrals from HIV/AIDS prevention programs that serve majority populations and minority populations, we identified nearly 300 minority-focused HIV/AIDS prevention programs nationwide.

CREATING AND PILOT TESTING INSTRUMENTS BASED ON THE FRAMEWORK

We devised a brief paper-and-pencil questionnaire based on the tool in the appendix. The questionnaire was designed to be mailed out to prevention programs for
self-administration by program staff. We also developed a follow-up 1-hour telephone interview protocol designed to elicit more detailed responses from program staff. Before implementing broad-scale use of these instruments on the 300 candidate programs, we conducted a pilot test to verify that the instruments were appropriate, comprehensible, and relevant to practitioners.

COLLECTING THE DATA

We mailed the paper-and-pencil questionnaire to each of the 300 candidate programs. Sixty one (61) programs passed the self-screening and returned the completed questionnaire. Given resource constraints and timelines, we could not explore the reasons for the nonresponses; therefore, we could not verify that the remaining programs successfully received the mailing or confirm that the programs elected not to participate. Because the brief questionnaire was intended for screening purposes only, we immediately followed up questionnaire returns with requests for telephone interviews. Of the 61 programs, 48 programs agreed to participate in an hour-long interview. We interviewed program staff who self-identified as being most knowledgeable about the program of each of the 48 programs. In some cases, staff interviewed were managers while others were line staff. The interviews were conducted by two researchers and lasted approximately one hour. After conducting the interviews, both researchers independently scored the program on the 33 indicators of cultural competence and evaluation readiness using the 3-point scoring framework for each indicator provided in the appendix. An interrater reliability coefficient of .7 was obtained, demonstrating the reliability of the tool. Discrepancies were resolved by talking through a consensus score; outstanding discrepancies were considered by the entire research team.

The 13 promising programs selected by this method proved to be a diverse lot. Most of these programs used combinations of prevention approaches, did not appear to rely exclusively on any one approach, were based in urban settings, tended to utilize more than one language medium, included a clinic but were not exclusively clinic based, and were likely to focus solely on HIV/AIDS prevention (as opposed to focusing on both prevention and treatment).

USING THE FRAMEWORK AND TOOL TO DESIGN A RESEARCH INVESTIGATION INTO THE RELATIONSHIP BETWEEN CULTURAL COMPETENCE AND PROGRAM EFFECTIVENESS

We received funding from the National Institute of Allergy and Infectious Diseases to conduct a pilot test of an outcome evaluation of the 13 minority-focused programs identified as promising through the use of our tool. The pilot evaluation is using a quasi-experimental design in which pretest, immediate posttest, and 3-month follow-up data are being collected from one participant-cohort cycle from each of the 13 promising programs selected with the help of the tool, as well as a comparison group carefully selected for each program. Of the 13 promising programs, 9 signed memoranda of agreement consenting to participate in these outcome evaluations. As of this writing, pretest and posttest data have been collected from 8 of the 9 programs, and 3-month follow-up data from three programs. Our high study recruitment rate (9 of 13 promising programs) provides preliminary evidence of the validity of the tool in selecting evaluation-ready programs. However, our pilot test results to date have also highlighted the ongoing challenges with completing such evaluations, even with “best practice” programs that are culturally competent and evaluation ready. Our pilot
evaluations showed the sample sizes for each program cycle for the various programs to be relatively small. The most common sample size for program participants and comparison groups was 10 individuals, and the sample sizes across all programs ranged from 7 to 23. Several cohort cycles would be needed to reach the sample sizes required by power analyses and such an evaluation design would exceed the duration of small funding awards. We found the assembly of suitable comparison groups to be difficult but not insurmountable for most of the programs participating in the pilot evaluations. However, a rigorous outcome evaluation with random assignment to treatment and comparison group was deemed “unethical” by all but one of the participating programs. In direct contrast and contradiction, a separate large grant proposal we submitted with a longer time line to allow formal evaluation of the programs was returned with a priority score too low for funding with the primary suggestion from reviewers to switch from a quasi-experimental to a true experimental design (with random assignment to treatment and control) if large grant funding were to be obtained. The field needs to come to grips with some of these mismatches between the worlds of practice and research.

OTHER POTENTIAL USES FOR THE TOOL

In addition to applying the tool to the identification of promising programs, the research-based tool in the appendix can be used by researchers and practitioners in other productive ways to minimize duplication of efforts and maximize limited resources. The tool can provide a cost-effective means to facilitate funding decisions (when effectiveness has not yet been demonstrated via a scientific evaluation), establish program performance benchmarks, develop and augment prevention programs, provide emphases for technical assistance, and create a framework for evaluation.

Funding decisions can be facilitated by the use of the tool. For example, standards could be established based on the tool’s indicators and criteria, helping funders identify and select promising programs. Funders could also design and craft funding initiatives or campaigns that promote these best practices, thereby encouraging the development of prevention programs typified by certain characteristics.

The criteria can also be applied to the creation of benchmarks that agencies use to guide program implementation. For example, government agencies could provide their funded programs with a list of goals, based on these criteria, to strive to achieve. Benchmarks, such as authentic involvement of target population in program design, could assist programs in conceptualizing program objectives. Agencies can also use these benchmarks to identify areas of weakness among programs and provide appropriately targeted technical assistance.

Researchers and practitioners can use the criteria to develop and augment programs. Application of these criteria allows practitioners and researchers to pick and choose from a variety of promising strategies as they develop or augment a prevention program to fit the specific needs of populations. Using the criteria, practitioners are able to develop promising prevention programs supported by experiences in the field, resulting in the saving of time and money that otherwise would have been devoted to trial and error in the field.

The use of the criteria can also help researchers narrow down the focus of future research when exploring the relationship between specific best practices in cultural competence and program effectiveness. In evaluating a program, researchers could focus on a given indicator to determine its role in program effectiveness. For example, researchers can focus on the ways in which programs include community input in pro-
gram design to determine the role that community involvement plays in program effectiveness. These evaluation results could provide guidance for federal initiatives that continue to emphasize joint, collaborative projects between organizations/agencies (governmental and nongovernmental) and communities.

Finally, the utilization of these criteria can provide practitioners and researchers with a means to assess programs that have not yet been evaluated. Because of cost and time constraints, formal evaluation can often be unrealistic. In the absence of such evaluation, the tool provides a relatively inexpensive, research-based approach to assessing the value of a program or activity.

APPENDIX: A RESEARCH-BASED TOOL FOR IDENTIFYING AND SELECTING PROMISING, EVALUATION-READY HIV/AIDS PREVENTION PROGRAMS

NOTE: Indicators are denoted by the numbers. Criteria for assessing level of performance on each indicator are denoted by bullets. Performance criteria range from inadequate (first dash) to sufficient (second dash) to high (third dash).

PROGRAM DEVELOPMENT

1. Ability to assess need among target population
   • How is the need for the program determined (e.g., response to federal/state RFA, national/local data, needs assessment, community input)?
     Continuum of intensity:
     – Program identifies need through analysis of national and/or local data.
     – Program also conducts needs assessment and/or obtains community input about need.
     – Program continually and actively assesses need through combination of above.

2. Written statement of program goals and objectives
   • Does the program have a written statement of the goals and objectives? Describe or include attachment.
     Continuum of intensity:
     – Program has clear, nonwritten ideas about goals and objectives.
     – Program articulates goals and objectives in written statement.
     – Program continually and actively assesses relevance of written goals and objectives for target population.

3. Adoption or development of definition of cultural and linguistic competence
   • Does the program have a working definition of cultural and linguistic competence? Describe.
   • Does the program have a written definition of cultural and linguistic competence? Describe. If the program doesn’t have a written definition, is the working definition referred to in program documents (e.g., mission statement, program goals and objectives, training materials)?
   • Does the program operationalize cultural and linguistic competence (e.g., checklists, assessments)?
     Continuum of intensity:
     – Program has clear, nonwritten ideas about cultural and linguistic competence.
     – Program articulates cultural and linguistic competence in written definition or refers to it in other documents.
     – Program operationalizes definition continually and actively integrates operationalization into self-assessments and evaluations.

4. Existence of written, logically consistent program model or program rationale that anticipates an evaluation plan
   • Is there a written program model that defines the target population, describes each intervention activity or service, and explains how each intervention activity or service is expected to result in the desired objectives and goals? Describe or include attachment.
   • Does the written program model describe how you will know when the desired objective or goal has been met? Does the program model describe what the evidence for change might look like? Describe or include attachment.
   • Did the possibility for evaluation influence the writing of the program model? Describe.
     Continuum of intensity:
     – Program has clear rationale and logic derived from internal experience and/or social science theories.
     – Program has written model that anticipates evaluation by outlining evidence and methodology for gathering evidence.
     – Program continually and actively tests model for relevance to goals and objectives and new information.
5. Existence of a written plan of implementation describing nature, sequence, timing, and duration of activities and services
   • Does the program have an operations manual or protocol describing the sequence, timing, and duration of intervention activities and services? Describe or include attachment.
   • Does the program have some other guideline for the implementation of the intervention(s) (e.g., a proposed manual, protocol or guideline)? Describe or include attachment.
   • How does the program assign roles and responsibilities relevant to the intervention(s) among staff (e.g., position, titles, roles, authority, responsibility, timeframe) including responsibility for the ensurement of cultural and linguistic competence (e.g., encouragement, incentives, and penalties)?

Continuum of intensity:
   – Program has clear, nonwritten ideas about implementation.
   – Program articulates implementation in written plan.
   Implementation plan includes sufficient detail for consistent delivery of services, including assignment of program roles and responsibilities (and responsibility for cultural and linguistic competence).

6. Use of findings in literature regarding programs that work
   • How does the program incorporate what is known about programs that work?
   • How does the program incorporate what is known about best practices and/or effectiveness (e.g., focus on improving behavioral skills, allow for ample duration and intensity of interventions, based on behavioral and social science theory, include multiple interventions or multiple components within an intervention)?

Continuum of intensity:
   – Program reviews HIV/AIDS prevention relevant literature, including literature on best practices and effectiveness, in developing interventions.
   – Program incorporates literature findings into development of interventions.
   – Program compares literature findings with internal experience and continues to track relevant literature.

7. Mechanisms and structures to identify cultural, linguistic, and socioeconomic issues among target population
   • How does the program identify cultural, linguistic, social, and economic issues that may affect the target population’s ability to participate in or benefit from the program (e.g., town meetings, staff and participant suggestions, other meetings)?

Continuum of intensity:
   – Program has clear ideas about issues relevant to target population, derived from internal experience and/or literature.
   – Program utilizes mechanisms that involve the target population to identify issues.
   – Program continually and actively solicits input of target population and seeks out new mechanisms for identification of issues.

8. Mechanisms and structures to identify resources, leaders of, influential members of, and individuals who know about and are respected by, the target population and the broader community to involve in program development and implementation
   • In what ways does the program identify leaders of, influential members of, and individuals who know about and are respected by, the target population and the broader community to involve in the program (e.g., asset mapping, staff and participant suggestions)?
   • What formal or informal efforts does the program make to be involved in community activities or initiatives that affect the target population? (The activities and initiatives can be health or nonhealth related)

Continuum of intensity:
   – Program has clear ideas about who leaders, influential members, and other resource individuals are, derived from internal experience and/or literature.
   – Program utilizes mechanisms that involve the target population to identify leaders, influential members, and other resource individuals.
   – Program continually and actively solicits input of target population and seeks out new mechanisms for identification of leaders, influential members, and other resource individuals.

9. Significant involvement of leaders of, influential members of, and individuals who know about and are respected by, the target population and the broader community involved in the development/design of the program (e.g., needs assessment, program planning, field testing, advisory board)

Continuum of intensity:
   – Program involves leaders, influential members, and other resource individuals through frequent but casual contributions in design.
   – Program actively seeks out and integrates contributions of leaders, influential members, and other resource individuals in design, covering both range and depth of contributions.
   – Program continually and actively seeks out and integrates new contributions.

10. Ability to tailor program to target population
    • How does the program define the target population for the program? Does the program make distinctions within the target population? If so, why?
    • How does the program design take into consideration the cultural, social, and religious beliefs, values, and norms of the target population and/or subgroups within the target population? Did this development work involve the target population?

Continuum of intensity:
   – Program has clear definition of target population and, if applicable, makes distinctions within target population.
   – During development, Program makes cultural, social, and religious adaptations for target population as relevant, with the involvement of the target population.
   – Program continually and actively seeks out feedback from target population regarding fit and adapts as relevant.
STRENGTHENING PREVENTION PROGRAMS

PROGRAM IMPLEMENTATION

11. Recruitment, retention of qualified, culturally competent and representative staff
   • How does the program identify and recruit potential staff who are qualified, culturally competent, and representa-
     tive of target population and the broader community (e.g., formalizing roles of community health workers)?
   • How does the program seek to reduce turnover among staff, particularly staff who are culturally competent and
     representative of the target population and the broader community (e.g., monitoring statistics in retention, polling
     staff about organizational improvement)?
   Continuum of intensity:
     - Program identifies individuals, or sources for individuals, who potentially could be qualified, culturally compe-
       tent and representative staff.
     - Program actively recruits and retains qualified, culturally competent and representative staff.
     - Program continually and actively works to recruit and retain qualified, culturally competent and representative
       staff.

12. Staff representation of target population at various levels of program
   • How are program staff representative of the target population and the broader community in terms of nationality,
     race, ethnicity, language, area of residence, and age (e.g., administrative, service delivery, management, and policy
     staff)?
   • Are there other ways that program staff are representative of the target population and the broader community?
     Describe.
   Continuum of intensity:
     - Program staff in direct contact with target population are representative in most ways.
     - Program staff at various levels of program are representative in most ways.
     - Program continually and actively works to achieve staff representation at various levels of program and organi-
       zation.

13. Support for improving/increasing staff attitudes, behaviors, knowledge and skills relevant to serving target popula-
    tion, including awareness of diversity within target population, especially if staff are not representative of target
    population
   • How does the program support or require improving/increasing attitudes, behaviors, knowledge, and skills relevant
     to serving the target population among all staff (e.g., continuing education, training, workshop, mentoring)? (This
     applies to knowledge and skills regarding cultural competence as well as prevention in general)
   • How does the program support awareness among staff of the diversity within the target population?
   • How does the program provide support and training to staff who are not representative of the target population?
   Continuum of intensity:
     - Program encourages improvements in attitudes, behaviors, knowledge, and skills.
     - Program actively provides mechanisms to improve attitudes, behaviors, knowledge, and skills.
     - Program formally incorporates mechanisms in scope of work requirements, performance measures.

14. Significant involvement of leaders of, influential members of, and individuals who know about and are respected
    by, the target population and the broader community in the implementation of program
   • Beyond staff members, how are leaders of, influential members of, and individuals who know about and are re-
     spected by, the target population and the broader community involved in the implementation, functioning, and
     day-to-day work of the program (e.g., training, service delivery, evaluation, program revision)?
   Continuum of intensity:
     - Program involves leaders, influential members, and other resource individuals through frequent but casual con-
       tributions in implementation.
     - Program actively seeks out and integrates contributions of leaders, influential members, and other resource indi-
       viduals in implementation, covering both range and depth of contributions.
     - Program continually and actively seeks out and integrates new contributions.

15. Ability to conduct outreach to and raise public awareness in target population
   • How does the program raise public awareness for the program in the target population (e.g., media campaigns,
     grassroots campaigns)?
   • How does the program recruit individuals from the target population and the broader community to help with out-
     reach and awareness (e.g., community health workers, advisory group)?
   Continuum of intensity:
     - Program has clear ideas about successful outreach and public awareness strategies, derived from internal experi-
       ence, input from target population, and/or literature.
     - Program conducts outreach to and raises public awareness in target population with the involvement of the tar-
       get population.
     - Program continually and actively solicits input of target population and seeks out new strategies for outreach
       and awareness.

16. Ability to provide program to intended target population
   • How does the program know which participants belong to the target population the program intended to reach?
   • Do the majority—about 70-75%—of program participants belong to the target population? If no, why not?
   Continuum of intensity:
     - Program utilizes mechanism(s) to assess participation.
     - Program obtains majority of participants from the target population.
     - Program continually obtains majority participation from the target population and continually assesses
       participation.

17. Evidence that most program participants stay with program until it is completed
   • How does the program know which participants stay with the program until it is completed? Do most partici-
     pants—about 70-75%—stay?
   • What does the program know about why program participants do not stay with the program until completion? De-
     scribe.
   Continuum of intensity:
Continuum of intensity:

1. Program utilizes mechanisms(s) to assess attrition and retention of participants.
2. Program retains most participants until completion.
3. Program continually retains most participants and continually assesses attrition and retention of participants.
4. Ability to address potential logistical barriers to accessing program.
   - What are the potential difficulties that program participants may have in accessing the program (e.g., transportation, scheduling, safety, location, cost of participating, child care)?
   - How does the program address potential difficulties that program participants may have?
5. Continuum of intensity:
   - Program has clear ideas about successful strategies to address logistical barriers, derived from internal experience, input from target population, and/or literature.
   - Program responds to barriers with the involvement of the target population.
   - Program continually and actively solicits input of target population and seeks out new strategies for addressing barriers.
6. Ability to modify/adapt program
7. Ability to integrate program with existing services, both internally and externally
8. Existence of infrastructure to collect information and track program participants
9. Sufficient resources
   - Program generally and currently has sufficient resources to carry out activities and interventions.
   - Program has clear estimate of needs relative to available and potentially available resources.
   - Program secures sufficient resources for program to accommodate new growth and innovation.
10. Existence of infrastructure to collect information and track program participants
   - Program collects salient information about program participants.
   - Program has ability to analyze information about participants.
   - Program analyzes information and applies information to inform development and implementation.
11. Ability to integrate program with existing services, both internally and externally
   - Program has clear ideas about successful strategies to integrate program with related/complementary services and to refer participants, derived from internal experience, input from target population, and/or literature.
   - Program continually and actively assesses attrition and retention of participants.
   - Program continually and actively attempts to evaluate and improve referral network and service integration.
12. Ability to modify/adapt program
   - Program generally and currently has sufficient resources to carry out the activities and interventions outlined in the program model and/or program materials (e.g., facilities, personpower, materials and curricula)? Describe.
   - Program has clear ideas about successful strategies to address linguistic needs, derived from internal experience, input from target population, and/or literature.
   - Program continually and actively attempts to evaluate and improve referral network and service integration.
13. Ability to address potential logistical barriers to accessing program
   - Program has clear ideas about successful strategies to address logistical barriers, derived from internal experience, input from target population, and/or literature.
   - Program continually and actively solicits input of target population and seeks out new strategies for addressing barriers.
14. Ability to address potential logistical barriers to accessing program
   - Program has clear ideas about successful strategies to address logistical barriers, derived from internal experience, input from target population, and/or literature.
   - Program continually and actively solicits input of target population and seeks out new strategies for addressing barriers.
15. Ability to address potential logistical barriers to accessing program
   - Program generally and currently has sufficient resources to carry out activities and interventions.
   - Program has clear estimate of needs relative to available and potentially available resources.
   - Program secures sufficient resources for program to accommodate new growth and innovation.
16. Existence of infrastructure to collect information and track program participants
   - Program has clear ideas about successful strategies to address logistical barriers, derived from internal experience, input from target population, and/or literature.
   - Program continually and actively solicits input of target population and seeks out new strategies for addressing barriers.
17. Ability to address potential logistical barriers to accessing program
   - Program has clear ideas about successful strategies to address logistical barriers, derived from internal experience, input from target population, and/or literature.
   - Program continually and actively solicits input of target population and seeks out new strategies for addressing barriers.
18. Ability to address potential logistical barriers to accessing program
   - Program has clear ideas about successful strategies to address logistical barriers, derived from internal experience, input from target population, and/or literature.
   - Program continually and actively solicits input of target population and seeks out new strategies for addressing barriers.
STRENGTHENING PREVENTION PROGRAMS

24. Ability to stabilize program for at least a year
   • Has the program been fully implemented with regularity and stability for at least a year (e.g., multiple cycles without changing program model)? If no, why not?
   • What are/were the dates of implementation for the program?
   • Has the program, while remaining substantively the same, experienced changes in name, support from parent organization/institution, or affiliation? Explain.

Continuum of intensity:
   – Program implements without change to program model.
   – Program implements without change to program model for at least a year, without extended or unplanned breaks in service delivery.
   – Program implements for more than 1 year.

25. Evidence of long-term commitment by parent organization/institution to support and institutionalize the program
   • If the program is associated with a parent organization/institution, has the parent organization/institution adopted the program into its range of programs and services (e.g., staffing, inclusion in organizational chart, listing in brochures)? Describe.
   • Has the parent organization/institution committed financial resources to the program (e.g., grant awards, inclusion in budget)? Describe.
   • Has the parent organization/institution supported or incorporated the program in other, informal ways (e.g., sit on advisory boards, provide technical assistance, in-kind donations, office/program space, volunteers)? Describe.

Continuum of intensity:
   – Parent organization/institution provides sufficient financial or other support to program.
   – Parent organization/institution adopts and incorporates program into range of services.
   – Parent organization/institution continually and actively solicits input of program and seeks out new ways to support program.

26. Multiyear support for program from outside source(s)
   • Has the program received financial support from outside sources such as foundations, government and social service agencies? If so, for how long? Describe.
   • Has the program received other forms of support from outside sources for any period of time (e.g., technical assistance, in-kind donations, use of office/program space, volunteers, other nonfinancial support)? If so, for how long? Describe.

Continuum of intensity:
   – Program has clear ideas about potential outside source(s) of financial support and other support.
   – Program currently receives sufficient multi-year financial support and other support from outside source(s).
   – Program secures sufficient financial support and other support for program beyond present and near future.

27. Ability to document program and communicate the value of the program to a variety of audiences
   • Other than formal evaluation, how does the program document the need for and process of the program?
   • How does the program communicate the value of the program to a variety of audiences (e.g., broader community, potential funders, policymakers, other programs)?

Continuum of intensity:
   – Program documents need for and process of the program.
   – Program communicates value of program to external audiences.
   – Program actively and continually seeks out different audiences/venues to communicate value.

PROGRAM VALIDATION

28. Evidence of participant satisfaction with, interest in, or enthusiasm for program
   • How does the program formally measure or assess the satisfaction with the program among previous and current participants (e.g., surveys, interviews)? What do the measurements and assessments tell you about participant satisfaction and dissatisfaction with the program?
   • In what ways does the program get other feedback (e.g., information gathered through settings outside of program) on the program from previous and current participants? What does the feedback tell you about participant satisfaction and dissatisfaction with the program?
   • What does the program do with the various feedback and information that it gets?

Continuum of intensity:
   – Program has informal sense of recent satisfaction/support or obtained past satisfaction/support from participants.
   – Program demonstrates recent satisfaction/support of participants from multiple sources.
   – Program continually and actively obtains, and improves if necessary, satisfaction/support, including involvement of previous and current participants in promotion and development.

29. Evidence of support for program among general members of community
   • How does the program formally measure or assess support for the program from general members of the community (e.g., those who are not and have not been program participants)? What do the measurements and assessments tell you about their satisfaction and dissatisfaction with the program (e.g., surveys, interviews)?
   • In what ways does the program get other feedback (e.g., information gathered in social settings, churches, etc.) on the program from general members of the community (e.g., those who are not and have not been program participants)? What does the feedback tell you about their satisfaction and dissatisfaction with the program?
   • What does the program do with the various feedback and information that it gets?
• How do members of the general community (e.g., those who are not and have not been program participants) support the work of the program (e.g., recruitment and outreach, advocacy and promotion, volunteering, training, endorsement)?

Continuum of intensity:
- Program has informal sense of recent support or obtained past support from general members of the community.
- Program demonstrates recent compelling evidence of support from general members of the community.
- Program documents support from general members of the community from multiple sources.

30. Evidence of staff enthusiasm, endorsement for program

• How does the program formally measure or assess the satisfaction with the program from previous and current staff (e.g., surveys, interviews)? What do the measurements and assessments tell you about staff satisfaction and dissatisfaction with the program?

• In what ways does the program get other feedback on the program from previous and current staff (e.g., staff meetings, one-one-one meetings)? What does the feedback tell you about staff satisfaction and dissatisfaction with the program?

• What does the program do with the various feedback and information that it gets?

• How do previous and current staff support the work of the program outside the scope of their formal job responsibilities?

Continuum of intensity:
- Program has informal sense of recent support or obtained past support from staff.
- Program demonstrates recent compelling evidence of support from staff.
- Program documents support from staff from multiple sources.

31. Evidence of support for program among other organizations, agencies also serving target population and broader community

• How does the program assess support, enthusiasm, and endorsement for the program among organizations and agencies that also serve the target population and broader community? What do the assessments tell you about their satisfaction and dissatisfaction with the program?

• What does the program do with the various feedback and information that it gets?

• In what other ways do other organizations and agencies that also serve the target population and the broader community support the program? Describe.

Continuum of intensity:
- Program has informal sense of recent support or obtained past support external organizations.
- Program demonstrates recent compelling evidence of support from external organizations.
- Program documents support from external organizations from multiple sources.

32. Evidence of intended program effect

• Does the program have case history testimonies from current and previous program participants of reduced risk behavior (or intention to reduce risk behavior) following the program? Describe.

• Does the program have other evidence of program effect of reduced risk behavior or intention to reduce risk behavior (e.g., pretests and posttests, survey results)? Describe.

• In what other ways does the program find evidence for the program’s intended effect?

Continuum of intensity:
- Program has clear ideas about successful strategies to assess program effect, derived from internal experience, input from target population, and/or literature.
- Program obtains and documents intended program effect with the involvement of target population.
- Program continually and actively improves program effect and seeks out new strategies for improving program effect.

33. Independent replication of program at another site

• Has the program shared/given its program materials, curricula, or ideas with other organizations and agencies that also serve the target population and the broader community? Describe.

• Has any portion of the program been replicated at another site? Describe.

• Has the entire program, without substantive change to the program model, been replicated at another site? Describe.

Continuum of intensity:
- Program shares program information with another site or portions of program are replicated at another site.
- Program is replicated, close to program model, at another site.
- Program is replicated at multiple sites or is considered a model by multiple programs.
REFERENCES


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