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HIV Prevention Through Early Detection
and Treatment of Other Sexually Transmitted
Diseases - United States



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*Recommendations
and
Reports*

MORBIDITY AND MORTALITY WEEKLY REPORT

HIV Prevention Through Early Detection and Treatment of Other Sexually Transmitted Diseases — United States

**Recommendations of the Advisory Committee
for HIV and STD Prevention**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333



LOCAL REINVENTION OF THE CDC HIV PREVENTION COMMUNITY PLANNING INITIATIVE

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ABSTRACT: The Centers for Disease Control and Prevention (CDC), in coordination with 65 states, cities, and territories, implemented HIV prevention community planning beginning in 1994. This large scale innovation in public health planning has involved tens of thousands of professionals and community residents. Though a single case study, Michigan provides a strong test of the implementation of this national prevention planning model because of the state's decentralized approach to HIV prevention community planning involving several hundred residents. A decentralized approach to community planning promises to maximize participation and the sharing of leadership as well as obstacles to community planning. Here, the CDC *Guidance* for community planning is contrasted with empirical observation of implementation in Michigan. We conclude that the high expectations for a decentralized approach to HIV prevention community planning can be best achieved when a distinction is drawn between *information-seeking* tasks and *decision-making* tasks. We recommend that information-seeking tasks be centrally coordinated, and that decision-making tasks be decentralized, to most fully achieve the potential of HIV prevention community planning.

INTRODUCTION

In the April, 1995, issue of this journal, the Centers for Disease Control and Prevention's (CDC) national strategy for improving HIV prevention programs through community planning was presented.¹ *HIV prevention community planning* is an ongoing process whereby states, territories and cities (grantees) receiving Federal funding for HIV prevention share responsibility for developing a comprehensive HIV prevention plan with other state and local agencies, nongovernmental organizations, and representatives of communities infected and or affected by HIV.² Under the

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community planning initiative, grantees must involve, in an open and participatory planning process, a variety of stakeholders including representatives of infected and or affected communities, public health professionals, representatives of relevant governmental agencies (i.e., substance abuse, mental health, social services, corrections, etc.), providers of HIV prevention and care services, and individuals with expertise relevant to the planning process (i.e., social and behavioral sciences, evaluation, administration, etc.).

Communities have become the locus of U.S. health planning and promotion for several reasons.³ First, community representatives hold the promise of bringing expertise and insights about local behavior and social norms to decision making that does not necessarily exist at Federal and state levels.⁴ In general, the more a health promotion intervention adopts the attitudes, behaviors, values, and language of at-risk individuals, the more effective the intervention.⁵ Secondly, research about behavior change and community participation suggests that people are more committed to initiating and maintaining those behaviors that they help design. That is, we are more likely to follow through on that with which we have a personal investment. Third, the social support inherent in a group of like community participants can overcome barriers to participation by members of stigmatized minorities in decision-making bodies. There is power in numbers. These three findings have led to innovations in community involvement policy across Federal departments and agencies, including the U.S. Agency for Toxic Substances and Disease Registry, the Department of the Interior, the Department of Agriculture, the National Oceanic and Atmospheric Administration, the Environmental Protection Agency, the Department of Energy, and the Department of Defense.⁶

The CDC community planning initiative is worthy of analysis because its intent is to involve community representatives as full partners. While policy makers in Federal agencies may invite the community in an consultative, advisory, or reflective role, they are often cautious about welcoming community participants as full partners in decision processes. Welcoming communities as partners means sharing authority, working with people who may not be technically proficient, allowing more time to reach decisions, and acknowledging the worth of and using nontraditional types of data to broaden the basis for decision-making. However, when Federal policy becomes the domain of the public—that is, the public becomes responsible for implementation—what is put into place can be expected to differ markedly from the design of the original innovation.

This process of altering an innovation is *reinvention*, the degree to which an innovation is changed by the adopter in the process of adoption

and implementation after its original development.⁷ Though innovators (i.e., program sponsors) typically perceive changes to their creation in negative terms, reinvention by users (i.e., practitioners) often produces positive outcomes when actual use of innovations is measured. In fact, behavioral research has consistently demonstrated the value added to "top down" innovations when the people responsible for policy implementation are encouraged to change the policies to best fit their situation-specific needs.⁸ Reinvention is especially likely when an innovation is complex, introduced into a system by persons outside of that system, and when users lack detailed working knowledge about the innovation. These conditions well characterize HIV prevention community planning, calling for a user-centered perspective of health promotion initiatives.⁹

Analysis of what those responsible for implementation actually do with an innovation is critical for theory-building about how and why health promotion innovations diffuse.¹⁰ Understanding how a Federal health promotion innovation may be changed during implementation is critical so that mid-course corrections can be anticipated and made to better enable goal achievement in other localities and for other health promotion interventions. In the study of HIV prevention community planning, analysis of its implementation is also critical to the saving of lives in a behaviorally transmitted epidemic. Accordingly, we have examined the CDC policy regarding HIV prevention community planning and studied its implementation in Michigan with the immediate goal of improving the planning process and the longer term goal of furthering theory-building.

IMPLEMENTING THE CDC COMMUNITY PLANNING INITIATIVE

The CDC is the Federal agency principally responsible for supporting HIV prevention efforts across the U.S. Funding is provided to health agencies in all fifty states, the District of Columbia, eight U.S. territories, and the six major U.S. cities hardest hit by the epidemic (New York, Chicago, Los Angeles, San Francisco, Philadelphia, and Houston). HIV prevention community planning grew from a general dissatisfaction with restrictive compliance requirements related to Federal funding and the manner in which HIV prevention was being approached in many areas of the country in the late 1980s and early 1990s. Prevention efforts often were not being targeted to people most at-risk, were not based on sound public health practice, and were not being delivered in culturally and linguistically competent ways. In several concomitant and complementary efforts community and government stakeholders sought to improve Federal

1- AIDS policy through greater community involvement in planning, delivery, and evaluation of prevention activities.^{11,12,13,14} The CDC agreed in October 1993 to develop and implement community planning for HIV prevention. Its 65 grantees were issued the *Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects* (the *Guidance*) in December 1993 which mandated that all state, territorial, and city health departments implement community-based planning for HIV prevention as a condition of continued Federal funding.

The mission of HIV prevention community planning is to provide evidence-based and culturally competent HIV prevention programming which is consistent with community identified and validated needs, priorities, and values. This mission is matched with the goal of developing a long-term comprehensive plan for HIV prevention via an open and participatory public process. To fulfill the mission, goal, and desired outcomes of HIV prevention community planning, the CDC *Guidance* requires that each grantee convene at least one community planning group. Planning group membership is to reflect the epidemiology of the current and projected epidemic.

The CDC requires seven tasks of community planning groups. These tasks were conceptualized by the CDC as time-ordered "steps" with a logical flow from one task to the next.¹⁵ The ordering of the seven steps represents this logic:¹⁶

1. Assess the present and future extent, distribution, and impact of HIV/AIDS in defined populations.
2. Assess existing community resources for HIV prevention to determine the community's capability to respond to the epidemic.
3. Identify unmet HIV prevention needs within defined populations.
4. Define the potential impact of specific strategies and interventions to prevent new HIV infections in defined populations.
5. Prioritize HIV prevention needs by defined high risk populations and by specific strategies and interventions.
6. Develop a comprehensive HIV prevention plan consistent with the identified high priority needs.
7. Evaluate the effectiveness of the planning process.

These steps were presented in terms of a formal decision model in the CDC *Guidance*, in documentation prepared for community planning group members,¹⁷ and in articles published by CDC staff.¹⁸

Grantees responding to the CDC *Guidance* exhibited considerable

1- variance in the degree to which implementation strategies were centralized.^{19,20,21} The Michigan Department of Community Health (MDCH) has supported a comprehensive approach to HIV prevention since 1986. The Department's HIV/AIDS Prevention and Intervention Section (HAPIS) provides oversight and management to prevention programming supported with state and Federal funding and coordinates training and technical support for agencies and organizations which provide HIV prevention services. In response to the CDC *Guidance*, HAPIS chose to implement a decentralized planning process. Michigan convened eight Regional Community Planning Groups (RCPGs) and one Statewide Community Planning Group (SCPG). The state coordinates the activities of the eight regional community planning groups, and groups must often coordinate with each other. Policy decisions are made by HAPIS by first proposing options to RCPG and SCPG members, engaging members in discussion, reaching consensus on what recommendation should be made back to HAPIS, and then making a decision into which SCPG and RCPG recommendations are factored. HAPIS and the planning groups share authority and responsibility for decisions related to prevention programming and resource allocation.

HAPIS' interpretation of the CDC *Guidance* resulted in the identification of several planning activities. First, RCPGs needed to identify and prioritize target populations based on epidemiological reports provided by the state as well as other data and community knowledge. Second, RCPGs needed to conduct a comprehensive needs assessment where the HIV prevention needs of prioritized populations were identified and also prioritized. Third, RCPGs were expected to assess and prioritize prevention interventions—that is, they were to assess the effectiveness and feasibility of interventions based on published evaluation studies, local program evaluation, and consumer feedback. Fourth, each RCPG was expected to compile a community resource inventory of current HIV prevention and related resources. Fifth, each RCPG was expected to conduct a gap analysis. The gap analysis was envisioned as a task of matching priority population needs (CDC steps one and two) with existing and potential interventions (CDC steps three and four). The gap analysis would be used by the regional planning groups to prioritize what types of interventions should be funded in each region for specific prioritized populations. All of this information would then be included in a comprehensive plan for HIV prevention in each region. The eight regional plans would then be compiled by HAPIS into a state application.

S- This planning process was communicated to RCPG leadership and
N- members through a planning workbook distributed by HAPIS, through
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annual skill building conferences, through direct technical assistance provided to each region, and through extensive correspondence between HAPIS and the regional planning groups. In addition, the planning process was reviewed at several SCPG meetings where members from each RCPG were present.

Michigan's decentralized approach to health promotion promises to maximize community participation and community leadership by involving as many people as possible in a relatively flat organizational structure. However, persons experienced in decentralized planning processes understand the obstacles to group progress that typically go hand in hand with decentralization: Great care must be taken to insure representation and equal voice among participants, participants will likely be characterized by considerable variance in technical skill and experience in knowledge of public health systems, government planning, and prevention program implementation and management so that assumptions of understanding cannot be made, disagreements over group process are to be expected, decisions will be slow, irregular attendance can be expected of participants whose time with the group(s) is not considered within the purview of their job, and group members may try to redo a portion of the planning process at any time. More centralized approaches to community planning sacrifice high degrees of community involvement but minimize these obstacles.

PROCESS EVALUATIONS OF HIV PREVENTION COMMUNITY PLANNING

Each year, the CDC required each grantee to conduct an evaluation of the community planning process. Here we report on our experience as consultants and evaluators of how this innovation in health promotion has been implemented in one state that is characterized by considerable diversity of population density, ethnicity, and geography. Our approach to evaluation over the last three years has been to focus on the relationships between the CDC guidance for community planning and its local implementation in Michigan. We have followed the work of evaluation theorists and methodologists who recognize the value of evaluation designs which seek immediate process improvement as well as reliable and valid measurement through close involvement with implementation.²² Our data-collection includes a content analysis of each RCPG's annual comprehensive plan, observational and self-report data, and a membership survey.

The first two years of the evaluation focused less on planning activities and more on issues related to membership composition, the develop-

1. ment of by-laws, and other meeting procedures. By the middle of the second planning year (1995), we—as evaluators—began to question the extent to which RCPG members understood and had the capacity to perform the various tasks associated with the planning process. We sent questionnaires focused on planning task achievement, group dynamics, and personal experiences to each RCPG member (N=285). Completed questionnaires were received from 142 members for a response rate of 50 percent. On the questionnaire, community planning members were asked to respond to a series of statements by indicating the extent to which they “strongly agreed” (indicated by a “1”) with the statement or “strongly disagreed” (indicated by a “5”) with the statement. Responses to questions about task achievement indicated that members’ self reports did not necessarily match with the content of the regional plans. In particular, we looked at the mean score (below in parentheses) for the following task-specific questions:

The RCPG developed a resource inventory that includes all local HIV prevention providers. (2.4)

We identified unmet prevention needs by comparing high risk populations with existing prevention activities. (2.6)

We matched unmet needs of high risk populations with potential interventions. (2.6)

These scores indicate that members were neutral concerning these activities—neither agreeing or disagreeing with the statements. A review of the RCPG comprehensive plans for 1995 indicated, however, that only one region had completed a resource inventory and that no RCPG has conducted the later steps associated with needs assessment—identifying unmet prevention needs and matching unmet needs with potential interventions. Given the content of the comprehensive reports, a more accurate community member response would have been that they “disagreed” or “strongly disagreed” with the above mentioned statements.

During the second year of the planning process, we observed that several RCPGs were reconfiguring the planning group or planning to hire consultants to conduct part of the planning process. In particular, three of the eight regions had decided to further subregionalize. That is, they created subregions within their regions. Planning tasks were then distributed at the subregional level with the RCPG playing more of a coordinating role. In some regions, RCPGs decided to hire consultants to determine the prevention needs of priority populations or to conduct the resource inven-

tory. In one region, planning group members released a request for proposals where the entire needs assessment and intervention assessment—including the resource inventory—would be contracted to a consultant. What does it mean when community members act to farm out the most critical group tasks to outsiders?

A content analysis of the RCPG planning documents at the end of the third year (1996) indicated that most RCPGs had still not completed a comprehensive needs assessment, had not prioritized prevention interventions, that many had not compiled a community resource inventory of current HIV prevention programs and related resources, and that the RCPGs had not conducted gap analyses. In addition, most RCPGs continued to struggle with bylaws, nomination and voting procedures, and group leadership. The regional planning groups experienced attrition in membership—a condition we associated with a general lack of knowledge about, and frustration with, the planning process.

The fact that each RCPG was struggling with completing the planning process forced HAPIS to reconsider the CDC's planning expectations. The CDC and others anticipated that community planning group members would experience confusion, divisiveness, contradictory political interests, and interpersonal conflict as a product of engaging in the group process.²³ But we doubt that the CDC and their advisors anticipated that community members would not be able to complete the planning tasks either because they have insufficient understanding of the process, lacked the skills necessary to conduct certain planning tasks, or that decentralized groups would not have sufficient unobligated time to conduct these tasks. In order to complete the planning process, and to honor the commitment by CDC and HAPIS to community partnership in decision-making, we worked to formalize the reinvention of community planning which our community members were struggling to recreate. A resulting model was then proposed to and approved by RCPG and SCPG members, and later adopted by HAPIS.

REINVENTION OF COMMUNITY PLANNING IN MICHIGAN

The reinvention of community planning in Michigan occurred through the actions and reactions of regional and statewide planning group members, state coordinators and consultants, and evaluators and technical assistance providers. Community planning groups had been asked to perform a variety of tasks, far more complex and wide-ranging than is typical of a group charged with decision making that is well-cod-

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ified by common approaches to needs assessment and formal models of decision analysis which were used to design the CDC initiative.^{24,25,26} To suggest that HIV prevention community planning is akin to such simple processes²⁷ is to underestimate the complexity and variety of tasks that past evaluations of HIV prevention community planning document.²⁸ Frustration tempered by a constant concern for the seriousness of the epidemic and the importance of the CDC charge characterized this state's experience in trying to fit the CDC logic with a decentralized approach to community planning.

A decentralized planning approach works for some tasks and not for others. Michigan's community planning groups now function as decision-making bodies that use data of several types to form collective judgments about prioritization decisions, the compilation of a comprehensive prevention plan, and monitoring progress toward achieving prevention objectives, and do not spend so much time learning how to gather, and then gathering, information. The logic of the *Guidance* requires planning groups to be intensely involved in both information-seeking and decision-making activities.

Information-seeking tasks demand the collection and analysis of data, and are represented in this logic-chain as assessing the spread of HIV and AIDS in a given geographic area, especially among populations at high-risk for HIV (step 1), assessing the coverage of ongoing interventions in the field, which becomes catalogued in a resource inventory (step 2), and developing an understanding of the potential of intervention types for specific populations, based on published social and behavioral research and local experience (step 4).

Decision-making tasks demand the overt application of group judgment, and are based on the identification and assessment of the unmet prevention needs of specific populations that were determined to be at high-risk for HIV (step 3), and the prioritization of those needs and the interventions that are most likely to best satisfy them (step 5).

For decentralized approaches to *Guidance* implementation, the required information-seeking tasks which contribute data to the central task of decision-making can be carried out in relatively centralized ways that still depend on regional inputs and does not compromise the integrity or promise of a decentralized community planning process. Likewise, the required decision-making tasks can be carried out in regional groups, drawing from the knowledge of the community and members' expertise. Lead responsibility for planning tasks characterized as information-seeking are most appropriately posited with grantee health departments (i.e., of a state or territory), while lead responsibility for tasks characterized as decision-

making are most appropriately posited with community planning groups. Community planning groups and health departments should maintain a consultative partnership in accomplishing these tasks.

Information-Seeking Tasks. Key tasks for administrators of HIV/AIDS prevention programming in such a decentralized approach to community planning, besides being the state, city, or territory liaison between community members and the CDC, are to compile and disseminate the information tools that enable decision-making in the planning groups: *An Epidemiologic Profile*, *Community Resource Inventory*, and *Summary Assessment of Intervention Effectiveness*. Accomplishing these tasks requires (1) a close working relationship with epidemiologists, if available, (2) knowledge of providers of related programs to ensure coordination in the field without redundancy, (3) use of existing lists of prevention providers from throughout the state, territory, or city, which become the basis for creating an inventory of which needs are met and unmet per priority population (a task being accomplished in Michigan through a new statewide survey of prevention providers), and interventions that have been demonstrated to be effective for particular needs and populations. Here we provide some detail about each of the three information tools.

States, territories, and cities with relatively decentralized models of community planning should centrally compile, disseminate, and periodically update a *Epidemiologic Profile*, an assessment of the present and likely future spread of HIV and AIDS based on epidemiological data. With epidemiologist leadership, the profile should rank-order the populations at greatest risk for HIV. This profile should be disseminated to each of the grantee's planning groups as a starting point for discussion and reanalysis by group members who then are responsible for amending or modifying the rank-order, or respecifying populations, justified by their experiences in the community and data obtained from local needs assessment activities. This is the approach now taken in Michigan.

States, territories, and cities with relatively decentralized models of community planning should centrally compile, disseminate, and periodically update a *Community Resource Inventory*, which describes current prevention efforts in terms of type of programming, target audience, venue of delivery, and agency capacity. In Michigan, current resource inventories and an ongoing statewide survey of providers and people at high risk for HIV formed the basis for a more detailed statewide inventory. HAPIS, working with regional planning group members, is building upon the last three years of data compilation by regional groups.

States, territories, and cities with relatively decentralized models of community planning should centrally compile, disseminate, and peri-

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1- odically update a *Summary Assessment of Intervention Effectiveness*, the goal of which would be to communicate to planning group members a general understanding of effective HIV prevention interventions as reported through published research, critiques, and reports, professional presentations of research, and conference proceedings. Planning group members will add to this inventory their local knowledge about the effectiveness of small-scale interventions in their geographic region based on summaries of formative, process, or outcome evaluation data of locally implemented interventions. In Michigan, a HAPIS *Annotated Bibliography of HIV Prevention Literature* and the state's annual comprehensive HIV prevention plans serve as the basis for this summary.

Decisions-Making Tasks. Community planning group members in a decentralized approach to community planning face a series of critical decisions that must be made while maintaining an open, inclusive, and representative group. Issues of group composition, the need to recruit representative members, conflicts of interest, training new group members in the basics of HIV prevention community planning, and drawing on members for group leadership and on health departments for administrative assistance are better understood as aspects of the ongoing planning process than as time-bound obstacles to be dealt with and forgotten. In Michigan, when a regional group seemed to be making rapid progress in decision-making, we came to realize that this was often an indicator that fundamental aspects of group process—such as involving people who are representative of the current and projected epidemic—had been ignored.

But as important as group process issues are, they are the means, not the objectives, of community planning. Group members have a job to do. It involves the subdivision of tasks so that members can make progress reviewing an *Epidemiologic Profile* rank-order of populations, consider changes to that rank-order that the group can support by reasoned argument and documentation, and finalization of the prioritization of population groups by risk. In Michigan, planning group members begin with a ranking of prevention priorities provided by state epidemiologists, tailored to each region. Behaviorally-defined populations (such as men who have sex with men) are ranked according to latest calculations of risk. Planning group members then are to identify sub-populations within the behaviorally-defined population (such as African-American men who have sex with men in suburban Detroit). It is the task of the planning group to then prioritize those sub-populations as appropriate targets for regional HIV prevention activities.

In Michigan's decentralized approach, a gap analysis is then performed for each prioritized sub-population. In a gap analysis, planning

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group members use their *Community Resource Inventory* to list all of the ongoing interventions in their region which target that sub-population. Members then assess the extent to which each intervention addresses or satisfies six target population needs (*knowledge* about transmission, risk behavior, and serostatus; *persuasion* to behave in a new healthy way; *social support* to reaffirm the value of a previously adopted healthy behavior; *communication skills* to enable the effective discussion and negotiation of safer behaviors; *access* to materials, tools, and services; and *supportive community norms* to promote better health). Planning group members use a variety of locally-originated data, including their own experience with these programs, to make these decisions. Then for each of the six needs, for the sub-population as a whole, a decision is made about whether that need is met or unmet.

This needs-driven approach to decision-making about sub-populations results in a clear understanding of unmet needs and, just as importantly, which needs are currently met, as well as where resources are currently directed but not needed by the target population. The groups then use the *Summary Assessment of Intervention Effectiveness* to specify which types of interventions should be used to satisfy specific needs. This cumulative information then forms the basis for the recommendations in the regional prevention plans that Michigan's regional groups prepare for the state. Requests for proposals and sole-source contracts are in turn written to reflect identified population needs.

CONCLUSION

Flaws in the design of the CDC *Guidance* make the implementation of decentralized community planning unworkable in practice without considerable reinvention. First, the relationships among the seven task steps is more complicated in practice than is suggested in the *Guidance*. Several of the steps can and should be accomplished concomitantly. Assessing the spread of HIV, assessing what interventions are already in place, and learning the strategies and interventions that tend to be most effective with certain populations are each discrete sets of mutually exclusive tasks that can, for example, be performed by different planning members in sub-committees. Moreover, each of the seven steps is iterative; they need to be done more than once since HIV prevention community planning is intended to be an ongoing and changing response to a moving epidemic. And these steps have different periodicities; that is, the cycle of iterations varies by task. Some need to be done annually; others need to be done

more or less frequently than once a year. So variability exists in task concomitancy, iteration, and periodicity, making the *Guidance* notion of time-ordered steps somewhat inaccurate in practice.

Second, more planning group competency is assumed in the *Guidance* than exists for carrying out a decentralized approach to community-based prevention planning. After three years, Michigan's regional participants were just beginning systematic prioritization of populations and interventions. The more taxing process of identifying and assessing the unmet needs of specific populations, with the high degrees of uncertainty that are necessarily involved, have been met with consternation and befuddlement, responses which CDC staff must have anticipated given their experience with public health departments, national minority organizations, and community-based organizations that were often not able to conduct reliable and valid needs assessments: "... we know from review of grant applications and from ongoing communication with CDC project officers (who are responsible for monitoring program activities) and program managers in grantee organizations that needs assessments are often not carried out in a comprehensive manner or are not conducted at all".²⁹ The CDC did not require needs assessments or inventories of ongoing prevention interventions, or provide technical assistance about these tasks to grantees. Identification and assessment of population needs is typically the work of researchers who are then trained in cultural competency with a given at-risk population, or of community-based service providers who are then trained in research protocol. Though they possess and make use of other skills, most Michigan planning group members do not possess these particular skills.

We conclude that Michigan's experience with HIV prevention community planning suggests that the promised benefits of decentralization are best achieved when community planning groups are charged with decision-making tasks, and not information-seeking tasks.

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Social Marketing and Diffusion-Based Strategies for Communicating with Unique Populations: HIV Prevention in San Francisco

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We conducted a 2-year investigation of the extent to which strategies based on social marketing and diffusion of innovations concepts are used in preventive health communication with unique (highly ostracized) populations. Of the 49 organizations in San Francisco that operate HIV prevention programs (N = 100), programs that most highly targeted unique populations were surveyed. Personal interviews were then conducted

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with 38 staff leaders who operated the most and least effective programs. Audiotapes and transcripts were content analyzed to identify the strategies used by program staff. Strategies based on social marketing concepts were more prevalent than strategies based on the diffusion of innovations. More effective programs were characterized by emphasis on homophily, audience segmentation, compatibility-based strategies, and interorganizational collaboration.

Social marketing and the diffusion of innovations are social change models with strong normative orientations toward prosocial development through improved public health. For decades, the concepts of social marketing and diffusion have been translated into strategies and utilized by public health staff throughout Africa, Asia, North America, and South America (Kotler & Roberto, 1989; Rogers, 1995). Although social marketing and diffusion of innovations concepts are widely used in ongoing public health programs and shorter-lived campaigns, these concepts are rarely used to reach people who are highly ostracized. Highly ostracized people are under unique constraints and constitute very small segments often not deemed large enough to justify the typical social marketing or diffusion approach to social change, yet they are of key health policy importance because they account for a disproportionate share of health services. Preventive health programs and campaigns are usually centrally managed, unidirectional (from source to receivers), mass mediated, and oriented toward a single, time-bound behavior (such as smoking cessation). We have argued, along with Bracht (1990), that when the target audience is a unique population, certain concepts become more important, and other concepts less important, in the development of strategies to change unhealthy practices (Dearing, Meyer, & Rogers, 1994; Meyer & Dearing, 1996). That is, changes to standard model-based approaches to social change are required.

In the present investigation, we studied strategies used to communicate HIV prevention techniques to unique populations in San Francisco. We did not seek programs using social marketing or diffusion approaches; rather, we inductively sought programs that were reaching ostracized, unique populations and then studied the strategies they used to do so. Data were collected through personal interviews with directors and staff members of prevention programs in community-based organizations (CBOs), local-government public health offices, hospitals and clinics, and for-profit businesses.

The following research questions guided the present study:

1. To what extent are populations targeted by HIV prevention programs in San Francisco?
2. Which uniqueness characteristics of the intended audiences for HIV prevention programs in San Francisco are most targeted?
3. What types of organizations operate the programs that are intended for unique populations?
4. Which communication channels are most commonly used by HIV prevention programs in San Francisco?
5. Which social marketing or diffusion of innovation concepts are most commonly used by highly targeted HIV prevention program staff?
6. Do more or less effective prevention programs use different social marketing and diffusion of innovations concepts?

Social marketing and diffusion of innovations share certain key concepts. For example, the idea that individuals pass through a series of psychological stages in their readiness to adopt a new attitude or behavior is represented in each model. The two models also complement each other. For example, social marketing includes an important role for

interpersonal communication in the persuasion process, whereas the diffusion model recognizes the advantages of mass media communication in raising awareness and knowledge. Yet each model also has distinct concepts.

Social Marketing

Social marketing is a process of designing, implementing, and controlling programs to increase the acceptability of a prosocial idea among population segments of consumers. This application of for-profit marketing principles to prosocial causes relies on (a) systematic targeting and audience segmentation through identification of certain demographic, situational, and behavioral characteristics to maximize the trade-off of message impacts and cost per individual contacted; (b) the use of consumer-based research and feedback from representative population segments about prototypical social products; and (c) management of a change program through evaluation (Kotler & Roberto, 1989). Social marketing programs make careful *a priori* analyses of environmental factors that may impede or facilitate the change program. A social marketing perspective conceptualizes target audience members as consumers and seeks to establish "brand" loyalty, perceptions of desirable status associated with the social product, and a network of product support. The five key concepts of social marketing, determined through a review of literature and discussions with social marketing scholars and practitioners, are (a) *audience segmentation*, the identification of one or more homogeneous subaudiences within a population; (b) *resource management*, the process of controlling a program's personnel, materials, and overhead; (c) *program development*, the design of a social product that is accomplished by considering the four Ps of product, price, place, and promotion; (d) *evaluation*, the systematic analysis of a program to make a judgment about its value; and (e) *preprogram data-gathering*, the investigation of factors that may affect a program prior to its design.

Diffusion of Innovations

Diffusion is the process through which an idea perceived as new is communicated through certain channels among the members of a social system (Rogers, 1995). Diffusion occurs through a combination of (a) the need for individuals to reduce personal uncertainty when presented with new information and (b) the need for individuals to respond to their perceptions of social and peer pressure as they imitate others who have adopted the innovation. Interpersonal influence is typically required to persuade individuals to adopt an innovation, especially innovations that are perceived as opposed by social norms, risky, expensive, taboo, requiring a radical behavior change, or difficult to understand. Diffusion approaches in public health programs stress the activation of interpersonal networks among people in a system through the activities of change agents and the cooperation of opinion leaders to create a multiplier effect on the rate of adoption. The six key concepts of the diffusion of innovations, determined through a review of literature and discussions with diffusion scholars, are (a) *communication channels*, the means by which a message is transmitted from one person to another; (b) the *innovation-decision process*, a sequence of five stages (awareness, knowledge, persuasion, implementation, and confirmation) that a target audience member passes through in adopting a new idea; (c) *homophily*, the extent to which two or more people who communicate perceive that they are similar; (d) *attributes*, perceived characteristics of an innovation that are positively or negatively related to an adoption decision; (e) *adopter categories*, classifications of individuals grouped on the basis of the relative time at which they adopt a new idea, technique, or process; and (f)

opinion leaders, people who are respected by others for their knowledge and reputation about a particular topic.

Population Uniqueness

Uniqueness is the degree to which a segment or group of relatively homophilous and ostracized persons differs from the larger social system of which it is a part. A unique population is distinguished from the broader population through shared member perceptions of behavioral, demographic, and situational characteristics (Henderson, 1994; Selik, Castro, & Pappaioanou, 1988), as well as by the shared belief that they are objects of discrimination by majority population members. For example, runaway boys in New York City who are gang members and use intravenous drugs constitute a unique population segment. If these boys also know each other, they have the properties of a group and are bound by patterned interpersonal communication and influence.

The perception of ostracism and discrimination leads people to further isolate themselves from dissimilar others. Identification with dissimilar others (out-group individuals) decreases as identification with similar others (in-group members) increases. Unique populations result, either in the abstract sense of self-identifying as a member of a population segment of similar people who do not necessarily know each other (Hyman, 1968) or in the concrete sense of being part of an interacting, closely knit group (Klov Dahl, 1985). Members of unique population groups who are connected through patterned interpersonal communication share strong ties. Members may experience harsh repercussions for behavior that threatens group solidarity (Cialdini, 1988; Motivational Education Entertainment Productions, 1992). Though the relational structure of such groups can be used strategically in preventive health programs (Kelly, 1992), the closed nature of unique population groups makes them difficult to identify (Watters & Biernacki, 1989), access (Casey, 1995; Kelly, St. Lawrence, Diaz et al., 1991), and sample (Braunstein, 1993).

Method

The Present Investigation

HIV prevention was chosen as our topic of study because by the early 1990s this virus represented a public health crisis among people in the United States who were behaviorally, situationally, and demographically outside of mainstream U.S. society.

San Francisco was chosen as the site for the present investigation because of its early and rapid rate of HIV infection. San Francisco is the world's most experienced city in its funding and organized response to HIV infection and AIDS (Arno, 1986; Dearing & Rogers, 1992; Morin, 1984). By 1993, at least 48% of the city's homosexual and bisexual male population had been infected with HIV (San Francisco Department of Public Health, 1993). HIV prevention activities in San Francisco in the 1980s achieved a high rate of awareness of HIV and a dramatic reduction in high-risk behavior among certain populations, especially homosexual White men (Fineberg, 1988; McKusick, Coates, Morin, Pollack, & Hoff, 1990; Winkelstein, Samuel, Padian, et al., 1987). Much HIV prevention in San Francisco now focuses on high-risk unique populations. The present investigation was an opportunity to investigate theoretical concepts and pragmatic strategies in a social system that serves as a bellwether for HIV transmission and prevention programs in other large cities with a high degree of cultural and ethnic diversity, such as Bangkok, Bombay,

Calcutta, Hong Kong, Rio de Janeiro, Mexico City, Los Angeles, New York City, Miami, London, Amsterdam, and Paris.

Identifying Prevention Programs That Most Highly Targeted Unique Populations

Our investigation was carried out between 1993 and 1995. Through multiple means, we identified all organizations that provided any AIDS-related service in San Francisco ($N = 401$) and, more specifically, HIV prevention ($N = 212$). A telephone survey identified the subset of organizations ($N = 49$) that conducted programs in which the content or emphasis was at least 50% on HIV prevention ($N = 100$ programs). A second survey was conducted with the staff of the 100 programs, in which respondents described their program and answered closed-ended questions about whether or not the programs targeted their intended audience in terms of 13 behavioral, situational, and demographic characteristics (e.g., HIV risk-related factors such as sexual orientation, gender, intravenous drug use, homelessness, etc). Whereas uniqueness describes a population segment or a group, targeting describes the uniqueness characteristics used by program staff to communicate with a segment or group. Targeting is the use of audience characteristics to customize the design and delivery of a program on the basis of the characteristics of a population segment.

Targeting scores for 99 prevention programs (targeting data are missing for one program we studied) varied from 0 (the intended audience was not being targeted by the program for any risk factor) to 10 (the intended audience was targeted for 10 distinct risk factors). For example, a prevention program designed to influence Black, male, runaway, teenage, low-income, low-education prostitutes (with a targeting score of 7) was considered a highly targeted program aimed at a unique population. In a community other than San Francisco with different social norms, a prevention program with a targeting score of 3 might be considered a highly targeted program (Meyer, 1995; Svenkerud, 1995). We focused our attention on the 41 programs that had targeting scores of 5 or more, as shown in Figure 1. In San Francisco, these are highly targeted programs aimed at unique populations.

Figure 2 shows that audiences were targeted by HIV prevention programs particularly on the basis of age, ethnicity, sex, and sexual orientation. Intravenous drug use, other drug use, language, and socioeconomic status were each targeted by 25 to 30 HIV prevention programs. Targeting an audience by ethnicity meant that other risk factors were also included in targeting efforts. The mean targeting scores of the 49 programs that did not target by ethnicity were lower ($M = 2.06$, $SD = 1.56$) than the mean targeting scores for the 50 programs that did target by ethnicity ($M = 6.10$, $SD = 2.37$), $t(97) = 10.04$, $p < .001$.

CBOs dominated the provision of HIV prevention to unique populations in San Francisco. CBOs operated programs that were targeted to significantly more unique populations ($M = 4.96$, $SD = 2.87$, $N = 51$) than were the programs operated by non-CBOs ($M = 3.18$, $SD = 2.55$, $N = 48$), $t(97) = 3.24$, $p < .01$. Of the 41 programs that targeted unique populations, CBOs operated 26 (63.4%).

Program staff primarily communicated with audiences either through face-to-face channels or through print channels. Most programs attempted to reach audiences through multiple channels to reinforce and complement HIV prevention messages. Differences existed in the use of certain face-to-face communication methods depending on the type of organization and the degree of population uniqueness. Small-group communication, $\chi^2(1, N = 93) = 4.30$, $p < .05$, and street outreach, $\chi^2(1, N = 93) = 8.16$, $p < .01$, were more likely to be used by CBO-based programs. Further, these face-to-face methods were used by pro-

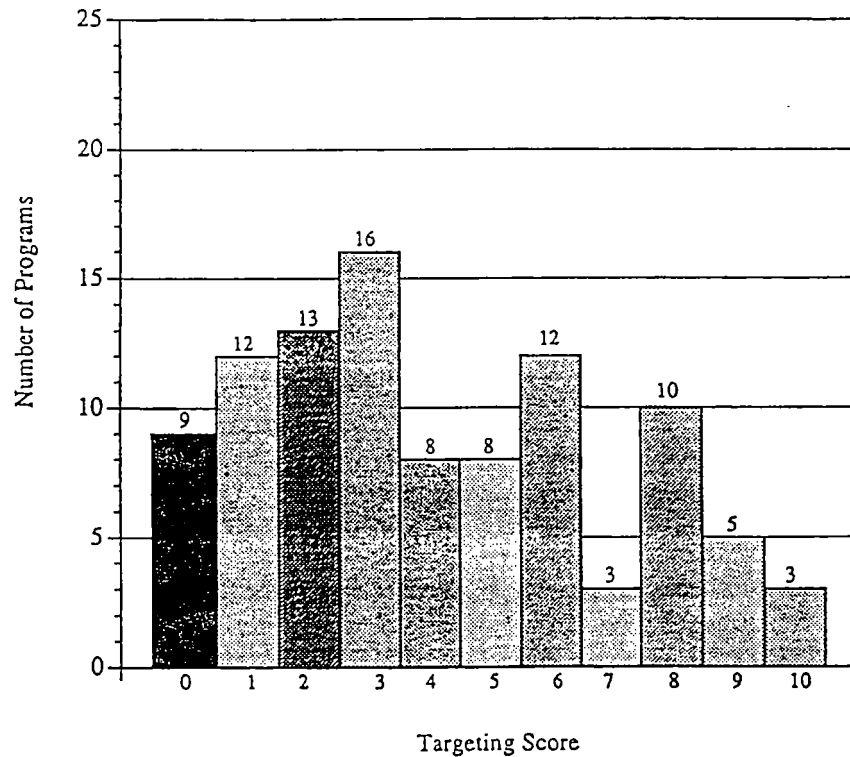


Figure 1. Targeting scores for 99 HIV prevention programs in San Francisco. We examined 100 programs from 49 organizations. Targeting data for one program are not included here. Programs scoring 5 or above were considered highly targeted to a unique population. The targeting score is based on the number of demographic, situational, and behavioral characteristics targeted by the organization.

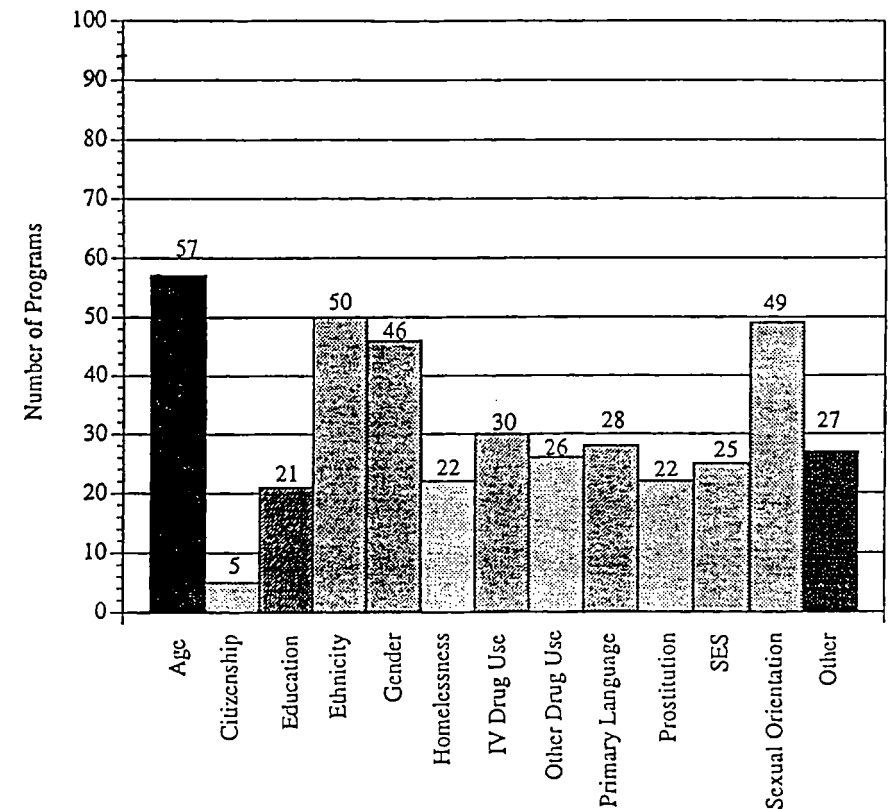
grams that targeted more unique populations: for small-group communication, $M = 5.03$, $SD = 2.79$, $t(90) = 2.45$, $p < .05$, and for street outreach, $M = 6.71$, $SD = 2.30$, $t(90) = 4.11$, $p < .001$. Group education such as classroom sessions and presentations were more often conducted by non-CBOs such as educational and governmental organizations, $\chi^2(1, N = 93) = 6.22$, $p < .05$.

Distinguishing Among Programs on the Basis of Process Effectiveness

We did not seek outcome measures such as actual changes in client behaviors because such data, even if available, would not permit comparison across programs. To enable comparison, we measured the process effectiveness of each program with indicators that we believed would be theoretically positively related to outcome effectiveness. Some of these indicators are commonly used by local, state, and federal funding sources and by private philanthropies to provide evidence of process effectiveness. For example, we believe that

a prevention program is more likely to be effective if its staff (a) collaborate more with other organizations in service provision, (b) has more experience, (c) work more often face-to-face with clients, (d) work more service hours, and (e) perceive that they are more successful than other programs on which they have worked and know about. Similarly, we believe that an organization that attracts more federal funding for its prevention activities, a greater diversity of funding sources, and more volunteers from the local community is more likely to be effective.

We used a comparative process effectiveness score to identify the relative effectiveness of the prevention programs we studied. Our 15-item composite scale was developed, pretested, and faxed to the administrators of the 41 programs. Administrators from 35 pro-



Means of Audience Targeting (Uniqueness Characteristics)

Figure 2. Number of HIV prevention programs that targeted audiences by different population characteristics in San Francisco. We studied 100 programs from 49 organizations. Targeting data for one program are not included here.

grams completed questionnaires. Three returned questionnaires were disqualified because of incomplete data. The comparative process effectiveness score was computed for each program by summing the numerical values for the 15 scale items and dividing by the total number of responses (7% of all scale-item responses were missing data). The average score for each respondent was inserted for each missing scale item. The 15 scale items were factor analyzed for unidimensionality with principal axis rotation. Most items had substantial factor loadings (greater than .40). All 15 items were internally consistent as measured by item-total score correlations and were retained in the scale. The 10 HIV prevention programs with the highest scores on the process effectiveness scale were considered more effective; the 10 programs with the lowest scores were considered less effective.

Personal Interviews to Identify Concept-Based Strategies

Research teams interviewed two program representatives at each of the 20 highly targeted HIV prevention program organizations. The interviewers did not know which of their interviewees represented the more effective and less effective programs. The interview format was open ended. Each tape-recorded interview lasted about 45 min and was transcribed for content analysis. All 40 interviews were completed (2 interviews from one prevention program were excluded from analysis because the program did not meet previously established criteria). Data on interorganizational collaboration were collected through personal interviews with administrators of the three most effective programs and the three least effective programs. A roster of all 100 HIV prevention programs in San Francisco was provided to these 6 respondents, who were then asked to indicate whether or not they collaborated formally or informally with staff of the other 99 programs.

Data Coding

Interviewee responses were divided into coherent thought units, which served as the units of analysis for our quantitative content analysis (Holsti, 1969). Two teams of quantitative coders were trained to categorize identified strategies as examples of social marketing or diffusion of innovations concepts: One team of coders was unaware of the purposes of the study and of the relationship of the concepts to the models, and the other team was knowledgeable about the study and the relationship of concepts to the two models. Inter-coder reliability (agreement) between the blinded and nonblinded coders in identifying and categorizing strategies was .91, obtained by randomly selecting nine interview transcripts from a weekend-long training and testing session and comparing coded responses. Examples of identified strategies from our interviews are grouped by concept in Table 1.

We regarded each of the 11 model concepts as the potential basis for program strategies. For example, the following thought unit

We have found turnover related to burnout to be a big problem among CHOWs [community health outreach workers] the last 2 years. Now we try to convert them to case managers after 18 months on the street.

was identified as a strategy reflecting the social marketing concept of resource management. Similarly, the following thought unit was coded as reflecting the diffusion concept of opinion leadership:

We watch in bars and approach the guys who are the most popular.

After identifying and categorizing strategies as representative of the 11 social marketing and diffusion concepts, coders further categorized the interview responses by identifying specific aspects of each coded concept. For example, when a strategy was coded as reflecting the diffusion concept of communication channels, coders further identified the type of communication channel, whether one-to-one, small group, large group, or other face-to-face communication; brochure, poster, or other print media; or radio, telephone, or audiovisual electronic media. The number of subconcept types ranged from 4 to 13 for each concept.

A third team of coders was trained to identify and then inductively create concepts that reflected respondents' meanings for the strategies that were discussed in the interviews (Taylor, 1994). This qualitative coding was designed to investigate a wider range of concept-based strategies, outside of our 11, as well as other factors (such as organizational dynamics or leadership style) that might distinguish more effective programs from less effective programs. Coder training consisted of reducing one interview into several sections, individually coding these sections, and discussing each coding to ensure consistency and understanding. Qualitative coders used both written transcripts and audiotapes.

Results

Which concepts were most commonly used by highly targeted HIV prevention programs? Quantitative coders identified 3,503 incidences of strategy; 62% were based on social marketing concepts, and 38% were based on the diffusion of innovations model. Program development, communication channels, audience segmentation, and resource management were the concepts identified most frequently, and adopter categories, opinion leadership, preprogram data gathering, and the innovation-decision process were the concepts identified least frequently (see Table 2).

Table 3 lists the 11 concepts, the number of strategies identified as reflecting each concept, and the percentage of mentions for dominant subconcepts. We concluded that (a) face-to-face communication was the dominant channel through which HIV prevention programs disseminated change messages; (b) audiences were segmented and change agents hired on the basis of their sex, age, ethnicity, and sexual orientation; (c) programs invested many resources in personnel; (d) several types of evaluation were used, with process evaluation the most common; and (e) few strategies utilizing opinion leadership and the systematic collection of data prior to program development (preprogram data gathering) were used. Strategies based on the categorization of potential adopters, in which target audiences can be conceptualized according to their relative readiness to change attitudes or behavior, were nearly nonexistent.

The qualitative coding identified aspects of cultural sensitivity, including audience segmentation, homophily, and the importance of target adopters' perceiving that a program was compatible with their previous experiences and beliefs. Cultural sensitivity was at the heart of most of the personal interview texts. Cultural sensitivity, for the staff members themselves, meant the tailoring of programs (including every aspect from organizational structure to message development) to the history and culture of the target population. Program staff talked about cultural sensitivity as essential to the effectiveness of their prevention programs. The majority of programs emphasized cultural sensitivity as essential to program development and success. One program director, who spoke about the importance of treating men and women differently, described this need in particularly compelling terms:

Table 1
Key Concepts as Reflected in Strategies Based on Social Marketing and the Diffusion of Innovations

Strategy	Example
	Social marketing
Audience segmentation (identification of one or more homogeneous subaudiences within a population)	"We try to reach those individuals who are at highest risk for HIV, namely, young African American male injection drug users who are homeless and work in the sex industry." "We only approach kids who are homeless and shoot up."
Resource management (the process of controlling a program's personnel, materials, and overhead)	"We have found turnover related to burnout to be a big problem among CHOWs the last two years. Now we try to convert them to case managers after 18 months on the street." "We could not engage in all of the activities we do without our volunteers. We find that if they have some decision-making power, they are more likely to work harder for us."
Program development (the design of a social product that is typically accomplished by considering the marketing mix of product, price, place, and promotion)	"We designed our kit to be discrete enough to fit into one's pocket." "We can't ask our clients to do that yet." "We have found bus shelters to be a good place for ads because people, while waiting for their bus, have something to read."
Evaluation (the systematic analysis of a program's effects to make a judgment about a program)	"We took three designs of the brochure into the streets to see what the kids [the target audience] thought of them." "We gave away 10,000 more brochures than last year." "Six months after our program started, we recorded a 15% decrease in shared needle use."
Preprogram data gathering (the investigation of factors that may affect a program prior to its design)	"Before we developed the program, we checked records from the San Francisco Department of Health to determine which Asian group was at highest risk for HIV." "We heard the state of California was going to fund bar outreach."

	Diffusion of innovations
Communication channels (the means by which a message is transmitted from one person to another)	"We do everything: brochures, posters. Those things kind of work to help us to get people talking, to get their attention on something other than their own lives, so that they open up to us." "Like, if someone just comes in off the street and needs something, like a condom, we won't say no, but we prefer to deal with them through outreach."
Innovation-decision process (sequence of five mental stages—awareness, knowledge, persuasion, implementation, and confirmation—a target audience member passes through in adopting a new idea)	"Part of the problem is that you've really got to know where the person is at. People don't want to stop doing what they're doing. There are a lot of us out there who are tired of it all, sick of all this AIDS stuff they didn't ask for." "See, she's not ready this week to make the commitment."
Homophily (the extent to which two or more people who communicate perceive that they are similar)	"We do it in Spanish, with Roberto, who is a young gay who is recovered." "Well we tried that and it didn't work because they wouldn't listen to a straight guy."
Attribute (a characteristic of a program that may be perceived either positively or negatively)	"Everything is provided free of charge." "It's in Japanese because that's who we're trying to reach."
Adopter categories (classifications of individuals grouped on the basis of the relative time at which they adopt a new idea, technique, or process)	"The department's epidemiological data is very clear about who is still not practicing safe sex. It's the young gays, 20-year-olds, and the relapsing 35-40-year-old gay White males. So those are sets of people that we're trying to reach through these methods." "Well, you don't have to target everybody for a new idea like ours. Some people are just naturally going to pick it up and do it and talk about it and play with their partners."
Opinion leaders (people who are respected for their knowledge and reputation on some particular topic)	"We watch in bars and approach the guys who are the most popular." "Well, he's just such a good spokesperson for this because everybody really respects him because of what he's done for the Castro."

Table 2

Total Number and Mean Number per Program of Strategies Based on the Social Marketing and Diffusion of Innovations Concepts

Model and concept	All programs	More effective programs (n = 10)	Less effective programs (n = 9)
Social marketing concepts			
Program development	874	49.2	42.4
Audience segmentation	483	31.3	18.7
Resource management	434	25.8	19.5
Evaluation	345	18.0	18.3
Preprogram data gathering	88	4.2	5.1
Total	2,224	128.5	104.0
Diffusion of innovations concepts			
Communication channels	566	32.6	26.6
Program attributes	361	19.2	18.7
Homophily	161	10.6	6.1
Innovation-decision process	110	7.6	3.7
Opinion leadership	77	3.5	4.6
Adopter categories	4	0.4	0.0
Total	1,279	73.9	59.8
Overall total	3,503	202.4	163.8

You cannot just provide AIDS prevention to women. It's absolutely meaningless. . . . I have worked on outreach projects where we really didn't treat the women any differently than the men. We might as well have just stood out in the street and ripped up the money.

Gender, ethnicity, sexual orientation, drug use, and age were seen as particularly influential in the creation of messages and the reception of messages by the intended audiences. For most programs in which ethnicity was a targeting factor, history was extremely influential in program development and philosophy. One staff member at a program directed exclusively at Native Americans stated:

I focus on all the issues that have affected our survival as Native people. Going back to smallpox, TB and influenza epidemics and then follow that up to current issues that affect our survival, including having adapted to Western diets and relocation issues. I talk about emotional health of our people from being placed in the reservation system to the boarding school system. In the mental health work in our communities, I talk about this intergenerational institutionalization of the people that has resulted in substance and alcohol use. . . . And so it's relearning. . . . We work with people at different levels of acculturation.

Table 3

Total Number of Strategies Coded and Percentage of Dominant Subconcepts Coded

Concept	Total no. coded	% of total
Social marketing model		
Program development	874	
Attitude and behavior change		53
Place of promotion		23
Audience segmentation	483	
Sex		24
Age		19
Ethnicity		18
Resource management	434	
Personnel issues		65
Materials		19
Evaluation	345	
Process evaluation		41
Outcome evaluation		32
Formative evaluation		26
Preprogram data gathering		
Demographic data		51
Sociocultural data		31
Diffusion of innovations model		
Communication channels	566	
One to one, face to face		38
Small group		24
Innovation attributes	361	
Compatibility		69
Homophily	161	
Ethnicity		28
Sex		17
Age		14
Innovation-decision process	110	
Knowledge stage		50
Persuasion stage		16
Decision stage		12
Opinion leadership	77	
Community leaders		30
Friends		20
Family members		14
Adopter categories	4	

A Latino male described the effects of acculturation on HIV prevention efforts:

I can distinguish two different groups among the Spanish population here. One is the kids who were brought here by their families and they were raised here or they were born here. . . . They are more acculturated. They know the language. They're covered by most of the services. And there's this other population of kids who migrate by themselves from Latin America. Their education level is really low. And they don't speak English at all.

Choice of language was also important for programs working with immigrant populations. For some groups, using English was not a possibility. One Latino program made Spanish fluency a priority in hiring criteria because most of their clients were monolingual.

I speak Spanish, but I'm not a native Spanish speaker, and it's very important that Juan is involved in the project because Juan, he knows for Mexico City and there's a specific dialect there that the guys speak. That's kind of a working class slang that he knows. And there's also Central American dialect, and it's very important that there's some sort of bonding going on, because they obviously trust Juan in the sense that they say this guy talks like us.

Do the strategies of more and less effective programs reflect different social marketing and diffusion of innovations concepts? Quantitative analysis showed that the overall differences were not statistically significant ($r = .26$, $n = 19$, $p = >.05$). When each of the 11 social marketing and diffusion of innovations concepts were considered separately, administrators of more effective programs mentioned the homophily concept more often ($M = 10.6$, $SD = 4.09$, $n = 10$) than did administrators of less effective programs ($M = 6.1$, $SD = 4.56$, $n = 9$), $t(17) = 2.25$, $p < .05$. Table 2 shows the mean number of each type of model concept used by more and less effective programs.

The qualitative coding supported the quantitative finding that the concept of homophily was related to program effectiveness and that the concept of audience segmentation and the subconcept of compatibility (a program attribute) distinguished more effective from less effective programs. Homophily was viewed as critical to program success in many other areas, including sex, age, ethnicity, sexual orientation, drug use, and transgender. As was also demonstrated in the quantitative results, sex was mentioned by several organizations. One staff member stated that it was important for women to talk to women and men to men because

If I was out there, and if I saw a man and he started talking to me about safe sex, I would shy away from him. I would feel more comfortable talking to a woman, because we're both females and she would understand the issues that I'm talking about.

Age was also mentioned as an important factor, particularly by programs working with youth. The following passage illustrates this factor:

It was an intensive search to look for young people who would represent, you know, a good portion of the high-risk youth, that had been seen in terms of

what was seen at the local city clinic . . . a part of what it was when we were actually recruiting for these positions.

Matching qualities of personnel with their intended audiences was consistently seen as necessary for programs targeting ethnicity (Asian, Filipino, Latino, Native, and African Americans). Some programs only hired staff who matched the ethnicity of their intended audience. One Native American staff member commented that for Native Americans, "the majority won't talk to anyone that's not a Native. They won't open up." A program director addressed this:

I think this is pretty basic for us, the philosophy of Natives helping Natives, and we got 100% Native staff, 100% Native board, most of our volunteers are Native, and it's really about hearing the information coming from another Native gay man.

Within one Asian program, the use of homophily was expanding. One staff member told us, "We're hiring more and more from our target population, and from our peer educators, from our volunteers. From those ranks we're filling the staffing of the agency."

Sexual orientation was also frequently mentioned as an important factor in hiring staff members and was frequently mentioned in conjunction with other characteristics such as ethnicity or, in the following case, drug use:

We act on the principle that peer relationships are the only things that work. And the more marginalized you are the more important it is that people be like you when they approach you for any reason. So the men who work in our outreach program are all gay or bisexual men. Most are in recovery themselves so they understand what those issues are about.

Several programs we studied targeted IV drug users. All had staff members who had recovered from drug use themselves, some of whom had been homeless. The following passage reflects the stories we heard:

I went to AA [Alcoholics Anonymous] because of my addiction, and I have that experience because I was down and out, living on the streets, living in my car, and I was homeless at one point in my life. So, you know, I use that experience to reach out and help these individuals because I've been there. I know what it feels like, I've gone through that process of turning my life around. You know, even myself, I slept in old cars, and, uh, garbage chutes. I did everything, I lost everything I had.

A comparison of data from the three most effective programs and the three least effective programs suggests the importance of interorganizational collaboration. The three most effective programs (Figure 3, Nodes 1, 2, and 3) had significantly more collaborative links with other organizations ($M = 17.34$, $SD = 2.89$, $n = 3$) than did the three least effective programs (Nodes 29, 30, and 31; $M = 6.34$, $SD = 5.03$, $n = 3$), $t(4) = 3.28$, $p < .05$. Further, the three most effective programs also had more collaborative links with other HIV prevention programs in San Francisco ($M = 22.00$, $SD = 6.92$, $n = 3$), than did the three least effective programs ($M = 2.34$, $SD = 2.52$, $n = 3$), $t(4) = 4.62$, $p < .05$.

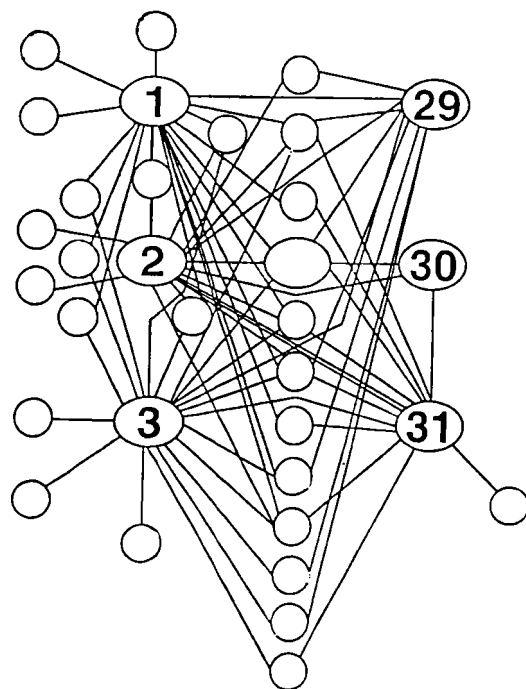


Figure 3. Collaborative network relationships for the three most effective (1, 2, and 3) and the three least effective (29, 30, and 31) programs studied. The 33 organizations shown are of the following types: Twenty are community-based organizations (CBOs), 4 are units of the San Francisco Department of Public Health, 2 are clinics, 2 are social service agencies, 2 are educational facilities, 1 is a for-profit organization, 1 is a hospital, and 1 is a religious institution. All three of the most effective programs (1, 2, and 3) are CBOs.

Interorganizational collaboration was one of the major themes identified in our qualitative coding. Program staff said they collaborated formally and informally with other HIV prevention staff as well as with the program staff of other types of local service organizations. Collaboration was perceived as a means of sharing limited resources and recruiting potential clients. Outreach workers sometimes collaborated in regularly scheduled support groups, which gave them an opportunity to share stories and experiences, ask for each other's advice, and coordinate geographic services to avoid overlap. Program staff saw interorganizational collaboration as a way to leverage their limited services into a larger help network for the benefit of their clients.

Discussion

Previous research on preventive health suggests that the most effective programs aimed at unique populations are community based, develop messages in the socioeconomic, cul-

tural, and linguistic terms that characterize such populations, and activate local opinion leaders and social networks to effect behavioral change (Bowles & Robinson, 1989). Did staff members of HIV prevention programs in San Francisco, where change agents are relatively far along the learning curve in knowing what works, develop messages in these ways? More effective HIV prevention programs in San Francisco did communicate messages in the socioeconomic, cultural, and linguistic terms that characterized their specific audiences. Janz et al. (1996) similarly found that designing culturally relevant and language-appropriate interventions and embedding AIDS interventions into broader social contexts facilitated intervention efforts. Yet other results suggest a finer specification of what works and why. Our respondents did not emphasize message content, which represents the thrust of most health behavior change literature. Our findings suggest that successfully communicating about HIV prevention with unique population members requires a nonjudgmental focus on relational access, development, and maintenance. The importance on relationships with clients can be understood by the ways in which staff at more effective programs attained cultural sensitivity through the use of strategies based on concepts of homophily (a perception of personal similarity between a change agent and unique population members), audience segmentation (carried out by staff members in preparation for beginning an intervention), and compatibility of the social product (i.e., HIV prevention interventions) with a potential adopter's perceived experiences, existing beliefs, and behavior. A combination of strategies based on these three concepts characterized the three most effective HIV prevention programs that we studied.

Program staff talked about concepts that are perhaps easiest to conceptualize: communication channels, the management of personnel, the demographics of communities, and the operating procedures of their HIV prevention programs. Strategies based on these concepts had a tangible basis. Opinion leaders and the social networks in which target audience members were embedded were used to effect behavior change, but only sparingly. Program staff understood the importance of using the social structure of their communities, but they tended not to use patterns of interpersonal influence already in place to effect behavior change. Similarly, program staff knew that a target audience member passes through such psychological stages as gaining knowledge about a new idea, seeking more information about it, deciding to use it, beginning to use it, and routinizing the new behavior into patterned behavior. But program staff seldom translated this appreciation of the innovation-decision process concept into a program strategy. For example, when the innovation-decision process was conceptualized and discussed by program staff, 50% of their emphasis was on the knowledge stage, with much less emphasis placed on the later stages when attitude and behavior changes occur. HIV prevention interventions were often directed at individuals without strategizing to use aspects of their social environment or their psychological readiness to make a behavioral change in the design of preventive health programs.

HIV prevention programs in San Francisco operated on the basis of personal experience, direct observations, and shared anecdotes of their program staff. Behavioral science models and theories were ignored or discarded because they might not precisely explain and predict target audience responses to a particular program. Our qualitative analysis suggests that staff members who were more effective in conducting HIV prevention programs used strategies based on social marketing and diffusion model concepts to a greater extent than did the staff of less effective HIV prevention programs, but our quantitative analysis did not. Strategies associated with *how* to communicate were more common than strate-

gies associated with *what* to communicate. Program staff did not emphasize strategies related to the content of change messages. Much as it did for Geertz (1973), culture meant context for our respondents.

More effective program staff recognized the value of collaboration and actively engaged in information sharing and pooling of resources. Program staff and administrators did not work in isolation, even in instances where they competed with each other for grant contracts and other resources. Organizational members were often personally invested in the communities they served and in providing HIV prevention services (Stevenson & White, 1994). Several of our 38 respondents disclosed to us that they were HIV positive. The lethal nature of HIV and AIDS is a compelling force for joint efforts, which often overrides organizational and program competition.

The ability to obtain funding in a competitive environment and the efficient management of resources influenced the quality of HIV prevention programs. CBOs operated the majority of HIV prevention programs in San Francisco, including the more highly targeted programs. These nonprofit, nongovernmental organizations mainly existed through external funding. Much emphasis was therefore placed on organizational maintenance through resource management strategies, particularly on issues related to personnel.

The present study has limitations. We expect that with a larger sample size (we compared data from 10 more effective programs with data from 9 less effective programs), statistically nonsignificant results that approached statistical significance for three social marketing concepts (audience segmentation, resource management, and program development) and two diffusion of innovations concepts (communication channels and the innovation-decision process) would be statistically significant when comparing more and less effective prevention programs. Also, our goal was not to measure outcome or impact effectiveness through the collection of data from the clients of prevention programs. Our operationalization of program effectiveness was based on a novel 15-item measure of process effectiveness, which allowed us to compare *across* programs. This first step in the development and testing of a comparative process effectiveness score is important because in the everyday world of program funders and administrators, process criteria are used regularly to decide the relative worth of programs that usually are not compared because they have different goals and classes of outcomes. Still, good process data are never as persuasive as good outcome data. Future research comparing preventive health strategies across programs that diverge in methods and procedure should move toward measuring comparative outcome effectiveness by gathering data about the perceptions of target audience members, a task beyond the scope of the present study.

Implications for Action

Unique populations are an increasingly important focus of public health activities and research, one that is vital for achieving U.S. Public Health Service goals of healthier Americans, less disparity among populations, and better access to preventive services (U.S. Department of Health and Human Services, 1990). Program funders, program designers and staff, and health policymakers in many other cities and countries wish to learn and apply lessons learned from the San Francisco experience with HIV prevention to stop the spread of AIDS. They look to San Francisco because this city was one of the places in which the epidemic was first discovered and in which it has been concentrated since 1981 and because San Francisco has been notably successful in slowing the rate of HIV infection. Since the 1981–1988 period, when almost half of the gay population of the

city was infected with HIV, the rate of new infections has decreased sharply and the total number of infected individuals has plateaued. On the basis of our research, what should be emphasized in communicating with unique population members?

1. Strategies based on homophily, audience segmentation, and compatibility should be emphasized by program staff when the goal is to create prosocial programs or campaigns for communicating preventive health to members of unique populations. For unique populations, the social marketing concept of audience segmentation identified the target audience. The diffusion of innovations concept of homophily was applied by preventive health program staff who relied on face-to-face communication. The diffusion subconcept of compatibility (like the social marketing emphases on formative evaluation and program development) matched messages with client expectations and experiences. As clients reacted to prevention messages, the change agent or paraprofessional modified her or his portrayal of the prevention messages during conversations to find the fit between the client's world—his or her needs and wants—and the preventive program.

Conversely, extant conditions in CBOs and in local-government public health agencies deemphasized resource-intensive concepts such as consumer-based research and pre-program data gathering, personnel and resource management, and integrated formative, process, and outcome evaluation designs, even though these concepts may be critical components of large-scale programs and campaigns aimed at general audiences.

2. Being sensitive to the on-the-street, survival-oriented, real-world complexity of program clients determines how, why, when, and where a client responds in a desired direction to a message about healthy behavior. Staff persons of more effective HIV prevention programs sought an insider, rich understanding of the context of health promotion and behavior change. They strove to establish a relationship based on trust as a necessary antecedent to communicating about health with unique population members. That is, the context of the staff-client relationship was more critical to successful health promotion than was the pro-health message when the target population was highly ostracized.

3. To maximize the potential of reaching unique population group members, face-to-face communication should be the primary channel through which HIV prevention information is communicated. Where possible, multiple communication channels should be used to reach audience members. Specialty or minimedia such as local newspapers or bar skits can be added to other means of communication to increase the likelihood of getting the message across to audience members.

4. One essential quality of the San Francisco model for HIV prevention is a nonjudgmental approach. Prevention program staff were careful not to imply to their target audience that injection drug use, commercial sex work, or promiscuity were undesirable. Instead, program staff sought to develop rapport with injection drug users, commercial sex workers, and others who are at risk so that the likelihood of HIV infection was decreased. Program efforts to change the behavior of their target audience would have been less effective if the staff of these HIV prevention programs had been judgmental.

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HIV Prevention Community Planning: Shared Decision Making in Action

Background

In December 1993, the Centers for Disease Control and Prevention (CDC) issued a new program guidance requiring HIV prevention community planning. The guidance was issued to the 65 health departments that receive federal HIV prevention funds. The new community planning process outlined in the guidance was, in part, a response to a general convergence of expert opinions in the early 1990s that publicly funded HIV prevention programs needed to improve in their ability to target interventions to those most at risk.⁽¹⁾ The country had nearly a decade of experience in implementing HIV prevention programs, evaluation studies were yielding informative results, the general knowledge and understanding of what works in HIV prevention was maturing, and infrastructure and capacity-building efforts were making progress toward institutionalizing HIV prevention efforts. This collective awareness on the part of governmental and nongovernmental organizations at the local, state, and national levels of the need to strengthen HIV prevention efforts focused on five critical areas: needs assessment, scientific foundation, comprehensiveness, involvement of affected communities, and local (rather than federal) planning.

CDC worked with a wide range of prevention partners to determine how best to address these needs, thereby strengthening the nation's HIV prevention program. With the input and support of partners, CDC initiated a major paradigm shift in the planning of HIV prevention programs when it issued the community planning program guidance. During 1994, all state and local health departments that received federal HIV prevention funds began convening HIV prevention community planning groups to help plan locally relevant HIV prevention programs.

The goal of community planning, then and now, is to improve the effectiveness of HIV prevention programs by strengthening the scientific base, community relevance, and population or risk-based focus of prevention interventions. This planning is accomplished by bringing together, at a level as close to the epidemic as possible, representatives of affected populations, epidemiologists, behavioral/social scientists, HIV/AIDS prevention service providers, health department staff, and others. Their tasks are to analyze the course of the epidemic in their jurisdictions, assess prevention needs,

prioritize populations and prevention needs, identify science-based HIV prevention interventions to meet these needs, and develop comprehensive HIV prevention plans that are directly responsive to the epidemics in their jurisdictions. The health departments then base their applications to CDC for federal HIV prevention funds on the priorities identified in these plans. The HIV prevention plans are intended to be comprehensive, going beyond those activities funded with CDC prevention funds and serving as a guide for all prevention efforts in the jurisdictions—federal, state, local, and private.

Prior to community planning, decisions about funding and HIV prevention programs were determined primarily at the state and federal levels. CDC guidance had encouraged jurisdictions to seek input from community members and scientific experts in the development of prevention programs. Some jurisdictions did so, but this was a relatively minimal effort compared to what is required now through community planning.

In 1993, the concept and principles of community planning were received enthusiastically. During the early years of implementation, health departments; national, regional, and community-based organizations; and the federal government committed human and fiscal resources to supporting the implementation of the new planning process.

CDC developed a technical assistance network—a collaboration between nongovernmental and private organizations to develop materials and trainings and to provide face-to-face technical assistance for health departments and community planning groups as they began to convene groups and tackle the tasks of planning. Also, each year since 1994, CDC has carefully monitored the implementation of the process nationwide.

In 1998, community planning is entering its fifth year of implementation, and, not unexpectedly, a critical transition phase. Although essential to the development of effective HIV prevention programs, collaboration between HIV prevention providers and consumers in assessing needs and planning programs is inherently challenging (2). With 4 years of experience, the initial ambitious expectations for the community planning process are evolving into more realistic and grounded expectations. The optimism and hope for immediate positive results have been tempered by the realities imposed by the need for more time and effort to implement an optimal process in every jurisdiction. Community planning group members are coming face-to-face with the difficult tasks of analyzing trends in their local epidemics and applying various sources of data in multi-attribute decision-making among persons with diverse backgrounds. As populations most affected by the epidemic shift, community planning groups must identify, recruit, and train new members that are representative of the shifts, as well as maintain current representatives. Responding to emerging trends requires additional needs assessment and further review of prevention priorities. Shifts in priority target populations requires shifts in funding. Understandably, these discussions are often controversial and easily politicized.

As community planning continues to evolve, CDC seeks to assemble, in this document, a summary report of the state of community planning across the country, highlighting both strengths and weaknesses, and assessing its impact to date on HIV prevention programs. This document also will propose a vision for the future of community planning.

Current Status of HIV Prevention Community Planning

Since 1994, HIV prevention community planning has undergone numerous evaluations and assessments (3). CDC established five core objectives in 1994, revised slightly in 1995, that synthesize the critical elements of community planning. CDC has used these five core objectives to monitor the nationwide implementation of the process. A number of other organizations have assessed and written about implementation of the process (4). This paper draws from all these sources.

In general, the state of community planning across the country continues to be strong. The most extensive assessment of progress is CDC's annual external review of HIV prevention cooperative agreement applications and the comprehensive HIV prevention plans. Annually, the 65 jurisdictions receiving federal HIV prevention funds (50 states, 6 cities, 7 territories, the District of Columbia, and Puerto Rico) must submit to CDC a progress report on the past year's activities and proposed activities for the upcoming year. Overall findings from the majority of these assessments (not including 6 or 7 territories, depending on the year) are provided below:

Overall Findings From External Review of HIV Prevention Applications and Plans Submitted for Years 1996-1998

Status	1996 (58 applications reviewed)	1997 (58 applications reviewed)	1998 (59 applications reviewed)
Jurisdictions making good progress in implementing community planning and in compliance with the principles described in the CDC guidance document	38(66%)	52(90%)	52(88%)
Jurisdictions making adequate progress, but experiencing some difficulties and needing specialized technical assistance	17(29%)	4(7%)	3(5%)
Jurisdictions out of compliance with CDC guidance, with 25% of prevention funds restricted until they take specific steps to bring their process into compliance	3(5%)	2(3%)	4(7%)

In 1998, as community planning entered its fifth year, CDC further "raised the bar" around its expectations for progress in meeting the principles of community planning. To accomplish this, CDC began to focus on three questions, in addition to its ongoing attention to group composition and process issues. The three questions are:

- (1) Are the priority populations and recommended interventions identified in the comprehensive HIV prevention plan consistent with the epi profile, needs assessment, and behavioral/social science data presented in the plan? Is there internal consistency?
- (2) Are the health department's prevention program activities and budget consistent with the plan?
- (3) Are any discrepancies adequately justified?

Despite "raising the bar," the community planning process fared very well in many jurisdictions in the 1998 external review.

What is the Structure of Community Planning and Who Makes Up the Groups?

Core Objective 1	Foster the openness and participatory nature of the community planning process
Core Objective 2	Ensure that the community planning group reflects the diversity of the epidemic in its jurisdiction, and that areas of expertise, as outlined in the guidance (e.g., epidemiology, behavioral science, health planning, evaluation) are included in the process

Recruiting, orienting, training, and maintaining membership that meets the CDC guidance requires a great deal of ongoing effort from health departments, community planning groups, and other partners. Numerous evaluation activities have documented a real commitment by health departments to opening the decision-making process and to welcoming input from community representatives. Concurrently, at-risk communities have worked to overcome histories of distrust and responded to the call to participate. Relationships between health departments and communities have improved as a result of working together. As planning groups experience the important contributions of diverse perspectives, they acknowledge the need to do even more in this area.

Structure

As jurisdictions have experimented with the best structure for community planning in their area, there has been a decrease in the total number of community planning groups responsible for developing plans, reviewing the prevention application, and signing letters of concurrence/nonconcurrence.

**Total Number of Community Planning Groups Reported by Jurisdictions by Year,
1996-1998**

Year	Local	Regional	State	Total
1996	31	110	41	182
1997	9	79	43	131
1998	7	67	46	120

Other Groups Providing Input to the Community Planning Group, 1998

Year	Local	Regional	State	Total
1998	81	121	14	216

At the same time, based on reports by CDC project officers, the number of county, regional, or other groups that provide regular input to the community planning group (not including subcommittees or workgroups of the community planning groups) is increasing. Although not asked in 1996 or 1997, the 1998 applications indicated that jurisdictions convened 216 additional groups on an ongoing basis to provide regular input to the community planning group.

Jurisdictions tend to prefer the option of convening numerous local, regional, and other groups that provide input to a centralized community planning group. This opens the process to more people, without demanding of each local or regional group the financial and logistical support necessary to meet CDC guidance. Also, the prominent trend of establishing subcommittee structures within community planning groups to accomplish the tasks of community planning opens the process to more people, seems to be efficient, and indicates trust and solidarity among group members.

In terms of geographic representation, the external reviewers noted that 46 jurisdictions (78%) had a community planning group structure that assured geographic representation throughout the jurisdiction.

CDC conducted an in-depth analysis on 50 of the 65 applications and plans for 1998, and abstracted specific information relevant to the composition, structure, and processes of community planning groups across the country. The abstracted information was retrieved only from the written information provided by 50 jurisdictions to CDC. Jurisdictions were asked to complete a grid that provided data (demographics, expertise, etc.) on the membership of the community planning group. Of the 50 jurisdictions, 42 completed the grids in a manner that could be analyzed, with a total of 1,118 reported planning group members. Of the members providing geographic information, 514 (67%) represented urban areas and 253 (33%) represented rural areas.

Coordination with other program planning activities, such as STD and TB prevention programs and Ryan White planning councils and consortia, has steadily increased since 1994. Coordination efforts include merged planning bodies, shared members, shared health department staff, or shared information, such as epidemiologic profiles, needs assessments, and the comprehensive plan. **However, continued efforts at coordination are needed.** In the in-depth analysis of 50 1998 applications, 31 (62%) reported they had established mechanisms for coordinating with Ryan White planning councils/ consortia; 26 (52%) with STD activities; 15 (30%) with TB Control; and 21 (42%) with other planning activities in their jurisdictions. Further evidence of coordination with Ryan White planning groups is that 45 jurisdictions (90%) have plans for linking primary and secondary prevention services.

Who Makes Up the Groups?

Each year since 1994, community planning groups have improved the diversity and expertise represented on their groups. These improvements represent tremendous efforts to recruit, orient, train, and retain appropriate membership. CDC commends groups across the country for their dedication and efforts in this area. Yet, these efforts need to continue.

Youth Representation

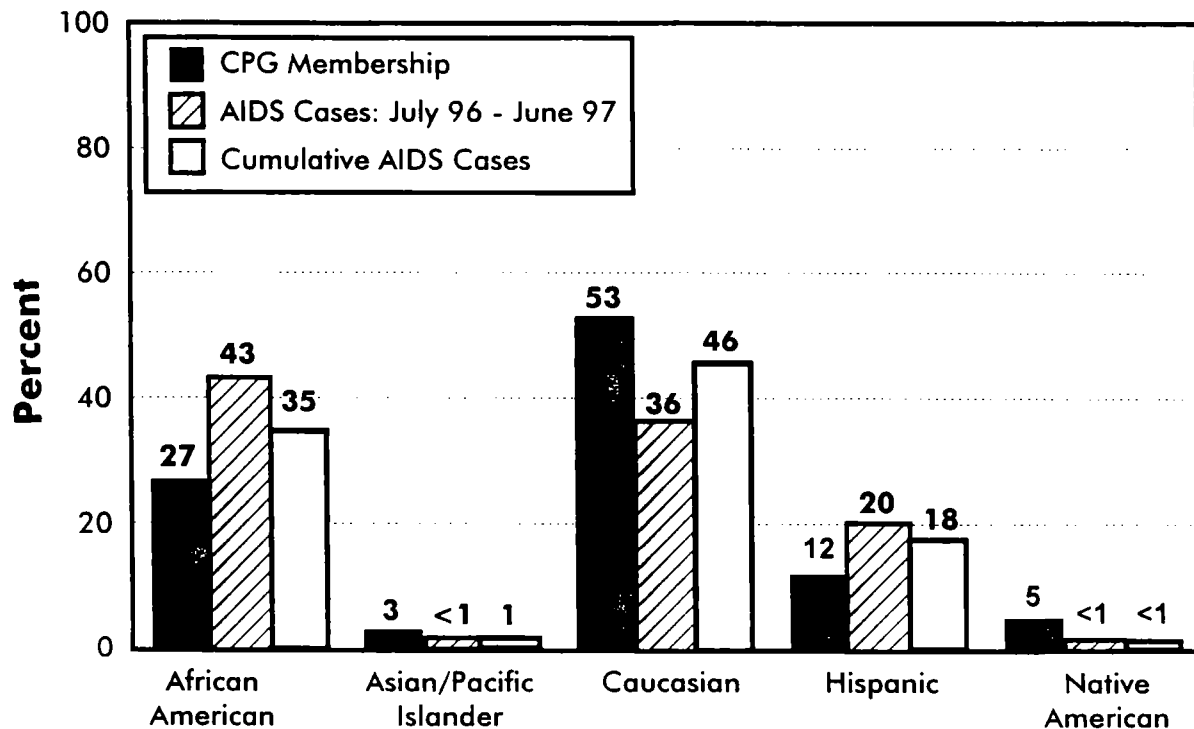
Of the 1,118 community planning group members for which demographic information is available to CDC, youth (under 24 years of age) representation continues to remain low at 50 (5%) of the planning group members. Twenty-one jurisdictions (50%) report having at least one member aged 18-24. Individuals aged 25-64 are well represented on community planning groups with a total of 645 members (92%) reported in this age group.

Racial/Ethnic Representation

Although steadily improving, minority racial/ethnic representation continues to need attention. Of the 1,064 members reported by race/ethnicity, Caucasians represent 53%; African-Americans, 27%; Hispanic/Latino, 12%; Native Americans/Alaskan natives, 5%; and Asian Pacific Islanders, 3%. For comparison purposes, cumulative reported AIDS cases and AIDS cases for July 1996 through June 1997 by race/ethnicity are provided in the graph on page 7.

Minority racial/ethnic representation varies by individual jurisdiction, with many jurisdictions reporting diverse and representative membership. **Yet, clearly there are community planning groups that need to identify specific steps for aggressively recruiting needed representative membership, especially African Americans, Hispanics, and young people.**

Racial/Ethnic Representation, 1998



Transmission Risk

Data reported by jurisdictions on the sexual identity of 811 community planning group members revealed that 261 (32%) of community planning group members self-identify as homosexuals; 30 (4%) as bisexuals; and 10 (1%) as lesbians. Heterosexual membership is high with 510 (63%) of the total reporting membership.

Data on self-reported risk is low in that such information was provided by only 389 members. Understandably, community planning group members are not always willing to disclose personal information for public purposes. Persons living with HIV/AIDS compose the largest percentage of members reported for self-identified risk, with 178 members (45%). In addition, 39 jurisdictions (93%) reported having members who are living with HIV/AIDS; 27 (64%) reported representation from injecting drug users (IDUs) or former IDUs; 22 (52%), gay men of color; and 15 (36%), sex workers or former sex workers.

Gender

The 1,041 members reporting gender, indicated that representation of males and females on community planning groups across the country is about equal. Nine members (1%) self-identify as transgendered persons.

Epidemiology and Behavioral/Social Science

The involvement of persons with expertise in epidemiology, behavioral/social science, evaluation, and health planning also appears to have improved. This is further confirmed by evidence that scientific theory and data appear to be driving the decisions of planning groups. Twenty-eight jurisdictions (67%) report having individuals with epidemiologic expertise serving on the planning group, and 34 (81%) report behavioral/social science expertise

on the group. Of the total planning group members reported by expertise, 47 (6%) reported expertise in epidemiology; 66 (8%) in evaluation; 11 (13%) in behavioral /social science; 297 (36%) in community expertise; 117 (14%) in health planning; and 57 (7%) in group process.

In most jurisdictions, epidemiologists are involved and have worked to provide the data needed by community planning groups. In many cases, they are not members of the group, but work with the group to develop and interpret the epidemiologic profile.

Over the past 2 years, the need for more involvement by behavioral/social scientists has been highlighted. Although this need still exists, the external reviewers noted improvement in this area.

Forty-seven jurisdictions report using mechanisms other than official membership on the group to get input from people who reflect the diversity of the epidemic as well as to ensure that appropriate expertise is included in the process. Community planning groups are using a wide variety of mechanisms to facilitate participation of members. Additional models are needed to engage essential perspectives in the development of the comprehensive HIV prevention plan.

A national technical assistance providers network supported by CDC is available to assist community planning groups in achieving appropriate representation to reflect both the scope of the epidemic and appropriate expertise on community planning groups. The number of requests for technical assistance has more than doubled since the first 2 years of community planning. The most recent focus of this technical assistance has been to identify local experts who understand the context and nature of local planning issues and can work as a resource for planning groups on an ongoing basis. Forty-nine jurisdictions (98%) received technical assistance during the past year, and 45 (90%) indicated they have identified needed technical assistance in the upcoming year.

What are Community Planning Groups Doing?

Core Objective 3 *Ensure that the priority HIV prevention needs are determined based on an epidemiologic profile and needs assessment (including community sources of information)*

Core Objective 4 *In the prioritization of interventions, ensure that explicit consideration is given to the priority needs, outcome effectiveness, cost effectiveness, theory, and community norms and values*

Epidemiologic Profiles and Needs Assessments

Community planning groups have collected, refined, and analyzed large amounts of data and are using this information as the foundation for their decisions and to direct their planning efforts. The external review indicated that in 48 (81%) of 59 jurisdictions, the priority populations and recommended interventions in the comprehensive plan were consistent with the epidemiologic profile, needs assessment, and behavioral/social science data

presented in the plan. In addition, the reviewers noted real progress in evidence-based priority setting. They were able to see the clear, logical use of evidence from the epidemiologic profile and needs assessment in determining prevention priorities.

However, there must be continued emphasis on interpreting and logically applying data in the decision-making process. The epidemiologic profile is noted by external reviewers to be the strongest part of the comprehensive prevention plans. But there are variations in the quality of the profiles, especially around appropriate use of certain data sets. **The epidemiologic profile is a crucial source of information for identifying high priority populations.**

Having data on values, norms, and consumer preferences also is critical in selecting interventions. The acceptability and cultural relevance of interventions is directly related to their effectiveness. The external reviewers noted tremendous variability in the quality of needs assessments. More technical assistance and models are needed in this area.

Prioritization

In setting priorities, 34 jurisdictions (68%) are considering all six of the required criteria (documented needs, outcome effectiveness, cost effectiveness, scientific theory, consumer preferences, and the availability of other resources). **Cost effectiveness is the least-often considered criteria in the priority-setting process.**

It is important to acknowledge that priority setting is a difficult decision making process, one that requires attention to multiple criteria and needs. This process also asks that planning groups make difficult decisions that may result in shifting financial support from one group to another. Priority setting remains the core objective with the highest number of technical assistance requests. It is clear that when community planning groups have an agreed upon methodology that everyone understands, then the prioritizing process runs more smoothly. Additional priority-setting models and information on cost effectiveness are needed.

Forty-eight jurisdictions (96%) are clearly identifying in their plans the priority populations in need of HIV prevention services. However, the populations are defined in very different ways (e.g., gender, risk behaviors, ethnicity, or sexuality) and range from very general definitions (women) to very specific, complex descriptors (African-American men who have sex with men in public sex environments).

An assessment of specific priority populations in need of prevention services (men who have sex with men [MSM], injecting drug users [IDU], women, ethnic minorities, and youth) revealed that 47 jurisdictions (94%) place MSM among the five highest priority groups; 10 (20%) of these jurisdictions place ethnic minority MSM among the highest five. Of these 10 focusing on ethnic minority MSM, 5 jurisdictions specifically target services for African American MSM and 2 for Hispanic/Latino MSM.

Thirty-seven jurisdictions (74%) rank IDU and 29 (58%) rank women among the five highest priorities; four of those targeting services to women specifically focus on racial/ethnic minority women.

Racial/ethnic minority populations are identified as highest priority in 23 jurisdictions (46%) and youth in 29 jurisdictions (58%).

An analysis of budget allocations (pages 10-13) reveals that concordance between reported AIDS cases and funded prevention interventions should be strengthened. However, there is a strong limitation in attempting to analyze concordance. State or local resources may be addressing specific needs and they are not accounted for in this budget analysis of CDC funds.

Forty jurisdictions (80%) prioritize specific prevention interventions for each priority population. The interventions most often prioritized for MSM are group-level interventions (71%), individual-level interventions (68%), and outreach (67%) and community-level interventions (67%). Interventions prioritized for women are group-level interventions (67%); counseling, testing, referral, and partner notification (CTRPN) (60%); and individual-level interventions (53%). For youth, prioritized interventions include outreach (73%), group-level interventions (67%), and individual-level interventions (53%). Interventions for racial/ethnic minority populations include individual-level interventions (62%), community-level interventions (56%), and group-level interventions (50%). Interventions for IDU include outreach (79%), individual-level interventions (71%), and community-level interventions (52%).

How is Community Planning Affecting HIV Prevention Programs?

Core Objective 5 **Strive to foster strong, logical linkages between the community planning process, plans, applications for federal funding, and allocation of HIV prevention resources.**

Programs

Community planning has had a positive effect on HIV prevention programs. Health departments are implementing the priorities identified by HIV prevention community planning groups. The external reviewers noted that in 53 (90%) of 59 jurisdictions, the target populations and interventions in the federal application are the same as those in the comprehensive plan. Of the 59 applications, 57 contained letters of concurrence from the community planning group, indicating that the health department and planning group had collaborated on the development of the plan and that the application reflected the priorities in the plan.

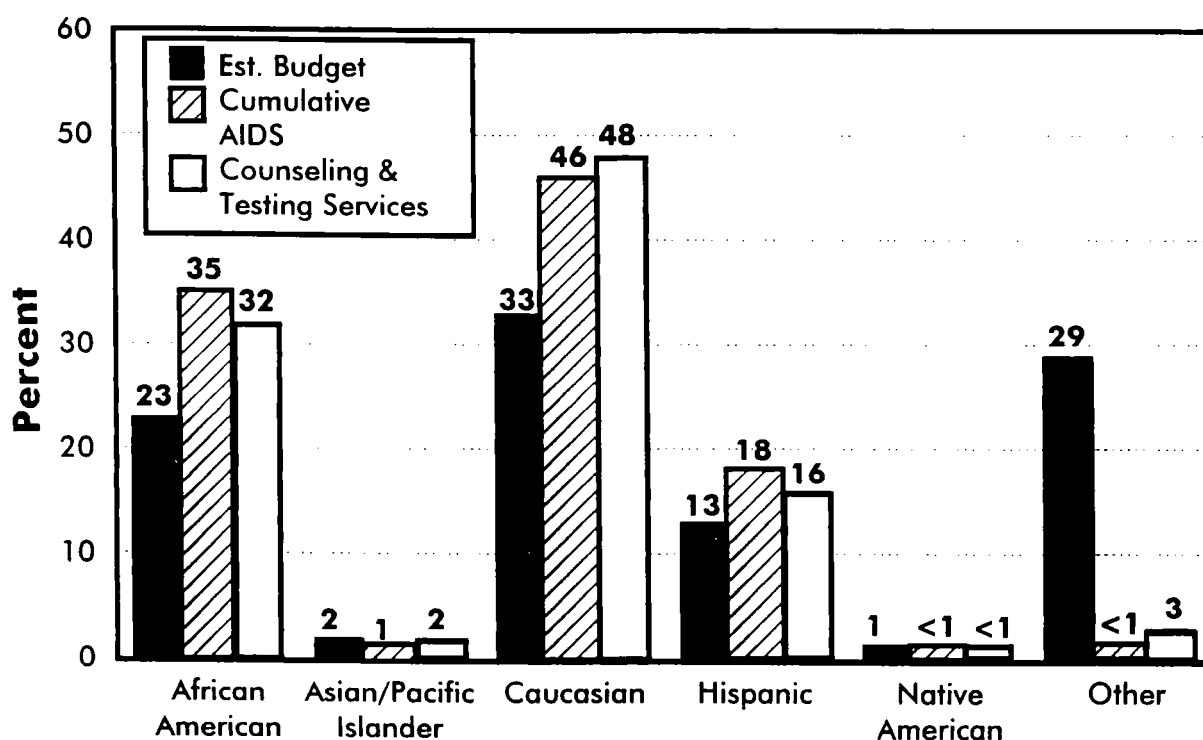
Budgets

Jurisdictions completed budget tables on the estimated expenditures of CDC funds in 1996 and 1997. The budget tables project allocation of federal funds in response to the priorities identified by community planning groups and thereby provide some indication of the impact of community planning.

An interesting comparison has been made of 1993 HIV prevention budgets (developed when federal funds were awarded by programmatic category and before implementation of community planning) to estimated 1996 and 1997 budgets (developed after categorical funding requirements were lifted and during the 3rd and 4th years of community planning). This comparison indicates that while \$102 million (65%) of the total HIV prevention cooperative agreement award was allocated to counseling, testing, referral, and partner notification (CTRPN) activities in 1993, this was reduced to 37% in 1996 and to 36% in 1997. Health education and risk-reduction activities increased from 23% in 1993 to 37% in 1996 and 39% in 1997. Public information activities decreased slightly from 5% in 1993 to 4% in 1996 and 3% in 1997. The amount of funds contracted to community-based organizations increased by 74% between 1993 and 1997.(5)

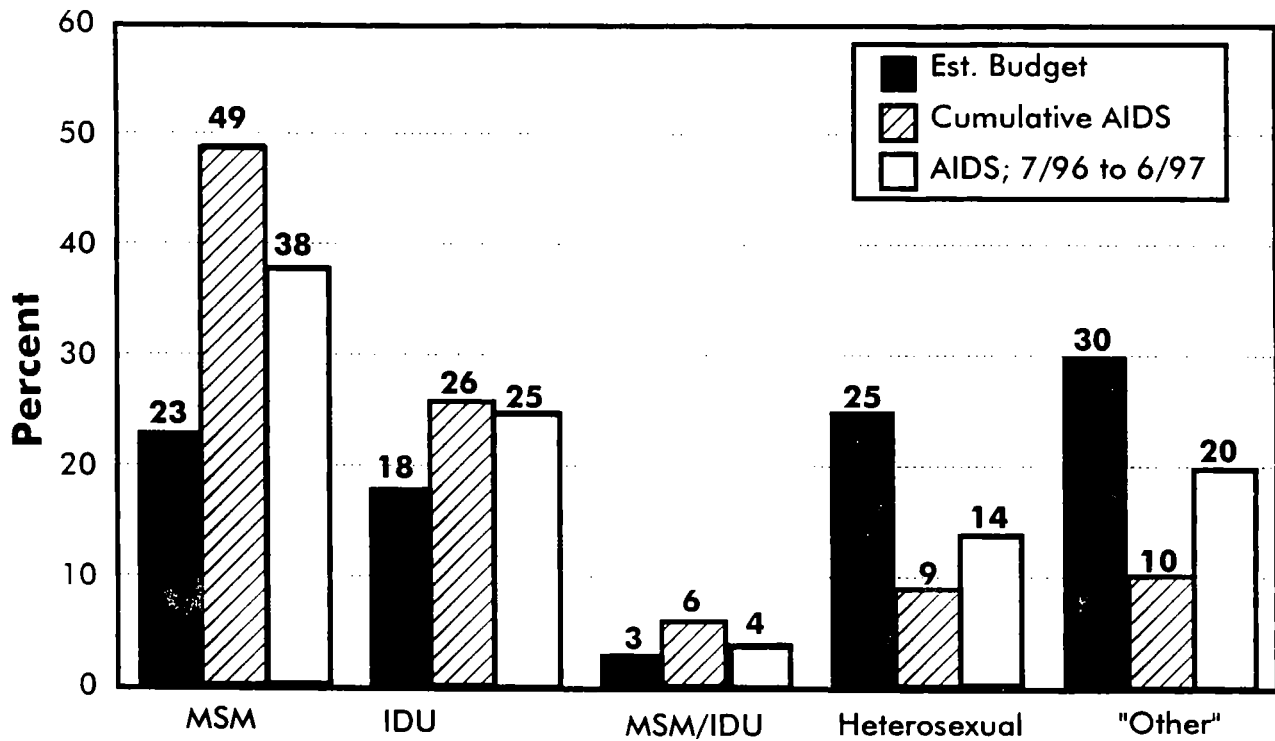
In 1997, jurisdictions estimated that \$92,379,227 (36% of the total cooperative agreement awards) was allocated to CTRPN activities. Of this amount, 33% was targeted to Caucasians; 23% to African Americans; 13% to Hispanics; 2% to Asian/Pacific Islanders; and 1% to Native Americans. Twenty-nine percent was not targeted by race/ethnicity. By risk categories, 28% targeted heterosexuals; 14%, IDU; 13%, MSM; 3%, MSM/IDU; and 42% was not targeted by risk category.

CTRPN by Race/Ethnicity and Service Delivery Statistics

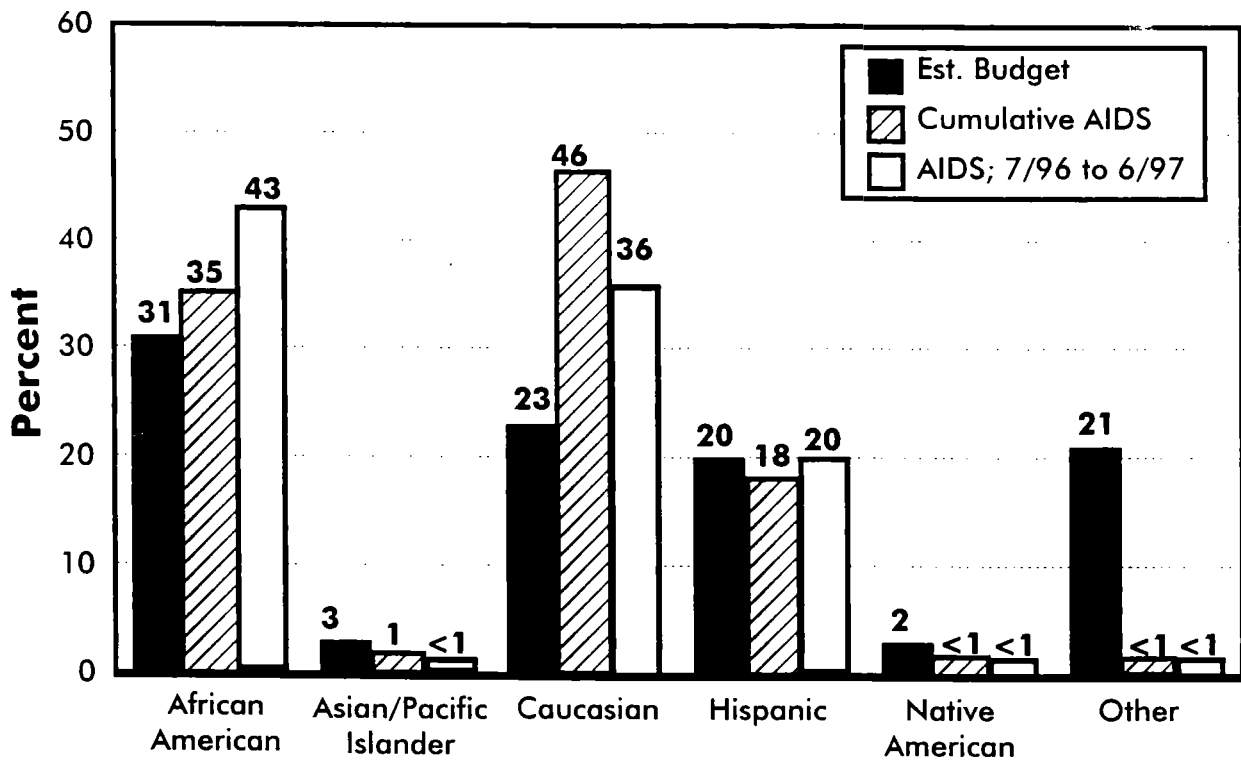


A total of \$98,539,316 (39% of the total cooperative agreement awards) was allocated to health education and risk-reduction (HE/RR) activities. For these activities, 31% was targeted to services for African-American populations; 23%, Caucasians; 20%, Hispanics; 3%, Asian/Pacific Islanders; 2% Native Americans; and 21% was not targeted by race/ethnicity. By risk categories, 25% targeted heterosexuals; 23%, MSM; 18%, IDU; 3% MSM/IDU; and 30% was not targeted by risk category.

HE/RR by Risk Category



HE/RR by Race/Ethnicity



Jurisdictions estimated that \$60.5 million (24% of the total cooperative agreement award in 1997) was targeted to services for youth, with 30% for African-American youth, 16% for Hispanic youth, 3% for Asian/Pacific Islander youth, and 1% for Native American youth.

This level of reporting on estimated expenditures of HIV prevention funding represents tremendous progress, however, the amount of funding that was not targeted by HIV exposure or transmission risk or by race is too high. A total of \$47.9 million (19%) is not accounted for by any of the categories. This is, in part, a result of programs that are targeting more than one risk or racial/ethnic population. But more clarity and focus in prevention activities eventually will reduce the amount of funds in this category.

Prevention allocations are not yet mirroring the epidemic in terms of race/ethnicity or transmission risk. Based on current estimated allocations provided by health departments, there is too much discrepancy between populations affected by HIV/AIDS and populations receiving HIV prevention services. Across all racial/ethnic and risk categories, community planning is pushing better targeting of prevention resources. But, progress towards targeting of resources needs to continue, especially for African American and Hispanic populations and men who have sex with.

The Future of Community Planning

CDC Commitment

CDC strongly supports the principles of HIV prevention community planning and is committed to evaluating and strengthening the process. The goal of community planning, as developed in 1993—to improve the effectiveness of HIV prevention programs by strengthening the scientific base, relevance, and focus of prevention interventions and by promoting representative community input—is still critically important. The community planning process provides a mechanism for carefully assessing the HIV/AIDS epidemic in a particular jurisdiction and determining the best array of interventions to prevent further transmission. Planning groups that are close to the epidemic in their jurisdiction, and are carefully monitoring it, can identify changing needs early and respond to them quickly. The groups are a vital link in the translation of prevention research into prevention program design and development. There currently is no better model that ensures community input and development of local, evidence-based responses to local epidemics. The planning of prevention programs has come a long way from the earlier federally mandated approach.

Each year, the process has evolved and improved. Groups have moved along the planning continuum, improving each step in the process and building on it to enhance the next step.

The planning is effecting prevention programs. Jurisdictions and community planning groups report that community planning has resulted in

- better targeted prevention programs,
- increased attention to evaluation of activities,
- improved coordination among programs,
- shifts in funding from lower- to higher-priority populations,
- increased funding to community-based organizations,
- changes in health department staffing, and
- changes in community roles and relationships.

Many jurisdictions are using the planning process to determine priorities for funds and programs beyond the HIV prevention cooperative agreement, and the comprehensive plans are being requested and used by organizations outside of the health department. Congress has indicated its support of community planning by appropriating a total of \$88.5 million additional dollars to HIV prevention since 1994.

Challenges to be Faced

Yet, there are clearly challenges to the process.

We need to redress budget discrepancies. The information gleaned from the 1997 budget tables provides a baseline from which to measure progress. Based on the budget allocations reported by health departments, there is discrepancy between populations impacted by HIV/AIDS and populations receiving HIV prevention services. The allocation of state or local resources, not accounted for in the federal budget tables, may affect this conclusion. We urge health departments and planning groups to carefully compare the epidemic in the jurisdiction to the planning group membership, the identified priority prevention needs, and the allocation of prevention dollars and to address any discrepancies.

We need to address criticisms of community planning. CDC still firmly supports the goal and principles of community planning. It is an ambitious process, but one which has begun to improve the science base and targeting of prevention interventions. It is also a process which is still evolving. Certainly we need to hear criticisms and concerns that people have about the planning process. But too often both criticisms and endorsements are broad and general in nature. To be effective, criticisms, concerns, and praise about community planning must be specific and clear. We must not assess the process with sweeping negative or positive statements, but base all comments on data and specific information.

Health Departments and community planning groups must continue to focus on the overall goal of improving prevention programs. Community planning is not an end unto itself, but instead is a planning process to improve prevention programs. By focusing on the goal, jurisdictions can avoid getting mired in the process of planning.

Community planning groups need to answer the "because" question. Planning group members should be able to clearly articulate *why* they have prioritized specific interventions for specific populations, and cite specific evidence that led to the decisions.

In an era of new testing technologies and improved treatments, the critical need to implement effective prevention interventions and to link with medical services must not be

lost. **Effective community planning can keep the spotlight on prevention needs and help ensure that the best possible prevention services are provided.**

We must commit to allocating the time and resources necessary to recruit and maintain representative membership and needed expertise. The community planning membership grids, like the budget tables, provide a baseline from which to measure progress. There continues to be a need to recruit members of at-risk groups to participate in the community planning process. This is especially true for young people, African Americans, Hispanics/Latinos, and men who have sex with men.

After a representative membership has been recruited, the issue of membership turnover has challenged most jurisdictions. HIV prevention community planning is complicated and time consuming. **For members to stay engaged, they should be empowered to own the process, to believe they are having a direct impact on programs and contributing directly to reducing HIV transmission.** Assessments have shown certain common elements among those groups that have maintained consistent membership and accomplished their tasks. These elements are that the members have (1) a clear understanding of the overall goal of community planning, (2) a common understanding and agreement on their roles and responsibilities and the procedures for making decisions, and (3) a belief that their work is having an impact. This requires

- assessing roles and responsibilities regularly to ensure common understanding and to evaluate their applicability,
- involving the group in meaningful tasks,
- providing groups with the information necessary to make decisions,
- updating groups regularly on the results of their decisions, and
- developing a range of flexible, task-specific activities that make participation more accessible and rewarding.

It is also critical to emphasize the overall goal of improving HIV prevention interventions for all at-risk communities. Community representatives, in addition to representing their communities, should participate as group members in objectively weighing the priority prevention needs of the jurisdiction as a whole.

We must better document and market the benefits and improvements resulting from HIV prevention community planning. To do this, we need better systems for monitoring and accounting for the impact of community planning. These systems should assist in identifying successes, but also in detecting problems that need immediate attention. Although 52 of 59 jurisdictions are making good progress, 4 jurisdictions are out of compliance, and 3 need specialized technical assistance to help them overcome specific obstacles. Depending on circumstances, jurisdictions may cycle in and out of difficulties with community planning. Better systems for monitoring and accounting could assist in early detection of problems and preventive actions.

It is essential that we look at prevention and care as complementary activities in an important continuum of services. Working together, prevention and Ryan White planning groups can design this continuum, ensuring consistent engagement with HIV-negative and HIV-positive persons.

Technical assistance to support the community planning process is critical. Technical assistance should be flexible to meet changing needs, relevant to a specific jurisdiction and its issues, easily accessible, and ongoing. It should be seen as a useful resource available to planning groups. Technical assistance providers can help in determining trends in needs and in developing tools to meet the needs. For example, it is clear that models of needs assessments and priority-setting methodologies should be identified and shared. More information on cost effectiveness should be made available. Access to peers on groups across the country should be improved. Peers sharing information and lessons learned with one another is a valuable resource. CDC currently is working with COSMOS Corporation to assess the national technical assistance system and to highlight models that have worked most effectively in providing technical assistance. The findings from this evaluation will help identify the specific components necessary for productive technical assistance.

It is important that we continue to evaluate community planning efforts. HIV prevention community planning evaluation is vital for examining the activities of the groups and the development of the comprehensive HIV prevention plans. The evaluation process will allow groups to monitor their progress and successes and to better understand how to plan and improve HIV prevention programs.

Based on the experience of the past 4 years, **CDC is revising the programmatic guidance on HIV prevention community planning.** With input from prevention partners, CDC intends to maintain the current principles and flexibility of community planning. The revised guidance will better address:

- the changing needs and roles of community planning groups,
- the importance of participation of at-risk communities and addressing their prevention needs,
- guidance on addressing the long-term, ongoing nature of planning, and
- accountability of health departments and community planning groups.

CDC will continue its support of community planning groups by providing:

- consultation, technical assistance, and training in all aspects of the planning process,
- up-to-date information, including emerging prevention technologies, diffusion of best practices, and effective prevention intervention models,
- national monitoring and evaluation of implementation, and
- regular reports on progress, accomplishments, and challenges.

The HIV prevention community planning process is challenging and dynamic. CDC's commitment to HIV prevention community planning is further strengthened by the commitment of thousands of HIV prevention community planning group members across the country who, through their dedication, tremendous effort, and hard work, have shown their support of the principles and their belief that the planning process is improving prevention programs

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