



**NASTAD  
TECHNICAL ASSISTANCE  
REPORT:  
Community Planning  
Approaches**

November 2007

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INTRODUCTION

The Need for Flexibility

An evidence-based decision-making process informed by communities impacted by HIV/AIDS that identifies the population or risk-based focus of HIV prevention interventions is critical for effective HIV prevention programming. In the U.S., the Centers for Disease Control and Prevention (CDC) mandates that each jurisdiction funded for HIV prevention convene a community planning group (CPG) with the explicit goal of developing a comprehensive plan for HIV prevention.

Many health departments say that HIV prevention community planning has helped HIV/AIDS programs support decisions that they cannot make alone, and others say that planning has helped build community understanding of public health and broaden support for the HIV/

AIDS program. Indeed, even before the advent of the CDC community planning guidance, many health departments had community advisory bodies, with many different roles and uses. There remains little debate that the identification of priority prevention needs based on community input is still a valid planning goal.

Yet community planning can be resource intensive, particularly with certain models or approaches. At the same time, jurisdictions have vastly different epidemics and different planning needs which have required health departments and CPGs to refine, revamp, revise and improve their planning approaches over the years. While community involvement in planning is critical, jurisdictions recognize that the community can also be involved and impact HIV prevention in other important ways like advocacy and building coalitions, in addition to the development of a comprehensive plan.

In December 2005, NASTAD administered an assessment of the 65 health departments funded by CDC for HIV prevention programs on the HIV prevention community planning process. At that time, respondents were evenly split when asked whether they were getting what they needed from the planning process. When asked to comment on the reasons for this response, themes that emerged related to the resource-intensive nature of planning and the need for greater flexibility to solicit community input.

Many jurisdictions have taken the initiative to modify their approach to planning and have found that these changes have helped sustain community participation in HIV prevention. One respondent stated, "Our program strongly believes in listening to the voices of community members. This would be facilitated by a more open structure in which to receive input. The community planning guidance does not provide alternative means for receiving input that would better use people's time." Another remarked, "Having to conduct labor-intensive capacity development while simultaneously producing usable products is an ongoing challenge. The talents and skill level of our health department staff allows us to produce what is needed internally or through consultant services that could save valuable resources to be redirected to direct service contracts ... a more concerted set of consultations could take place for emerging prevention policies, best practices or intervention strategies that members can actively engage in and have recently been profoundly useful for planning and decision making."

Another factor driving the need for more flexibility in implementation of planning has been the reduction in resources available for prevention, leading to the need to direct resources to programs and

services directly impacting risk of HIV transmission. For example, many jurisdictions have explored ways to change or adapt community planning to respond to the changing priorities outlined in *Advancing HIV Prevention* (AHP) and other recent policy initiatives, which have mandated that people living with HIV receive top priority in prevention program decision-making.

NASTAD's community planning survey found that there are many ways jurisdictions have approached making the planning process more efficient:

- Seven respondents reported that their jurisdiction had reduced the number of staff dedicated to planning;
- Fourteen reduced their planning budget;
- Seven combined their prevention with Ryan White care planning group(s);
- Five combined meetings with other meetings (e.g., care planning);
- Fourteen combined data gathering tasks;
- Sixteen convened fewer meetings;
- Four reduced the number of members on planning group(s);
- Five reduced the number of planning groups (e.g., eliminated regional planning groups);
- Five planning groups review and recommend/prioritize effective interventions only;
- Six planning groups have broadened their mission; and
- Nine planning groups review a portion of health department-developed CDC progress reports.

## CURRENT U.S. PLANNING TRENDS

*There are several characteristics of all U.S.-based community planning models:*

### ***Community-driven Prioritization***

In all the models currently in use for HIV prevention planning in the U.S., community members have a role in identifying the priorities for the jurisdiction.

### ***Persistent Capacity Building Needs***

With expected turnover, both planned and through attrition, groups continue to receive an influx of new participants who require orientation to planning, HIV prevention strategies and the circumstances of the epidemic in the jurisdiction. Therefore, all the U.S. based models involve some type of orientation and all have specific rules and structure for conducting planning.

### ***A Cadre of Planning Experts, Many With Advanced Skills/Needs***

While planning groups are continually adding new members to their groups, there are also many participants who have been involved for a long time. These “veteran” planners have many ideas and extensive experience and want to take planning to the next level. However, they sometimes feel hamstrung with current planning requirements.

### ***Agencies at the Table a Must***

Even those with a consumer model or consumer-oriented philosophy have some way to involve agency partners from the state and community-based organizations (CBO) in planning.

### ***Integration of Care and Prevention Planning***

To varying degrees, NASTAD has observed a trend toward collaborative and integrated care and prevention planning. The reasons for this trend include maximizing participants’ time, reducing overlap and redundancy, and better linking prevention and care planning and service delivery.

### ***Consolidating Groups***

There has been a general trend away from supporting multiple planning groups, although many jurisdictions still have informal or local input groups that interact in some way with the jurisdiction-wide group that sets prevention priorities.

### ***Multi-year Planning***

Many jurisdictions and CPGs have found that a multi-year planning process, in which steps are undertaken over two, three or even five years to develop a multi-year plan, has been the most effective way to make use of members’ time and to be as thoughtful and comprehensive as possible. Many groups have found that while the epidemic can be dynamic, much of the information necessary for planning does not change dramatically from one year to the next.

## CURRENT GLOBAL PLANNING TRENDS

*While community planning naturally differs in every country, NASTAD has observed some similarities and themes across global models. These include:*

### ***Multi-Sectoral Planning Bodies***

In most countries, community planning bodies are multi-sectoral. Agencies from all sectors of government and/or society are charged with participating in and implementing HIV community planning activities. In these models, it is inconceivable that HIV prevention and care needs be considered separately. While multi-sectoral approaches can create problems around communication and role definition, they can also be powerful enough to ensure the integration of HIV prevention and care into multiple existing mainstream programs and make HIV a priority in all aspects of public discourse.

### ***Planning and Implementing Bodies***

In the U.S., HIV prevention community planning is separate from HIV prevention program implementation. Here, the CPG meets, identifies priorities and then develops a plan that the health department implements. In the multi-sectoral models that NASTAD works with, the community planning body tends also to be the implementing/funding body. For example, in Ethiopia, *woreda* (district) AIDS councils develop plans that also serve as proposals for funding. In Botswana, the District Multi-Sectoral AIDS Committees plan for and oversee distribution of local government HIV funds.

### ***Simpler Planning Processes***

The global community planning processes NASTAD supports are shorter and simpler than the processes seen in the U.S. For example, prioritization of target populations tends not to be as important a step in countries with generalized HIV epidemics. Also, identifying priority interventions is often irrelevant as these are initiated by international donors. Because of these realities, these community planning efforts tend to be much more a process of inventorying and coordinating existing resources, identifying gaps and mobilizing community and donors to work together to fill them.

### ***More Directive yet Less Time Consuming Planning Processes***

In its global work, NASTAD often responds to community planning technical assistance (TA) requests by collaborating with the end users to develop community planning toolkits and manuals. In these tools, the steps of planning are dictated in great detail, unlike domestic community planning efforts where the development of the planning process is left up to the community.

In communities that are predominantly poor and illiterate, using more directive, toolkit-based planning allows community to focus on their knowledge of resources, needs and norms and significantly shortens the planning process itself. It also does not require that participants bring knowledge and skills on "planning" to the table. For example, in Ethiopia, the *woreda* AIDS council can develop a comprehensive plan/proposal within one week by following the training manual.

Because of these factors and trends, NASTAD has recommended that CDC support multiple models or approaches for achieving the goals of planning, as well as for local determination for how to most effectively conduct planning.

Furthermore, the perspectives shared through NASTAD’s community planning assessment point to a need to broaden the goal of community planning from the current focus on engaging in a planning process to produce a comprehensive HIV prevention plan. Many jurisdictions are looking at integration of not only care and prevention planning, but also strategies to integrate viral hepatitis planning and coordinate with other STDs. At this point in the epidemic, some jurisdictions are exploring other ways to capitalize on the input from communities.

### What’s Inside

NASTAD produced this *Technical Assistance Report* to support a broader view of planning and demonstrate that multiple models for planning are already in use around the country. By sharing information about these approaches, as well as other approaches that are untried or have been tried in other countries, NASTAD hopes to spark further peer-to-peer networking and technical assistance on strategies for supporting a vibrant, meaningful and efficient planning process that truly helps ensure delivery of effective HIV, STD, and viral hepatitis prevention in the U.S. And finally, NASTAD hopes to identify some trends and areas of focus to help inform subsequent guidance from CDC on community planning.

### Planning Approaches

In addition to the global planning processes mentioned on page 5, NASTAD identified six community planning structures in the U.S from the data

collected in the 2005 survey. The following section provides a brief description of these planning approaches, followed by one or more profiles from jurisdictions where the approaches are being implemented.

#### A. State Group With Local Input Groups

Some jurisdictions support a state-wide planning group that receives input from local groups to inform the state’s planning process. In this model, the state provides funding to support state-level planning efforts and, in some cases, also provides funding to support the local or regional planning. To gather local input, representatives from the local groups may sit on the state planning group, and/or state representatives may meet with local groups or communities to discuss their work. The state planning group develops the state’s formal comprehensive plan to which the health department responds in their funding and programmatic decisions.

## CALIFORNIA

NASTAD interviewed Gail Sanabria, Chief of the HIV Community Prevention Section in the California Office of AIDS (OA), to develop this profile.

### Model

In California, prevention and care planning are integrated at the state level. Because the state is so large and diverse, the state planning group addresses policy issues and statewide priorities and disseminates these to the local health department level.

The local health department jurisdictions (LHJs) have their own planning groups called Local Implementation Groups (LIGs). There are currently 55 LIGs (one LIG is a regional LIG covering five LHJs and one LIG covers two LHJs), which focus on developing local implementation plans for priorities that pertain locally, rather than on setting priorities to bubble up to

the state group. LHJs with the lowest-impact are not required to have a local planning council.

The statewide group includes a Steering Committee, which is comprised of two health department chairs, two community chairs, a community co-chair elect and chairs of the group's various task forces. Task forces work on specific issues or communities including injection drug users (IDU), men who have sex with men (MSM), women, prevention-care integration and resource allocation.

***Integration with Care Planning***

In 1995, there were separate prevention and care planning bodies at the state level. The first attempt to integrate the groups was unsuccessful, primarily because of the different philosophies within the health department. Care utilized two information groups, one comprised of providers and the other of clients. The currently integrated statewide group became possible when the health department branch managers for prevention and care worked together to establish a coordinated goal and objectives for the utilization of the statewide planning body.

***Membership/Parity, Inclusion and Representation (PIR)***

On the state group, 25 percent of membership must be HIV-positive. A statewide recruitment effort is undertaken to solicit affected and infected individuals who bring a variety of perspectives to the planning table. The Membership Committee screens applicants, and, along with the Steering Committee, makes selections which are then provided to the Office of AIDS Division Chief for approval. Not all LIGs are represented on the state group, but there is a geographic balance. Some members of the state group are appointed, including representatives from

the state's directly-funded jurisdictions in San Francisco and Los Angeles County. The state group also includes representatives from the Department of Education, Department of Alcohol and Drug Abuse and the Department of Corrections (OA is also working on getting representation from the Department of Mental Health). The statewide group's turnover is minimal since it is partially appointed; participants have two-year terms.

***Function***

The LHJs that get little funding may have their LIGs meet only twice a year; once to provide input on their funding process and a second time to review how the funds were spent. Twenty-eight LHJs get the majority of the available funding for implementing prevention for the jurisdictions, and most meet monthly to look at needs and what the local community provides.

The state group meets three times a year, alternating between the northern, central and southern parts of the state. This gives opportunities for public comment across the state, as well as opportunities for planning group members to visit various providers.

The state group completes a five-year plan. In the interim years, it looks at changes to the epidemiologic profile, changes in trends, changes in policy and whether it is targeting its resources appropriately.

***Priority Setting***

To provide input on the revision of the local community plans, OA staff work with LHJs through a web-based system for input on the local populations and capabilities, technical assistance and monitoring site visits. This year, California is choosing largely from Diffusion of

Effective Behavioral Interventions (DEBIs), homegrown strategies and core components (e.g. epidemiologic data, needs assessments) for its 2007 priorities.

The statewide priorities are very general, and LIGs in turn then make these priorities relevant to local needs and determine implementation strategies.

There is good communication from the state group to the LIGs, especially via the state's website. The OA also provides updates to the LHJs which, in turn, share these updates with their LIGs.

The co-chairs for the statewide group are responsible for the concurrence letter in the annual application for funding to CDC. Decision-making is via consensus using colored cards, with voting by majority used if consensus cannot be reached.

### ***Staff and Funding***

California uses state and federal funding to support planning. Various OA prevention and care staff bill time to planning, since there is an OA staff-person assigned to each state planning group task force. There are two staff positions that support the Steering Committee as well. California contracts with a planner to assist with logistics and facilitation of meetings.

### ***Successes***

While the consensus model is time consuming as a decision making model, it has been successful in California. It allows for more buy-in and agreement among the members and less feelings of win/lose. Also, the diversity of membership on the state planning body is successful and California works very hard to be inclusive and ensure representation of all infected communities. Community planning has helped California gain support for hard decisions.

### ***What Would You Change?***

The model in California works for the state and is supported by the community. California has gone through changes in its planning structure over the years and has now created a body that works well. Sanabria says, "It always ends up being better because we have planning."

## **FLORIDA**

NASTAD worked with Vanessa Crowther, Prevention Program Administrator, and Leisha McKinley, Prevention Program Advisor, in the Florida Bureau of HIV/AIDS, to develop this profile.

### ***Model***

In January 2004, the statewide Florida HIV/AIDS Community Planning Group was re-engineered into the Florida Comprehensive Planning Network (FCPN) comprised of three entities: the Prevention Planning Group (PPG), the Patient Care Planning Group (PCPG) and the Hepatitis Council.

Members of the PPG and PCPG also participate in regional community planning partnerships. In addition, each planning group invites guests and other planning body members to attend and provide input.

### ***Integration with Care Planning***

As the umbrella group for the three statewide planning bodies, the FCPN is comprised of the co-chairs for each group and meets at least once a year. Each group keeps the others informed in two ways: circulating newsletters with summaries of their respective meetings, and having a standard agenda item that allows an update from each group. Otherwise, representation for each of the three planning bodies is separate.

## ***Managing Transitions***

One of the main reasons Florida transitioned to this network of planning groups was to help foster and facilitate a more effective and cost efficient community planning process. Prior to January 2004, the statewide community planning group membership was massive and the process cumbersome. After much discussion, the members decided to re-engineer the group to provide more focus and productivity for Florida's statewide community planning process.

The group began the change process by selecting a steering committee from among the FCPG members to discuss opportunities to improve the statewide community planning process. The steering committee and the newly developed PPG produced a membership selection and nomination criteria tool. The tool improved the recruitment process and the outcomes of membership selection for the FCPN, PPG and PCPG. The committee also focused on the improvement of the group's resources, experience and expertise for identifying and producing evidence-based processes and assessments in the field of HIV prevention planning. Also, the committee wanted to develop a more cost-efficient meeting process with support for providing more effective, committed and inclusive participation from around the state.

## ***Membership/PIR***

The FCPN and its three statewide planning groups are comprised of regional representatives nominated by local partnerships across the state, based on a selection criteria and tool using information from epidemiologic profiles, the demographics of the nominees and each nominee's years of experience and expertise in community planning and HIV/

AIDS prevention work. Ideally, the three statewide planning groups' membership mirror the Florida HIV/AIDS epidemic, providing support for broad-based community participation in HIV prevention planning directed by CDC.

The roles and responsibilities of the regional members at the statewide level include building a relationship between their regional planning groups and the statewide planning groups. The members are also a resource for information, collaboration on ideas and technical assistance between the local and statewide planning groups.

## ***Function***

The planning groups meet three times a year in different areas of the state, allowing for more members of local partnerships to visit meetings of the three statewide planning groups and to review their activities. The network as a whole meets at least once or twice a year.

The PPG completes a three-year plan. The group appoints work groups to complete different sections of the plan. The chairs of those work groups are appointed to the writing team. The writing team assists the health department with writing the comprehensive plan.

## ***Priority Setting***

In 2006, Florida created a document called the "four fold methodology" to use HIV case data, disproportionate impact, resource disparities and local/community input data to set priorities. Each of these data points were weighted the same, and the PPG found that this left too much room for interpretation, or misinterpretation. Therefore, after the process was completed, the PPG decided the state should come up with another priority tool, currently under development.

The Florida PPG compares the health department's application to CDC with its comprehensive plan during their August PPG concurrence meeting. If there is very little discussion, concurrence is achieved using voting slips completed during the meeting. If there is much discussion and the PPG requires more time to review the application, Florida schedules concurrence calls so the PPG can further review the application and ask questions. The health department convenes three to four calls to accommodate all who wish to participate.

### ***Staff and Funding***

Florida spends approximately \$153,000 a year for community planning. The health department outsources coordination of meeting logistics, including staff support, travel for planning members and stipends for members that qualify.

### ***Successes***

Florida's experience has been that the groups in the new FCPN are more effective because they have more focused objectives and goals within each planning process. Furthermore, the groups are more cost efficient because they can have fewer meeting days, while at the same time achieving more inclusive participation among the community planning partnerships around Florida. Through continual monitoring and evaluation of the planning group meetings, information about planning processes and group improvements and technical assistance needs for members and guests have been shared. This has made planning in Florida more cost effective and more productive.

### ***What Would You Change?***

Florida would like to see more communication between the three groups of the FCPN. At the same time, Florida's local partnerships are requesting more consultation on the statistical information

they need so that it is clearly connected to community planning objectives and strategic planning. Also, planning group members are requesting more specific guidance for writing local partnership plans.

### **B. State and Regional Groups**

In this approach, both a state group and regional groups inform the priorities that become the comprehensive HIV prevention plan. The state planning budget supports planning for both the state and the regional planning bodies.

## **WASHINGTON**

NASTAD interviewed Brown McDonald, HIV Prevention Services Manager in the Washington State Department of Health, to develop this profile.

### ***Model***

Washington has a unique planning situation. In addition to the guidance from CDC, its planning model is also driven by the State AIDS Omnibus Law, which mandates six AIDS service regions, called Regional AIDS Networks (AIDSNET), to cover the state. This law includes a formal legislative requirement for planning in each of these six regions. Therefore, these Regional AIDSNETs are responsible for planning and allocating all HIV funding across prevention and care. The law comes with state-appropriated resources. The regions have agreed to let the state administer the care funding at the state level.

As a result, Washington's model includes six regional planning groups plus one statewide group. Each regional group writes a letter of concurrence on its regional plan and the statewide group writes a letter of concurrence on the consolidated statewide plan and the state's application to CDC.

The state planning group's responsibility is to provide supplemental guidance to the Regional AIDSNETs, document the regional planning processes and consolidate regional plans into a statewide HIV prevention plan. There has also been a provision to set aside a small portion of the federal CDC cooperative agreement resources to address unmet statewide needs not addressed by the regions (e.g., interventions conducted with the Department of Corrections).

### ***Integration with Care Planning***

At the regional level, the Seattle Regional AIDSNET has a planning group for care and prevention, although others do not. One chief reason the other regions haven't integrated is that while integration may create some efficiencies, there are many programs and priorities to integrate, which is also challenging.

### ***Membership/PIR***

Each of the Regional AIDSNETs uses a different approach to selecting membership, although they must all meet CDC's requirements for PIR, particularly that the populations most at risk are represented by at least one person.

Each Regional AIDSNET appoints three members to the state group. The state group also has 12 at-large members and includes people with specific expertise from the state health department, other agencies like education and substance abuse and from research. Washington involves approximately 100 people with HIV prevention planning across the state.

### ***Function***

Washington uses a multi-year planning approach, and each group schedules their process for what they want to accomplish at the beginning of the cycle. Committees

are organized around the products of planning (e.g., membership, community services agencies, epidemiology). Caucuses for target populations are also convened when needed.

### ***Priority Setting***

In Washington, the HIV/AIDS epidemiologist uses the epidemiologic profile to establish the populations most at risk, and then the planning groups prioritize among those top ten priority groups. The State Intervention Subcommittee identifies interventions for populations most at risk for each region to use as it sees fit. Each of the Regional AIDSNETs is presented with the resource allocation for CDC and state prevention resources. The statewide planning group makes decisions using a modified consensus model for decision-making.

### ***Staff and Funding***

Washington funds one person at the state level to coordinate planning. It uses consultants for local activities like needs assessments. The state group meets six to eight times a year in the Seattle-Tacoma area. In the regional groups, meetings by region vary from five to seven meetings per year. Each region has a Regional AIDSNET coordinator to run planning and other parts of the local prevention program. Some regions use consultants to run the meetings and write reports.

Washington estimates a cost of approximately \$60,000 to support planning at the state level. Regions also spend money on planning.

### ***Successes***

Washington's model has resulted in broad-based participation in planning and increased buy-in for HIV prevention.

## ***What Would You Change?***

Multi-year planning/funding grant cycles should make it acceptable to complete a multi-year concurrence letter. That way, the groups would not need to meet as often each year for the required “update,” and may conserve funds by not meeting as frequently.

### **C. Consumer-based Group**

In a consumer-based group, the planning group is comprised solely of consumers—people impacted or affected by HIV and/or who may participate in prevention services. Health department personnel, scientific experts and CBO representatives do not participate as voting members of the group, but may participate in planning activities or provide input.

## **MAINE**

NASTAD interviewed James Marciewicz, HIV Prevention Program Manager in the Maine Department of Health, to develop this profile.

### ***Model***

In 2004-2005, Maine restructured its planning process for two reasons. First, the epidemiology had been static for the past decade. Second, the group was comprised of several providers who had not cycled off the group for some time, and the consistent participants who were doing the bulk of the work were becoming burnt out.

In order to reinvigorate planning, and after researching other states’ planning processes, Maine decided to comprise the planning group solely of consumers, along with the health department co-chair. To compensate for not having providers at the table, the planning group’s community co-chair attends quarterly providers meetings, and provider input is a standing agenda item for planning group meetings.

## ***Integration with Care Planning***

Maine investigated whether to link prevention and care planning, but with the move toward a consumer-based model, it felt the specific knowledge bases for prevention and care would make it too difficult to integrate or merge.

### ***Membership/PIR***

Maine’s new structure mandates a 12-15 person all-consumer planning group. To keep expectations clear, the bylaws state that no providers are allowed and that the consumers are expected to be gatekeepers for their communities.

Because Maine’s group is consumer-based, it is careful about providing enough support to allow them to participate (mileage, food, transportation), without providing too many incentives that might impact their eligibility for care and treatment services.

### ***Function***

Maine has reduced the number of meetings from ten to between six and eight, with one retreat convened for decision-making purposes. The community planning group (CPG) always meets centrally in Augusta, and members may join by conference call should an issue arise.

### ***Priority Setting***

The CPG has a two-day retreat in April where the bulk of the work is done to finalize populations, interventions and needs. The CPG uses a modified consensus approach, meaning that if two attempts to reach consensus fail, a super majority of those present determines the outcome (75 percent plus one).

### ***Staff and Funding***

For 2007, the health department created a

project assistant position for planning. This position provides administrative support to the CPG, while the co-chairs facilitate the meetings. Together, the health department CPG coordinator and the co-chairs, in conjunction with the health department, make sure the guidance is followed. The AIDS director is currently the health department co-chair and the prevention staff members attend the meetings. Maine estimates that it spends about \$80,000 on planning each year.

**Successes**

A consumer model is inherently more tied to community and lacks the power imbalance that can result when providers and consumers sit together. This results in more community voice and lack of conflict of interest. To help assure the valuable skills of CPG members are developed and used in this new model, the Executive Committee of the CPG has responsibility for ensuring PIR, and CPG members are matched with TA providers to co-deliver TA.

**What Would You Change?**

Recruitment, retention, and supporting participation in a rural state are barriers for a consumer-based model. However, Maine has found creative ways to increase participation, particularly to address health-related concerns. Maine is currently working to streamline its approach. Once membership has stabilized, it plans to broaden consumer and community input through town hall meetings.

**TEXAS**

NASTAD worked with Brenda Howell, Planning Specialist in HIV Epidemiology and Surveillance in the Texas Department of State Health Services, to develop this profile.

**Model**

In 2006, Texas began to explore options for modifying its regional planning structure and transitioning to one statewide prevention planning group: the Texas HIV Prevention Community Planning Group (TxCPG). Planning in Texas has expanded from one state planning group in the early 1990s to ten groups organized around the public health regions of Texas, then to six planning areas that were designed to represent matching morbidity across the state and finally back to one state prevention planning group.

**Integration with Care Planning**

At the current time there is no plan to combine the prevention planning group with care planning because Texas has five Part A Ryan White Funded areas, and one direct-funded CPG in Houston. Texas feels the coordination could be too difficult given the different funding schedules and product due dates. However, there are seats on the planning group for both the Ryan White Program Part A and Part B planners as well a representative from the Houston CPG.

**Membership/PIR**

The transition team (see text box) decided on the membership composition and goals. For the purposes of description, proposed seats on the THPPG will be split into two groups: population/risk group perspective seats and skills/expertise seats. These groupings are named after the characteristics that the group wants to ensure are present on the body.

**D. State/Jurisdiction-wide Group**

In a state/jurisdiction-wide model, all identified stakeholders participate in one planning group for the entire jurisdiction. This group may meet centrally or across the various regions of the state/jurisdiction.

## SPECIAL FOCUS ON MANAGING TRANSITIONS

Since this is not the only state that has changed its structure or approach more than once, Texas provided an interesting case study in how to manage transitions. Texas' current co-chairs made the final decision to form one planning group for prevention. The technical assistance provider for Texas produced a comparison paper on states with statewide planning groups with relatively the same morbidity. Since it was difficult to find a state with the same square mileage of Texas, the group used a hybrid of several state models as comparison.

Once the decision was made to move to a statewide model, the co-chairs selected one member from each of the six current planning areas to represent the area on a transition team. The transition team met the first time via conference call and split into three teams. One developed the basic structure of the prevention planning group, one drafted the purpose and mission statement and one developed the frame for the bylaws. Each of the groups was led and supported by health department planners.

Once all draft documents were completed, the transition team was brought to Austin for a two-day work session to finalize the documents. After the meeting, the state planning staff developed the application for membership and a commitment statement, posted them on the Department of State Health Services (DSHS) website and advertised them at the state HIV/STD Conference.

Some decision statements were developed to help select members of the first planning body. For example, previous members of the community planning process were given extra consideration for membership in the first call for members. Membership applications were due in January 2007 and the transition team met in early February. A new prevention planning group was formed by April and the first face-to-face meeting took place in late spring.

The TxCPG will have no more than 40 members, and it may be possible for the body to have fewer than 40 members and still have members with all the desired perspectives and skills. While the population/risk group perspective seats will be filled through the application process, some of the skills/expertise seats will be designated by DSHS or others. PIR is ensured through the provision of travel support, planning group orientation and opportunities to participate in conferences and trainings.

### **Function**

Member terms will be for two years and staggered to prevent loss of expertise due to membership turnover. The group plans to meet at least four times a year. Texas has retained a technical assistance provider that will do some of the training and orientation of the group as well as do some focus group or special studies for the group.

The TxCPG will likely develop a mixture of task and target population committees,

with the likely retention of the interventions review panel as a standard or standing committee.

### **Priority Setting**

As Texas is in transition, the process for setting priorities is not firmed up, however, in the past, the regional planning bodies made decisions based on consensus using guided discussions to identify priorities.

### **Staff and Funding**

Currently, Texas has one person at the state level supporting prevention planning and one staff person assigned with duties regarding the TxCPG.

### **Successes**

Texas anticipates that the strength of the new model will include increased ability to manage the group, increased efficiency, fewer burdens for planning staff and an increased and more concentrated capacity to focus on quality outputs.

**E. Integrated/Collaborative Care-Prevention Group**

NASTAD calls approaches that combine care and prevention planning an integrated, or collaborative, model. This model has also been referred to as a “combined” model in the past, but NASTAD has found that in most cases, the groups are truly integrating their planning activities and therefore now uses the term “integrated.” However, the implementation of integrated planning varies considerably. Some groups produce separate prevention and care plans, while others develop an integrated plan.

**NEBRASKA**

NASTAD worked with Sandy Klocke, Administrator of HIV Prevention, Ryan White, Hepatitis and HOPWA Programs in the Nebraska Department of Health and Human Services, to develop this profile.

**Model**

Nebraska has one statewide planning body, the Nebraska HIV Care and Prevention Consortium (NHCPC). NHCPC’s mission is to develop the HIV Care and Prevention Plan, identifying specific strategies and interventions responsive to validated needs within defined target populations. The purposes of the NHCPC are to:

- Assess the impact of HIV prevention and care in defined areas;
- Identify and prioritize high-risk populations based on epidemiologic and other surrogate data;
- Assess prevention and care needs and gaps and barriers in service;
- Identify, prioritize and recommend care and support services including standards of practice;
- Identify and recommend strategies and interventions to develop a comprehensive plan consistent with

priority needs;

- Review and endorse the Statewide Coordinated Statement of Need (SCSN); and
- Review the prevention application and conduct the concurrence process.

**Managing Transitions**

When HIV prevention community planning was initiated in 1994, Nebraska formed seven regional planning groups and one statewide planning body, all running independently from the four rural Ryan White consortia for care and treatment services and other local planning bodies already in operation. Nebraska eliminated the state prevention planning group in 1996. By 1998, five of the regions had merged their care and prevention planning bodies, and Nebraska was considering ways to better coordinate planning across the state. Nebraska’s integrated statewide group was officially chartered in March 2000, after more than two years of discussion, planning and development.

**Integration with Care Planning**

Nebraska completed three major changes when it moved to the collaborative planning model:

- Reduction from six regional prevention planning groups to one state planning group;
- Reduction of four Ryan White Part B (formerly Title II) consortia to one; and
- Integration of prevention and care planning.

These changes were made to address problems with maintaining PIR in rural areas due to stigma and fear, the challenges of maintaining capacity and skills of planners with constantly changing regional membership and the increased

expectations from CDC alongside decreasing resources. In addition, it was a challenge to develop quality plans for each region with different priorities, interventions and strengths. Furthermore, the community participants felt overburdened with requirements for travel and attendance to regional meetings, especially if they were members of prevention planning groups and Ryan White consortia. They found they could not meet these expectations with limited planning resources. They also had trouble identifying leaders. Instead, they indicated a preference for focusing on implementation and case management rather than planning.

**Membership/PIR**

The NHCCPC is comprised of 36 members appointed or elected to represent specific categories. Appointed members of the NHCCPC represent linkage partners working across Ryan White Programs, the AIDS Drug Assistance Program (ADAP), other sexually transmitted diseases (STDs), corrections, surveillance, Medicaid and school health. Elected organizational members represent key functions/ activities, such as local health departments, case management, minority CBOs, consumers, faith community, business leaders, and counseling, testing and referral (CTR) staff. Elected individual members represent the impacted communities in Nebraska, and regional members provide local input from across the state.

In addition to the “official” membership of NHCCPC, Nebraska broadens access to planning by including community members, health department staff liaisons and other professionals with specific expertise in their committees. The State’s Ryan White Part B Coordinator and Community Planning Coordinator are also members. The HIV Program Administrator serves as an ex-officio member.

**Function**

The NHCCPC meets four times each year. The NHCCPC has the following standing committees:

- Care Services: Reviews adequacy of services available to meet identified needs, recommends additional services as necessary and assists in the development of services as needed;
- Assessment and Evaluation: Reviews and provides recommendations for prevention and care evaluation and assessment processes and results, including reviewing evaluation plans submitted to CDC and the Health Resources and Services Administration (HRSA) for comprehensive prevention and care evaluation;
- Intervention: Uses statewide needs assessment information for the purposes of identifying, prioritizing and recommending behavioral interventions for funding;
- Membership: Recruits and orients persons committed to addressing prevention and care concerns of those at risk for or living with HIV disease;
- Public Information: Reviews proposed educational materials, discusses media and education made available to communities, makes recommendations for educational materials and participates in the development of a public information plan; and
- Co-Infection (new 2004/2005): Monitors emerging co-infection issues through data collection and analysis and establishes a co-infection response for incorporation into the comprehensive plan.

Operational guidelines specify duties and responsibilities of the consortium, members, committees and chairs, as well

as general conduct of all activities. Committees develop annual objectives and work plans to accomplish the overall goals for the NHPC. Meetings are structured to allow blocks of time for committee work at each meeting, with additional assignments made as necessary to complete work items between meetings.

### **Priority Setting**

A key function of the NHPC is to identify priority populations and appropriate interventions in order to guide funding allocations. The priority setting process was developed over a two year period and utilizes a defined process that results in an objective, mathematically-based outcome to determine the most affected, impacted populations and subgroups (i.e., MSM with priority to African American males, etc.). This is based on a weighting and ranking process that considers group-defined factors including AIDS prevalence, HIV prevalence, predominant mode and risk factors, barriers and emerging trends for the identified at-risk populations (MSM, MSM/IDU, etc). Numbers are calculated in this process when a defined scale is multiplied by a weight for each factor. A *Race/Ethnicity and Age Factors* scoring process, which includes measures of surrogate data (e.g., STD rates, counseling and testing data, drug abuse), is applied to the risk populations. A combination of these scores results in the identification of prioritized populations.

While the preliminary developmental work for the process was accomplished via ad hoc committees, the NHPC makes the final decisions regarding all definitions, processes and assigned weighting factors. The entire group participates in the actual discussion, scoring and finalization of the priority populations for the defined period.

The second step of the process involves

defining the interventions that become the priority in each population segment. The majority of this work is accomplished through the Intervention Committee which is tasked with researching the available interventions and meeting specified criteria for each identified priority populations. Once scored, the Committee recommends interventions for each priority populations to be presented to the NHPC for a final vote and adoption.

Concurrence on the annual application is simplified because funding is based directly on the priority populations and interventions that have been approved by the NHPC. Nebraska's process covers multiple years. Therefore, if a request for funding a project or intervention happens in the interim that does not directly fit into the defined categories, a discussion with the Intervention Committee is held and notice given to the full NHPC.

Final application concurrence is assigned by the NHPC to the NHPC Executive Committee which is responsible for reviewing the application, providing input and recommendations, participating in a concurrence conference call and providing final concurrence on behalf of the larger group.

### **Staff and Funding**

A full-time Community Planning Coordinator is responsible for all the planning processes in Nebraska. The co-location of HIV Prevention, Ryan White, Hepatitis and HOPWA staff promotes flexibility and allows for each NHPC committee to have a staff liaison. This enhances communication, coordinates support and ensures the NHPC understands all facets of the program. For 2006, the estimated costs for community planning, including staffing time, were between \$150,000 and \$160,000.

## **Successes**

With the current process, Nebraska has found that members are better prepared to meet state, CDC and HRSA obligations and have better reciprocal understanding of care and prevention. It has also found that shared functions nets better efficiencies. Membership is now more stable, with less burnout, and meetings and committees are more productive. In addition, the planning group is better represented by impacted, infected and affected populations, and members are building stronger networks. Finally, the comprehensive plan now better reflects Nebraska needs, resources and gaps, giving Nebraska a more unified voice to advocate issues.

## **What Would You Change?**

Nebraska would like the flexibility to truly implement a five-year planning model. As a low incidence jurisdiction, it is wrestling with the need for quarterly meetings for the entire five years while still maintaining capacity and interest of the planning group.

## **NEW HAMPSHIRE**

NASTAD worked with Denise Rondeau, Administrator for the New Hampshire STD/HIV Prevention Section, to develop this profile.

## **Model**

The New Hampshire Community Planning Group (NHCPG) is comprised of approximately 24 to 42 members, with prevention and care services as the two main committees. The NHCPG develops one statewide comprehensive HIV/AIDS service plan.

## **Managing Transitions**

In 2000-2001, New Hampshire's prevention and care services planning groups began discussing merging planning bodies, motivated by a desire to reduce the burden on members, streamline the planning process and link systems for

improved services. Prior to merging, several care-focused groups were convening meetings: the Medical Advisory Group—infected disease providers and consumers; the Consumer Advisory Group—consumers from AIDS service organizations (ASOs); and the Statewide Coordinated Statement of Need Group—representatives from ASOs, Dartmouth Hitchcock Medical Center and Ryan White (then) Title I, II and IV representatives. In Spring 2001, these three groups combined into one group called the New Hampshire Care Services Planning Group (CSPG).

During the spring of that same year, the New Hampshire HIV prevention community planning group (CPG) received technical assistance (TA) on collaborative planning at its annual retreat. In the fall of 2002, the CPG and the CSPG met to begin the merger process. The two planning bodies were presented with overviews of what each group was required to accomplish over the course of the planning cycle so that they could meet the mandates of their cooperative agreements with CDC and HRSA. Discussions were held on the similarities in the planning cycles, the benefits and major concerns of merging and how a merged planning group would change the structure of both groups. The groups voted to merge within one year's time. A merger committee was formed to work out the details and report to the planning bodies over the course of that year.

## **Integration with Care Planning**

Although New Hampshire has merged the two planning bodies, certain aspects of planning remain unique to care services and certain items unique to prevention. Many activities benefit from a merged planning body, such as the integrated epidemiological profile, the gap analysis, the resource inventory and the needs assessment work for the prioritized target populations. Linkages between care

services and prevention also ensure smooth ongoing collaborations for partner counseling and referral services (PCRS) (care providers have begun to view PCRS as an ongoing voluntary beneficial service for clients, and they now have the ability to provide clients with prevention services such as prevention case management).

**Membership/PIR**

A Membership/Mission and Bylaws committee selects members for the NHCPG. New Hampshire’s planning group consists of no less than 51 percent consumer representation (individuals directly affected and/or infected by HIV/AIDS) and no more than 49 percent service providers. Membership of the CPG consists of individuals who are directly affected by HIV/AIDS, service providers, youth and advisors. Those who are directly affected by HIV/AIDS, providers and youth are members who have voting privileges. Advisors are members who do not have voting privileges.

**Function**

New Hampshire’s combined CPG meetings are held every other month and last up to six hours. The meetings primarily focus on identified planning group TA needs, target population prioritization, developing and reviewing needs assessments, gap analyses and resource inventories, the selection of evidence-based interventions and epidemiological presentations. All of the major decision-making and voting issues take place during these meetings. Several subcommittees and workgroups complete various planning activities.

Every CPG member must serve on either the Prevention or Care Committee (or both). The Care

Committee focuses on issues specific to care services to inform the annual prioritization of services, Ryan White funding allocation, identification of unmet need and utilization of the Ryan-White-funded services. The Prevention Committee focuses on findings within the prioritized target populations, research on evidence based interventions, behavioral surveillance and epidemiologic data for newly reported HIV infections and trends.

Also, a Steering Committee is charged with planning, development and oversight of the meeting agendas and obtaining TA/informational topics for the various meetings. And a Membership, Charter and Mission Committee is charged with oversight of the composition of the CPG to assure that the membership reflects the HIV/AIDS epidemic in New Hampshire and maintains compliance with the CPG charter. It also sets the order of meetings.

In addition to these committees, there are currently two work groups: the Data Assessment and Evaluation Work Group and the Policy Review Work Group. These workgroups research and compile information for the CPG as a whole or for the committees to provide more detailed review of the issues that could direct and/or impact prevention and care services.

**Priority Setting**

The NHCPG specifies that a quorum must be present for decision-making voting to occur and that decision making is by consensus whenever possible, with decisions by majority vote of those present when consensus cannot be reached.

## ***Staff and Funding***

The New Hampshire STD/HIV Section has historically staffed the community planning process via an independent contractor. The most recent RFP for this contract, released in the Fall of 2005, sought applicants to provide logistical support and associated TA to the New Hampshire HIV Community Planning Group. Funds to support the community planning process are approximately \$67,000 a year with the HIV Prevention Program contributing 66 percent of the funds and Care Services contributing 34 percent of the funding.

New Hampshire has two staff members that serve as public health co-chairs for the CPG, one staff is from the HIV Prevention Program and the second public health co-chair is on staff in the Ryan White Part B Program. Other staff members serve as committee liaisons to the various committees and work groups.

## ***Successes***

New Hampshire reports that a major success of the merger has been strengthening the connections between care and prevention, especially for considering the prevention needs of individuals living with HIV/AIDS. Another key success has been better and improved linkages between care and prevention services for clients.

## ***What Would You Change?***

When considering merging prevention and care planning, New Hampshire recommends avoiding having too many committees, focusing too much on personalities, focusing too much on process issues and avoiding turf battles (while simultaneously acknowledging the existing issues).

## **F. Workshop Models – Global**

In workshop planning models, a representative community planning group is convened in year one that meets daily for three to four days. It uses an epidemiologic profile and community services index data produced by the health department, with a training and group exercise process to identify priority target populations and priority interventions. The health authority then takes the results of the workshop to develop the plan and reconvenes the group to review and approve the plan. In years two and three, an ad-hoc group reviews and approves the updated plan.

These models focus on community participation in identification of HIV prevention needs. These models also help with engaging community members who know little about HIV and community planning, since the workshop simultaneously orients and solicits input from participants. They can also be tailored to more clearly articulate ways for identifying specific attributes or characteristics of identified interventions.

## **BOTSWANA**

### ***Model***

In Botswana, under the guidance of BOTUSA (CDC/Botswana), NASTAD partners with the Ministry of Local Government (MLG) to provide TA in district planning. The MLG created District Multi-Sectoral AIDS Committees (DMSACs), which are responsible for managing the response to the epidemic in their districts, including the activities of non-governmental organizations (NGOs) and sectors (the local level ministries). The MLG hires District AIDS Coordinators (DACs) to administer the district AIDS planning activities and coordinate and oversee the implementation of planned activities. DACs are somewhat akin to local health department AIDS program managers in the U.S.

NASTAD has helped build the capacity of the DACs to oversee the creation

and implementation of comprehensive district HIV/AIDS work plans as mandated in the National Strategic Framework and National Operations Plan. A DMSAC Planning Toolkit, created by NASTAD with the MLG, emphasizes an evidence-based approach to ensure that each district's plan responds specifically to the unique situation in that district.

### **Membership/PIR**

DMSAC membership is outlined in Terms of Reference contained in the National Strategic Framework. Members include district representatives of national AIDS programs such as the national antiretroviral therapy (ART) program, Masa, and the HIV counseling and testing program *Tebelopele*, as well as representatives of the District Health Team and local government sectors (e.g., Agriculture, Transportation, Labor, Education, etc.). The Terms of Reference also encourage representation from traditional healers and people living with HIV/AIDS.

### **Function**

Since Botswana is a small country (population: 1.5 million) many HIV/AIDS control activities are coordinated centrally [i.e., anti-retroviral treatment (ART), prevention of mother to child transmission (PMTCT), home-based care, etc.]. The function of the DMSAC is to create and implement an annual comprehensive plan for the district for HIV/AIDS control activities that are not implemented nationally. These are usually HIV prevention and certain care based activities.

A planning toolkit provides agendas for four DMSAC planning meetings:

- Meeting One: Familiarize the group with the planning process, the National Strategic

Framework (NSF), the current district plan and begin the District Profile and Community Services Inventory;

- Meeting Two: Review District Profile and Community Services Inventory and determine what additional data are needed;
- Meeting Three: Set priorities and determine district specific objectives; and
- Meeting Four: Approve the final comprehensive plan.

Reporting forms required by MLG are also included in the toolkit, along with instructions on how to complete them.

### **Priority Setting**

Initially, the DMSAC identifies priority HIV needs and assigns them to each sector for implementation (e.g., if a need for school-based prevention is identified, the Education sector would likely be assigned this activity). The DMSAC then collates these sector plans into one single comprehensive plan, which is approved before being forwarded to the MLG for approval and to the National AIDS Coordinating Agency (NACA) for funding.

### **Staff and Funding**

Each district in Botswana is assigned a DAC, who is hired by the MLG, and supervised by the District Commissioner. The DAC is responsible for coordinating the DMSAC planning process.

### **Successes**

In the past, many districts submitted comprehensive plans that were a mere amalgamation of individual sector proposals, resulting in selection of non-critical and duplicate activities that discouraged collaboration. The community planning process has now become more

standardized in Botswana, and most DMSACs are coming together to identify district priorities before assigning activities to sectors to implement.

### ***What Would You Change?***

More work needs to be done to educate DACs and DMSAC members (who are not AIDS experts) in effective behavioral interventions so that selected activities are more likely to be effective.

## **ETHIOPIA**

### ***Model***

Participants from local neighborhood government (*kebeles*) and the affected community come together for a three-day participatory workshop and training that results in a comprehensive plan which is used to access funding and guides implementation of local HIV/AIDS activities.

A training of trainers (TOT) manual was developed and is used to train regional and district representatives to deliver and facilitate the community planning workshop. District community planning facilitators use a training manual which simultaneously teaches *kebele* AIDS committee members about community planning and also results in a completed HIV/AIDS plan/proposal for funds.

### ***Membership/PIR***

Ethiopian government is quite decentralized, with government entities located at the national, regional, *woreda* (district) and *kebele* (local) levels. Each government entity has an HIV Advisory Council whose membership is outlined in the National Strategic Plan. At the *kebele*

level, where community planning takes place, the *kebele* AIDS committee consists of PLWHAs, representatives from CBOs, community leaders, community health workers, traditional birth attendants and the health center provider or team leader.

### ***Function***

The *kebele* AIDS committees meet on a regular basis and support efforts in the community to provide prevention, care, and support including efforts to reduce stigma and improve adherence. Through the HIV/AIDS committees, *kebeles* refer patients to their respective health centers and volunteers conduct home visits. *Kebele* AIDS committees are both implementing and planning bodies.

### ***Priority Setting***

The *kebele* AIDS committees must approve the plan submitted by the *kebele* to the regional HIV/AIDS Prevention Control Office (HAPCO) for funding.

### ***Staff and Funding***

The training is integrated into the existing responsibilities of the AIDS health extension workers located at the *woreda*.

### ***Successes***

NASTAD's 2004 evaluation reported that since the community planning began in Ethiopia, all 203 *kebeles* in Addis Ababa had submitted plans that were then funded. Additionally, four regions had trainers available for regional community planning and trainings were scheduled throughout the country. Now, in-country partners use community planning to promote mobilization around ART delivery. NASTAD works with stakeholders to train planning groups to carry out and promote their planned activities.

## G. Pacific Approach to Community Input

CDC has worked with the six funded U.S. Affiliated Pacific Island jurisdictions to develop a new process to ensure that community input is part of HIV prevention program planning and implementation. This has resulted in the Pacific Island HIV/AIDS Community Action Network (PIHACAN). A guidance for PIHACAN is under development and will clearly describe the process, the components of PIHACAN, its expected outputs, roles and responsibilities of involvement and how that is to take place. This new process was necessary in a large part due to the specific resource, capacity and geographic situations in the Pacific that impact their ability to conduct specific HIV planning models. In the Pacific process, the main tasks of planning are to: 1) assess the target communities and elicit feedback and input from the communities; 2) plan HIV activities based on the assessment and input; 3) implement HIV activities; and 4) monitor and evaluate HIV activities.

## H. Untried Models

The following models are ideas and approaches some jurisdictions have considered, or used in the past, or may be incorporating alongside of their existing planning processes. While these have not been endorsed in existing guidance or requirements, they are being offered here as ideas to consider in an effort to identify a broader set of models and approaches for prevention planning.

### Independent Advocacy Group

In this approach, the planning group acts as an advocacy group, organized and managed independently of the health department. While the health department is not responsible for the ongoing maintenance of the group, it could provide the information necessary to respond to issues in an educated fashion on request and use the group to meet CDC planning requirements if paired with an ad-hoc approach (see page 24).

PIHACAN is based on the idea that community input is critical to effective HIV prevention programming and achieving community input is realized by meeting the community where it is and providing it with the ability, capacity and support to provide input. Because of capacity and cultural issues, PIHACAN does not actually require community members to attend formal meetings. However, the PIHACAN Core Group meets several times a year to plan events and strategies for reaching people at risk to learn about their issues and to get answers to questions about their needs and views for HIV prevention services.

There are no specific membership requirements in this model, primarily because that requirement would be counter-productive to ensuring involvement and input of the community. This process also strives to increase community awareness and involvement in HIV prevention and also allows for the community to be part of the implementation of HIV prevention activities. The main products of planning are a Community Assessment Report and a Yearly HIV Activity Plan.

### Action Group

The planning group could be convened as an *action* group, rather than a *planning* group, addressing issues of collaboration, networking and referral critical to maintaining comprehensive HIV prevention programming, such as developing intra-agency referral and follow up methods; identifying methods for providing peer technical assistance, training and mentorship; replacing or absorbing advisory groups convened for World AIDS Day activities; and reviewing social marketing activities. This may not result in overall cost savings, but, rather, a transfer of costs to prevention programming by, for example, a reallocation of some prevention contract staff time to this activity or by a creating a funded mandate within prevention contracts requiring participation in the group. CDC planning requirements could be met by pairing this approach with an ad-hoc planning approach (see page 24).

## **Ad Hoc Planning**

In ad hoc planning, community members are convened on an ad hoc basis, and different people can be convened for each meeting to provide feedback. This obviates the need for orientation and ongoing support of community planning members. Following is a likely scenario for ad hoc planning:

### ***Year One***

- Ad hoc group reviews epidemiologic profile and selects target populations;
- The health department develops priorities based on this review;
- The same ad hoc group is reconvened to review and approve implementation plan; and
- There is community participation in request for proposals (RFP) review (selection of priority interventions).

### ***Years Two and Three***

- Funded interventions must be reviewed by community advisory groups;
- Ad hoc groups form as advisory groups to health department (as convened and determined by the group); and
- Ad hoc group reviews and approves implementation plan and prevention RFP (concurrence).

This model limits the degree of community participation for the purposes of identifying HIV prevention needs to review, discussion and a certain degree of modification of health department produced recommendations. However, it does engage community to a greater extent in some accountability and oversight functions (e.g., RFP review process, participation in community advisory groups to funded programs).

## **CONCLUSION**

### **Looking Ahead: The Future of Community Planning**

**E**ffective community input creates greater understanding about HIV/AIDS, counteracts stigma and broadens the cadre of advocates for effective HIV prevention programs. But how this input is gathered can be fraught with difficulty if not matched to local needs and circumstances.

One respondent to NASTAD's 2005 survey said the community planning group "has stimulated greater interest and involvement of a diversity of stakeholders in HIV/AIDS issues. It has prompted health departments to be more deliberative in health planning efforts and prevention programs are probably stronger for this. It has also provided a mechanism through which to strengthen relationships between health departments, communities and other stakeholders. At the same time, involving communities in core public health functions is challenging and, sometimes, results in unhelpful and unproductive tension between health departments and communities. The emphasis on involving communities in health planning, which is the role and responsibility of public health, has probably diminished the potential for community planning to serve as a vehicle for coalition building."

What this also underscores is that while the models and structure for planning can and should be flexible, the goal for planning should be carefully examined to ensure it is relevant for the prevention realities of today. The overarching goal may make sense, but how this is operationalized in principles and steps of planning should be carefully considered.

In its survey, NASTAD asked jurisdictions to describe what they

think would make the community planning process more useful and meaningful in their jurisdictions. The main themes of the responses were 1) that the roles and/or purposes for the planning groups need to be changed or expanded, and 2) that these changes relate to the difficult cross-walk of technical, data-driven work and processes for community input.

One jurisdiction is focused on expanding the capacity building aspect of its group and another would like to see “emphasis on use of the products beyond the CDC application, for education with stakeholders and community-level advocacy.”

Examples of expanding the roles of community planning were also provided. One respondent said, “We are beginning to use the CPG as a source of input to improve the work our prevention grantees do. For example, we are turning over to the CPG the development of an effective prevention program client stipend policy that we will use with the grantees; we are asking for their input on making outreach a more effective intervention in terms of getting clients into other services via outreach.”

Another respondent said that, “To the extent that prioritizing populations is objective and data driven, leading the CPG through understanding epidemiology and quantitative priority setting processes tied to epidemiologic data as currently practiced is more about getting buy-in than about empowering the group in decision-making. It would be more useful and meaningful to direct their

effort toward their area of expertise, which is their indigenous knowledge of the populations whose perspectives they reflect. For example, with a three-year planning cycle, members would be individually involved with health department staff in activities related to the community services assessment (CSA) during the first two years of the cycle and in year three, the group would meet to review CSA data and intervention models and formulate recommendations for the next multi-year plan.”

Thus, jurisdictions have already found utility in expanding the roles for community input and activities undertaken by the planning groups. Two of the models discussed in this report question the assumption that the main goal of community input is to develop a plan. Instead, they describe alternative outcomes for convening community: advocacy and action. At this stage of the epidemic in the U.S., these goals need room to counteract complacency and re-invigorate communities to the threat posed by HIV/AIDS.

### **Share Your Models**

Consistent with NASTAD’s peer-to-peer TA model, this *Technical Assistance Report* includes profiles from several jurisdictions which are intended to provide ideas and peer-based experience for those in other jurisdictions. NASTAD relied on a convenience sample to develop the profiles for this *Technical Assistance Report*. However, NASTAD encourages all jurisdictions to share their planning models through [NASTAD’s on-line Resource Bank](#).

### Acknowledgements

This document was produced with funding from the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. The contents of this document are solely the views of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

This *Technical Assistance Report* was written by Lynne Greabell, Director of Service and Support, and Lucy Slater, Associate Director for the Global Program. Dave Kern, Director of Prevention, and Melanie Doon, Communications Manager, provided significant content and editorial review. NASTAD thanks the jurisdictions profiled in this *Technical Assistance Report* for sharing their experiences and perspectives on planning and community input, and Vicky Rayle at CDC for her assistance with planning approaches in the Pacific Island jurisdictions.

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November 2007