

Tools for  
Community Planning  
Group Members

# HIV Prevention

## Setting HIV Prevention Priorities: *A Guide for Community Planning Groups*

March 2005



Center on AIDS & Community Health

*Developed by the AED Center on AIDS & Community Health with  
funding provided by the Centers for Disease Control and  
Prevention under contract #200-97-0605 task 084.*

# HIV Prevention

## Setting HIV Prevention Priorities *A Guide for Community: Planning Groups*

March 2005



Center on AIDS & Community Health

*Developed by the AED Center on AIDS & Community Health with  
funding provided by the Centers for Disease Control and  
Prevention under contract #200-97-0605 task 084.*

# Acknowledgments

*“Setting HIV Prevention Priorities: A Guide for Community Planning Groups”* was initially published October 2000 and based on the collective experiences of many people working in and with HIV prevention community planning groups around the country. We want to continue expressing our appreciation to the following individuals who shared their insights for the initial prioritization document: Maurice Call and Andy Handler from California; Kendra Phillips from Chicago; Bob Bongiovanni from Colorado; Cal Baker, Mike Mizwa, Peggy Rogers, and Deborah Scott from Houston; Ann Rogers and Patricia Young from Iowa; Lisa Longfellow from Louisiana; Liisa Randall from Michigan; Lucy Slater from Minnesota; Frank Gray, Sally Klein, Kathleen Martin, Ernie Saxman, and Annie Sondag from Montana; Steve Saunders from New Jersey; Brenda Crowder-Gaines, John Morrow, David Napp, Pat Oxendine, and Ricky Rouse from North Carolina; and Kitten Holloway and Cathy Hurst from Texas. Thanks are also due to the project area coordinators who supplied materials for this document: Iowa, Florida, Louisiana, North Carolina, San Francisco, and Wisconsin.

We also want to thank the reviewers who contributed so much time and knowledge to the 2000 *“Setting HIV Prevention Priorities”* guide, including: A.D. McNaghten and Joyce Neal, formerly of the Council of State and Territorial Epidemiologists; David Cotton, ORC Macro International; Lynne Greabell, National Alliance of State and Territorial AIDS Directors; Duane Wilkerson, American Psychological Association; Nancy Hall, Washington State Department of Health; David Napp, consultant; Lyn Paleo, consultant; Annie Sondag, University of Montana; Steve Saunders, New Jersey Department of Health; and Lucy Slater, Minnesota Health Department.

In addition, we want to acknowledge Janet Cleveland, Sue Dietz, and Sam Taveras, **Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention, Intervention Research & Support**, for their review comments and continued support for community planning. Several CDC project officers and team leaders also contributed their time and feedback on the original document including: Nikki Economou, Wendy Lyon, Kevin O’Connor, Tim Quinn, and Mary Willingham-Wettrich.

The main authors for the initial 2000 guide were **Academy for Educational Development** (AED) staff including Frank Beadle de Palomo, Rosanne Hoffman, and Jackson Peyton, with special assistance from Annette Martin. Additional AED contributors included Kanwaldeep Bajwa, Alexandra Burtea, Michael Kaplan, Sharon Novey, Gabriel Rendon, Sue Stein, Wanda Womack, and Joy Workman.

Carolyn Mulford, with The Writing Coach, served as senior editor for the initial 2000 guide and Ronne Ostby-Malling designed and formatted the original document. Derek Hodel, with The Daystar Group, developed additional materials for the original document.

After 2000, modifications and revisions were made to the Community Planning Guidance and therefore, it was essential to update the prioritization guide. This revised guide also reflects the **Centers for Disease Control and Prevention's (CDC) Advancing HIV Prevention Initiative**. Many contributors to the original guide were also instrumental in this revision. Our appreciation goes to them and to the many newly involved individuals who were generous with their time and comments for this revision: Floyd Meeks, Pima County Health Department, Arizona; Drew Johnson, California Health and Human Service Agency; Nancy Kern, Hawaii State Department of Health; Kathy Donner and Liatris Studer, Kansas Department of Health and Environment, Jennifer Logan, Massachusetts Department of Public Health, and Tracy Luster Welch, Ohio Department of Health. Thanks also to the project area coordinators who posted materials on the Internet: Iowa, Nebraska, New Jersey, and Pennsylvania.

Thanks also are due for the review comments and the knowledge contributed by CDC staff including: Janet Cleveland, Marlene Glassman, Robert Kohmescher, Romel Lacson, Corinne Matthews, June Mayfield, Mac McCraw, Thomas Painter, Victoria Rayle, Bryce Smith, Sam Taveras, Linda Wright-Deaguero, Keith Yamaguchi, and Aaron Zee. Lynne Greabell from the National Alliance of State and Territorial AIDS Directors also provided counsel on this revision.

Several additional AED staff reviewed and commented on this revision including: Nickie Bazell, Deborah McGruder, Melanie Ogleton, Denise Raybon, Scott Thompson, and Joy Workman. Jean Kohanek and Jose Noda of AED revised and formatted this document. Miguel Santos Gonzalez translated this document into Spanish. Please accept our apology if your name has been omitted from this acknowledgment page.

The **AED Center on AIDS & Community Health** prepared this document under contract with the Centers for Disease Control and Prevention (contract #200-97-0605, task #084) to provide technical assistance and support for HIV prevention community planning.

This document is available online at: [www.HIVAIDSTA.org](http://www.HIVAIDSTA.org). For additional copies of this publication, please contact the National Prevention Information Network at 1-800-458-5231. Ask for publication identification #E196.

# Table of Contents

- Chapter 1: Introducing Priority Setting . . . . . 1**
  - Purpose of This Guide . . . . . 2
  - How to Use This Guide . . . . . 3
  - Common Questions and Answers About Priority Setting . . . . . 4
  - A Scenario: The Adventures of the *Better the Second Time Around* HIV Prevention CPG . . . . . 9
  - Priority Setting Overview . . . . . 16
  - Notes . . . . . 18
  
- Chapter 2: Getting Ready to Set Priorities: Group Process . . . . . 19**
  - Review Your Bylaws . . . . . 21
  - Choose a Decision-Making Method . . . . . 21
  - Review or Develop Conflict-of-Interest Statements . . . . . 21
  - Identify Roles and Responsibilities of Committees . . . . . 23
  - Review Communication and Team-Building Exercises . . . . . 25
  - Priority Setting in Project Areas with Multiple Groups . . . . . 28
    - Worksheet 1: Reviewing and Developing Management Procedures* . . . . . 30
  - Notes . . . . . 35
  
- Chapter 3: Getting Ready to Set Priorities: Managing The Work . . . . . 37**
  - Clarify Current Priorities . . . . . 37
  - Develop Workplans With Timelines . . . . . 39
  - Gather Resources . . . . . 40
    - Worksheet 2: Clarify Current Priorities* . . . . . 42
    - Worksheet 3: Develop a Workplan with a Timeline* . . . . . 44
    - Worksheet 4: Current Target Populations and Interventions* . . . . . 48
  - Notes . . . . . 50

<b>Chapter 4: The Key Steps of Priority Setting</b> . . . . .	<b>51</b>
Understanding Factors . . . . .	51
Understanding Weights . . . . .	52
Understanding Rating . . . . .	53
Understanding Scoring . . . . .	54
Evaluating the Results . . . . .	55
Worksheet 5: Vacation Priorities Exercise . . . . .	56
Notes . . . . .	62
<b>Chapter 5. Priority Setting Steps for Target Populations</b> . . . . .	<b>63</b>
What the <i>Guidance</i> Says . . . . .	63
Step 1: Identify and Define Target (High-Risk) Populations . . . . .	66
Step 2: Determine Factors . . . . .	70
Step 3: Weight Factors . . . . .	72
Step 4: Rate Target Populations Using Factors . . . . .	78
Step 5: Score Target Populations Using Factors . . . . .	84
Step 6: Rank Target Populations . . . . .	85
Step 7: Review Rankings, Set Priorities, and Rank-Order the Final List . . . . .	86
Worksheet 6: Identify and Define Target Populations . . . . .	90
Worksheet 7: Determine Factors for Target Populations . . . . .	92
Worksheet 8: Weight Factors for Target Populations . . . . .	94
Worksheet 9: Rate Factors for Target Populations . . . . .	96
Worksheet 10: Score Target Populations Using Factors . . . . .	98
Worksheet 11: Rank-Order Target Populations . . . . .	100
Notes . . . . .	102
<b>Chapter 6: Steps for Choosing Interventions</b> . . . . .	<b>103</b>
What the <i>Guidance</i> Says . . . . .	103
Step 1: Identify Interventions . . . . .	104
Step 2: Determine Factors . . . . .	111
Step 3: Weight Factors . . . . .	116
Step 4: Rate Interventions Using Factors . . . . .	118
Step 5: Score Interventions Using Factors . . . . .	125
Step 6: Rank Interventions . . . . .	126
Step 7: Review Scores and Complete List of Interventions for Each Target Population . . . . .	128
Worksheet 12: Identify and Define Interventions . . . . .	129
Worksheet 13: Determine Factors for Interventions . . . . .	131
Worksheet 14: Weight Factors for Interventions . . . . .	133
Worksheet 15: Rate Factors for Interventions . . . . .	135
Worksheet 16: Score Interventions Using Factors . . . . .	137

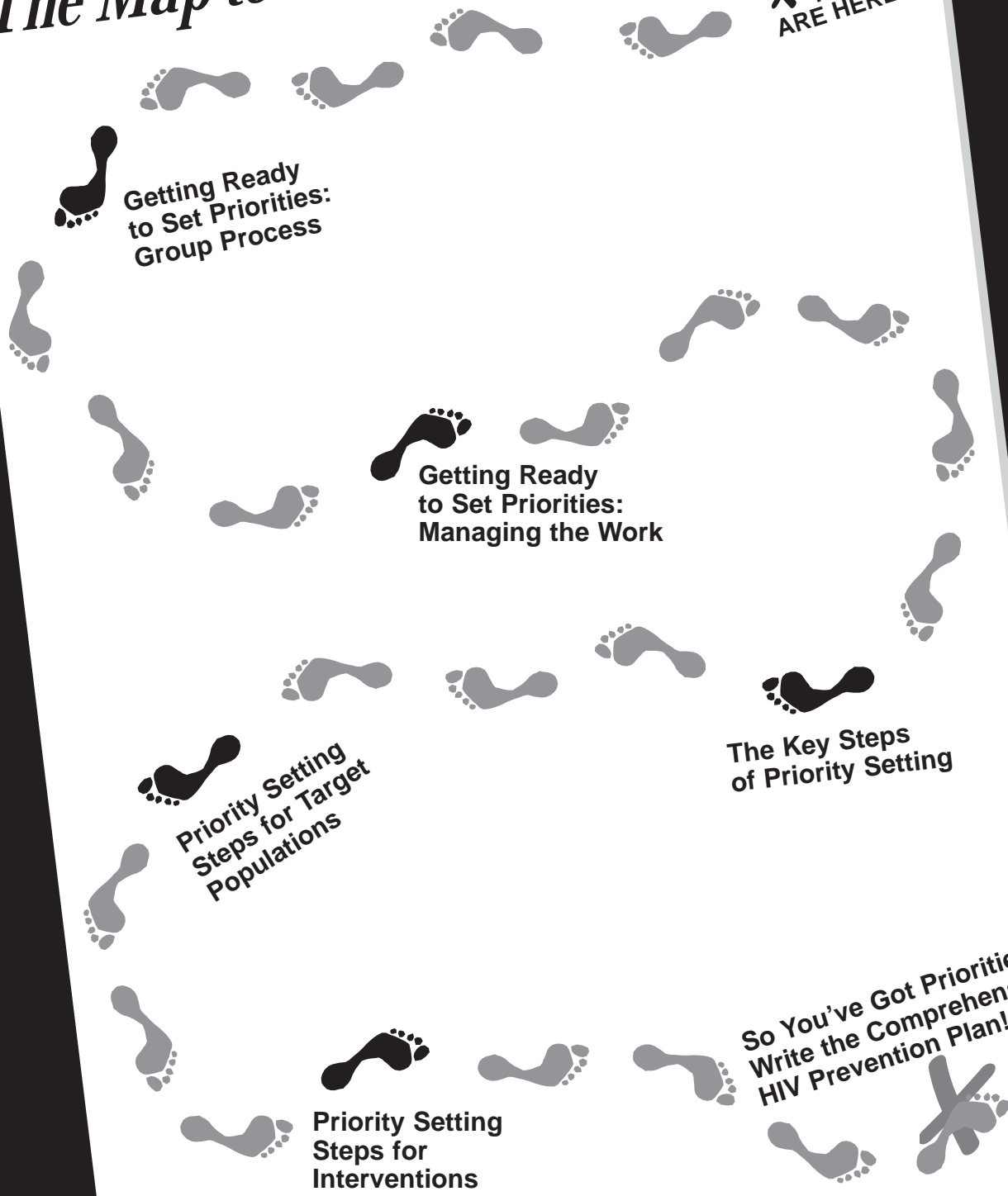
<i>Worksheet 17: Rank-Order Interventions</i> . . . . .	139
Notes . . . . .	141
<b>Chapter 7: So You've Got Priorities. Now What?</b> . . . . .	<b>143</b>
The Comprehensive HIV Prevention Plan and Concurrence . . . . .	143
Writing the Plan . . . . .	143
What Does the Plan Include? . . . . .	143
How Often Is the Plan Written? . . . . .	144
What Is the Difference Between the Plan and the Application? . . . . .	144
Writing the Prioritized Populations and Recommended Interventions Section of the Plan . . . . .	145
Concurrence . . . . .	146
<i>Worksheet 18: Write the Plan</i> . . . . .	149
Notes . . . . .	151
<b>Glossary</b> . . . . .	<b>153</b>
<b>Appendices</b> . . . . .	<b>163</b>
Appendix A: CDC National Technical Assistance Providers' Network . . . . .	163
Appendix B: Sample Ground Rules for Planning Groups . . . . .	167
Appendix C: Decision-Making Methods . . . . .	169
Appendix D: Sample Conflict-of-Interest Disclosure Form . . . . .	173
Appendix E: Keeping Your Committee Focused and Efficient . . . . .	175
Appendix F: Structuring an Effective Committee . . . . .	177
Appendix G: Icebreakers, Energizers, and Team Builders . . . . .	179
Appendix H: Sample Letters of Concurrence and Nonconcurrence . . . . .	181
Appendix I: Interventions for HIV Positive People . . . . .	187
<b>Bibliography</b> . . . . .	<b>193</b>
Community Planning and CDC Initiatives . . . . .	193
Group Process . . . . .	195
Epidemiology and Community Services Assessment . . . . .	196
Target Populations . . . . .	197
Interventions . . . . .	198
Project Area Web Sites . . . . .	201





# The Map to Priority Setting

**X YOU ARE HERE!**



# A Scenario: The Adventures of the *Better the Second Time Around* HIV Prevention Community Planning Group

The Adventures of the *Better the Second Time Around* HIV Prevention Community Planning Group is a tale of a fictional group as it sets population and intervention priorities. The full story is told at the end of Chapter 1, and a portion appears at the beginning of each chapter.

## Chapter 1: Introducing the CPG

### Situation

It's time for the CPG to reconsider its priorities. It is the end of the second year of a three-year cycle, and members don't want to rush through the process. Ten members, including the community co-chair, were not involved in setting priorities last time. The group members who did participate all say that it was a painful period for the group. All of the veteran priority setters report struggling with how to identify target populations — by risk behavior or demographic description or a combination of both.

### Project-area profile

Large state  
Moderate incidence  
Epidemiology: three major risk groups impacted  
    Behavioral Risk Group 1  
    Behavioral Risk Group 2  
    Behavioral Risk Group 3  
HIV names reporting introduced one year ago  
Two large cities (over 500,000 people)  
Large rural areas

### CPG profile

One statewide group with 30 members  
Four regions represented in group (from four advisory groups that are not required to concur with the health department application)  
Overall, the group is representative of the epidemic in the state, but it is difficult to get members of Behavioral Risk Group 2 to participate.

### CPG member profile

**Health department co-chair:** Paula, 44 years old. She is a nurse who has worked for the health department for 17 years and has been health department co-chair for four years. Paula is concerned that the group will not concur with the health department's application.

**Community co-chair:** Kim, 33 years old. He began his term as co-chair three months ago after being in the group for one year. Kim is the executive director of a community-based organization serving Behavioral Risk Group 2. His major concerns are that the group is not focusing on the real epidemic and that he will be perceived as having a conflict of interest.

**Priority setting committee chair:** Helen, 51 years old. She is a nurse with extensive HIV care experience who is uncomfortable with the "looseness of the community planning process."

**Bylaws and governance committee chair:** Norma, 56 years old. Norma is an attorney whose favorite brother died of AIDS. She is quite concerned that the group won't follow proper parliamentary procedures.

**Interventions committee chair:** Luis, 24 years old. He is enthusiastic about making sure the group has the latest information on intervention effectiveness. Luis teaches math in a junior high school.

# 1

## Introducing Priority Setting

**Successful decision making in HIV prevention starts with setting priorities.**

Priority setting is complex and may be controversial. It's also crucial, for it determines how the health department spends limited resources for HIV prevention. Community planning groups (CPGs) need a solid, tried-and-true priority setting system — one that will be fair, objective, and practical, one that will get the job done, and one that will be easy to duplicate.

**We need to establish priorities — a ranking of choices that reflects our sense of what's important.**

We all make choices every day of our lives. Some decisions are simple and can be made quickly. For example, suppose you must make two important telephone calls, one to your doctor to schedule your next physical and the other to your talkative relative to gossip about the family. Which call will you make first? You may decide based on the amount of time each conversation will take. In this case, you decide to call your doctor first, since that will not take more than five minutes. You can then spend more time enjoying a lengthy conversation with your relative.

**Decision making can become more complicated when many people take part in the process.** The more people involved, as with community planning, the more perspectives you need to take into account. For example, suppose you are planning to go out to dinner with four friends. Where should you go? How will the five of you decide? We will use this example in Chapter 4 to illustrate some of the basic concepts of priority setting for HIV prevention community planning: factors, weighting, rating, scoring, and ranking.

## Purpose of This Guide

This guide is a reference and workbook for HIV prevention community planning groups as they perform the following tasks:

- Developing or reviewing and modifying a priority setting process that is clear and acceptable to the community, the health department, and the Centers for Disease Control and Prevention (CDC)
- Orienting new members and health department staff to the priority setting process
- Making explicit the factors used to set priorities
- Documenting the evidence used to justify decisions

But let's start at the beginning — with an overview of what this guide will help your CPG accomplish. With the aid of examples, exercises, worksheets, and nuts-and-bolts explanations, this guide will show step by step:

- What priorities are, in the context of HIV prevention community planning
- What preliminary steps you need to take to avoid later pitfalls
- How to work as a group and manage the priority setting process
- How to identify and develop population priorities that reflect the 2004-2008 *Guidance for HIV Prevention Community Planning*
- How to identify and select a set of appropriate science-based prevention activities and interventions
- How to ensure priorities are included in the comprehensive prevention plan
- How to handle concurrence requirements
- Where to go for more help

“There aren't enough dollars for HIV prevention, and there are likely to be fewer in the future. HIV prevention efforts have to be focused on the people most at risk. The question that all groups need to answer is: How can we prevent the most infections in our community?”

— *Community co-chair*

## How to Use This Guide

This guide is designed for individuals and committees who set HIV prevention priorities. Each chapter begins with a list of priority setting tasks to complete and with the relevant portion of a priority setting scenario. The complete scenario, which describes a group's trials, tribulations, and successes, appears at the end of this chapter.

**W** Each chapter ends with worksheets that will help you carry out the tasks discussed in that chapter. The worksheets are referenced throughout the text and are identified by this icon.

Use the worksheets to structure your CPG's work and to document its priority setting process. Once completed, the assembled worksheets summarize your priority setting process and outcomes. You can use these to write the comprehensive HIV prevention plan required by the *Guidance*.

Go to the Glossary on page 155 for definitions of new terms and explanations of acronyms.

To realize the greatest benefit from this guide, consider the following uses.

- **Community planning group members**

New group members should read Chapters 1 and 4 first. Read other chapters as you become comfortable with the material. Check your understanding of the material by reviewing the worksheets at the end of each chapter.

Experienced group members should skim the Table of Contents and pick and choose the material that seems most relevant. Most group members will find it helpful to review the basics of priority setting in Chapter 4.

- **Co-chairs**

Refer to Chapters 2 and 3 to ensure that the group is ready to work together to set priorities and that the necessary logistical and data collection needs have been considered. Review other chapters as necessary to clarify processes and desired outcomes.

- **Priority setting committee** (or other groups responsible for designing the priority setting process)

Review Chapter 1 to ensure that you can find the information you need. Consider conducting the priority setting exercise in Chapter 4 with the entire planning group. Carefully review Chapters 5 and 6 to help you develop a recommended priority setting process for the group.

## Common Questions and Answers About Priority Setting

**Q:** What are priorities in terms of HIV prevention community planning?

**A:** Priorities are the most important target populations and the interventions you recommend for them.

**Q:** What is priority setting in HIV prevention community planning?

**A:** It is the CPG's main task. The priority setting process produces a list of ranked priority target populations and recommended interventions for them. This process helps the health department direct prevention funds to those populations most at risk for HIV. CDC set forth requirements and expectations for HIV prevention community planning in the *Guidance*, which says:

*The primary task of the CPG is to develop a comprehensive HIV prevention plan that includes prioritized populations and a set of prevention activities/interventions for each population.*

**Q:** What does CDC expect CPGs to do to make the community planning process consistent with the Advancing HIV Prevention initiative?

**A:** CPGs will be expected to make people living with HIV the highest priority for prevention services. CPGs are still expected to prioritize activities for those populations of unknown or negative serostatus who are at highest risk for becoming infected based on the Integrated Epidemiological Profiles and Community Services Assessment. Counseling, testing, and referral as well as partner notification services are important strategies to help people at risk learn of their infection status.

**Q:** What, then, is the role of CPG members in setting priorities?

**A:** CPG members still need to learn about all prevention needs in their community. Members then use that information to decide objectively which target populations will receive specific HIV prevention interventions and services.

Not all people living with HIV or AIDS (PLWHA) are at equal risk for transmitting HIV or for becoming reinfected. Your CPG will have to decide which subgroups are at greatest risk and which interventions will help them to stop risky behaviors. Of course, you will still have to set priorities among HIV-negative people and people of unknown serostatus.

“CPG members' input in the priority setting process is essential. HIV prevention resources must be rationed with or without the community planning group's input.”

—Health department co-chair

The *Guidance* says:

*Review and use key data to establish prevention priorities. The CPG should review all existing and new products (i.e., epidemiologic profile, community services assessment, prioritized target populations, selected set of prevention activities/interventions, and the comprehensive HIV prevention plan) prior to all decision making.*

**Q: Why did CDC mandate that PLWHA be considered the highest priority in our HIV prevention plans?**

**A:** The goal of HIV prevention is to stop the spread of disease. Two general priority populations should be targeted for HIV prevention: 1) persons living with HIV/AIDS who are likely to transmit infection because of unsafe behaviors and 2) uninfected persons who are likely to become infected because of their unsafe behaviors. The first group is the higher priority because the chance of transmission is far greater in this group than in the second group. Each population has groups of individuals who are at greater risk.

**Q: Where does priority setting fit into HIV prevention community planning?**

**A:** Priority setting results from the work done in producing the epidemiologic profile and the community services assessment, which includes the needs assessment, resource inventory, and gap analysis. It is important to ensure that the results of the CPG's work are incorporated into the comprehensive HIV prevention plan and disseminated widely throughout the community.

The CPG will rank HIV prevention target populations with an accompanying set of interventions according to their urgency. This prioritized list will form the basis for the comprehensive HIV prevention plan that the health department will use in its application to CDC for HIV prevention funding.

**Q: What is the Program Evaluation and Monitoring System (PEMS)?**

**A:** PEMS is CDC's software for collecting standardized HIV prevention program data. That information will be used to assess service delivery, program performance, and budgetary information. It will also be used to monitor the implementation and quality of the HIV prevention community planning process.

**Q: How will PEMS affect HIV prevention community planning?**

**A:** PEMS will not change the community planning process, but PEMS requires that health departments describe priority populations and interventions in a specific manner. CPGs will want to use the same rules and language to ensure that the plan matches the health department's CDC application and progress reports. Ask your health department for clarification on its PEMS reporting requirements.

**Q: How does PEMS specify that target populations be described?**

**A:** PEMS allows health departments to report up to 99 target populations. Of course, the number one target population must be HIV-positive people. The number two through 99 populations may be HIV-positive, HIV-negative, or of unknown status.

PEMS also requires health departments to describe these characteristics for each target population.

- Priority population (name)
- Transmission risk
- Race
- Ethnicity
- Gender
- Age
- HIV status

Additional desirable information includes priority population size, proportion of priority population that is reachable with an intervention, geographic location, HIV/AIDS prevalence, prevalence of risky behaviors, and the community's input into a population's prevention needs.

**Q: How does PEMS specify that interventions be described?**

**A:** PEMS requires that health departments be very specific in describing interventions.

- Program name
- Program Model Name
- Program model Start Date and End Date
- Target population
- Basis for program model (choose one)
  - Evidence-based study (See models listed in: [www.cdc.gov/hiv/pubs/HIVcompendium.htm](http://www.cdc.gov/hiv/pubs/HIVcompendium.htm))
  - CDC recommended guidelines (See Procedural Guidance Documents: [www2a.cdc.gov/hhivpra/pa04064.html](http://www2a.cdc.gov/hhivpra/pa04064.html))
  - Other basis (scientific, theoretical, or operational)

**Q: What are the challenges of setting priorities?**

**A:** In many cases, CPGs have had difficulty making decisions about priorities. Here are some reasons.

- Some CPG members feel that all populations deserve prevention services. Everyone does deserve HIV prevention services, but those individuals most at risk need special attention. The reality is that funding is too limited to help everyone.



Some CPG members fear they lack the expertise and information to make decisions about prevention needs. Every member brings knowledge and insight to the group. It is the group's responsibility to disseminate information so that all members understand it. Also, sometimes CPG members do not trust the data that are available. A clear priority setting process will build trust and allow the group to identify the best available information.

- Some CPG members are afraid to exclude racial, ethnic, and/or sexual minorities for fear of appearing racist, insensitive, or homophobic. Traditionally, individuals in various minority communities have been underserved. As the epidemic increases in these communities, they deserve a fair share of prevention efforts. But HIV infection results from specific behaviors, not from belonging to a certain group. If a need can be demonstrated (i.e., documented through the epidemiologic profile and community services assessment), then the CPG must decide how to prioritize the need.
- Some CPG members have difficulty separating their role as advocates for specific populations from their role as CPG members. It's hard to put aside a strong commitment to a specific population. However, CPG members are responsible for preventing HIV infections among the entire community. Members need to step back and examine the entire context of the HIV epidemic in their communities. It is important for all members to put allegiances aside and trust the priority setting process.
- Some CPG members feel they have to represent the interests of a particular agency. This is a conflict of interest. The CPG member's role is to ensure that the populations most at risk are made priorities.

**Q: What are the benefits of setting priorities?**

**A:** Community planning groups face formidable challenges, but clear, well-defined priorities offer many benefits. These benefits include:

- Resources targeted to where they will be most effective in preventing HIV transmission
- Guidelines for the health department as it applies for funds from CDC and other sources
- Guidelines for the grantee health department as it allocates funds to local health departments and community-based organizations
- Reasons for foundations and corporations to invest in HIV prevention
- Justification for controversial programs
- Justification for supporting organizations that reach marginalized populations
- Increased collaboration among organizations
- Community endorsement of prevention programs

**Q: Where can we get additional help with priority setting?**

**A:** CDC funds a national network of technical assistance providers (see Appendix A on page 161) to assist with all phases of community planning. If you need help in designing a priority setting process or would like more information about what other project areas are doing, contact your CDC project officer at (404) 639-5230.

Please note that CDC does not fund the technical assistance network to carry out your priority setting process or responsibilities of health department staff or community planning group members. A technical assistance provider can help you develop a process, review samples from other project areas, and develop training for your members in that process.

**TARGET POPULATION**

As in CDC's *Guidance*, this guide uses the terms target population and high-risk population interchangeably. Both terms refer to groups that are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior. These groups are often identified using a combination of behavioral risk factors and demographic characteristics. Because some people may be sensitive to these terms, CPGs should discuss what term members prefer. For example, some CPGs prefer behavioral risk group, prevention group, primary audience, target audience, or at-risk population.

## A Scenario: The Adventures of the *Better the Second Time Around* HIV Prevention Community Planning Group

The Adventures of the *Better the Second Time Around* HIV Prevention Community Planning Group is a tale of a fictional group as it sets population priorities and makes intervention recommendations. The full story is told here, and a portion appears at the beginning of each chapter. Follow along as the *Better the Second Time Around* CPG revises its priority setting process and sets priorities.

### Chapter 1: Introducing the CPG

#### *Situation*

It's time for the CPG to reconsider its priorities. It is the end of the second year of a three-year cycle, and members don't want to rush through the process. Ten members, including the community co-chair, were not involved in setting priorities last time and don't understand how the priorities were selected. The group members who did participate seem united in saying that it was a painful period for the group. All of the veteran priority setters report struggling with how to identify target populations — by risk behavior or demographic description or a combination of both.

Some of the CPG members are concerned that the CDC's Advancing HIV Prevention initiative requires them to rank as top priority people living with HIV/AIDS (PLWHA). What's left for us to do? How can they decide for us who is most at risk? The interventions committee chair is puzzled that the *Guidance* asks the CPG to recommend a set of interventions for each target population but not a set of intervention priorities.

#### *Project-area profile*

- Large state
- Moderate incidence
- Epidemiology: three major risk groups impacted
  - Behavioral Risk Group 1
  - Behavioral Risk Group 2
  - Behavioral Risk Group 3
- HIV names reporting introduced one year ago
- Two large cities (over 500,000 people)
- Large rural areas

#### *CPG profile*

- One statewide group with 30 members

Overall, the group is representative of the epidemic in the state, but it is difficult to get members of Behavioral Risk Group 2 to participate

### *CPG member profile*

**Health department co-chair:** Paula, 44 years old. Her background is in public health and nursing. She has worked for the health department for 17 years and has served as health department co-chair for four years. Paula is a supporter of community planning. She is quite concerned that the group will not concur with the health department's application.

**Community co-chair:** Kim, 33 years old. He began his term as co-chair three months ago after being in the group for one year. Kim is the executive director of a community-based organization serving Behavioral Risk Group 2. His major concerns are that the group is not focusing on the real epidemic and that he will be perceived as having a conflict-of-interest because of his work.

**Priority setting committee chair:** Helen, 51 years old. She is a nurse with extensive HIV care experience. She is uncomfortable with what she describes as the "looseness of the community planning process."

**Bylaws and governance committee chair:** Norma, 56 years old. Norma is an attorney whose favorite brother died of AIDS. She is quite concerned that the group won't follow proper parliamentary procedures.

**Interventions committee chair:** Luis, 24 years old. He is very enthusiastic about making sure the group has the latest information on intervention effectiveness. Luis teaches math in a junior high school.

## **Chapter 2: Getting Ready to Set Priorities: Group Process**

### *Situation*

The CPG knows it's time to reconsider priorities, and the co-chairs have asked Helen, chair of the priority setting committee, to schedule a meeting for the full group in three weeks. Helen, using her best diplomatic skills, says that this project may take a little more than three weeks.

### *Action*

The CPG chose Helen to chair the committee because she was there the last time the CPG set priorities and because she gets things done. A few members affectionately call her the "process queen."

The deadline looming, Helen feels that the members of her committee are being asked to "do it all." She doubts that the group is ready to take on priority setting and is uncertain where to begin. She has an uneasy feeling that they need to take care of some housekeeping tasks first. Several committee members

participated in the last round of priority setting and want to get outside help. One suggests contacting a co-chair from another project area who had presented a workshop on priority setting at the HIV Prevention Community Planning Leadership Summit.

Helen calls that person and receives a checklist of things that needed to be considered. (See page 17, “Getting Ready to Set Priorities: Group Process.”) She asks the co-chairs to help her review and clarify the list. After several conference calls and a meeting, the CPG decides on the following:

- Use consensus decision making when possible, and a majority vote when consensus isn’t possible.
- Because the roles and responsibilities of its various committees aren’t clear, the committee chairs will meet to clarify these. The community services assessment and epidemiologic committees must settle who will gather certain data sets and who will be responsible for analyzing the information and getting it back to the full CPG.
- The bylaws are quite clear about conflict of interest, but the group needs to review the policy, and all members need to sign a conflict-of-interest statement.
- Because several new members of the group have felt a split between old and new members, the group will spend the first half day of its next meeting working on team building. Social events will be a part of each meeting. The CPG will also conduct a thorough orientation for new members.
- The group won’t use an outside facilitator because it feels an outsider wouldn’t understand its needs.

## Chapter 3: Getting Ready to Set Priorities: Managing the Work

### *Situation*

The group is growing restless. Some of the members feel they are spending too much time talking about setting priorities and not enough time doing. But Helen, the priority setting committee chair, and Kim, the community co-chair, still feel they aren’t ready to proceed.

### *Action*

Helen and Kim call for a detailed workplan with a timeline. A subcommittee, assisted by a health department staff member, contacts a neighboring state’s CPG and gets a copy of its workplan that might serve as a template.

The subcommittee gathers information from the various committees about their tasks and timelines. They are dismayed to find that the community services assessment committee isn’t planning to finish its work until August, too late for the group to use the information in priority setting. This means that the gap analysis won’t be complete for all populations. Several similar problems come up, including a delay in the epidemiologic profile.

Several members point out the need for more information about some of the potential target populations, especially those groups that seem to be at high risk but have not emerged in significant numbers in the epidemiologic profile. Everyone wants more information about interventions for those populations.

The community services assessment committee burns the midnight oil and gathers as much information as possible. They aren't happy with the results for all populations and ask that Helen and Kim extend the workplan to include more research about these populations.

The gap analysis results come in on time. While the gap analysis couldn't be completed for all of the populations, the group feels it has enough information to proceed. The group is pleased to find that evidence-based interventions are in place in most areas for the top three behavioral risk populations. However, there are gaps in service for Behavioral Risk Group 2 in one large metropolitan area, and no services are available at all in many rural areas.

Finally, an AIDS director from another project area advises the group, "Don't start from scratch! Use the priorities you have and make them better." He reports that in his project area, new members were grateful for a review of current priorities, and that talking about the history of how those priorities were set helped the group avoid several stumbling blocks.

## Chapter 4: The Key Steps of Priority Setting

### *Situation*

Emotions are running high inside the CPG. Several members want to go ahead and set priorities since "everyone knows who gets AIDS." Besides, the group knows that PLWHA are already the top priority. The priority setting committee feels it needs a way to explain the priority setting process it has developed. But they're afraid some of the group members are so anxious to get the job done they will rush through the process without considering all the steps.

### *Action*

Several group members attend a priority setting workshop at the National HIV Prevention Conference. Part of the workshop is an exercise that gives them a chance to set priorities about taking a vacation, a much less emotionally charged issue than deciding about HIV prevention priorities. They enjoy the exercise and decide to replicate it to orient the entire group to the key steps of priority setting. The CPG tries to do the exercise without using weights and finds the results confusing. They agree that weighting factors seems a better way to develop a clear set of priorities.

## Chapter 5: Priority Setting Steps for Target Populations

### *Situation*

At last, the group feels it is ready to consider setting priorities among high-risk populations. The full group asks Helen and her priority setting committee to identify a list of potential target populations and factors to be used in setting priorities among those populations.

### *Action*

The priority setting committee balks: “Identifying target populations is not our job. The community services assessment committee was supposed to do that.” In fact, that committee, using the epidemiologic profile and the components of the community services assessment — the needs assessment, the resource inventory, and the gap analysis — has developed a list of potential target populations. Helen and her committee take this list and develop a suggested set of factors for the full CPG to consider. They find the principles from North Carolina especially helpful (see page 72) and select five factors, a mix of fact and value-based items. The priority setting committee also asks that the workplan be modified to include three meetings to consider priorities for target populations and three meetings to develop intervention recommendations for the target populations.

When the committee presents its extensive list of potential target populations, Luis looks surprised. He says, “Wait a minute. You have all PLWHA lumped together. Not all PLWHA are at equal risk for transmitting the virus or for becoming reinfected. That’s like saying that all men who have sex with men are at high risk.”

Helen responds that her committee was only doing “what the *Guidance* says.” A call to their project officer resolves the issue. The project officer agrees with Luis and says, “CPGs should name the PLWHA subpopulations. That’s the only way to be sure that you recommend interventions for each subgroup that will really help positive people avoid risky behaviors.” Luis is relieved, and Helen and her committee produce a new list of potential populations.

A few people have comments about the priority setting committee’s suggested factors. Two vocal group members argue that the draft set of factors places too much emphasis on HIV incidence. They point out that their state doesn’t yet have sufficient data because unique-identifier reporting began only one year earlier. After considerable discussion, the group arrives at a set of factors members are comfortable with. They agree on the relative importance (weight) of each of the factors and a system for rating each of them.

Before the next meeting, the community services assessment committee sends out information relevant to each of the factors about the potential target populations. The committee selects information carefully — the group has learned that there’s a limit to how much they can absorb. The committee invites several experts to discuss behavioral risks for different populations at the next meeting.

When the day arrives to actually set priorities, one of the group's veteran members comments: "I never thought we'd get here, but this is so much easier than last time. I feel like I have a lot of information to make decisions."

## Chapter 6: Selecting Interventions for Each Target Population

### *Situation*

Luis, chair of the interventions committee, believes the group shouldn't start from scratch in developing intervention recommendations for each priority population. He convinces his committee, and then the full CPG, that using the seven-step process is still the best way to proceed even though CDC doesn't require prioritized interventions anymore. He thinks that factors and weights are still important for the group to make good decisions about the most effective interventions.

### *Action*

Developing intervention recommendations goes more quickly than setting target population priorities. The group knows the process, takes pride in its success so far, and has solid information from the interventions committee. The priority setting committee had asked that Luis's committee recommend factors and weights for selecting interventions. Committee members were happy to do this and presented a clear idea of why they selected some factors and not others and why they felt some were more important than others. The list included data factors reflecting as much science as the committee could find and enough value-based factors to ensure that interventions would be feasible and acceptable to the target populations. The committee reached consensus on the factors quickly.

However, Luis and his committee were concerned about not finding evidence-based interventions for all the high-risk populations. The committee complains that "we're supposed to make all PLWHA our highest priority, but there aren't interventions for all the PLWHA subgroups." Luis was especially concerned that he could find no evaluations of interventions for those using Internet meeting places.

At the next meeting, the group asks a behavioral scientist to review the components of an effective intervention and to talk about specific interventions for their target populations. While this isn't new information for most of the group, it helps to focus discussion and allows people to ask about lingering issues. Several members say they're grateful to know that many of the interventions already in place in their project area are "state of the art." Luis says that it will be easier now for his committee to support the recommendations for interventions that don't have a long history of proven effectiveness.

Deciding on intervention priorities is still not easy. One CPG member, a popular and vocal advocate for a population that has ranked as a low priority, argues vehemently that this population is going to be left out, and that the health department will be forced to stop funding the general information campaign that was supposed to reach this group. The CPG is not swayed. After using the numeric process, mem-



bers take one last look and agree that their recommendations are based on solid data. Almost everyone on the group agrees that they have done the best they can to develop a plan that will stop as many infections as possible, given the limited resources.

## Chapter 7: So You've Got Priorities. Now What?

### *Situation*

Now that target population and intervention priorities are set, a consultant, hired by the health department with the assistance of the CPG, writes the comprehensive HIV prevention plan. The health department incorporates the population priorities and suggested set of interventions recommended by the CPG into its application for funding and sends the application to the community co-chair for review. Paula, the health department co-chair, is concerned the group may not concur.

### *Action*

The CPG had developed a plan to examine the health department application for concurrence. The plan is to circulate a synopsis of the health department's application to the full CPG. The group agrees that comments are due to Kim, the community co-chair, in two weeks. If there are concerns about the application, Kim will convene a conference call to discuss the actions needed.

Kim receives many comments, all positive. He signs the letter of concurrence signifying that the application reflects the priorities the group spent so much time and effort developing.

The CPG decides to use its next meeting to celebrate its hard work, to talk about how to publicize the plan, and to develop a plan for plugging the information gaps the group identified during the process. Everyone agrees that setting priorities was hard work but the final product is worth the effort.

# PRIORITY SETTING OVERVIEW

## □ **Getting Ready to Set Priorities: Group Process**

1. Review or develop ground rules.
2. Review bylaws for clarity about decision making, conflict of interest, and committee structure.
3. Review or develop a decision-making method.
4. Review or develop conflict-of-interest statements.
5. Identify roles and responsibilities of committees.
6. Review communication and team-building exercises.
7. Prepare to deal with conflict.

## □ **Getting Ready to Set Priorities: Managing the Work**

1. Review the priority setting process you used to select your current priorities.
2. Develop workplans with timelines.
3. Gather information and resources your group will need, including:
  - Up-to-date epidemiologic profile
  - Current needs assessment data
  - Gap analysis results
  - List of potential target populations
  - Intervention effectiveness information for each target population

# PRIORITY SETTING OVERVIEW

## □ **Priority Setting Steps for Target Populations**

1. Identify and define target populations.
2. Determine factors for target populations.
3. Weight factors.
4. Rate target populations using factors.
5. Score target populations using factors.
6. Rank target populations.
7. Review rankings and prioritize target populations.

## □ **Steps for Selecting Interventions**

1. Identify a list of interventions for each target population.
2. Determine factors for interventions.
3. Weight factors.
4. Rate interventions using factors.
5. Score interventions for each target population using factors.
6. Rank interventions for each target population.
7. Review rankings and select recommended interventions for each target population.

## □ **So You've Got Priorities. Now What?**

1. Write the comprehensive HIV prevention plan.
2. Determine concurrence.

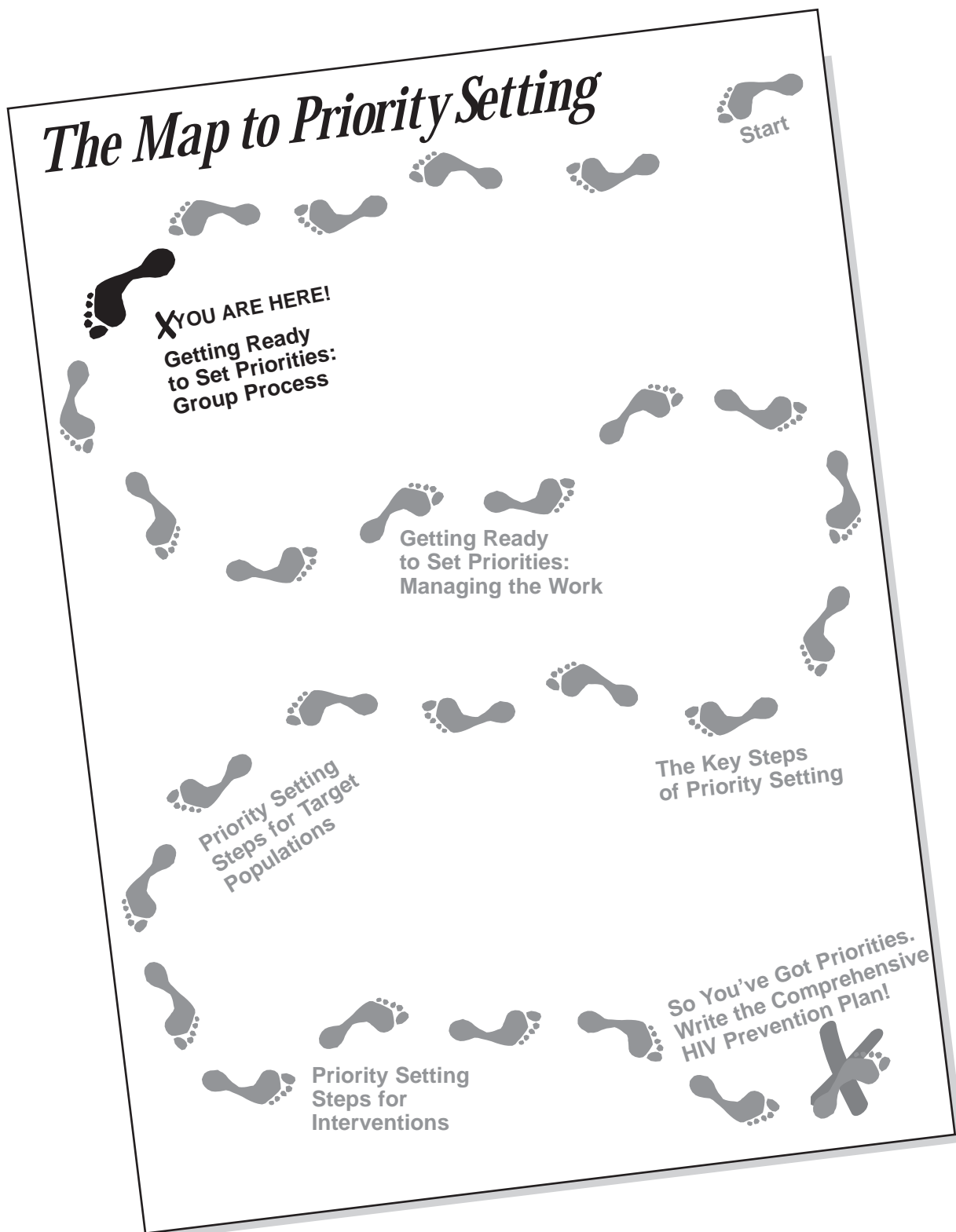
# 1

## Notes

1

INTRODUCING PRIORITY SETTING

# 2 Getting Ready to Set Priorities: Group Process



# The Continuing Adventures of the *Better the Second Time Around CPG*

## **Situation**

The CPG knows it's time to reconsider priorities, and the co-chairs have asked Helen, chair of the priority setting committee, to schedule a meeting for the full group in three weeks. Helen, using her best diplomatic skills, says that this project may take a little more than three weeks.

## **Action**

The CPG chose Helen to chair the committee because she was there the last time the CPG set priorities and because she gets things done. A few members affectionately call her the "process queen."

The deadline looming, Helen feels that the members of her committee are being asked to "do it all." She doubts that the group is ready to take on priority setting and is uncertain where to begin. She has an uneasy feeling that they need to take care of some housekeeping tasks first. Several committee members participated in the last round of priority setting and want to get outside help. One suggests contacting a co-chair from another project area who had presented a workshop on priority setting at the HIV Prevention Community Planning Leadership Summit.

Helen calls that person and receives a checklist of things that needed to be considered. (See page 12, "Getting Ready to Set Priorities: Group Process.") She asks the co-chairs to help her review and clarify the list. After several conference calls and a meeting, the CPG decides on the following:

- Use consensus decision making when possible, and a majority vote when consensus isn't possible.
- Because the roles and responsibilities of its various committees aren't clear, the committee chairs will meet to clarify these. The needs assessment and epidemiologic committees must settle who will gather certain data sets and who will be responsible for analyzing the information and getting it back to the full CPG.
- The bylaws are quite clear about conflict of interest, but the group needs to review the policy, and all members need to sign a conflict-of-interest statement.
- Because several new members of the group have felt a split between old and new members, the group will spend the first half day of its next meeting working on team building. Social events will be a part of each meeting. The CPG will also conduct a thorough orientation for new members.
- The group won't use an outside facilitator because it feels an outsider wouldn't understand its needs.

# 2

## Getting Ready to Set Priorities: Group Process

Setting priorities involves two distinct steps.

**Step One:** Developing a priority setting method

**Step Two:** Applying the method to produce priorities

### KEY TASKS IN GETTING READY TO SET PRIORITIES

The following checklist identifies the key tasks for your group to perform in assessing your CPG's readiness to develop a priority setting method.

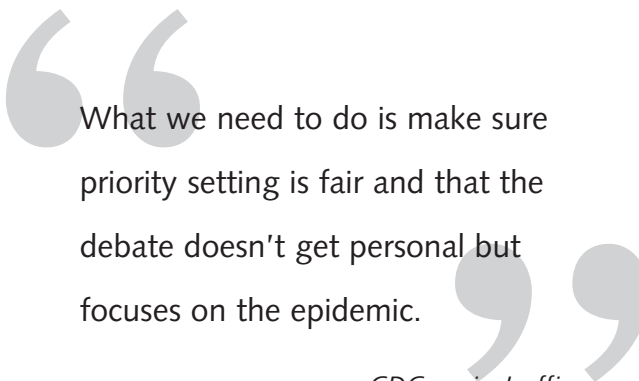
- Review or develop ground rules.
- Review bylaws for clarity about decision making, conflict of interest, and committee structure.
- Review or develop a decision-making method.
- Review or develop conflict-of-interest statements.
- Identify roles and responsibilities of committees.
- Review communication and team-building exercises.
- Prepare to deal with conflict.
- Decide whether to use an outside facilitator.

It's easy to overlook or underestimate the importance of step one. Developing a priority setting method for your CPG takes more time and effort than actually applying the method. Action-oriented CPG members may become impatient, but the time invested in developing your method will pay off when your CPG sits down to set priorities. CPG members with experience in priority setting identify adequate preparation as the key to a smooth process and a sound product.

Part of that preparation is making sure your group functions well. In this section, you will assess your CPG's readiness by looking at how your group makes decisions, deals with conflicts of interest, and delegates responsibility to committees. Use the worksheets at the end of this chapter to help you structure your work.

Before your CPG begins the priority setting process, it's helpful for members to agree on a set of ground rules for behavior during meetings. If your CPG already has written ground rules, review them and make any necessary changes or additions.

It's useful to have the ground rules easily available to CPG members throughout the entire priority setting process. Some CPGs also find it helpful to post these during meetings. If one or more members aren't respecting the rules, reviewing these gives the group an opportunity to remedy the situation. For a suggested list of ground rules, see Appendix B on page 169.



What we need to do is make sure priority setting is fair and that the debate doesn't get personal but focuses on the epidemic.

— CDC project officer



## Review Your Bylaws

An important step in developing a priority setting method is to review your bylaws. Ensure that everyone involved understands what the bylaws say about:

- Decision making: What are the rules about how your group makes decisions?
- Conflict of interest: How do your bylaws define and discourage conflict of interest?
- Committee roles and responsibilities: What committees do the bylaws specify? What are their roles and responsibilities in relation to priority setting?

**W** If your bylaws do not address these issues, the following sections will help you do so. Use Worksheet 1: Step 1 on page 30 to help you clarify your CPG's governance procedures and management tasks.

## Choose a Decision-Making Method: How Will Your Group Decide?

To ease decision making, your CPG should discuss and agree on how the group will make decisions for priority setting. Your CPG may already have a well-established decision-making procedure. If so, you may want to review it before beginning the priority setting process, and if necessary, modify it. If your group does not have a decision-making procedure, it's important to create one before you begin setting priorities.

While various decision-making methods may work for your group, the most critical factor is that every member of the group clearly understands in advance and agrees to the method by which decisions will be reached. There are several different decision-making methods that your group can use, such as group consensus, voting, nominal group technique, and delphi technique. Your CPG may want to vary the decision-making method it uses depending on the decision at hand.

**W** Use Worksheet 1: Step 2 on page 31 to clarify or select your CPG's decision-making method. See Appendix C on page 167 for descriptions of decision-making methods.

## Review or Develop Conflict-of-Interest Statements

Conflicts of interest often occur when CPG members who are advocates for particular groups take part in a process intended to meet the needs of many groups. For example, the executive director of a homeless youth organization is likely to push issues affecting homeless youth. While that is understandable (and even desirable in many cases), a CPG requires a process based on data. Your CPG members must consider how priority setting will affect all populations being considered. Although the executive director's job, and perhaps even CPG seat, depends on a commitment to the interests of homeless youth, this

member must base his/her decisions on the epidemiologic profile and other data characterizing the jurisdiction's HIV epidemic.

Conflicts of interest must not rule the group. They are not inherently bad, but if your group doesn't deal with these openly, they may bias your process. To ensure a fair outcome, your group can take certain key steps to lessen the conflict of interest problem.

Your CPG already may have established some policies and mechanisms for addressing conflicts of interest. If so, refer to those before beginning the priority setting process. If your CPG has not developed such policies, you should do so before beginning the priority setting process. The policies take time to develop, but these will save much time later by limiting conflicts of interest. State and local laws often define conflict of interest. Contact your county or state attorney general's office for a specific legal definition.

By reviewing or developing your CPG's conflict-of-interest policies, your group can assure a fair process that includes diverse participants.

**W** Use Worksheet 1: Step 3 on page 34 to review or develop conflict-of-interest policies. See Appendix D on page 175 for an example of a CPG's conflict-of-interest disclosure form.

## CONFLICT OF INTEREST

While the *American Heritage Dictionary of the English Language* defines conflict of interest simply as "conflict between the private interests and the public obligations of a person in an official position," your CPG may wish to provide a more precise definition. The Iowa CPG wrote the following.

### "Conflict of interest occurs when:

(1) an appointed voting member of the CPG has a direct fiduciary interest (which includes ownership; employment; contractual; creditor, or consultative relationship to; or Board or staff membership) in an organization (including any such interest that existed at any time during the twelve months preceding her/his appointment), with which the CPG has a direct, financial and/or recognized relationship; and

(2) when a member of the CPG knowingly takes action or makes a statement intended to influence the conduct of the CPG in such a way as to confer any financial benefit on the member, family member(s), or on any organization in which s/he is an employee or has a significant interest."

## Identify Roles and Responsibilities of Committees

Priority setting is the responsibility of the CPG as a whole, but you can complete much of the process through committees. Each CPG assigns a different set of tasks to committees. The tasks may vary according to the size of the CPG and the severity of the epidemic in the project area.

**W** Use Worksheet 1, Step 4 on page 35 to identify the roles and responsibilities of your CPG's committees.

### APPLYING THE CONCEPT! How to Address Conflicts of Interest

Before your group begins the priority setting process, carry out these basic tasks.

- Develop a definition of conflict of interest that all members accept and agree to abide by.
- Develop a policy stating how the CPG will deal with apparent conflicts of interest. This policy varies greatly from group to group. It includes everything from barring participation in any discussion and voting related to the conflict to allowing participation in the discussions but not in the voting. The key is agreeing upon a procedure for addressing conflicts of interest before any conflicts — real or perceived — arise.
- Create a process that enables all community planning members to disclose conflicts of interest to the CPG. It helps to have a process that includes a written form and to keep these forms accessible to all members. It also helps to have a specific group, committee, or individual be responsible for oversight of the disclosure process.
- Clarify in writing the consequences of not cooperating with the conflict-of-interest policy. CPG members should be fully aware of the gravity of violating the policy.

### Designate Tasks

In some cases, committees perform only those tasks that involve getting ready for the priority setting process. These tasks might include:

- Researching different priority setting methods
- Proposing a new priority setting method or revising the current method
- Identifying the training the CPG may need to implement the method
- Recommending the use of an outside facilitator and clarifying that individual's role

- Designing the priority setting process, including developing workplans with timelines
- Coordinating the overall priority setting process

In some project areas, priority setting committees focus on gathering data. A committee's tasks might include:

- Defining target populations and interventions
- Recommending specific factors to consider
- Compiling and presenting data

A CPG may ask a committee to recommend priorities for the whole CPG to vote on. In this case, the committee will perform all of the priority setting tasks that this guide outlines.

For each task identified, answer the following questions:

- Who will be responsible for seeing the task through to completion? The priority setting committee? The health department? The co-chairs?
- Who will participate in completing the task?
- When will the task be completed?

### **Structure an Effective Committee**

It is vital that committee members understand fully their assigned tasks, the deadlines they must meet, and what they must prepare before the actual priority setting begins. Every committee must understand the limits of its decision-making authority.

A key to organizing an effective committee is selecting a strong, enthusiastic, reliable chair. Look for a person who is good at motivating, listening, using others' talents, and working with others. Also, the CPG should offer as much organizational support as possible to the committee (i.e., arranging a meeting space, preparing minutes, photocopying, and mailing). Appendix F on page 179 contains a complete list of an effective committee's characteristics.

## Review Communication and Team-Building Exercises

You have your process and committees. Now it's time to set the stage for a positive priority setting experience.

### Communication

An effective process may hinge on a group's ability to communicate — to express ideas and feelings and to hear and interpret messages. Individuals and groups differ in the ways they communicate and interpret information, approach decision making, solve problems, complete tasks, interpret attitudes, manage or cope with conflict, and form expectations.

#### APPLYING THE CONCEPT! Effective Committee Meetings

One of the greatest challenges is keeping your committee "on task." The committee chairperson can do this by using the following techniques.

- Establish a time-phased workplan for your committee with key meeting dates, tasks, responsibilities, products, and deadlines, and use this as your master plan for all committee work.
- Schedule meetings well ahead of time and standardize them, if possible (i.e., second and fourth Friday of the month).
- Do as much as possible in subcommittees or individually, but maintain contact with committee members between meetings.
- Make committee meetings effective through good planning, an appropriate agenda, well-oriented and informed members, and appropriate leadership and guidance from the chairperson.
- Keep all committees closely attached to the full planning group and the staff.
- Develop recommendations with realistic implementation plans.
- Work hard to make the committee a cohesive and cooperative work team, that is also comfortable with its disagreements.

See Appendix E on page 177 for more suggestions on how to keep your committee focused and efficient.

Source: *Effective Committees: A Guide for Community Planning Bodies*. Emily Gantz McKay, MOSAICA, Washington, D.C., 1998.

During the priority setting process, it's critical for CPG members to feel that the group will hear and value equally their information, perspectives, and expertise. Communication skills, particularly the art of listening, are critical to nurturing an environment for effective group work.

Listening is one of the key methods for establishing trust, cooperation, and understanding in an exchange of ideas. Some tips for active listening are:

- Listen carefully for ideas, not just facts.
- Avoid jumping to conclusions or making hasty evaluations.
- Give your full attention.
- Try not to overreact to delivery or content.
- Listen “between the lines.” Be alert to body language and non-verbal cues.
- Avoid interrupting speakers or finishing their sentences.
- When appropriate, restate the main points in your own words to check the message you received.

## **APPLYING THE CONCEPT!**

### **Tips to Manage Conflicts and Disputes**

#### **Establish a clear process to help limit disputes.**

- Clarify roles, responsibilities, assumptions, and expectations.
- Encourage open communication.
- Take time for team building.
- Adopt and revisit ground rules for group communication and decision making.
- Anticipate varied areas for conflict and develop a plan to manage them.

#### **Don't ignore conflict when it occurs.**

- Take time to discuss issues sparking disagreement.
- Always try to take a read of the group and the atmosphere and facilitate a positive environment.
- Deal with conflict situations directly.

#### **Keep members talking and engaged in the process to identify and resolve conflict.**

- Define the problem.
- Gather information that will help clarify the issue(s).
- Generate ideas for conflict resolution.
- Implement a strategy.
- Obtain feedback from individuals who are arguing.
- Take a read on the group. (Has the atmosphere improved so that effective functioning can resume?)

Source: Adapted from *Team Building*, MOSAICA, Washington, D.C., 1996.

## Team Building

It's easy to get caught up in the tasks of priority setting and neglect to build the team. Team-building, energizing and icebreaking exercises will help your group build or improve interpersonal relations, increase motivation, set goals, and become a strong team.

- Icebreakers allow group members to get to know one another better and reduce group tensions.
- Energizers increase the energy level of the group.
- Team builders help to develop unity among group members.

See Appendix G on page 181 for sample exercises.

## Be Prepared to Deal With Conflict

In any diverse group, tensions among members sometimes arise. Although discomfoting, the tensions remind the group that the process is working — different perspectives and ways of processing and interpreting information are being considered in the decision-making process.

These tensions must be acknowledged, however, for interpersonal disputes can quickly escalate and slow progress. By drawing on the team building and conflict management principles outlined in the box entitled “Tips to Manage Conflicts and Disputes” on the previous page, your CPG can minimize disputes and address conflicts in a positive way.



Use Worksheet 1: Step 3 on page 32 to prepare your CPG to deal with conflict.

## Decide Whether to Use an Outside Facilitator

Many CPGs use an outside facilitator to assist in conducting their meetings. Using a neutral facilitator allows the co-chairs to participate in discussions. A good facilitator sets a tone that encourages everyone to participate fully, ensures that the meeting stays on task, enforces the group's rules of conduct, and encourages a thorough airing of difficult issues.

Some CPGs contract with outside facilitators for all meetings. Other groups use them only for meetings about controversial topics. Outside facilitators should attend at least one CPG meeting prior to priority setting. This preliminary meeting allows the CPG and the facilitator to familiarize themselves with each other.

Some of the tasks your CPG may ask an outside facilitator to do include:

- Assisting co-chairs with meeting agenda and objective development
- Facilitating meetings
- Summarizing proceedings
- Training members to participate effectively in meetings

Working with a facilitator requires time and preparation. You will probably need to:

- Use a committee appointed by the full group to interview and select a facilitator.
- Ensure the facilitator understands she or he must remain neutral.
- Specify the exact services expected from a facilitator.
- Review the duties and performance of the facilitator at regular intervals.

## Priority Setting in Project Areas with Multiple Groups

### What the *Guidance* Says

The process for setting priorities in project areas with multiple planning groups varies depending on the structure of community planning in the project area. CDC asks for a single set of priorities from project areas with multiple planning groups. For areas without a jurisdiction-wide group, CDC requires a summary of the recommendations and conclusions from all groups as well as the single set of priorities.

Section III. A. of the *Guidance* says:

*If a jurisdiction implements more than one CPG, the comprehensive plan should summarize any multiple or regional plans into one document.*

### Approaches to Merging Priorities

CPGs are structured in one of four ways. The following list highlights methods that some project areas use to merge different sets of priorities.

- Project area-wide group: The statewide group sets priorities. No merging of priorities is required.
- Project area-wide group with regional groups: Project areas with this structure set priorities in different ways. In one case, the statewide group sets priorities and then regions set priorities within those parameters. In another case, the regional groups set priorities that the statewide group combines into a single set of priorities.
- Regional groups only: Each regional group sets priorities for its region. As described in the *Guidance*, where no jurisdiction-wide group exists, health departments are responsible for developing jurisdiction-wide HIV prevention goals for priority populations.
- Project area-wide group with regional advisory groups: The statewide group sets overall priorities by incorporating regional priorities into a single set. Regional advisory groups often provide input and data on target populations and interventions that become the basis for priorities at the state level.

If you would like more information about setting priorities in areas with multiple planning groups, contact your CDC project officer or AED technical assistance liaison (see Appendix A, on page 165).



## LESSONS LEARNED by Project Areas with Multiple Planning Groups

The most important lesson learned by project areas with multiple groups is that priority setting should be coordinated across regions. Project areas that have succeeded in coordinating priority setting across regions report that coordination does not mean imposing a process on a region but rather developing a process with recommendations from each region. While each project area is different, several common lessons have emerged.

- Ask regional groups to use a standard priority setting process.
- Define target populations in the same manner and use the same language.
- Define interventions in the same manner and use the same language.
- Use the same factors for decision making about priorities whenever possible.
- Coordinate workplans among the regions.
- Avoid duplication of effort; share the work of conducting intervention effectiveness literature searches and other tasks that need to be done in all of the regions.
- Be clear about how regional priorities will be considered or used.

# Worksheet 1

## Reviewing and Developing Management Procedures

**PURPOSE:**

To clarify governance procedures and management tasks.

**CLARIFY ROLES:**

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

**DIRECTIONS:**

Answer the following questions in order to review and clarify your CPG's procedure.

**Step 1: Review your bylaws**

QUESTIONS/ISSUES	ANSWERS/COMMENTS	ACTIONS
a. Do your bylaws spell out how your group makes decisions? If so, what is the method?		What: Who: When:
b. What do your bylaws say about conflict of interest?		What: Who: When:
c. What committees do your bylaws specify?		What: Who: When:
d. What are the roles and responsibilities of these committees related to priority setting?		What: Who: When:

**Step 2: Clarify or select a decision-making method**

What decision-making method will your CPG use? If your CPG has decided to use multiple methods, indicate which method you will use for what purpose. (For a review of decision-making methods, see Appendix C on page 167.)

QUESTIONS/ISSUES	ANSWERS/COMMENTS
<p><input type="checkbox"/> <b>Voting</b></p> <p>a. Does your group require a simple majority, two-thirds majority, or unanimous vote to decide questions?</p> <p>b. What steps does your group take in the event of a tie vote?</p>	
<p><input type="checkbox"/> <b>Consensus</b></p> <p>c. What procedure does your CPG use to determine if consensus has been reached?</p> <p>d. What does your CPG do when it is not possible to reach consensus?</p>	
<p><input type="checkbox"/> <b>Nominal group technique</b></p> <p>e. In what situations might this technique be appropriate for your group?</p> <p>f. Who would develop the questions to be considered?</p> <p>g. Who would facilitate the process and tally results?</p> <p>h. What would your group do with the results?</p>	

Step 3: Review or develop conflict-of-interest policies and procedures

QUESTIONS/ISSUES	ANSWERS/COMMENTS
i. What is your definition of a conflict of interest?	
j. Do you have a disclosure process for members? What is it?	
k. Who makes decisions about conflicts of interest?	
l. Who is responsible for enforcing conflict-of-interest policies and procedures?	
m. If your bylaws are not clear about conflict-of-interest policies and procedures, how will you develop them?	

**Step 4: Identify roles and responsibilities of committees**

In the table, list the committees your CPG will use for completing priority setting, the committees’ tasks/responsibilities, and the key decisions each committee must make. The key below provides a list of possible committees; your CPG may add to this list.

COMMITTEE	TASKS/RESPONSIBILITIES	DECISIONS TO MAKE

**KEY: Committees\***

- PSC = Priority setting committee
- EDC = Epidemiology/data committee
- CSAC = Community service assessment committee
- EVC = Evaluation committee
- TAC = Technical assistance committee
- CCPG = Complete community planning group

*\*Note: CDC does not require these committees. This list includes examples of committees set up by CPGs around the country.*

**Step 5: Be prepared to deal with conflict**

Which of the following steps has your group taken to maintain a positive environment?

- Reviewing ground rules at each meeting
- Effective communication training
- Routine team-building exercises
- Using an outside facilitator

QUESTIONS/ISSUES	ANSWERS/COMMENTS
<p><b>n.</b> Does your group have a specific conflict management policy?</p>	
<p><b>o.</b> Have you conducted conflict management training for group members?</p>	
<p><b>p.</b> What are the triggers for sending a dispute for a formal conflict resolution?</p>	
<p><b>q.</b> Who makes that decision?</p>	

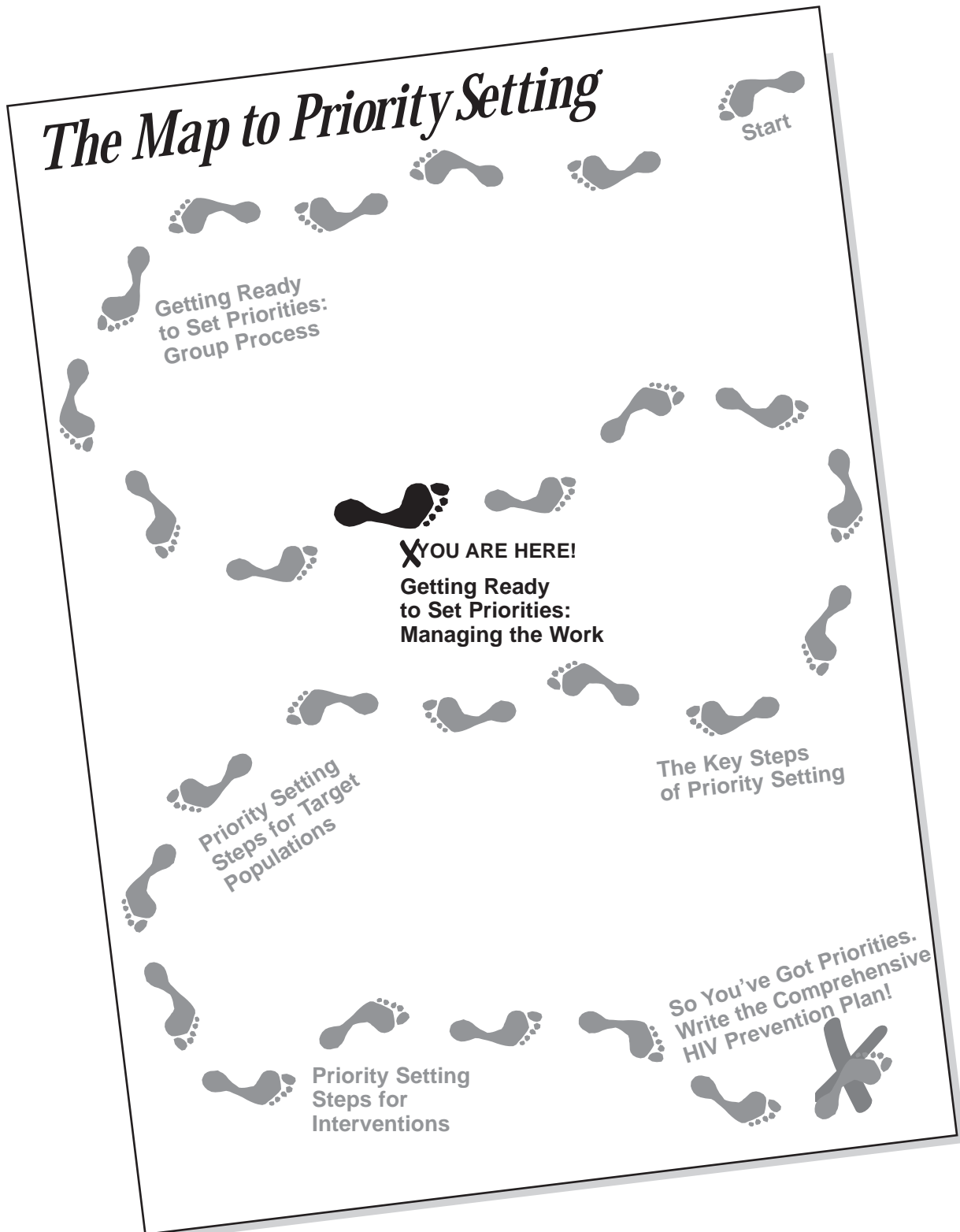
# 2

## Notes





# 3 Getting Ready to Set Priorities: Managing the Work



# The Continuing Adventures of the *Better the Second Time Around CPG*

## **Situation**

The group is growing restless. Some of the members feel they are spending too much time talking about setting priorities and not enough time doing. But Helen, the priority setting committee chair, and Kim, the community co-chair, still feel they aren't ready to proceed.

## **Action**

Helen and Kim call for a detailed workplan with a timeline. A subcommittee, assisted by a health department staff member, contacts a neighboring state's CPG and gets a copy of its workplan that might serve as a template.

The subcommittee gathers information from the various committees about their tasks and timelines. They are dismayed to find that the needs assessment committee isn't planning to finish its work until August, too late for the group to use the information in priority setting. This means that the gap analysis won't be complete for all populations. Several similar problems come up, including a delay in the epidemiologic profile.

Several members point out the need for more information about some of the potential target populations, especially those groups that seem to be at high risk but have not emerged in significant numbers in the epidemiologic profile. Everyone wants more information about interventions for those populations.

The needs assessment committee burns the midnight oil and gathers as much information as possible. They aren't happy with the results for all populations and ask that Helen and Kim extend the workplan to include more research about these populations.

The gap analysis results come in on time. While the gap analysis couldn't be completed for all of the populations, the group feels it has enough information to proceed. The group is pleased to find that excellent programs are in place in most areas for the top three behavioral risk populations in the epidemiologic profile and needs assessment. However, there are gaps in service for Behavioral Risk Group 2 in one large metropolitan area, and no services are available at all in many rural areas.

Finally, an AIDS director from another project area advises the group, "Don't start from scratch! Use the priorities you have and make them better." He reports that in his project area, new members were grateful for a review of current priorities, and that talking about the history of how those priorities were set helped the group avoid several stumbling blocks.

# 3

## Getting Ready to Set Priorities: Managing the Work

Another part of preparing to set priorities is creating a plan for managing the work and gathering all the materials you'll use during the actual priority setting process. In this section, you will go through several steps to help you organize the tasks of developing and applying a priority setting method.

**W** Use worksheets 2 (page 44), 3 (page 46), and 4 (page 50) to help you structure your work.

### Clarify Current Priorities

Your CPG should begin its priority setting process by reviewing the current priorities for your jurisdiction. In other words, don't start from scratch; build on previous work.

Whether your group is planning to develop an entirely new process or use an existing one, it's important to learn what the priorities are now, how the CPG set these, and how the health department implemented the priorities. Then your group can decide whether and how to modify existing priorities. Since changes in the HIV epidemic occur slowly in most areas, your CPG may decide to keep the current priorities. Or you may decide that new or better data make revision necessary. Below are key questions to ask about your current priorities.

## What are your current target population priorities?

Review the list of target populations from your last priority setting process. How many target populations are there? What factors did the group consider when setting priorities among populations? What decision-making process did your group use to select these populations?

## How did you define target populations?

Did you define populations by behavior, demographics, or a combination of both? Were the populations mutually exclusive or did they overlap? For example, was there a category for Latino men who have sex with men or one category for Latinos and one for men who have sex with men? Once you review how you defined target populations, your group can decide whether you need to change definitions to comply with the 2004-2008 *Guidance for HIV Prevention Community Planning*.

It's ideal to use consistent definitions from year to year, but the *Guidance* asks that groups make their population definitions as specific as possible. Begin defining target populations by the behavior that places them at risk and then expand the definitions with demographic data. (See Chapter 5, page 65, for a full discussion of how to define target populations.)

## What are your current intervention recommendations?

Review the list of interventions for each population. What factors did the group consider when choosing these interventions? What evidence of effectiveness was used in selecting interventions? What process did the group use to decide on interventions?

## What process was used to set priorities?

Review your last priority setting process. How did the CPG select priorities? What factors did it use?

### MANAGEMENT TASKS

These tasks will help your group prepare to set priorities.

- Review current priorities.
- Review the priority setting process you used to select your current priorities.
- Develop workplans with timelines.
- Gather information and resources your group will need, including:
  - Up-to-date epidemiologic profile
  - Community services assessment data
    - Resource inventory
    - Needs assessment data
    - Gap analysis results
  - List of potential target populations
  - Intervention effectiveness information for each target population

### When were the population and intervention priorities set?

How long have the priorities from your last priority setting process been in place?

### How long are the current priorities in effect?

See when the current priorities were actually implemented. Health departments typically implement HIV prevention priorities through a variety of funding mechanisms. Your CPG should be aware of contract cycles. Keep in mind that some priorities may be implemented at different times. Because of multiple-year contracts, shifts in priorities may not affect a program for several years.

### What resources do the current priorities affect?

To understand how resources are being allocated now, review the health department's current HIV prevention budget and the "Community Planning Linkage Worksheets." How do the budget and worksheet reflect the current priorities? What proportion of health department resources is allocated to these priorities? How does the health department distribute dollars among the different priorities? What other funding sources — including state, local, and private — were used to address the current priorities?

**W** Use Worksheet 2 on page 44 to review your previous priority setting method and the priority populations and interventions that this method produced.

## Develop Workplans With Timelines

The first thing to consider when developing workplans with timelines is the planning cycle in your project area. How often do you set priorities? Some groups set priorities annually, and some work on a multiyear cycle. The *Guidance* requires that CPGs develop at least one Comprehensive HIV Prevention Plan every five years. However, it specifies that CPGs must update the plan every year to reflect the current epidemic in their project area. Regardless of your planning cycle, the CPG must review the health department's application and progress reports on an annual basis to assess concurrence. (For more information on concurrence, see Chapter 7, page 145.)

Next, develop a list of other processes you need to coordinate with priority setting. The list should include tasks that the health department as well as the community planning group needs to do such as developing the epidemiologic profile and writing the application.

### Now complete the following steps for each process on your list.

- Identify major milestones and their completion dates.
- Identify the key tasks required to achieve each milestone.
- Identify when each task will begin and when it will be completed. Work backwards from the milestone completion date.
- Identify who is responsible for assuring completion of each task.

You may find it helpful to work backward when developing a timeline. Begin with a vision of what you want to complete and when, and then work backward to identify all of the necessary steps to get there.

**W** Use Worksheet 3 on page 46 to identify the major tasks of community planning for your CPG and to assign roles, responsibilities, and deadlines for each task.

### Gather Resources

You've developed a clear process, including workplans with timelines, and have committees to help set new priorities. It's time to gather the resources you need for decision making.

To save time, learn from the past by reviewing earlier target populations, epidemiologic profiles, community service assessments, literature reviews, etc. Your group will need several types of resources, including:

- **Epidemiologic profile:** Data from your project area's most recent epidemiologic profile helps you identify and define target populations.
- **Community services assessment data:** Data from your project area's most recent resource inventory, needs assessment, and gap analysis help you review met and unmet needs, identify and define target populations most at risk, and determine what additional prevention services are needed.

### TERMINOLOGY FOR PRIORITY SETTING

Before setting priorities, your group should know several terms, including:

- Target (or high-risk) population
- Intervention
- Prevention need
- Met and unmet needs

These terms can be confusing! The glossary at the end of this guide includes a comprehensive list of definitions for these and other priority setting terms. Your CPG may want to review these terms at the beginning of the priority setting process to ensure that all CPG members share an understanding of the terms' meanings.

- **List of potential target populations:** This list serves as the basis for setting priorities among populations.
- **Intervention effectiveness information for each target population:** This information serves as the basis for making recommendations about interventions for each target population.



Use Worksheet 4, page 50, to clarify your current target population priorities and intervention recommendations.

# Worksheet 2

## Clarify Current Priorities

### PURPOSE:

To review the previous priority setting method and the priority populations and interventions that this method produced.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

Answer the following questions to familiarize yourself with the processes your CPG used the last time.

QUESTIONS/ISSUES	ANSWERS/COMMENTS
<p>a. What are your current target population priorities?</p>	
<p>b. How did you define target populations? Behaviorally? Demographically? Both (e.g., African American men who have unsafe sex with men)?</p>	
<p>c. What factors did you consider when prioritizing these target populations?</p>	



QUESTIONS/ISSUES	ANSWERS/COMMENTS
<p>d. What decision-making process(es) did the group use?</p>	
<p>e. How long have the current population priorities and intervention recommendations been in place?</p>	
<p>f. For what period are the current priorities in effect?</p>	
<p>g. How does the health department distribute dollars among the different priorities?</p>	
<p>h. What other funding sources (i.e., state, local, private) were used to address the current priorities?</p>	
<p>i. What other information about current priorities do you have?</p>	

# Worksheet 3

## Develop a Workplan with a Timeline

### PURPOSE:

To identify the major tasks of community planning and to assign roles, responsibilities, and deadlines for each task.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Organize** your priority setting activities by completing the chart.
- **Check off** the tasks as they are completed to guide you through the priority setting process.

WHAT MILESTONES MUST BE REACHED?	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE?	WHO IS RESPONSIBLE FOR COMPLETING THESE TASKS?	WHEN WILL EACH TASK BEGIN?	WHEN WILL EACH TASK END?
<b>Example:</b> <input type="checkbox"/> Review bylaws	1) Read bylaws 2) Convene bylaws committee	Bylaws committee	1) May 2001 2) May 2001	1) June 2001 2) June 2001
<input type="checkbox"/> Review bylaws				
<input type="checkbox"/> Review or select a decision-making method				
<input type="checkbox"/> Review or develop conflict-of-interest statements				

WHAT MILESTONES MUST BE REACHED?	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE?	WHO IS RESPONSIBLE FOR COMPLETING THESE TASKS?	WHEN WILL EACH TASK BEGIN?	WHEN WILL EACH TASK END?
<input type="checkbox"/> Identify roles and responsibilities of committees				
<input type="checkbox"/> Review communication and team-building exercises				
<input type="checkbox"/> Decide whether to use an outside facilitator				
<input type="checkbox"/> Develop a workplan with a timeline				
<input type="checkbox"/> Gather information including: epi profile, needs assessment, community services assessment, list of potential target populations, and intervention effectiveness information for each target population				
<input type="checkbox"/> Review current priorities				

WHAT MILESTONES MUST BE REACHED?	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE?	WHO IS RESPONSIBLE FOR COMPLETING THESE TASKS?	WHEN WILL EACH TASK BEGIN?	WHEN WILL EACH TASK END?
<input type="checkbox"/> Identify target populations				
<input type="checkbox"/> Determine factors for target populations				
<input type="checkbox"/> Weight factors				
<input type="checkbox"/> Rate factors				
<input type="checkbox"/> Score and rank target populations				
<input type="checkbox"/> Review rankings and prioritize target populations				
<input type="checkbox"/> Identify interventions				
<input type="checkbox"/> Determine factors for interventions				

WHAT MILESTONES MUST BE REACHED?	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE?	WHO IS RESPONSIBLE FOR COMPLETING THESE TASKS?	WHEN WILL EACH TASK BEGIN?	WHEN WILL EACH TASK END?
<input type="checkbox"/> Weight factors				
<input type="checkbox"/> Rate factors				
<input type="checkbox"/> Score and rank interventions using factors				
<input type="checkbox"/> Review rankings and develop recommendations for interventions				
<input type="checkbox"/> Write priority setting section of the plan				

# Worksheet 4

## Current Target Populations and Interventions

### PURPOSE:

To clarify current population and intervention priorities.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- List the **target populations** your CPG decided upon from your previous priority setting process.
- List the **interventions** recommended for each target population.

TARGET POPULATIONS	INTERVENTIONS FOR EACH TARGET POPULATION
1.	
2.	
3.	

TARGET POPULATIONS	INTERVENTIONS FOR EACH TARGET POPULATION
4.	
5.	
6.	
7.	
8.	
9.	
10.	

# 3

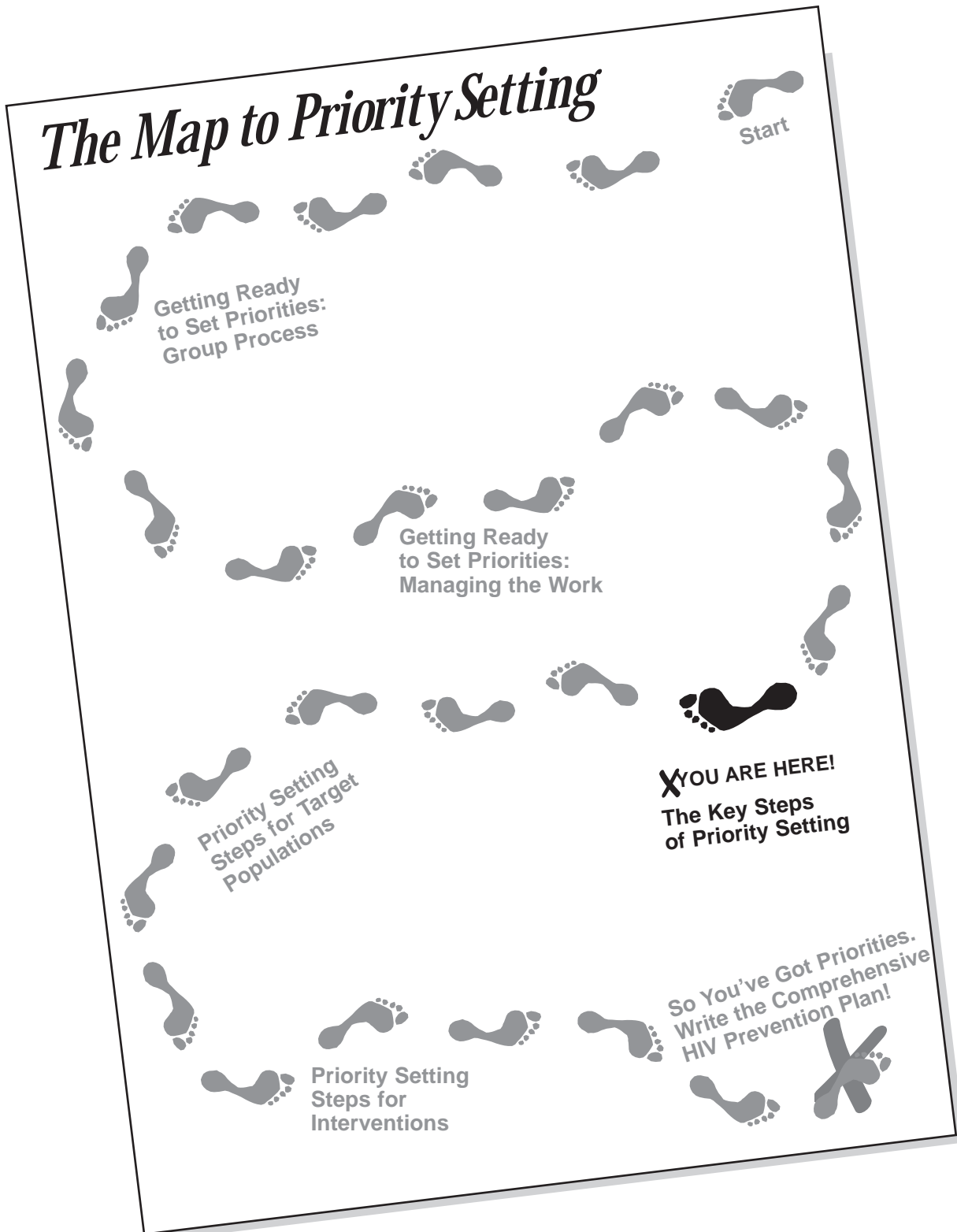
## Notes

3

MANAGING THE PROCESS



# 4 The Key Steps of Priority Setting



# The Continuing Adventures of the *Better the Second Time Around CPG*

## **Situation**

Emotions are running high on the CPG. Several members want to go ahead and set priorities since “everyone knows who gets AIDS.” The priority setting committee feels it needs a way to explain the priority setting process it has developed. But they’re afraid some of the group members are so anxious to get the job done they will rush through the process without considering all the steps.

## **Action**

Several group members attend a priority setting workshop at the Community Planning Leadership Summit. Part of the workshop is an exercise that gives them a chance to set priorities about taking a vacation, a much less emotionally charged issue than deciding about HIV prevention priorities. They enjoy the exercise and decide to replicate it to orient the entire group to the key steps of priority setting. The CPG tries to do the exercise without using weights and finds the results confusing. They agree that weighting factors seems a better way to develop a clear set of priorities.

# 4

## The Key Steps of Priority Setting

You and four friends are planning to meet for dinner, so the group must choose a restaurant everyone will like. To do that, you will use the same concepts — factors, weighting, rating, and scoring — your CPG uses in priority setting for HIV prevention community planning.

### Understanding Factors

We all consider different factors — pieces of information — when making a decision. In choosing a restaurant, you consider such factors as:

- How much will the meal cost?
- What kind of food does the restaurant serve?
- What is the restaurant's atmosphere?
- Where is the restaurant located?

Each person's preferences differ, and each considers some factors to be more important than others. You may be most concerned about the cost, another friend about the kind of food served, and another about the location. Even simple decisions become complex when several people must consider several factors.

To ease and speed the choice of restaurants, you and your friends should identify the factors that are most important to everyone. Once you've done that, you can begin to suggest restaurants. It's important to agree as a group which factors to consider. Otherwise, each person may base the decision on personal preferences, and it will become impossible to select a restaurant everyone likes.

In the much more complex world of HIV prevention community planning, it's extremely important to agree upfront which factors your CPG will consider. Your group must decide which target populations are at greatest risk for HIV and choose the interventions that will be most effective in serving them. To make these tough decisions in a fair and consistent way, all CPG members must consider the same set of factors. Agreeing on the factors also will save time and frustration by minimizing debates on personal or political opinions.

Chapter 5, page 73, suggests a list of factors for populations, and Chapter 6, page 114, suggests one for interventions.

### FACT-BASED VERSUS VALUE-BASED DECISION MAKING

Some factors are based primarily on facts (Where is the restaurant located?), and others are based primarily on values (Do I like the food?). Most factors combine elements of both facts and values. For example, considering price requires both facts (Do I have enough money with me to pay for the meal?) and values (Is the meal worth the price?).

CDC expects priority setting to reflect both fact-based data, such as the epidemiologic profile, and more value-based considerations, such as the preferences of target populations. Your CPG should make its consideration of both fact- and value-based factors as explicit as possible. Additionally, your CPG may want to:

- Consider some factors based strictly on values. For example, when recommending interventions, incorporate community values by using such factors as consumer preferences, provider preferences, or community norms and values.
- Consider nonquantifiable data. Key informant interviews and focus group findings are not easily quantifiable, but both may supply current, valuable information.

## Understanding Weights

Once your friends have decided which factors to consider in choosing a restaurant, you need to determine the relative importance — or weight — of each factor. For example, if all agree that cost carries the most weight, it becomes your main factor for choosing a restaurant.

If you and your friends decide to assign weights to the factors on a one-to-five (least-to-most) scale, your chart might look like the one that follows.

Thus, the factors' order (from most to least important) is cost, type of food, atmosphere, and finally, location. You have weighted the factors so that the group can make the most objective decision possible. That's exactly what the CPG wants to do.

FACTOR	WEIGHT
Cost	5
Location	2
Type of Food	4
Atmosphere	3

Your CPG can determine the weight of each factor in one of two ways. In the first, each group member sets weights individually. Then members compare their weights and, as a group, develop one set of weights. In the second, the group discusses each factor until members agree on the relative importance — weight — of each factor.

You may use numbers or words to indicate the level of importance of factors. The above example uses a numeric scale, with 5 indicating most important and 1 the least important. A word scale may consist of phrases, such as “not important,” “somewhat important,” and “very important.” Numbers give more precise weights than words do, but you may find it easier to use words. When weighting factors for target populations or interventions, your CPG should decide as a group whether to use numeric or non-numeric weights.

Another option is not to weight factors at all. The *Guidance* does not require that CPGs weight factors, but without weighting, all the factors are equally important. Be sure that everyone realizes this. Whatever you decide, it's important to discuss weighting and to determine how to proceed.

## Understanding Rating

Let's look at what happens if five friends choose a restaurant using these factors. Ask each person to rate all potential restaurants individually, using a 1-to-5 (worst-to-best) rating scale.

One friend's ratings for Restaurant Tres Chic and Restaurant Pizzeria may look like this.

FACTOR	TRES CHIC RATING	PIZZERIA RATING
Cost	1	5
Location	3	2
Type of Food	4	3
Atmosphere	1	2

## Understanding Scoring

Now you can determine which restaurant most closely suits all your friends. To figure the score for each restaurant, multiply the rating by its weight (rating x weight) so that the more important factors have the most impact on the final decision. Then, to get each restaurant's final score and ranking, add the scores for each factor. Here's how you figure a score for Restaurant Tres Chic.

FACTOR	WEIGHT	TRES CHIC RATING	SCORE (WEIGHT x RATE)
Cost	5	1	5
Location	2	3	6
Type of Food	4	4	16
Atmosphere	3	1	3
Final Tres Chic Score			<b>30</b>

Compare the score for Restaurant Tres Chic with that for Restaurant Pizzeria (below).

FACTOR	WEIGHT	PIZZERIA RATING	SCORE (WEIGHT x RATE)
Cost	5	5	25
Location	2	2	4
Type of Food	4	3	12
Atmosphere	3	2	6
Final Pizzeria Score			<b>47</b>

Restaurant Pizzeria wins big. Your friend prefers the inexpensive and laid-back atmosphere of Restaurant Pizzeria to the costly and uncomfortable Restaurant Tres Chic. Others may or may not agree. To find out and choose the restaurant the group prefers, add the scores for each restaurant. The top score wins.

### Evaluating the Results

Every decision-making process has strengths and limitations. After you complete a group decision-making process, review the results as a group and make sure that they are acceptable to everyone. It's also important to record the group's suggestions for improving the process next time.

**W** For an enjoyable rehearsal of priority setting, try the vacation exercise in Worksheet 5, page 58.

# Worksheet 5

## Vacation Priorities Exercise

### PURPOSE:

To provide your community planning group with an enjoyable practice session before you begin setting priorities for populations and interventions.

### CLARIFY ROLES:

Who will facilitate this exercise?

By what date?

### DIRECTIONS:

#### Instructions to the facilitator

##### *Advance preparation*

- Copy enough handouts for each participant.
- Post discussion questions on a flip-chart page.

##### *Topic/Activities*

*Total time: 50 minutes*

- |  |               |
|--|---------------|
| ■ Introduction to exercise and instructions        | 5–10 minutes  |
| ■ Break into small group                           | 5 minutes     |
| ■ Individual work in small groups                  | 10–15 minutes |
| ■ Small-group discussion and tabulation of results | 10 minutes    |
| ■ Large-group discussion                           | 15 minutes    |

#### Notes to the facilitator

The discussion questions are designed to elicit realization of the parallels between the exercise and setting priorities in HIV prevention community planning. Other points to address if they don't come out in the discussion are:

- Instructions were vague.
- Information provided was erratic and incomplete.
- In this case, factors were provided, but they won't be with prevention priority setting.
- Each person set his or her own weights. In prevention priority setting, if the group decides to weight factors, it's important that the group discuss and agree upon weights.

*(continued, next page)*



**Instructions to group members**

- Form small groups of about eight people each.
- Choose a facilitator for each group to guide the discussion.
- Read the descriptions of each vacation and follow the instructions on the following pages.
- Discuss the following questions with your group after you have made your vacation choice.
  - What method did you choose to make your decisions?
  - Besides the factors listed, did you use others in making your decision?
  - Which factors were more important than the others? How was this decided?
  - Did you encounter any situations where you felt pressure to change your mind?
- What other information would you have liked before making a decision?

You will be going on a vacation with your small group. You have three available travel packages from which to choose: beach-hopping in California, dinner and dancing in New Orleans, and jungle-trekking in Indonesia. Read through the following vacation descriptions and then follow the instructions to determine where your group will travel.

**Vacation Package 1: Beach-Hopping in California**

This one-week vacation costs \$500 per person for airfare, food, and lodging. To save costs, the whole group will eat all meals together. The hotel is near Santa Cruz, and several beaches are within walking distance. The weather is generally sunny and breezy.

Currently, there is no information about the quality of the hotel. Someone who stayed there last year said that the food was pretty good and the management friendly (since then the management has changed), but the showers sometimes ran out of hot water.

**Vacation Package 2: Dinner and Dancing in New Orleans**

It will cost about \$50 per person for a Saturday-night dinner at a local restaurant, followed by dancing on the outdoor deck with an open bar. Only the outdoor deck will be open for this group event. The famous Caribbean Allstars will provide live music. The weather tends to be cool in the evenings, with occasional rain.

**Vacation Package 3: Jungle-Trekking in Indonesia**

This one-month vacation includes airfare, food, and basic lodging. The group will arrive in Sumatra and hike for several weeks through the local jungle and mountains, staying in trail huts along the way. There will be many opportunities to see local cultures and wildlife. Although porters will be available, the trek will be physically demanding. The weather tends to be sunny and mild, with low humidity.

The trip's exact cost is hard to determine because the value of the Indonesian rupiah has been fluctuating wildly. A travel company quoted a price of \$3,000 per person, but someone on the trip planning committee found a brochure from another company that listed the trip at \$1,500 per person.

### Step 1: Weighting the vacation factors

Now that you've read through the description of each vacation package, decide individually which factors are most important to you. Weight the importance of the factors using a numerical scale of 1 to 5, 1 indicating the least important and 5 indicating the most important. (In priority setting for target populations and interventions, decide on a standard set of weights as a group. This exercise will illustrate the importance of this process.)

FACTOR	WEIGHT
Cost of the vacation	
Length of the vacation	
Enjoyability of the vacation	
Weather during the vacation	

### Step 2: Rating the vacations according to the factors

Individually, rate each vacation according to the factors provided in the chart. Use the following scale to rate the factors: 1 = no, 2 = somewhat, 3 = yes.

FACTOR	CALIFORNIA	NEW ORLEANS	INDONESIA
Is the vacation affordable?			
Is this a good length for a vacation?			
Will the vacation be enjoyable?			
Is the weather good for a vacation?			

### Step 3: Scoring each vacation according to the weights and factors

Now multiply the weight by the rating for each factor and write the score in the box. Next add the scores for each factor to obtain the total vacation score.

#### Vacation Package 1: Beach-Hopping in California

<b>FACTOR</b>	<b>WEIGHT (FROM STEP 1)</b>	<b>RATING (FROM STEP 2)</b>	<b>SCORE (WEIGHT x RATE)</b>
Is the vacation affordable?			
Is this a good length for a vacation?			
Will the vacation be enjoyable?			
Is the weather good for a vacation?			
<b>Total Vacation Score</b>			

#### Vacation Package 2: Dinner and Dancing in New Orleans

<b>FACTOR</b>	<b>WEIGHT (FROM STEP 1)</b>	<b>RATING (FROM STEP 2)</b>	<b>SCORE (WEIGHT x RATE)</b>
Is the vacation affordable?			
Is this a good length for a vacation?			
Will the vacation be enjoyable?			
Is the weather good for a vacation?			
<b>Total Vacation Score</b>			

### Vacation Package 3: Jungle-Trekking in Indonesia

FACTOR	WEIGHT (FROM STEP 1)	RATING (FROM STEP 2)	SCORE (WEIGHT x RATE)
Is the vacation affordable?			
Is this a good length for a vacation?			
Will the vacation be enjoyable?			
Is the weather good for a vacation?			
<b>Total Vacation Score</b>			

#### Step 4: Making a final decision with your group

Assign a recorder to tally the group scores using the following format. The higher the score of the vacation, the higher the vacation priority for the group. Discuss the total vacation scores and determine which vacation is the group's choice.

- For the first vacation, add together each person's score for each factor and write the total under total factor score.
- Add the total factor scores and write the sum next to total vacation score.
- Repeat these calculations for the other two vacations.
- Rank the vacations according to the total vacation scores.

**Vacation Package 1: Beach-Hopping in California**

*Total Group Factor Score*

Is the vacation affordable? ..... \_\_\_\_\_

Is this a good length for a vacation? ..... \_\_\_\_\_

Will the vacation be enjoyable? ..... \_\_\_\_\_

Is the weather good for a vacation? ..... \_\_\_\_\_

*Total Vacation Score:* \_\_\_\_\_

**Vacation Package 2: Dinner and Dancing in New Orleans**

*Total Group Factor Score*

Is the vacation affordable? ..... \_\_\_\_\_

Is this a good length for a vacation? ..... \_\_\_\_\_

Will the vacation be enjoyable? ..... \_\_\_\_\_

Is the weather good for a vacation? ..... \_\_\_\_\_

*Total Vacation Score:* \_\_\_\_\_

**Vacation Package 3: Jungle-Trekking in Indonesia**

*Total Group Factor Score*

Is the vacation affordable? ..... \_\_\_\_\_

Is this a good length for a vacation? ..... \_\_\_\_\_

Will the vacation be enjoyable? ..... \_\_\_\_\_

Is the weather good for a vacation? ..... \_\_\_\_\_

*Total Vacation Score:* \_\_\_\_\_

As a group, we have decided to take the following vacation together:

- California       New Orleans       Indonesia

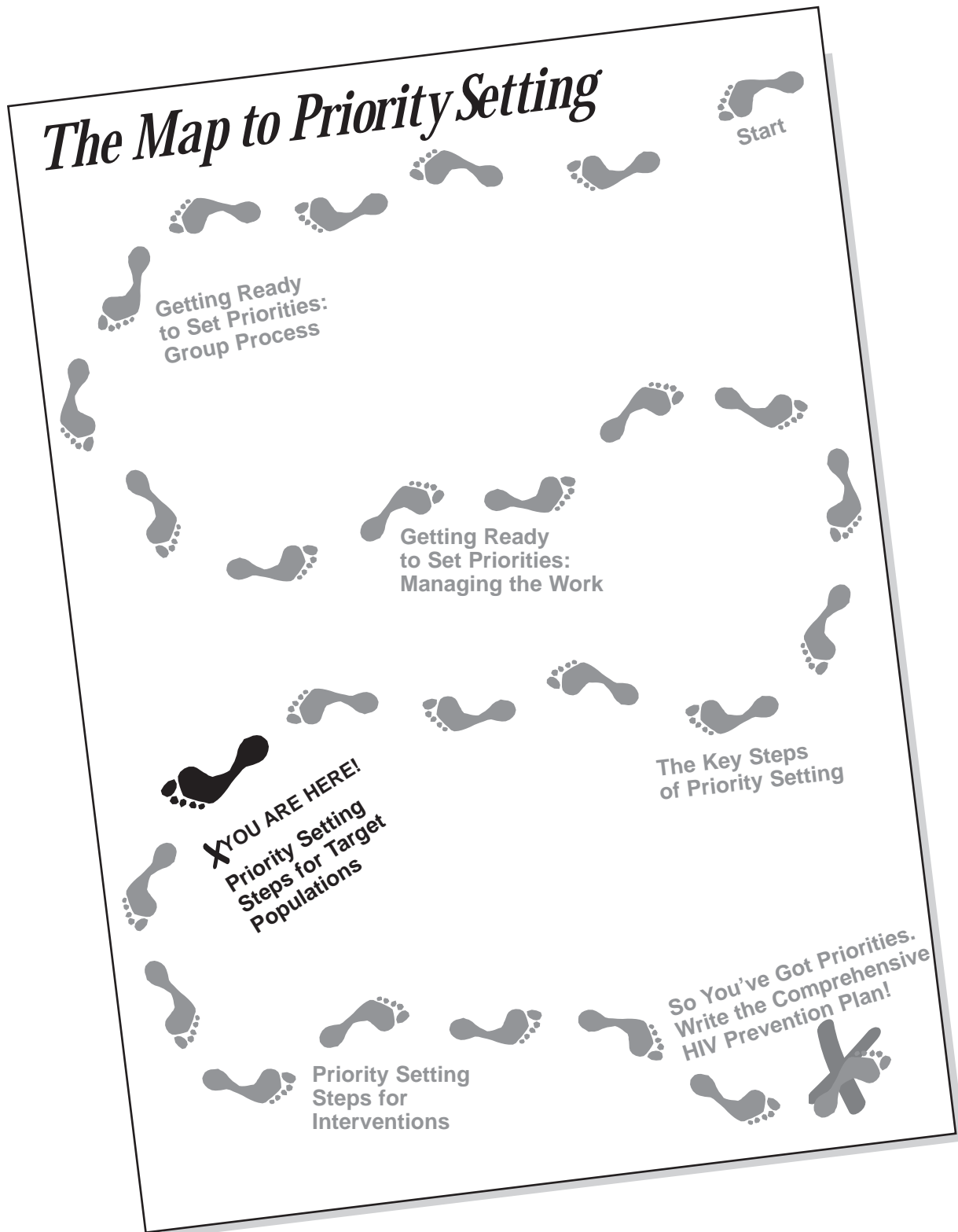
# 4

## Notes

4

KEY STEPS OF PRIORITY SETTING

# 5 Priority Setting Steps for Target Populations



# The Continuing Adventures of the *Better the Second Time Around CPG*

## **Situation**

At last, the group feels it is ready to consider setting priorities among high-risk populations. The full group asks Helen and her priority setting committee to identify a list of potential target populations and factors to be used in setting priorities among those populations.

## **Action**

The priority setting committee balks: “Identifying target populations is not our job. The needs assessment committee was supposed to do that.” In fact, the needs assessment committee, using the epidemiologic profile and the components of the needs assessment — research about populations, the resource inventory, and the gap analysis — has developed a list of potential target populations. Helen and her committee take this list and develop a suggested set of factors for the full CPG to consider. They find the principles from North Carolina especially helpful (see page 72) and select five factors, a mix of fact and value-based items. The priority setting committee also asks that the workplan be modified to include three meetings to consider priorities for target populations and three meetings to consider intervention priorities for the target populations.

The full CPG agrees to the extensive list of potential target populations, but disagrees about several of the factors. Two vocal group members argue that the draft set of factors places too much emphasis on HIV incidence. They point out that their state doesn’t yet have sufficient data because unique-identifier reporting began only one year earlier. After considerable discussion, the group arrives at a set of factors members are comfortable with. They agree on the relative importance (weight) of each of the factors and a system for rating each of them.

Before the next meeting, the needs assessment committee sends out information relevant to each of the factors about the potential target populations. The committee selects information carefully — the group has learned that there’s a limit to how much they can absorb. The committee invites several experts to discuss behavioral risk for different populations at the next meeting.

When the day arrives to actually set priorities, one of the group’s veteran members comments: “I never thought we’d get here, but this is so much easier than last time. I feel like I have a lot of information to make decisions.”



# 5

## Priority Setting Steps for Target Populations

In HIV prevention community planning, priority setting should lead to programs that respond to high-priority, community-validated needs within defined populations. Each CPG develops two products that are the basis for the comprehensive prevention plan:

- Target (or high-risk) population priorities
- Recommended interventions for each target population

This chapter focuses on setting priorities for high-risk populations. (Chapter 6, page 105, focuses on recommending interventions.) The steps outlined have proven effective in many project areas. If your group chooses not to follow these, be sure to document the process you do follow. Use the worksheets at the end of this chapter to help you structure your work.

### What the *Guidance* Says

The *Guidance* continues to emphasize that community planning groups should assess priority HIV prevention needs on the basis of the epidemiologic profile and community services assessment, which includes the resource inventory, needs assessment, and gap analysis.

Three changes in the 2004-2008 *Guidance* will affect your priority setting process.

#### 1. HIV-positive populations must be priority number one.

The Advancing HIV Prevention initiative, as described in the *Guidance*, says:

*Because of its potential to substantially reduce HIV incidence, HIV Prevention Community Planning Groups will be required to prioritize HIV-infected persons as the highest priority population for appropriate prevention services. Uninfected, high-risk populations such as sex or needle-using partners of PLWHA, should be prioritized based on local epidemiology and community needs.*

**2. CPGs must define target populations more specifically.**

*Attribute 40 (Target Populations): Define target populations by transmission risk, gender, age, race/ethnicity, HIV status, and geographic location.*

**3. A new set of attributes helps a CPG evaluate whether it is meeting its objectives.**

Section VI. Accountability says:

*Priority target populations and a recommended set of interventions/activities identified in the comprehensive*

*HIV prevention plan are based on (a) having the greatest impact on reducing HIV transmission and (b) reducing HIV transmission in populations with greatest incidence. Priority target populations and prevention intervention/activities should be consistent with the epidemiologic profile, community services assessment, and behavioral/social science data presented in the plan;*

The *Guidance* contains a set of “attributes” upon which a set of evaluation indicators are based. The presence of these attributes provides “some level of confidence” that objectives are being met. The *Guidance* also notes, however, that **jurisdictions are not required to individually report on each attribute.**

## SEVEN KEY STEPS IN SETTING PRIORITIES FOR TARGET POPULATIONS

1. Identify target populations: Identify and define which populations to consider.
2. Determine factors: Decide which factors the CPG will use to set priorities for target populations.
3. Weight factors: Assign a weight (level of importance) to each factor.
4. Rate target populations using factors: Use the factors to rate each target population.
5. Score target populations using factors: Determine a score for each factor by multiplying the rating by the weight.
6. Rank target populations: For each target population, add the factor scores together. Compare the total scores to determine an overall rank.
7. Review rankings and prioritize target populations: Review the results and agree upon the final list of target populations.

Objective E says:

*Ensure that priority target populations are based on an epidemiologic profile and a community services assessment. The presence of the following attributes is critical to achieving this objective:*

*Attribute 37 (Target Populations): Evidence that the size of at-risk populations was considered in setting priorities for target populations.*

*Attribute 38 (Target Populations): Evidence that a measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence or prevalence), if available, was considered in setting priorities for target populations.*

*Attribute 39 (Target Populations): Evidence that the prevalence of risky behaviors in the population was considered in setting priorities of target populations.*

*Attribute 41 (Target Populations): Target populations are rank ordered by priority, in terms of their contribution to new HIV infections.*

## What PEMS Requires Health Departments to Report

The HIV/AIDS Prevention Program Evaluation and Monitoring System (PEMS), CDC's standardized data collection system, requires that health departments describe target populations by transmission risk, race, ethnicity, gender, age, and HIV status. CDC also asks for the priority population size and proportion of the priority population that can be reached as well as the geographic location of that population, HIV/AIDS prevalence, prevalence of risky behaviors, and a description of the community's input on the population's prevention needs. (Ask your health department for a more complete description of these descriptors.)

## What do these changes mean for our priority setting process?

**The essential steps of priority setting have not changed.** The CPG's main tasks remain collecting data, choosing and weighting factors, and making informed decisions about the populations most at risk for transmitting or acquiring HIV.

Some CPGs have complained that CDC has taken away their power to decide priorities in their area. Closer examination shows that the *Guidance* says only that HIV positive populations will be a top priority. CPGs continue to have the power to set priorities among the various HIV-positive populations and, of course, to set priorities among those people at greatest risk for becoming infected.

At the end of this chapter, you will find options for setting priorities among HIV-positive populations. Follow the steps outlined in this chapter to get a set of overall priorities before deciding how you will make choices about HIV-positive populations.

## Step 1: Identify and Define Target (High-Risk) Populations

### Identify and define which populations to consider for prioritization

CDC asks CPGs to identify target populations by behaviors because the risk of acquiring or transmitting HIV depends not on who someone is but on how that person behaves. For example, not all men who have sex with men are at risk for transmitting or acquiring HIV.

**Defining target populations** — In HIV prevention community planning, target population refers to a population that requires prevention efforts because of high rates of HIV infection and high incidence of risky behaviors.

Start to define target populations by broad risk behaviors, such as:

- Men who have unsafe sex with men
- Injecting drug users
- High-risk heterosexuals

Then expand the behavioral definitions with demographic data. Depending on the epidemiologic data available, CPGs should expand basic behavioral descriptions of target populations with demographic data (e.g., gender, race/ethnicity, age, or geographic setting). (See *Example from the Field! New Jersey*.) Ultimately, CPGs should describe target populations as fully and specifically as data permits. For example:

- Men of color of unknown serostatus who have unsafe sex with men between the ages of 18 and 35 in bathhouses
- HIV-positive injecting drug users of all races/ethnicities in the correctional system

### TARGET POPULATION VERSUS HIGH-RISK POPULATION

As in CDC's *Guidance*, this guide uses the terms target population and high-risk population interchangeably. Both terms refer to groups that are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior. Because some people may be sensitive to these terms, CPGs should discuss what term members prefer. For example, some CPGs prefer behavioral risk group, prevention group, primary audience, target audience, or at-risk population.

### CRITERIA FOR DESCRIBING TARGET POPULATIONS: THE *GUIDANCE* AND PEMS

- \*Transmission risk
- \*Race
- \*Ethnicity
- \*Gender
- \*Age
- \*HIV status
- Population size
- Proportion of population reachable
- Geographic location
- HIV/AIDS prevalence
- Prevalence of risky behavior

(Ask your health department for more complete definitions.) \*Required by CDC in health department applications and progress reports.

- Young heterosexual females with STDs in a specific neighborhood

**Create a list of all possible target populations.** To save time, learn from the past by reviewing earlier priority setting target populations or groups, epidemiologic profiles, needs assessments, literature reviews, etc. Key issues to consider when identifying target populations include:

- How do the communities or groups define themselves?
- What populations does the epidemiologic profile identify as being at risk for transmitting or becoming infected with HIV?
- What does the community services assessment identify as the prevention needs of populations at risk?
- What target population needs does the resource inventory indicate are being met? Unmet?
- What current programs for specific target populations will you need to sustain? Do those populations have unmet needs? In identifying target populations, CPGs should consider populations with both met and unmet prevention needs.

### TASKS — What do you need to do?



Perform the following basic tasks. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

- Review a comprehensive set of data and information (for example, the epidemiologic profile and all components of the community services assessment [needs assessment, resource inventory, and gap analysis]) and list all defined populations. Make sure that you are reviewing the most recent versions.

Use Worksheet 6 on page 91 to help you do the following:

- Define potential target populations, beginning with behavior and then adding demographic characteristics. (Review *Examples from the Field! New Jersey, Iowa, Nebraska, and Pennsylvania.*)
- Develop a list of potential target populations for priority setting. This list will be used in later steps.

**EXAMPLE FROM THE FIELD! Identifying Target Populations: New Jersey**

<http://hpcpsdi.rutgers.edu/njhpcpg/downloads/Comprehensive%20Plan.pdf>

In New Jersey, the HIV Prevention Community Planning Group determined these priority populations for 2002-2003. See the Web site for a more complete listing.

**Rank**

- 1 HIV+ Injecting Drug Users
- 2 HIV+ Men Who Have Sex With Men
- 3 HIV+ Women Who Are At Risk Through Sexual Transmission
- 4 HIV+ Non-Injection Drug Users
- 5 HIV+ Youth Not-Yet-Patterned In High Risk Behavior
- 6 HIV+ Men Whose Only Identified Risk Is Heterosexual Transmission

**EXAMPLE FROM THE FIELD! Identifying Target Populations: Iowa**

[http://www.idph.state.ia.us/adper/hiv\\_aids\\_programs.asp#top](http://www.idph.state.ia.us/adper/hiv_aids_programs.asp#top)

In Iowa, a low-incidence state, the CPG defined target populations based upon broad behavioral designations. These target populations are Iowa's 2004-2006 priorities.

**Rank**

- 1 HIV Positive Persons
- 2 Men Who Have Sex With Men
- 3 Injecting Drug Users
- 4 High-Risk Heterosexuals
- 5 Incarcerated Individuals
- 6 High-Risk Youth

**EXAMPLE FROM THE FIELD! Identifying Target Populations: Nebraska**

<http://www.hhs.state.ne.us/dpc/comprehensiveHIVplan.htm>

In Nebraska the HIV Care and Prevention Consortium determined the Priority Populations for 2005-2008 at the February 12, 2004, meeting. The top four priority populations are as follow.

Priority I: HIV positive persons

- Men who have sex with men (MSM)
- Female high risk heterosexual (HRH)
- Male high risk heterosexual (HRH)  
(IDU is included with each subpopulation)

Priority II: Men who have sex with men

- African American ages 20-49
- Hispanic ages 20-39
- Native American ages 20-29
- White ages 20-39

Priority III: Female high risk heterosexual

- African American ages 20-49
- White ages 20-39
- Hispanic ages 20-39
- Native American ages 20-29

Priority IV: Female injecting drug users

- African American ages 20-49
- Native American ages 30-50+

*(2005-2008 priorities)*

**EXAMPLE FROM THE FIELD! Identifying Target Populations: Pennsylvania**

[http://www.stophiv.com/planning\\_committee/index.html](http://www.stophiv.com/planning_committee/index.html)

Summary result of prioritization model for HIV/AIDS ranked population/transmission groups: 2003 by sex, age, and group

1. HIV+ White men who have sex with men
2. HIV+ Black male and female injecting drug users
3. HIV+ Black men who have sex with men and black injecting drug users
4. HIV+ White men who have sex with men and injecting drug users
5. HIV+ Black heterosexual males and females
6. HIV+ White male and female injecting drug users
7. HIV+ White heterosexual males and females (mostly female ex-partners of IDU)
8. HIV+ Hispanic male and female injecting drug users
9. HIV+ Black men who have sex with men
10. HIV+ Hispanic heterosexual males and females (mostly female ex-partners of IDU)  
*(2003 priorities)*

## Step 2: Determine Factors

### Decide which factors the CPG will use to set priorities for target populations.

Once you have listed target populations, the next step is to determine which factors to consider in making decisions. In selecting factors, your CPG needs to strike a balance — choosing enough factors to guide the priority setting process without choosing so many that they overwhelm the group.

What are factors, and how do I know one when I see one? Factors are simply pieces of information to consider in decision making. For example, when you buy cereal, you may think about such factors as cost, fiber content, sugar content, vitamins, and taste. Some factors will be more important to you than others. You may struggle to choose between cost and taste.

The same kind of struggle occurs in priority setting for target populations. Unless the CPG decides which factors to consider as a group, the decisions are likely to be based on personal — often biased — impressions rather than on neutral information.



Begin by developing a list of factors that your CPG will need to consider. Be thorough. You can always go back and narrow your choices later. The factors that you consider may be evidence-based (e.g., information documented in the epidemiologic profile) or value-based (e.g., consumer preferences). Some CPGs begin by developing a list — often through brainstorming — of all possible factors. Then, they trim the list, either by consensus or voting, until only the most important factors remain. (See *Example from the Field! North Carolina.*)

The *Guidance* continues to allow CPGs some flexibility in choosing factors to consider for setting priorities for target populations. Your CPG should consider a core set of factors as described in the following table.

### TASKS — What do you need to do?

Perform the following basic tasks. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

- Decide what information is most important to the CPG. This will be easier if you review a comprehensive set of data to determine who is at risk for HIV transmission and acquisition.

Use Worksheet 7 on page 93 to guide you through choosing factors for target populations. The worksheet will help you:

- Create a list of all the factors your CPG may consider. Describe the factors as accurately and specifically as possible.
- Decide on a process to select the specific factors your CPG will consider in decision making.

#### **EXAMPLE FROM THE FIELD! Guiding Principles for Choosing Factors: North Carolina**

The North Carolina CPG developed a set of principles to guide members in choosing factors. The CPG determined that the factors it would consider must:

- Be easy to use, and not too abstract
- Be readily available to all members
- Be clear, and not open to multiple interpretations
- Be straightforward and not too hard to define
- Achieve a balance between quantitative and qualitative data *(1999 priorities)*

- Develop a list of factors to be used in setting priorities for target populations.

### Step 3: Weight Factors

Assign a weight (level of importance) to each factor.

<p><b>FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS</b></p> <p><i>Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.</i></p>		
FACTOR	DEFINITION	DISCUSSION
HIV/AIDS Surveillance		This factor shows the extent of the HIV/AIDS epidemic among the target population.
AIDS incidence	The number of AIDS cases diagnosed in a defined population in a specified period, often a year	<p>Because of a comprehensive national AIDS surveillance system, AIDS incidence data are among the most reliable and complete population-based epidemiologic data available. AIDS incidence data may help CPGs understand the extent to which AIDS has affected a given population relative to another.</p> <p>In considering AIDS incidence data, however, CPGs should be aware that recent declines in AIDS incidence are attributable in large part to antiretroviral therapies. Currently, differences in AIDS incidence among groups (e.g., by race/ethnicity or age) may represent differences in treatment success or in access to or use of health care.</p>
AIDS prevalence	The number of people living with AIDS in a defined population on a specified date	AIDS prevalence data show the number of people living with advanced HIV disease. While AIDS incidence data show the total number of AIDS diagnoses in a specified period in time, prevalence data show how many people are living with AIDS, regardless of when they were diagnosed.

## FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS

*Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.*

FACTOR	DEFINITION	DISCUSSION
<b>AIDS mortality</b>	<p>The number of deaths among people with AIDS in a specified period, often a year</p>	<p>Like AIDS incidence and AIDS prevalence data, AIDS mortality data can be useful in understanding the extent to which the epidemic has affected a given population relative to another.</p> <p>Recent declines in AIDS deaths are attributable in large part to antiretroviral therapies. Differences in AIDS deaths among groups (e.g., by race/ethnicity or age) may represent differences in treatment success or differences in access to or use of health care.</p>
<b>HIV incidence (diagnosed)</b>	<p>The number of HIV cases diagnosed in a defined population in a specified period, often a year</p>	<p>The number of HIV infections diagnosed among people who received HIV tests during a specified period of time, usually a year. The data do not show the total number of HIV infections because not everyone is tested. Nor do the data show when HIV infections occurred, for people may be tested years after infection.</p> <p>To distinguish between HIV incidence among people with and without AIDS, we refer to diagnosed HIV (including AIDS) incidence and diagnosed HIV (not AIDS) incidence. In general, diagnosed HIV (not AIDS) incidence represents people infected with HIV more recently than people represented by AIDS incidence data.</p>
<b>HIV prevalence (diagnosed, including AIDS)</b>	<p>The number of people living with diagnosed HIV (including people with AIDS) in a defined population on a specified date</p>	<p>This factor shows the total number of people diagnosed with HIV or AIDS, minus those who have died, at a given point in time. Diagnosed HIV prevalence includes only people who have been tested, diagnosed, and reported; people who were tested anonymously are not included.</p> <p>Almost all areas now have HIV reporting; however, two years of HIV reporting data are considered the minimum for projecting trends. Diagnosed HIV (not AIDS) prevalence represents those people living with HIV infection but not AIDS.</p>

<b>FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS</b> <i>Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.</i>		
FACTOR	DEFINITION	DISCUSSION
Documentation of HIV-Risk Behaviors		<b>This factor provides data about behaviors that may lead to HIV transmission/acquisition.</b>
<b>Key indicators of HIV-risk behaviors</b>	Data sets that document that HIV-risk behaviors are occurring within the target population	<p>Although it's impossible to know how often target populations engage in HIV-risk behaviors, CPGs may use a variety of data to estimate occurrences.</p> <p>Sexually transmitted diseases (STDs): Gonorrhea, syphilis, and chlamydia are reportable STDs in most project areas. Because STD rates are reliable indicators of high-risk behavior (unprotected sex), groups with high rates of STDs are potentially at increased risk for HIV infection. Additionally, some STDs increase the risk of transmission in individuals who are exposed to HIV. The extent to which STD rates correlate with HIV risk will depend on the HIV prevalence (diagnosed) within the sexual network of persons practicing unsafe sex and on the local dynamics of STD transmission.</p> <p>Note: STD data alone do not indicate a risk for HIV infection. For example, if HIV prevalence (diagnosed) is extremely low, even high STD rates do not indicate a high risk. If HIV prevalence (diagnosed) is extremely high, even low STD rates do not indicate a low risk for HIV infection.</p> <p>Youth Risk Behavioral Surveillance System (YRBSS): This study measures health-risk behaviors among adolescents in school through representative biennial national, state, and local surveys. Out-of-school youth may have higher levels of HIV risk behaviors.</p>

## FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS

*Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.*

FACTOR	DEFINITION	DISCUSSION
<p><b>Other indicators of risk behaviors</b></p>	<p>Other data sets that may signal HIV risk behaviors occurring within the target population</p>	<p>Adolescent sexual activity: Teenage pregnancy is sometimes a marker for early initiation of unprotected sex, and an indication of high-risk behaviors. Take care in interpreting these data because teenage pregnancy may be intentional.</p> <p>Other behavioral data: Depending on local data collection and research systems, CPGs may be able to access local population studies of behaviors associated with HIV transmission, such as anal intercourse or needle sharing, and studies of the determinants of high-risk behaviors.</p> <p>CPGs should work with epidemiologists, behavioral scientists, etc., to determine whether other studies that collect behavioral data exist (especially any funded by federal — e.g., NIMH, NIDA, CDC — or state agencies).</p>
<p><b>Riskiness of population behaviors</b></p>	<p>The nature and relative risk of behaviors that occur in the target population</p>	<p>This factor considers the relative risk of behaviors among target populations. The risk for HIV transmission and acquisition associated with the highest-risk behaviors is well understood. The three most risky behaviors for transmitting HIV are, in descending order of risk, the use of HIV-infected injection equipment, unprotected receptive anal sex with an infected partner, and unprotected vaginal sex with an infected male partner.</p>
<p><b>Multiple high-risk behaviors</b></p>	<p>The extent to which multiple high-risk behaviors occur within the target population</p>	<p>This factor considers the occurrence of more than one high-risk behavior within a given population. For example, men who have unsafe sex with men and inject drugs are engaging in multiple high-risk behaviors.</p>

<b>FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS</b>		
<i>Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.</i>		
<b>FACTOR</b>	<b>DEFINITION</b>	<b>DISCUSSION</b>
<b>Sociodemographic Characteristics</b>		This factor, which can be measured in several different ways, examines complex issues that may affect the provision of HIV prevention interventions.
<b>Size of target population</b>	The estimated size of the target population in the geographic area where the program will be implemented.	Estimating target population size has been difficult for many project areas. CDC recommends using a World Health Organization methodology available at: <a href="http://www.who.int/docstore/hiv/Core/Chapter_9.10.html">http://www.who.int/docstore/hiv/Core/Chapter_9.10.html</a>
<b>Difficulty of meeting population needs</b>	The complexity of needs and whether the population has been reached by current programs, whether service providers have capacity, etc.	CPGs may use a variety of data sets, such as racial/ethnic composition, population density (urban, rural, frontier), education (especially level of completion and literacy rates), socioeconomics, service utilization data (services mapping, services access and utilization, etc.) to determine risk in a population.  Review all available data and information sets, including the results of the gap analysis. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.
<b>Barriers to reaching the population</b>	The extent to which barriers to providing HIV prevention programs exist in a high-risk population.	CPGs may consider the following sociodemographic characteristics when looking for indicators of barriers — cultural, linguistic, socioeconomic status, family or social network structures, gender and sexual orientation studies, religion and spiritual beliefs, consumer preferences, provider preferences, and community norms and values. Studies that focus on knowledge, attitudes, behaviors, and beliefs will also provide information about barriers.  Review all available data and information sets. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.

When your CPG has decided which factors to consider, you are ready to determine the relative importance (weight) of each factor. Weighting is optional, but if you don't do it, all factors will have the same importance. Faced with complex decisions, many CPGs find that weighting factors eases the priority setting process and increases objectivity. It helps with one of the hardest steps, comparing two or more options. No formula tells you which factors are most important, but it helps to ask:

- How well does this factor demonstrate the prevention needs of the target population?
- To what extent does the factor focus on a greater risk for HIV infections among the target population?

**W** By weighting factors, your CPG shows how important it thinks each factor is compared to the other factors. For example, you may believe that “HIV incidence (diagnosed),” “AIDS incidence,” and “multiple high-risk behaviors” are more important factors for determining the target populations than “AIDS mortality” and “barriers to reaching the population.” The last two factors, then, carry less weight.

<b>DATA SOURCES FOR TARGET POPULATION FACTORS</b>	
<b>TARGET POPULATION FACTOR</b>	<b>DATA SOURCES</b>
AIDS incidence AIDS prevalence AIDS mortality HIV incidence (diagnosed) HIV prevalence (diagnosed)	Epidemiologic profile
Key indicators of risk behavior	Epidemiologic profile, state/local STD departments, Youth Risk Behavior Surveillance Survey (YRBSS)
Other indicators of risk behavior	Epidemiologic profile, other state/local statistics
Riskiness of population behaviors	Local behavioral data/research systems
Multiple high-risk behaviors	Local behavioral data/research systems
Size of the population	Estimated from epidemiologic data
Difficulty of meeting population needs	Community services assessment (HIV Prevention Community Planning and Ryan White CARE Planning), including qualitative research, state/local vital statistics, state/local health utilization surveys, education surveys, services mapping
Barriers to reaching the population	Community services assessment (HIV Prevention Community Planning and Ryan White CARE Planning), including qualitative research, state/local vital statistics, state/local health utilization surveys
For data sources in your project area, see <i>Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning, Appendix B: Data Sources by Jurisdiction</i> , available online at: <a href="http://www.cdc.gov/hiv/pubs/guidelines.htm">http://www.cdc.gov/hiv/pubs/guidelines.htm</a> .	

You can use numeric or non-numeric weights.

- **Numeric weights** — Numeric weights are based on a scale, such as 1 (least important) through 3 (most important).

Numeric weights have the advantage of being precise. In a 1-to-5 (least-to-most important) scale, 4 always beats 2.

Although using a large scale (such as 1 to 100) may be tempting, it's probably unnecessary as the factors' weights won't differ a great deal. Large scales also take more calculation time.

- **Non-numeric weights** — Non-numeric weights are words or symbols, such as low, medium, and high; not important, somewhat important, and very important; and plus (+) and minus (-). It's important to choose words or symbols everyone understands.

While words aren't as precise as numbers, many CPG members may find using words easier.

When you begin to compare words or symbols, however, you may have to assign a numeric value to each, such as low=1, medium=2, and high=3.

### **TASKS — What do you need to do?**

Perform the following basic task. Decide whether a small group, such as a priority setting committee, or the full CPG should do it.

Use Worksheet 8 on page 95 to help you assign weights to the factors for each target population. The worksheet will help you:

- Determine whether to use numeric or non-numeric weights.
- Clarify the scale — which number is highest or most important, which is lowest or least important.
- Assign a weight to each factor.

## **Step 4: Rate Target Populations Using Factors**

**Using each factor as a measure, rate each target population.**

Key sub-tasks include:



## APPLYING THE CONCEPT! The Advantages of Using Numerical Values

The process of assigning numeric weights to factors often helps CPG members clarify their thinking and share their thoughts.

*Example:* A CPG assigned a numeric weight to each factor, with 5 representing most important and 1 least important. Here is how they weighted their factors.

FACTOR	WEIGHT	ORDER OF FACTORS
HIV incidence (diagnosed)	5	1
HIV prevalence (diagnosed)	5	1
Riskiness of population behaviors	4	2
AIDS prevalence	2	3
Key indicators of risk behavior (STD data)	2	4
Difficulty of meeting need	2	4

Because the CPG used numeric weights, everyone understood the importance of each factor, accepted the process, and the group had no trouble explaining its decisions to others.

- Assembling necessary data
- Developing a rating scale for each factor
- Rating target populations using each factor

**W**

You're ready to use the weighted factors to rate each of the potential target populations.

**Why is it important to rate factors?** To compare different factors, you need an identical scale for each factor. That is, the scale must have the same number of values. For example, you may want to find out which CPG member loves chocolate the most. You pass out dark chocolates and ask the members how much they love this chocolate. Two individuals report, "Not at all...hate chocolate." Some say, "I only like milk chocolate." A few write, "Good." Adora tells the group, "I love this chocolate! I give it a 10." Frank says, "I love it too. I give it a 100!" Who loves the chocolate the most — Adora or Frank? You can't tell because they used two different rating systems. Is 100 ten times greater than 10 here? Does Frank love the chocolate ten times more than Adora? If we ask them both to rate their choices

using the same scale, they will tie. Adora and Frank would both rate the chocolate at the top of the scale.

You may want to use the following three-part process to develop a scale for rating each factor.

### 1. Assemble the necessary data.

Determine what data or other information you need to consider for each factor. In some cases, data may be limited or even nonexistent. Request staff support. Many CPGs find health department staff invaluable in assembling, interpreting, and summarizing data. Consultants, a committee, or volunteers can also do the work.

The information from your project area's community services assessment is an essential resource to determine met and unmet service needs among target populations. (For more information about the needs assessment, see *Assessing the Need for HIV Prevention Services: A Guide for Community Planning Groups*. You can obtain a copy by calling CDC's National Prevention Information Network [NPIN], ID#D153, at 1-800-458-5231. It is also available online at [www.healthstrategies.org](http://www.healthstrategies.org).)

**Present data so it's relatively easy for CPG members to study.** Because CPG members must review masses of data that can be difficult to interpret, it's often better to summarize. Helpful summaries may include tables, charts, and condensed literature reviews. For example, someone can develop data summaries for each target population, with data sets corresponding to each factor.

### 2. Develop a rating scale for each factor.

**Simple scales:** The simplest way to do this is to consider the range of possible values for each factor and then assign numeric values to low, medium, and high points. The simpler the scale the better. In some cases, a two-point (usually yes/no, or +/-) scale will do. For example, all of the following factors could be rated using a two-point scale.

**Large scales:** Large scales provide more precision than simple ones do. Rating target populations using a two- or even five-point scale may seem simplistic, but remember you will be multiplying each factor's value by its weight. That makes complicated scales difficult to compute.

### 3. Rate target populations using each factor.

The third step is to use your scale to rate each target population. In some cases, such as AIDS prevalence, the data will be obvious, and the CPG can simply assign a rating. In other cases, where data are open to interpretation, members will need to discuss the meaning and, possibly, compromise.

Using the same factors, you can consult data from a variety of sources to rate target populations. For the target population "women engaging in risky behaviors," a CPG may rate each factor as on the following page.

**TASKS — What do you need to do?**

Perform the following basic tasks. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

<b>APPLYING THE CONCEPT! Simple Scale</b>		
<b>FACTOR</b>	<b>RATING INFORMATION</b>	<b>SCALE: YES OR NO</b>
<b>AIDS prevalence</b>	<ul style="list-style-type: none"> <li>■ Has the number of people living with AIDS in the target population increased by more than 15% in the past three years?</li> </ul>	Yes or No
	<ul style="list-style-type: none"> <li>■ Is the number of people living with AIDS in the target population greater than 1,000?</li> </ul>	Yes or No
<b>HIV incidence (diagnosed)</b>	<ul style="list-style-type: none"> <li>■ Has the number of people diagnosed with HIV in the target population increased by more than 5% in the past year when compared to the previous year?</li> </ul>	Yes or No
<b>HIV prevalence (diagnosed)</b>	<ul style="list-style-type: none"> <li>■ Has the number of people living with HIV in the target population increased by more than 25% in the past three years?</li> </ul>	Yes or No
	<ul style="list-style-type: none"> <li>■ Is the number of people living with HIV in the target population greater than 5,000?</li> </ul>	Yes or No
<b>Key indicators of risk behaviors (STDs)</b>	<ul style="list-style-type: none"> <li>■ Has the reported gonorrhea incidence among the target population increased by more than 10% in the past two years?</li> </ul>	Yes or No
	<ul style="list-style-type: none"> <li>■ Is the reported gonorrhea case rate among the target population greater than 19:100,000?</li> </ul>	Yes or No
<b>Riskiness of population behaviors</b>	<ul style="list-style-type: none"> <li>■ Do the HIV risk behaviors known to occur among the target population include sharing of contaminated injection equipment or unsafe anal intercourse?</li> </ul>	Yes or No
<b>Difficulty of meeting population needs</b>	<ul style="list-style-type: none"> <li>■ Are there significant barriers to reaching the target population with HIV prevention interventions?</li> </ul>	Yes or No

- **Assemble necessary data.** If the group has already assembled a comprehensive set of data for Step 1: Identify and Define Target Populations, then use the same information here. If not, you

<b>APPLYING THE CONCEPT! Large Scale</b>		
<b>FACTOR</b>	<b>RATING INFORMATION</b>	<b>SCALE*</b>
<b>AIDS prevalence</b>	<ul style="list-style-type: none"> <li>■ How many people in the target population are living with AIDS?</li> </ul>	1: 0-50 2: 51-250 3: 251-500 4: 501-1,000 5: >1,000
<b>HIV incidence (diagnosed)</b>	<ul style="list-style-type: none"> <li>■ How many people in the target population tested HIV-positive in the past year?</li> </ul>	1: 0-10 2: 11-25 3: 26-50 4: 51-100 5: >100
<b>HIV prevalence (diagnosed)</b>	<ul style="list-style-type: none"> <li>■ What is the estimated number of people living with HIV in the target population?</li> </ul>	1: 0-100 2: 101-500 3: 501-2,500 4: 2,501-5,000 5: >5,000
<b>Key indicators of risk behaviors (STDs)</b>	<ul style="list-style-type: none"> <li>■ What was the reported gonorrhea case rate among the target population?</li> </ul>	1: 0-15:100,000 2: 16-50:100,000 3: 51-100:100,000 4: 100-250:100,000 5: >250:100,000
<b>Riskiness of population behaviors</b>	<ul style="list-style-type: none"> <li>■ What is the primary HIV risk behavior known to occur among the target population?</li> </ul>	1: None, unknown, or low-risk 2: Oral sex w/infected partner 3: Vaginal sex w/infected partner 4: Anal sex w/infected partner 5: Sharing contaminated injection equipment
<b>Difficulty of meeting population needs</b>	<ul style="list-style-type: none"> <li>■ Are there significant barriers to reaching the target population with HIV prevention interventions?</li> </ul>	1: Few or virtually no barriers 3: Moderate barriers 5: Substantial barriers**
<p>* These scales are examples only. Your CPG should create a scale relative to the incidence/prevalence in your project area.            ** In some instances, you may have fewer than five data points on a five-point scale.</p>		

<b>APPLYING THE CONCEPT!</b> <b>Target Population: Women Engaging in Risky Behaviors</b>		
<b>FACTOR</b>	<b>SCALE*</b>	<b>RATING</b>
<b>AIDS prevalence</b> ■ How many people in the target population are living with AIDS?	1: 0-50 2: 51-250 3: 251-500 4: 501-1,000 5: >1,000	3
<b>HIV incidence (diagnosed)</b> ■ How many people in the target population tested HIV-positive in the past year?	1: 0-10 2: 11-25 3: 26-50 4: 51-100 5: >100	2
<b>HIV prevalence(diagnosed)</b> ■ What is the estimated number of people living with HIV in the target population?	1: 0-100 2: 101-500 3: 501-2,500 4: 2,501-5,000 5: >5,000	2
<b>Key indicators of risk behaviors (STDs)</b> ■ What was the reported gonorrhea case rate among the target population?	1: 0-15:100,000 2: 16-50:100,000 3: 51-100:100,000 4: 100-250:100,000 5: >250:100,000	4
<b>Riskiness of population behaviors</b> ■ What is the primary HIV risk behavior known to occur among the target population?	1: None, unknown, or low-risk 2: Oral sex w/infected partner 3: Vaginal sex w/infected partner 4: Anal sex w/infected partner 5: Sharing contaminated injection equipment	3
<b>Difficulty of meeting population needs</b> ■ Are there significant barriers to reaching the target population with HIV prevention interventions?	1: Few or virtually no barriers 3: Moderate barriers 5: Substantial barriers**	5
* These scales are examples only. Your CPG should create a scale relative to the incidence/prevalence in your project area. ** In some instances, you may have fewer than five data points on a five-point scale.		

will need to review a comprehensive set of the most recent data and information sets (for example, the epidemiologic profile and community services assessment components).

Use Worksheet 9 on page 97 to help you create a scale to rate each factor. The worksheet will help you to:

- Develop a rating scale for each factor.
  - Determine whether you will use a small or a large scale. *Caveat:* This is a very difficult task to do as a large group. Your CPG may want to use a small group, task force, or a committee to develop the rating scales, test them, and then explain the reasoning behind the choices and train the CPG on their use.
- **Plan for discussion.** In some cases, such as AIDS prevalence, the data will not be controversial, and your CPG can simply assign a rating. Design group decision-making processes to handle situations in which data are open to interpretation.

## Step 5: Score Target Populations Using Factors

### **W** Determine a score by multiplying the rating by the weight (rating x weight).

Next, your CPG will determine a final score for each factor for each target population. To determine each factor's score, multiply the factor's rating by its weight (rating x weight). Using this method to get the scores ensures that the more important factors have the most impact on the final decision.

Using the factors from the “women engaging in risky behaviors” example on page 84, a CPG may score each factor as follows.

### **TASKS — What do you need to do?**

Perform the following basic tasks. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

- Revisit past decisions and processes.** If you carry out your priority setting process over some time, members may not remember what they have done. Create a process in which you collect information at each step and review it frequently. Also, encourage members to keep track of the completed worksheets. Some CPGs have designed task binders for members and distribute new information on three-hole-punch paper for easy organization.

Use Worksheet 10 on page 99 to score factors for each target population.

<b>APPLYING THE CONCEPT!</b>			
<b>Target Population: Women Engaging in Risky Behaviors</b>			
<b>FACTOR</b>	<b>WEIGHT</b>	<b>RATING</b>	<b>FACTOR</b>
AIDS prevalence	3	3	9
HIV incidence (diagnosed)	5	2	10
HIV prevalence (diagnosed)	5	2	10
Key indicators of risk behaviors (STDs)	2	4	8
Riskiness of population behaviors	4	3	12
Difficulty of meeting population needs	2	5	10
<b>Overall Score</b>			<b>59</b>

## Step 6: Rank Target Populations

**For each target population, add the scores together so you can compare them and determine an overall rank.**

Adding the scores from all factors produces an overall score for that target population. This overall score reflects the combined impact of all the factors used to rate that target population. You have objective numbers to use in comparing target populations in order to set priorities.



**Rank-order target populations:** Looking at the overall scores, you can rank the target populations quickly and easily. Rank-ordering (listing in order of priority) provides the clearest explanation of your group's decisions.

To rank-order target populations, simply place target populations in order of their overall scores (either highest to lowest or lowest to highest, depending on the rating scale). In the example below, the target population with the highest overall score ranked #1.

### TASK — What do you need to do?

Perform the following task. Decide whether a small group, such as a priority setting committee, or the full CPG should do it.

- Rank-order target populations. Make sure that you document the results.

Use Worksheet 11 on page 101 to determine an overall rank for each target population.

<b>APPLYING THE CONCEPT! Ranking Target Populations</b>		
<b>TARGET POPULATIONS</b>	<b>OVERALL SCORE</b>	<b>RANK</b>
HIV-positive men who have unsafe sex with men	97	1
HIV-positive African American male injection drug users	82	2
HIV-positive young men (up to age 25) who have unsafe sex with men	75	3
HIV-negative women engaging in unprotected sex with positive partners	59	4
HIV-negative youth (male and female, up to age 25) engaging in very high risk behaviors	50	5
HIV-negative people in rural areas engaging in very high risk behaviors	24	6

## Step 7: Review Rankings of Target Populations, Set Priorities, among HIV-Positive Populations, and Rank-Order the Final List

**Review the results and agree upon the final list of target populations.**



- Set priorities among HIV-positive populations.



- Review final list of rank-ordered priorities.

Now you have a rank-ordered list of target populations. But your work is not quite done. The Advancing HIV Prevention initiative requires that HIV-positive people be priority number one. However, not all HIV-positive people are at risk for transmitting the virus or for being reinfected. Your CPG will need to determine which subgroup or groups of HIV-positive people are at greatest risk.

### 1. Set priorities among HIV-positive populations.

The following checklist will help you decide your method of setting priorities.

- How long have you had HIV reporting in your project area? If it's been less than two years, CDC recommends that you emphasize this data less than you would older data. Do you have epidemiologic data for each HIV positive subgroup? If not, is it possible to get that information? Sometimes the Health Department can reconfigure existing data. This may not be possible for various reasons, such as too few people in each subgroup.
- Do you have community services assessment (needs assessment) data for each HIV positive subgroup? Is there information you could gain from other sources? Do you understand each group's knowledge of transmission risk, their attitudes towards transmitting the virus, their behaviors that transmit the virus and the situations in which those behaviors are most likely to occur? Do you understand what each group believes about infecting other people? Do you know where they congregate?
- While it would be ideal for every CPG to have this information about every HIV positive subgroup, it's not always possible. For example, if there are very few people in one subgroup and many in another, precious needs assessment resources should be targeted at the largest group.

If your group was able to say yes to most of the items on the checklist, you'll want to consider the second option. Many groups, however, don't have complete information. The less complex option, number one, may be more appropriate in that case. Reviewing to see what information is missing is a good way to help decide what additional information you'd like from future community services assessments.

### Options for setting priorities among HIV-positive populations

Option one is less complex than option two. A group's choice should be based on such factors as adequacy of data, relative population sizes, and the group's capability to conduct the process.

#### *Option 1:*

**Step 1:** Set priorities for all populations using factors, weights, and rates. This produces a list of priority populations that includes both HIV-positives and negatives.

**Step 2:** Subtract HIV-positives from each priority population.

**Step 3:** Rank each HIV-positive subpopulation in the same sequence as the ranking of the overall population

Sample Priorities:

1. HIV-positive male African American IDUs in downtown mid-size city
2. HIV-positive African American women sex partners of male IDUs in downtown mid-size city
3. HIV-positive White MUSM crystal methedrine users ages 18-35 in downtown mid-size city
4. HIV-negative or unknown serostatus male African American IDUs in downtown mid-size city
5. HIV-negative or unknown serostatus African American women sex partners of male IDUs in downtown mid-size city
6. HIV-negative or unknown serostatus White MUSM crystal methedrine users ages 18-35 in suburban mid-size city

*Option 2:*

**Step 1:** Set priorities for all populations using factors, weights, and rates. This produces a list of priority populations that includes both positives and negatives.

**Step 2:** Subtract HIV-positives from each priority population.

**Step 3:** Develop a set of factors and weights specific to these HIV-positive subpopulations. These factors and their relative weights should reflect such considerations as relative risk for transmitting infection, as measured by both biological transmission factors (e.g., injecting drugs as compared to oral sex) and behavioral factors (e.g., multiple partners, amphetamine use, sex for drugs or money).

**Step 4:** Set ranked priorities among positive populations using the new factors and weights.

Sample Priorities:

1. HIV-positive male African American IDUs in downtown large city who share needles at crack houses
2. HIV-positive White MUSM crystal methedrine users ages 18-35 in downtown large city who engage in penetrative unprotected anal sex
3. HIV-positive African American women who have multiple sex partners
4. HIV-negative or unknown serostatus male African American IDUs in downtown large city
5. HIV-negative or unknown serostatus African American women sex partners of male IDUs in downtown mid-size city
6. HIV-negative or unknown serostatus White MSM crystal methedrine users ages 18-35 in downtown large city

## 2. Review final list of rank-ordered populations.

The last step in the seven-part process is to review your rankings and develop a final list of prioritized target populations.

Most CPGs use overall scores to rank target populations. Some use the scores as a springboard for further discussions. If final priorities do not reflect overall scores, however, you should justify the difference and specify the data used to support your decisions.

At this point, it's a good idea to assess how comfortable your group is with the final list of prioritized target populations. Every decision-making process has strengths and limitations. After you complete a group decision-making process, it helps to review the results as a group and make sure everyone accepts them.

Some CPGs have been unhappy with their initial set of target population priorities. They report that the first version seemed to be more of a gut reaction than a well-reasoned set of priorities. However, on their second pass, the process seemed better thought through and more objective. It's also important to record the group's suggestions for improving the process next time.

### TASKS — What do you need to do?

Perform the following basic tasks. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

- Set priorities among HIV-positive populations.
- Develop a final rank-ordered list of prioritized target populations. Make sure that the CPG supports the final results.

Congratulations! You have walked through the entire process of developing a set of priorities among target populations for HIV prevention.

# Worksheet 6

## Identify and Define Target Populations

### PURPOSE:

To identify and define the target populations your CPG will consider in the priority setting process.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- Define the target populations your CPG should consider for prioritization by risk behavior and demographics (i.e., gender, age, race, ethnicity, geography, other sociodemographic characteristics).
- Define target populations initially by behavior. Then include a combination of demographics, such as race or ethnicity, age, gender, and geographic location.

RISK BEHAVIOR FOR TARGET POPULATION	OTHER DEMOGRAPHICS FOR TARGET POPULATION	COMPLETE DESCRIPTION OF TARGET POPULATION
<p><i>Example:</i> Men who have sex with men (MSM)</p>	<p><i>African American Youth ages 15-24 in a specific zip code</i></p>	<p><i>African American MSM Youth ages 15-24 in a specific zip code</i></p>

RISK BEHAVIOR FOR TARGET POPULATION	OTHER DEMOGRAPHICS FOR TARGET POPULATION	COMPLETE DESCRIPTION OF TARGET POPULATION

# Worksheet 7

## Determine Factors for Target Populations

### PURPOSE:

To select the factors your CPG will consider to make decisions about target populations and to identify sources of information about each factor.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- Check those factors that your group will use to set priorities for target populations.
- Fill in the data source column to show where your group will find data for each factor you choose.

### FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS

FACTOR	DEFINITION	DATA SOURCES
HIV/AIDS Surveillance	This factor shows the extent of the HIV/AIDS epidemic among the target population	
<input type="checkbox"/> AIDS incidence (diagnosed)	The number of AIDS cases diagnosed in a defined population in a specified period, often a year	
<input type="checkbox"/> AIDS prevalence	The number of people living with AIDS in a defined population on a specified date	
<input type="checkbox"/> AIDS mortality	The number of deaths among people with AIDS in a specified period, usually a year	

<b>FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS</b>		
<b>FACTOR</b>	<b>DEFINITION</b>	<b>DATA SOURCES</b>
<input type="checkbox"/> HIV incidence (diagnosed)	The number of HIV cases diagnosed in a defined population in a specified period, often a year	
<input type="checkbox"/> HIV prevalence (diagnosed, including AIDS)	The number of people living with diagnosed HIV (including people with AIDS) in a defined population on a specified date (only available in areas with HIV reporting)	
<b>Documentation of HIV-Risk Behaviors</b>	<b>This group of factors provides data about behaviors that may lead to HIV transmission.</b>	
<input type="checkbox"/> Key indicators of HIV-risk behaviors	Data sets signaling HIV risk behaviors within the target population	
<input type="checkbox"/> Other indicators of risk behaviors	Other data sets signaling HIV risk behaviors within the target population	
<input type="checkbox"/> Riskiness of population behaviors	The nature and relative risk of risky behaviors that occur in the target population	
<b>Sociodemographic characteristics</b>	<b>This group of factors examines complex issues that may affect the provision of HIV prevention interventions.</b>	
<input type="checkbox"/> Size of target population	Estimated from epidemiologic data	
<input type="checkbox"/> Difficulty of meeting population needs	The complexity of need determined by whether the population has been reached by current programs, whether service providers have capacity, etc.	
<input type="checkbox"/> Barriers to reaching the population	The extent to which barriers to providing HIV prevention programs to the population have been identified	
<b>Other factors your group plans to consider</b>		

# Worksheet 8

## Weight Factors for Target Populations

### PURPOSE:

To assign weights to target population factors to indicate the relative importance of each factor for assessing the risk of target populations.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Create a scale** for applying weights to your target population factors. Weights can be numeric or non-numeric. For example, you may use a scale from 1 to 5 or from low to medium to high.
- **List the factors** you chose from Worksheet 7 in the table below. Then assign weights to these according to their level of importance in assessing risk among target populations.
- **Discuss the weights** with your CPG and agree on how each factor will be weighted.

WEIGHTING SCALE: _____	
FACTOR	WEIGHT



FACTOR	WEIGHT
<p><b>Comments:</b></p>	

# Worksheet 9

## Rate Factors for Target Populations

### PURPOSE:

- To create a rating scale for assessing each factor.
- To rate each target population according to the developed scale.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Make enough photocopies** of this sheet to use for each of your target populations.
- **Write the name** of the target population you are assessing at the top of the table.
- **List the factors** you chose from Worksheet 7 in the column to the left.
- **Decide which questions** to pose for each factor. Write these under Rating Information.
- **Develop a scale** for rating each factor and write it under Scale Rating.
- **Rate the factors** for each target population. Write the answers under Rating.
- **Proceed** with the same process for each additional target population.

TARGET POPULATION: _____			
FACTOR	RATING INFORMATION	SCALE RATING	RATING

TARGET POPULATION: _____			
FACTOR	RATING INFORMATION	SCALE RATING	RATING

# Worksheet 10

## Score Target Populations Using Factors

### PURPOSE:

To determine a final score for each factor for each target population.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Make copies** of this sheet to use for each of your target populations.
- **List the factors** that your group chose from Worksheet 7 in the column to the left.
- **List the weights** that you assigned to each factor on Worksheet 8.
- **List the ratings** that you assigned to each factor on Worksheet 9.
- **Multiply** the weight by the rating for each factor to obtain the final score.
- **Add the scores** for all the factors to obtain the overall score for the target population.
- **Proceed** with the same steps for each additional target population.

TARGET POPULATION: _____			
FACTOR	WEIGHT	RATING	SCORE

<b>TARGET POPULATION:</b> _____			
<b>FACTOR</b>	<b>WEIGHT</b>	<b>RATING</b>	<b>SCORE</b>
<b>Overall Score</b>			

# Worksheet 11

## Rank-Order Target Populations

### PURPOSE:

To determine the overall rank of each target population, according to the final score for each population.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Place** target populations in the chart in order of their scores (either highest to lowest or lowest to highest, depending on your scale).
- **Decide** on a ranking system (numeric or non-numeric). For example, a numeric system ranks populations in numeric order; a non-numeric system ranks populations by associating them with such words as low, medium, and high.
- **Rank** target populations.

### RANKING TARGET POPULATIONS:

RANK	TARGET POPULATION	OVERALL SCORE

RANKING TARGET POPULATIONS: _____		
RANK	TARGET POPULATION	OVERALL SCORE
<b>Comments:</b>  		

**Congratulations!** You have completed the entire process of developing a set of priorities for target populations for HIV prevention.

# 5

## Notes

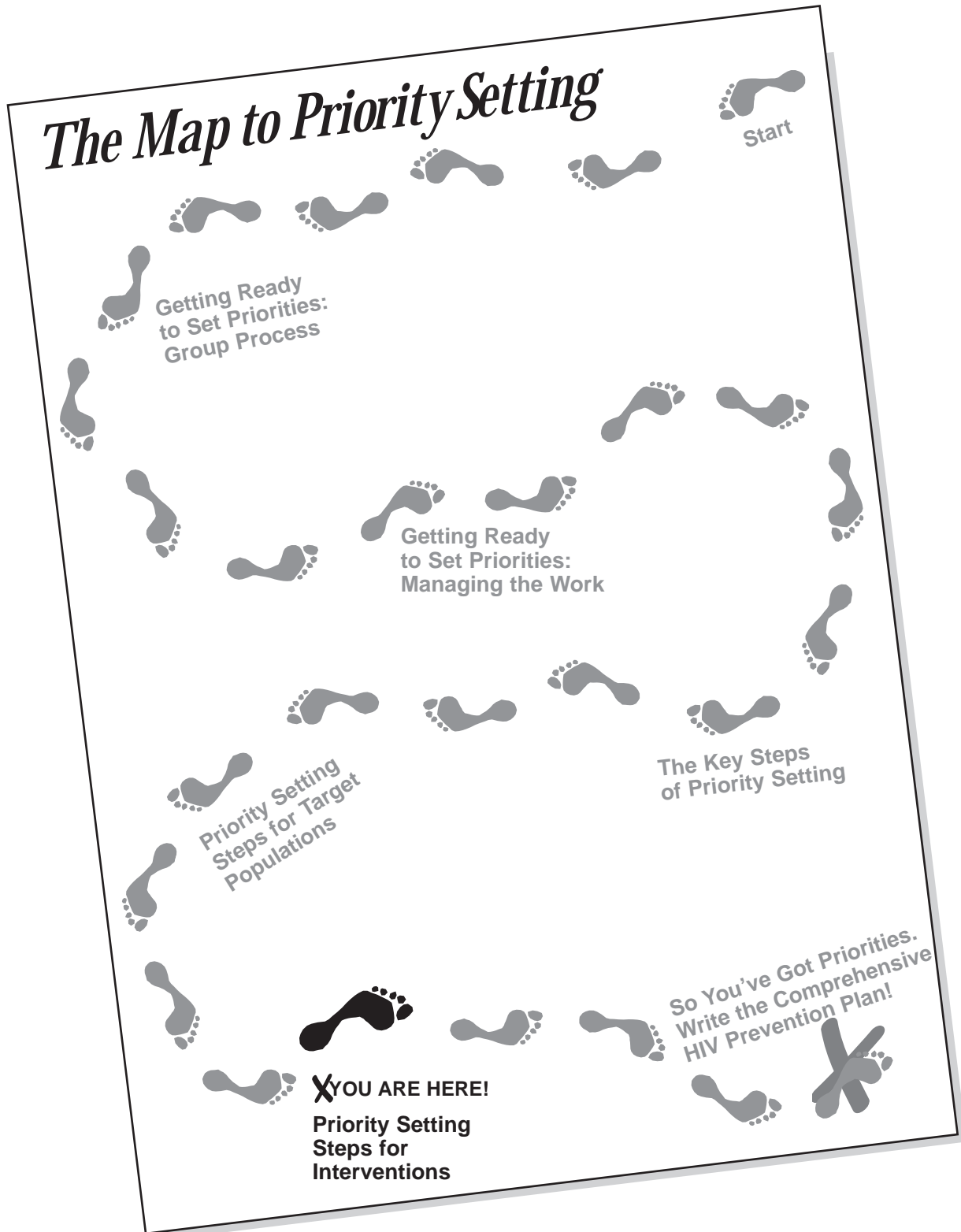
5

TARGET POPULATIONS



# 6

## Priority Setting Steps for Interventions



# The Continuing Adventures of the *Better the Second Time Around CPG*

## **Situation**

Luis, chair of the interventions committee, believes the group shouldn't start from scratch in setting intervention priorities. He thinks that the factors used in selecting interventions were more straightforward than those for choosing populations.

## **Action**

In fact, setting intervention priorities goes more quickly than setting target population priorities. The group knows the process, takes pride in its success so far, and has solid information from the interventions committee. The priority setting committee had asked that Luis's committee recommend factors to be used in priority setting. Committee members were happy to do this and presented a clear idea of why they selected some factors and not others. The list included data factors reflecting as much science as the committee could find and enough value-based factors to ensure that interventions would be feasible and acceptable to the target populations. The committee reached consensus on the factors quickly.

At the next meeting, the group asks a behavioral scientist to review the components of an effective intervention and to talk about specific interventions for their target populations. While this isn't new information for most of the group, it helps to focus discussion and allows people to ask about lingering issues. Several members say they're grateful to know that many of the interventions already in place in their project area are "state of the art."

Deciding on intervention priorities is still not easy. One CPG member, a popular and vocal advocate for a population that has ranked as a low priority, argues vehemently that this population is going to be left out, and that the health department will be forced to stop funding the general information campaign that was supposed to reach this group. The group is not swayed. After using the numeric process to set priorities, members take one last look and agree that their priorities are based on solid data. Almost everyone on the group agrees that they have done the best they can to develop a plan that will stop as many infections as possible, given the limited resources.

# 6

## Steps for Choosing Interventions

Priority setting in HIV prevention community planning should lead to programs that respond to high-priority, community-validated needs within defined populations. Your CPG needs to develop two products that will serve as the basis for the comprehensive plan:

- Target (or high-risk) population priorities
- Recommended interventions for each target population

This chapter focuses on developing a set of interventions for each target population.

### What the *Guidance* Says

The 2004-2008 *Guidance* no longer requires that CPGs set priorities among interventions, but CDC still expects CPGs to recommend science-based interventions that the target population finds acceptable.

***Goal Two** – Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.*

“The Comprehensive HIV Prevention Plan and Key Products” section of the *Guidance* says that CPGs should recommend:

*Appropriate science-based prevention activities/interventions: a set of prevention activities/interventions (based on intervention effectiveness and cultural/ethnic appropriateness) necessary to reduce transmission in prioritized target populations.*

## What PEMS Requires Health Departments to Report

The HIV/AIDS Prevention Program Evaluation and Monitoring System (PEMS), CDC's standardized data collection system, requires that health departments describe interventions by program name, program model name, start date and end date, target population, and the basis for the program model. Program models may be supported by an evidence-based study, CDC Recommended Guidelines, or by a scientific, theoretical, or operational basis. (Ask your health department for a more complete description of these descriptors.)

The steps for choosing a set of interventions are identical to those for setting population priorities except that you don't have to develop a rank-ordered list of interventions. Instead, your final product will be a well-described set of interventions for each target population.

### SEVEN KEY STEPS IN SETTING PRIORITIES FOR INTERVENTIONS

1. **Identify interventions:** Identify and determine what interventions should be considered for each population.
2. **Determine factors:** Decide which factors the CPG will use to choose interventions.
3. **Weight factors:** Assign a weight (level of importance) to each factor.
4. **Rate interventions using factors:** Use the factors to rate each intervention.
5. **Score interventions using factors:** Determine a score by multiplying the rating by the weight.
6. **Rank interventions:** For each intervention add the scores together to determine an overall rank.
7. **Review scores and select interventions:** Review the results and agree upon the final list of interventions for each target population.

## Step 1: Identify Interventions

### Identify and determine what interventions to consider for each target population.

How should CPGs identify interventions? What is an intervention? Where should you begin? CDC encourages CPGs to define an intervention as a specific activity or set of related activities intended to reduce HIV risk in one target population. The *Guidance* emphasizes that CPGs should *conceptualize interventions/activities as a set or mix of interventions/activities versus one specific intervention/activity for each target population*. The set of interventions/activities should build upon each other and work together to reach the maximum number of people at risk using as many methods and in as many locations as possible.

**In defining HIV prevention interventions, what makes sense?** CDC expects your CPG to identify a set of activities that you can use to prevent new HIV infections within high-risk target populations.

**Your objective in selecting activities is to create a comprehensive list of proven and potentially effective HIV prevention interventions for each of your CPG's high-priority target populations.**

**List all possible HIV prevention interventions for the jurisdiction.** List all interventions that you've identified to meet the prevention needs of each target population. To compare interventions, you need

to use consistent terminology in your list. As a start, review how your CPG has defined interventions previously. It's a good idea to use the same definitions from year to year, and to be clear about any you change. See *Intervention Types*.

**INTERVENTION:** A specific activity (or set of related activities) intended to reduce HIV risk

- In a particular target population
- Using a common strategy for delivering the prevention messages
- With distinct process and outcome objectives, and
- A protocol outlining the steps for implementation

**Program** — For an agency, a related set of interventions serving a particular population.

Source: *Evaluating CDC-Funded Health Department HIV Programs*. CDC (June 2001).

**Consult the CDC list of effective interventions and intervention literature.** Be sure to consult the HIV prevention literature about effective interventions. CDC and other funders ask CPGs to propose interventions that have evidence of effectiveness. Several Web sites now provide excellent summaries of effective interventions by target population. Appendix I lists CDC-endorsed interventions for people with HIV and for people at high risk of contracting HIV. The interventions were identified by CDC's HIV/AIDS Prevention Research Synthesis Project (PRS) as having used rigorous study methods and demonstrated evidence of effectiveness in

reducing sex- and drug-related risk behaviors and/or improving health outcomes. See Table: *Data Sources for Intervention Factors* on page 120.

Not all target populations in all settings have evidence-based interventions. Despite major advances in prevention science, many gaps remain. For example, Internet interventions for men who have unsafe sex with men have not been evaluated. Yet, some CPGs have community services assessment data demonstrating that this is an unmet prevention need.

If your CPG has a high-risk population for which there are no proven interventions, conduct a literature search for interventions tried in other locations, consult with other project areas likely to have similar populations and situations, and ask for technical assistance. Your project officer may be able to help you find another project area that is addressing this issue. Finally, remember that any recommended intervention should be based on sound theory, be targeted toward a specific audience and risk behavior, and be acceptable to the target audience.

**Consider capacity building.** Capacity building refers to any activity that increases your community's ability to deliver effective HIV prevention programs. As you identify potential interventions, your group may want to recommend capacity-building activities as a necessary first step in developing a full HIV prevention portfolio. For example, some project areas may not have community-based organizations

that serve all target populations. Or the community-based organizations may lack enough capacity to design, implement, and sustain the recommended HIV prevention interventions. Helping them to acquire the necessary skills, personnel, or other resources is a capacity-building activity. Capacity-building activities are not interventions in and of themselves. Health departments may wish, however, to incorporate capacity-building activities into a long-range plan to develop a comprehensive intervention portfolio.

Your CPG can identify the need to build capacity in its community services assessment. In most cases, the need is specific to certain target populations, and it probably corresponds to the lack of availability of other related services for that population. Some CPGs respond to the need for capacity building by matching capacity-building activities to the interventions for each target population. In other cases, CPGs recommend capacity building for the overall project area.

**Learn from the past.** By reviewing past priority setting target populations or groups, needs assessments, research literatures, etc., you may be able to develop a list of potential interventions quickly. Much of the information you need may be available in the project area's needs assessment, resource inventory, and gap analysis. Also, review pertinent components of CDC's Evaluation Guidance (*Evaluating CDC-Funded Health Department HIV Programs*).

Key issues to consider when identifying potential interventions include:

- What target population prevention needs does the community services assessment identify?
- How do the health department and HIV prevention service agencies describe their interventions? Do the descriptions specify what services are provided and to whom?
- What target population intervention needs are met or unmet according to the resource inventory? In identifying specific interventions for target populations, consider populations with both met and unmet prevention needs.

## INTERVENTION TYPES

The CDC Evaluation Guidance — *Evaluating CDC-Funded Health Department HIV Prevention Programs* — provides a categorization of interventions (see page 111 of this guide for more detailed information). The seven types of interventions identified in this document are:

- Individual-level interventions
- Group-level interventions
- Outreach
- Prevention case management
- Partner counseling and referral services
- Health communication/public information
- Other interventions (including community-level interventions)

### EXAMPLE FROM THE FIELD! Identifying Interventions for Target Populations: Iowa

In Iowa, a low-incidence state, the CPG selected the following priority interventions for persons living with HIV. These interventions are Iowa's 2004-2006 priorities.

#### TARGET POPULATION: PERSONS LIVING WITH HIV EVIDENCE-BASED INTERVENTIONS TO BE USED IN IOWA

Name of Intervention	Type of Intervention
Community Promises	Multiple Intervention Program <ul style="list-style-type: none"> <li>■ Individual-Level Intervention</li> <li>■ Group-Level Intervention</li> <li>■ Community-Level Intervention</li> <li>■ Outreach</li> <li>■ Structural Level</li> </ul>
Healthy Relationships	Group-Level Intervention
Learning Immune Function Enhancement (LIFE)	Prevention Counseling
Partner Counseling Referral Services	Partner Counseling Referral Services (IDPH)
Prevention Case Management	Prevention Case Management

#### EMERGING INTERVENTIONS THAT HAVE BEEN USED IN IOWA

Name of Intervention	Type of Intervention	Comments
Phone-Eze (Iowa)	Group-Level Intervention	
Retreats — Conference	Health Communications/ Public Information	Multiple topics offered over consecutive days
Retreats — Curriculum	Group-Level Intervention	Curriculum-based activity offered over 1-2 days
Internet	Health Communications/ Public Information	Need to assure participants have access to Internet Need to assess whether usable as information sharing or for "hooking up"

## TASKS — What do you need to do?

Perform the following basic tasks. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

- **Review previous recommended interventions, the CDC list of effective interventions, and the intervention literature.** Local program evaluations and information collected by your health department on funded interventions will also be helpful in identifying interventions. (See *Data Sources for Intervention Factors* on page 120.)
- **Work with your health department staff to ensure that the categorization approach you use is consistent with what they have to report to CDC.** (See Table: *Intervention Types Used in CDC's Evaluation Guidance*.)



Use Worksheet 12, page 131, to help you do the following:

- Define each potential intervention, including which target population(s) each addresses, as specifically as possible. This is very important: **CPG members should understand how CDC defines interventions.** See *Intervention Types* on page 111. Include examples for each intervention definition.
- Develop a list of potential interventions for each target population. (This list will be used in later steps.)



<b>INTERVENTION TYPES USED IN CDC'S EVALUATION <i>GUIDANCE</i></b>	
<b>INTERVENTION TYPE</b>	<b>DEFINITION/DESCRIPTION</b>
<b>A. Individual-level interventions (ILI)</b>	<p>Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services (e.g., substance abuse treatment) in both clinic and community settings in support of behaviors and practices that prevent transmission of HIV. They help clients make plans to obtain these services.</p> <p><b>Note:</b> According to a strict categorization, outreach and prevention case management also are “individual-level interventions.” However, for the purposes of this reporting, ILI does not include outreach or prevention case management, each of which constitutes its own intervention category.</p>
<b>B. Group-level interventions (GLI)</b>	<p>Health education and risk-reduction counseling (see above) that shift the delivery of service from the individual to groups of varying sizes. Use peer and nonpeer models involving a wide range of skills, information, education, and support.</p> <p><b>Note:</b> Many providers consider general education activities to be “group level interventions.” However, for the purposes of this reporting, GLI does not include one-shot educational presentations or lectures that lack a skills component. Those types of activities should be included in the Health Communication/Public Information category. (see F)</p>
<b>C. Outreach</b>	<p>HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face to face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. These interventions usually include distribution of condoms, bleach, sexual responsibility kits, and education materials.</p>
<b>D. Prevention case management (PCM)</b>	<p>Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple complex problems and risk-reduction needs. A hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.</p>
<b>E. Partner counseling and referral services (PCRS)</b>	<p>A systematic approach to notifying sex and needle-sharing partners of HIV+ persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS help partners gain early access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.</p>

<b>INTERVENTION TYPES USED IN CDC'S EVALUATION <i>GUIDANCE</i></b>	
<b>INTERVENTION TYPE</b>	<b>DEFINITION/DESCRIPTION</b>
<b>F. Health communication/ public information (HC/PI)</b>	<p>The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences. The messages are designed to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection on how to obtain specific services.</p> <p>Broadcast media: Means by which information is conveyed to large groups of people. These include radio and television public service announcements, news broadcasts, infomercials, etc., that reach a large-scale (e.g., city-, region-, or statewide) audience.</p> <p>Print media: Printed materials that may reach a large-scale or nationwide audience; includes newspapers, magazines, pamphlets, and billboards and transportation signage.</p> <p>Hotline: Telephone service (local or toll-free) offering up-to-date information and referral to local services, e.g., counseling/testing and support groups.</p> <p>Clearinghouse: Interactive electronic outreach systems using telephone and mail to provide a responsive information service to the general public, professionals, and high-risk populations.</p> <p>Presentations/lectures: Information-only activities with minimal interaction; for small audiences; often called "one-shot" education interventions.</p>
<b>G. Other interventions</b>	<p>Category to be used for those interventions funded with CDC 99004 that cannot be described by the definitions provided for the other six types of interventions (examples A-F). This category includes community-level interventions (CLI).</p> <p>CLIs seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole rather than on individuals or small groups. A CLI often attempts to alter social norms, policies, or characteristics of the environment. Examples of CLIs include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.</p>
Source: <i>Evaluating CDC-Funded HIV Health Department Programs</i> . CDC. Volume 1: June 2001.	

## Step 2: Determine Factors

### Decide which factors the CPG will use to choose a set of interventions.

Now that your CPG has listed the potential interventions, your next step is to determine which factors to consider in making decisions. In selecting factors, your CPG needs to strike a balance — choosing enough factors to inform the process without choosing so many that they overwhelm the group.

#### **EXAMPLE FROM THE FIELD!** **Guiding Principles for Choosing Factors: North Carolina**

The North Carolina CPG developed a set of principles to guide members in choosing factors. They determined that the factors they would consider must:

- Be easy to use, and not too abstract
- Be readily available to all members
- Be clear, and not open to multiple interpretations
- Be straightforward, and not too hard to define
- Achieve a balance between quantitative and qualitative data

**What are factors, and how do I know one when I see one?** Factors are simply pieces of information to consider in decision making. For example, when you buy cereal, you may think about such factors as cost, fiber content, sugar content, vitamins, and taste. Some factors will be more important to you than others. You may struggle to choose between cost and taste.

The same kind of struggle occurs in selecting interventions. Unless the CPG decides which factors to consider as a group, decisions are likely to be based on personal — often biased — impressions rather than neutral information.

**Begin by developing a list of the various types of information that the CPG will need to consider.** Be thorough. You can always go back and narrow your choices later. The factors that you consider may be evidence-based (i.e., information documented in the evaluation research studies) or

value-based (i.e., consumer preferences). Some CPGs begin by developing a list — often through brainstorming — of all possible factors. Then, they narrow down the list, either by a group consensus process or voting, until only the most important factors remain (see *Example from the Field! North Carolina*).

The *Guidance* identifies criteria to be used in selecting interventions in Objective F:

*Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.*

<b>FACTORS FOR CHOOSING INTERVENTIONS</b>	
<b>FACTOR</b>	<b>DISCUSSION</b>
<b>Targets a specific population and a specific risk behavior</b>	<p>Does the intervention description contain the following elements?</p> <ul style="list-style-type: none"> <li>■ Focus – targeted population</li> <li>■ Level – individual, group, community</li> <li>■ Risk – exact risk behavior that is expected to change</li> <li>■ Setting – where</li> <li>■ Frequency/Duration – for how long and how often</li> <li>■ Scale and Significance – numbers of people in the priority population who need to be reached to have a significant influence on the epidemic</li> </ul>
<b>Outcome evidence</b>	<p>Are there indicators that the intervention is effective, or might be effective, in averting or reducing high-risk behaviors within the target population? The evidence might include (in order from strongest to weakest):</p> <ul style="list-style-type: none"> <li>■ An outcome evaluation of the intervention – how much the intervention reduced risky behaviors in the population and setting for which it was developed</li> <li>■ An evaluation of an intervention that shares core common elements, characteristics, and procedures with an intervention that has outcome data</li> <li>■ An evaluation of an intervention that has been adapted and that maintains the core elements of an evaluated intervention (The intervention is being delivered to a different population or in a different venue than the one in which the efficacy was originally demonstrated.)</li> <li>■ An evaluation of an intervention that has been tailored and that maintains the core elements of an evaluated intervention (The intervention strategy is changed to deliver a new message, at a new time, or in a different manner than was originally described.)</li> <li>■ The intervention is based on theory and is acceptable to the target audience</li> </ul>
<b>Acceptable to the target population</b>	<p>Is it culturally appropriate, relevant, and acceptable?</p>

<b>FACTORS FOR CHOOSING INTERVENTIONS</b>	
<b>FACTOR</b>	<b>DISCUSSION</b>
<b>Intervention feasibility</b>	<p>Several factors comprise feasibility, including:</p> <ul style="list-style-type: none"> <li>■ Capacity – Does the capacity exist to implement the intervention? Is the intervention practical given available expertise, funding, and implementation time? (Remember: Capacity building is encouraged.)</li> <li>■ Sustainability – Is the intervention sustainable over a long enough period to make a difference?</li> <li>■ Resources – Are there other supporting activities to assist and supplement delivery of the intervention?</li> <li>■ Legality – If an intervention is illegal, the group may still want to endorse that intervention as a high priority. For example, needle exchange/syringe access programs have proven effective in reducing HIV infections but cannot be funded with federal dollars and often require policy and legal changes.</li> </ul>
<b>Developed by or with input from the target population</b>	Has the intervention been developed by or with input from the target population?
<b>Ability to have the greatest impact on decreasing new infections</b>	When choosing between two similar interventions for the same population and targeting the same behavior, which one provides the greatest outcome for the least cost?

Attributes 42 to 48 provide more detail on criteria for intervention selection and the format for describing interventions. These are summarized below and described in *Factors for Choosing Interventions* on page 114.

- Characterization by focus (specific target population), level (individual, group, community, other), factors expected to affect risk, setting, frequency/duration, scale, and significance
- Outcome evidence of effectiveness
- Acceptability to the target population
- Feasibility for the intended population in the intended setting
- Developed by or with input from the target population
- Ability to have the greatest impact on decreasing new infections

**EXAMPLE FROM THE FIELD! Setting Priorities for Interventions: Louisiana**

The Louisiana CPG decided to use the following intervention factors and definitions:

**Outcome Effectiveness:** The extent to which evaluation indicates that high-risk behavior is averted/reduced in the target population, thereby reducing HIV/STD infection

**Intervention Feasibility and Cost Effectiveness:** The extent to which the intervention is practical and workable, given the available expertise, cost-effectiveness, and implementation time

**Addresses Community/Cultural Norms and Values:** The extent to which the key elements of the intervention address behaviors, attitudes, beliefs, and barriers of the target population and are consistent with its norms and values

**Accessible to the Target Population:** The extent to which the intervention can reach the intended audience. The extent to which barriers (e.g., language, hours of operation, geographic distance) do not exist or do not significantly affect the population's exposure to the intervention

**Addresses High-Priority Needs:** The extent to which the intervention targets documented HIV prevention needs

**TASKS — What do you need to do?**

Perform the following basic tasks. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

- **Decide what information is most important to the CPG.** To make this task easier, review your previous intervention choices. Consult the literature to learn what interventions have been studied for each population group, especially in your jurisdiction. (See *Data Sources for Intervention Factors*, page 120, and the Bibliography on page 195 for compilations of HIV intervention literature.)

**W**

Use Worksheet 13 on page 133 to guide you through choosing factors for interventions. The worksheet will help you:

- List all the possible factors to consider. Make sure the list describes the factors as accurately and specifically as possible.
- Decide on a process to select the specific factors the CPG will consider in decision making.
- Develop a list of factors to be used in selecting a set of interventions for each target population. (This list will be used in later steps.)

## EXAMPLE FROM THE FIELD! Iowa's Criteria for Intervention Selection

**Review data:** In 2003 the Strategies for Prevention Interventions and Community Endeavors Committee presented the new categorization scheme to the CPG. The committee described each intervention as specifically as possible to assure that CPG members were comfortable with how interventions or curriculums are defined. Examples of each intervention derived from Iowa's current prevention projects were given.

**Selection criteria:** A set of interventions for each target population was presented and the CPG voted unanimously to accept the lists. The following criteria were used to choose interventions.

- Are there indicators that the intervention is effective or might be effective in averting or reducing high-risk behavior?
- Is the intervention based on behavioral and/or social science theory?
- Is the intervention specifically designed to reach the target population?
- Does the intervention target specific behaviors, attitudes, beliefs, norms, or barriers that place people at risk for HIV infection?
- How feasible is the intervention?
- Is the intervention legal?
- Is the intervention practical given available expertise, funding, and implementation time?
- Are there resources available to assist in the delivery of the intervention?
- Is the intervention sustainable over time?
- Is the intervention acceptable to the target population?
- Is there evidence that the intervention is cost-effective?
- How accessible is the intervention to the target population?
- Can the intervention be adapted for rural communities?

## Step 3: Weight Factors

### Assign a weight (level of importance) to each factor.

When your CPG has decided which factors to consider, you are ready to determine the relative importance (weight) of each factor. Weighting is optional, but if you don't do it, all factors will have the same importance. Faced with complex decisions, many CPGs find that weighting factors clarifies their process and increases objectivity. It helps with one of the hardest steps, comparing two or more options.

Weighting factors calls for judgment, for no precise formula tells you which factors are most important. In comparing factors to determine their relative weights, ask how well a factor demonstrates an intervention's potential for reducing the number of new HIV infections.

By weighting factors, your CPG shows how important it thinks each factor is compared to the other factors. For example, you may believe that “effectiveness,” “sound theoretical basis,” and “intervention feasibility,” are more important factors for determining your interventions than “legality.” The last factor, then, carries less weight.

### You can use numeric or non-numeric weights.

- **Numeric weights** — Numeric weights are based on a scale, such as 1 (least important) through 3 (most important).
  - Numeric weights have the advantage of being precise. In a 1-to-5 (least-to-most important) scale, 4 always beats 2.
  - Although using a large scale (such as 1 to 100) may be tempting, it's probably unnecessary as the factors' weights won't differ a great deal. Large scales also take more calculation time.
- **Non-numeric weights** — Non-numeric weights are words or symbols, such as low, medium, and high; not important, somewhat important, and very important; and plus (+) and minus (-). It's important to choose words or symbols everyone understands.
  - While words aren't as precise as numbers, many CPG members may find using words easier.
  - When you begin to compare words or symbols, however, you may have to assign a numeric value to each, such as low = 1, medium = 2, and high = 3.



## TASKS — What do you need to do?

Perform the following basic tasks. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

**W** Use Worksheet 14 on page 135 to help you assign weights to the factors for each intervention. The worksheet will help you:

- Determine whether to use numeric or non-numeric weights.
- Clarify the scale — which number is highest or most important, which is lowest or least important.
- Assign a weight to each factor.

### APPLYING THE CONCEPT! The Advantages of Using Numerical Values

The process of assigning numeric weights to factors can often help individuals clarify their thinking and share their thoughts.

*Example:* A CPG assigned a numeric weight to each factor, with 5 representing most important and 1 least important. Here is how they weighted their factors

FACTOR	WEIGHT	ORDER OF FACTORS
Effectiveness	5	1
Targets a specific population	4	2
Targets a specific behavior	4	2
Intervention feasibility — capacity	3	3
Sound theoretical basis	2	4

Because the CPG used numeric weights, everyone understood the importance of each factor, accepted the process, and the group had no trouble explaining its decisions to others.

## Step 4: Rate Interventions Using Factors

Using each factor as a measure, rate each intervention.

Key sub-tasks include:

- Assembling necessary data
- Developing a rating scale for each factor
- Rating interventions using each factor

You're ready to use the weighted factors to rate each of the potential interventions for each target population.

<b>DATA SOURCES FOR INTERVENTION FACTORS</b>	
<b>TARGET POPULATION FACTOR</b>	<b>DATA SOURCES</b>
<b>Effectiveness</b>	<ul style="list-style-type: none"> <li>■ <i>Compendium of HIV Prevention Interventions with Evidence of Effectiveness</i>. Atlanta, GA: Centers for Disease Control and Prevention, Prevention Research Synthesis Project, November 1999. (Revised August 31, 2001)  Provides information about interventions with evidence of reducing risks and the rate of HIV/STD infections.  <b>Availability:</b> <a href="http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm">http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm</a></li> </ul>
	<ul style="list-style-type: none"> <li>■ <b>REP+, Replicating Effective Programs.</b>  REP programs are science-based behavioral interventions with demonstrated evidence of effectiveness in reducing risky behaviors or in encouraging safer ones. The interventions are available in user-friendly packages that guide prevention providers in replicating effective risk-reduction programs in their communities.  <b>Availability:</b> <a href="http://www.cdc.gov/hiv/projects/rep/default.htm">http://www.cdc.gov/hiv/projects/rep/default.htm</a> Or call: CDC's National Prevention Information Network at 1-800-458-5231 for publication ID# D275.</li> </ul>

<b>DATA SOURCES FOR INTERVENTION FACTORS</b>	
<b>TARGET POPULATION FACTOR</b>	<b>DATA SOURCES</b>
Effectiveness (continued)	<ul style="list-style-type: none"> <li> <p>■ <b>Center for AIDS Intervention Research (CAIR), Medical College of Wisconsin</b></p> <p>CAIR develops, conducts and evaluates new HIV prevention interventions. CAIR's <i>Partners in Prevention</i> manuals were developed to fill the gap between HIV prevention research findings and applied practice in community settings. The men's and women's editions are downloadable from the site. It also includes a searchable database of articles related to HIV/AIDS prevention and links.</p> <p><b>Availability:</b> <a href="http://www.cair.mcw.edu">http://www.cair.mcw.edu</a></p> </li> </ul>
	<ul style="list-style-type: none"> <li> <p>■ The Center for AIDS Prevention Studies (CAPS) at the University of California San Francisco. HIV prevention fact sheets.</p> <p>Provides information about the effectiveness of HIV prevention interventions.</p> <p><b>Availability:</b> <a href="http://www.caps.ucsf.edu">www.caps.ucsf.edu</a></p> </li> </ul>
	<ul style="list-style-type: none"> <li> <p>■ <b>Diffusion of Effective Behavioral Interventions (DEBI) project</b></p> <p>The Diffusion of Effective Behavioral Interventions project provides training and technical assistance on selected evidence-based HIV/STD prevention interventions to state and community HIV/STD program staff. See the Web site for a list of interventions.</p> <p><b>Availability:</b> <a href="http://www.effectiveinterventions.org">http://www.effectiveinterventions.org</a></p> </li> </ul>
	<ul style="list-style-type: none"> <li> <p>■ <b>Procedural Guidance for Selected Strategies and Interventions for Community Based Organizations Funded under Program Announcement 04064</b></p> <p>The Guidance is divided into three sections. Section 1 describes procedures for targeted outreach and health education/risk reduction for high-risk individuals. Section 2 describes procedures for targeted outreach and counseling, testing, and referral services for high-risk individuals. Section 3 describes procedures for prevention interventions for people living with HIV and their partners of negative or unknown status. Section 3 also describes interventions for people at very high risk for HIV infection.</p> <p><b>Availability:</b> <a href="http://www.cdc.gov/search.do?action=search&amp;queryText=Procedural+Guidance">http://www.cdc.gov/search.do?action=search&amp;queryText=Procedural+Guidance</a></p> </li> </ul>

DATA SOURCES FOR INTERVENTION FACTORS	
TARGET POPULATION FACTOR	DATA SOURCES
Theoretical basis	<ul style="list-style-type: none"> <li>■ <i>Compendium of HIV Prevention Interventions with Evidence of Effectiveness</i>. Atlanta, GA: Centers for Disease Control and Prevention, Prevention Research Synthesis Project, November 1999. (Revised August 31, 2001) Provides information about interventions with evidence of reducing risks and the rate of HIV/STD infections. <b>Availability:</b> <a href="http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm">http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm</a></li> </ul>
	<ul style="list-style-type: none"> <li>■ Valdiserri, West, Moore, Darrow, and Hinman. "Structuring HIV Prevention Service Delivery Systems on the Basis of Social Science Theory," <i>Journal of Community Health</i>. Vol. 17(1992):259-69. Describes ways prevention programs can use behavioral science theory in interventions</li> </ul>
Cost-effectiveness	<ul style="list-style-type: none"> <li>■ Holtgrave, D. R. (ed.). <i>Cost-Effectiveness Handbook – Handbook of Economic Evaluation of HIV Prevention Programs</i>. New York: Plenum Press, 1998. Focuses on allocation decision making. Discusses cost and cost-effectiveness analysis, the analysis framework, and methods required to perform HIV prevention analysis. <b>Availability:</b> <a href="http://isbndb.com/d/book/handbook_of_economic_evaluation_of_hiv_prevention_programs.html">http://isbndb.com/d/book/handbook_of_economic_evaluation_of_hiv_prevention_programs.html</a></li> </ul>
	<ul style="list-style-type: none"> <li>■ Pinkerton, S. D., Holtgrave, D. R., DiFranceisco, W. J., Stevenson, L. Y., and Kelly, J. A. 1998. "Cost-Effectiveness of a Community-Level HIV Risk Reduction Intervention," <i>American Journal of Public Health</i>. 88(8):1239-1242. Gives cost-effectiveness analysis of a community-level intervention that used peers to educate gay men.</li> </ul>
	<ul style="list-style-type: none"> <li>■ Holtgrave, D. R., Valdiserri, R. O., &amp; West, G. A. 1994. "Quantitative Economic Evaluations of HIV-Related Prevention and Treatment Services: A Review," <i>Risk: Health Safety &amp; Environment</i>. 5:29-47. Analyzes cost benefits and cost effectiveness of HIV-related prevention and treatment services.</li> </ul>

**Why is it important to rate factors?** To compare different factors, you need an identical scale for each factor. That is, the scale must have the same number of values. For example, you may want to find out which CPG member loves chocolate the most. You pass out dark chocolates and ask the members how much they love this chocolate. Two individuals report, “Not at all...hate chocolate.” Some say, “I only like milk chocolate.” A few write, “Good.” Adora tells the group, “I love this chocolate! I give it a 10.” Frank says, “I love it too. I give it a 100!” Who loves the chocolate more — Adora or Frank? You can’t tell because they used two different rating systems. Is 100 ten times greater than 10 here? Does Frank love the chocolate ten times more than Adora? If we ask them both to rate their choices using the same scale, they will tie. Adora and Frank would both rate the chocolate at the top of the scale.

You may want to use the following three-part process to develop a scale for rating each factor.

### 1. Assemble the necessary data

Determine what data or other information you need to consider for each factor. In some cases, data may be limited or even nonexistent. Request staff support. Many CPGs find health department staff invaluable in assembling, interpreting, and summarizing data. Consultants, a committee, or volunteers can also do the work.

<b>APPLYING THE CONCEPT! Simple Scale</b>		
<b>FACTOR</b>	<b>RATING INFORMATION</b>	<b>SCALE: YES OR NO</b>
<b>Targets a specific population</b>	<ul style="list-style-type: none"> <li>■ Is the intervention specifically designed to reach the target population?</li> </ul>	Yes or No
<b>Targets a specific behavior</b>	<ul style="list-style-type: none"> <li>■ Does the intervention target specific behaviors, attitudes, beliefs, norms, or barriers that it is intended to modify or reinforce, and is it designed to achieve that objective?</li> </ul>	Yes or No
<b>Effectiveness</b>	<ul style="list-style-type: none"> <li>■ Is there evidence to show that this intervention is effective in averting or reducing HIV risk behaviors?</li> </ul>	Yes or No
<b>Sound theoretical basis</b>	<ul style="list-style-type: none"> <li>■ Was behavioral and/or social science research and theory used as a basis for designing the intervention?</li> </ul>	Yes or No
<b>Program feasibility — funding</b>	<ul style="list-style-type: none"> <li>■ Is there evidence to show that the intervention is practical given available funding?</li> </ul>	Yes or No

### APPLYING THE CONCEPT! Large Scale

FACTOR	RATING INFORMATION	SCALE
<b>Targets a specific population</b>	<ul style="list-style-type: none"> <li>Is the intervention specifically designed to reach the target population?</li> </ul>	1: No; the intervention was designed for another population or is not population specific. 3: Somewhat; the intervention is designed to reach a similar target population. 5: Yes; the intervention was designed specifically to reach this target population.*
<b>Targets a specific behavior</b>	<ul style="list-style-type: none"> <li>Does the intervention target specific behaviors, attitudes, beliefs, norms, or barriers that it is intended to modify or reinforce, and is it designed to achieve that objective?</li> </ul>	1: No; the intervention barely defines (or does not define) specific behaviors. 3: Somewhat; the intervention partially defines specific behaviors. 5: Yes; the intervention clearly defines specific behaviors.*
<b>Effectiveness</b>	<ul style="list-style-type: none"> <li>Is there evidence to show that this intervention is effective in averting or reducing HIV risk behaviors?</li> </ul>	1: No theoretical or experimental support 2: Theoretical support only 3: One-time experimental support 4: Limited replication 5: Published outcome data
<b>Sound theoretical basis</b>	<ul style="list-style-type: none"> <li>Was behavioral and/or social science research and theory used as a basis for designing the intervention?</li> </ul>	1: No theoretical basis 3: Yes, but theoretical basis is unclear 5: Well-established theoretical basis*
<b>Program feasibility — funding</b>	<ul style="list-style-type: none"> <li>Is there evidence to show that the intervention is practical given available funding?</li> </ul>	1: Inadequate funding 3: Some funding available 5: Sufficient funding available*

\* In some instances, you may have fewer than five data points on a five-point scale.

- Present data so it's relatively easy for CPG members to study.** Because CPG members must review so much data that can be difficult to interpret, it's often better to summarize. Helpful summaries may include condensed literature reviews, tables, and charts. For example, someone can develop data summaries for each target population, with data sets corresponding to each factor.

<b>APPLYING THE CONCEPT!</b> <b>Group-Level Intervention for HIV+ Men Who Have Sex with Men</b>		
<b>FACTOR</b>	<b>RATING INFORMATION</b>	<b>RATING</b>
<b>Targets a specific population</b> Is the intervention specifically designed to reach the target population?	1: No; the intervention was designed for another population or is not population specific.  3: Somewhat; the intervention is designed to reach a similar target population.  5: Yes; the intervention was designed specifically to reach this target population.	5
<b>Targets a specific behavior</b> Does the intervention target specific behaviors?	1: No; the intervention barely defines specific behaviors.  3: Somewhat; the intervention partially defines specific behaviors.  5: Yes; the intervention clearly defines specific behaviors.	3
<b>Effectiveness</b> Is there evidence to show that this intervention is effective in averting or reducing HIV risk behaviors?	1: No theoretical or experimental support 2: Theoretical support only 3: One-time experimental support 4: Limited replication 5: Published outcome data	5
<b>Sound theoretical basis</b> Was behavioral and/or social science research and theory used as a basis for designing the intervention?	1: No theoretical basis  3: Yes, but theoretical basis is unclear  5: Well-established theoretical basis	5
<b>Program feasibility — funding</b> Is there evidence to show that the intervention is practical given available funding?	1: Inadequate funding  3: Some funding available  5: Sufficient funding available	4

## 2. Develop a rating scale for each factor

**Simple scales:** The most common way to do this is to consider the range of possible values for each factor and then assign numeric values to low, medium, and high points. The simpler the scale the better. In some cases, a two-point (usually yes/no, or +/-) scale will do.

**Large scales:** Large scales provide more precision than simple ones do. Rating target populations using a two- or even five-point scale may seem simplistic, but remember you will be multiplying each factor's value by its weight. That makes complicated scales difficult to compute.

## 3. Rate interventions using each factor

The third step is to use your scale to rate each intervention. In some cases, the data will be obvious, and your CPG can simply assign a rating. In other cases, where data are open to interpretation, members will need to discuss the meaning and, possibly, compromise.

Using the same factors, you can use data from a variety of sources to rate interventions. For the group-level intervention focusing on skills building for negotiating safer sex for the target population “men who have sex with men,” a CPG may rate each factor as follows.

### TASKS — What do you need to do?

Perform the following basic tasks. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

Use Worksheet 15 on page 137 to help you create a scale with which to rate each factor. The worksheet will help you:

**W**

- Assemble necessary data. If the group has already assembled a comprehensive set of data for Step 1: Identify Interventions, then use the same information here.
- Develop a rating scale for each factor. Determine whether you will use a small or a large scale. Caveat: This is a very difficult task to do as a large group. Your CPG may want to use a small group, task force, or a committee to develop the rating scales, test them, and then explain the reasoning behind the choices and train the CPG on their use.
- Plan for discussion. In some cases the data will not be controversial, and your CPG can simply assign a rating. Design group decision-making processes to handle situations in which data are open to interpretation.



## Step 5: Score Interventions Using Factors

Determine a score by multiplying the rating by the weight. **Although you are not required to rank-order interventions, scoring the interventions will provide you with an evidence-based method for selecting interventions and will help you document your process.**

Next, your CPG will determine a final score for each factor for each intervention. To determine each factor's score, multiply the factor's rating by its weight (rating x weight). Using this method to get the scores ensures that the more important factors have the most impact on the final decision.

Using the factors from the “men who have sex with men” example on page 125, a CPG may score each factor as follows.

<b>APPLYING THE CONCEPT! SCORING INTERVENTIONS</b>			
<b>Group-Level Intervention for HIV+ Men Who Have Sex with Men</b>			
<b>FACTOR</b>	<b>WEIGHT</b>	<b>RATING</b>	<b>FACTOR</b>
Targets a specific population	4	5	20
Targets a specific behavior	5	3	15
Effectiveness	5	5	25
Sound theoretical basis	2	5	10
Feasibility	3	4	12
<b>Overall Score</b>			<b>82</b>

### TASKS — What do you need to do?

Perform the following basic task. Decide whether a small group, such as a priority setting committee, or the full CPG should do it.

- Revisit past decisions and processes.** Members may not remember what they have done. Create a process in which you collect information at each step and review it frequently. Also, encourage members to keep track of worksheets. Some CPGs have designed task binders for members and distribute new information on three-hole-punch paper for easy organization.

**W** Use Worksheet 16 on page 139 to score factors for each target population.

## Step 6: Rank Interventions

For each intervention, add the scores together to determine an overall rank.

Adding the scores from all factors produces an overall score for that intervention. This overall score reflects the combined impact of all the factors used to rate the intervention. You have objective numbers to use in comparing interventions in order to set priorities.

Rank-order interventions: Looking at the overall scores, you can rank the interventions quickly and easily. Rank ordering (listing in numerical order by priority) provides the clearest explanation of your group's decisions.

To rank-order interventions, simply place interventions for each target population in order of their overall scores (either highest to lowest, or lowest to highest, depending on the rating scale). In the example below, the intervention with the highest overall score ranked #1.

<b>APPLYING THE CONCEPT! Ranking Interventions</b>		
<b>INTERVENTION</b>	<b>OVERALL SCORE</b>	<b>RANK</b>
Group-level intervention (skills building)	82	1
Group-level counseling	74	2
Individual-level counseling	69	3
HIV counseling and testing	61	4
Electronic media	57	5
Referral	51	6
Other interventions (social marketing)	45	7
Outreach programs	42	8
Prevention case management	33	9
Hotlines	32	10
Voluntary partner counseling and referral	28	11
Clearinghouse	24	12
Community-level interventions	23	13

**APPLYING THE CONCEPT! SCORING INTERVENTIONS**  
**Target Population: HIV+ Men Who Have Sex with Men**

INTERVENTION	OVERALL SCORE	RANK
Group-level intervention (skills building)	82	High
Group-level counseling	74	High
Individual-level counseling	69	High
HIV counseling and testing	61	High
Electronic media	57	Medium
Referral	51	Medium
Other interventions (social marketing)	45	Medium
Outreach programs	42	Medium
Prevention case management	33	Medium
Hotlines	29	Low
Voluntary partner counseling and referral	28	Low
Clearinghouse	24	Low
Community-level interventions	23	Low

### TASKS — What do you need to do?

Perform the following basic task. Decide whether a small group, such as a priority setting committee, or the full CPG should do this task.

- Rank-order or cluster. Since you are not required to rank-order interventions, you may want to cluster them instead. Make sure that you document the reasoning and results.



Use Worksheet 17 on page 141 to summarize each intervention.

## Step 7: Review Scores and Complete List of Interventions for Each Target Population

Review the results and agree upon the final set of interventions for each target population.

The last step in the seven-part process is to review your rankings and to develop a final list of recommended interventions for each target population. Most CPGs use overall scores to decide which interventions to include. Some use the scores as a springboard for further discussions.

At this point, it's a good idea to assess how comfortable your group is with the final list of recommended interventions. Every decision-making process has strengths and limitations. After you complete a group decision-making process, it helps to review the results as a group and make sure everyone accepts them.

Some CPGs have been unhappy with their initial set of intervention priorities. They report that the first version seemed to be more of a gut reaction than a well-reasoned set of priorities. However, on their second pass, the process seemed better thought out and more objective. It's also important to record the group's suggestions for improving the process next time. Be sure to review these suggestions before the next process begins.

### TASK — What do you need to do?

Perform the following basic task. Decide whether a small group, such as a priority setting committee, or the full CPG should do each one.

- **Develop a final set of recommended interventions for each target population.**

Congratulations! You have walked through the entire process of developing a set of HIV prevention interventions for each target population.

# Worksheet 12

## Identify and Define Interventions

### PURPOSE:

To identify interventions for each target population.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Make enough photocopies** of this sheet to use for each of your target populations.
- **Identify and define** which HIV interventions to consider to meet the prevention needs of each target population. Much of the information needed to complete this step may be available in the needs assessment, resource inventory, and gap analysis.
- **Check each intervention** type that your group will consider and include additional specific interventions that pertain to your populations. You may explain interventions further in the column for specific intervention type.

*Example* — Target population: Females with STDs. General Intervention: Individual-level Intervention; Specific Intervention: Peer counseling on condom use

TARGET POPULATION: _____	
GENERAL INTERVENTION TYPE	SPECIFIC INTERVENTION TYPE
<ul style="list-style-type: none"> <li>■ <b>Individual-level interventions (ILI)</b> Definition: Health education and risk-reduction counseling provided to one person at a time</li> </ul>	
<ul style="list-style-type: none"> <li>■ <b>Group-level interventions (GLI)</b> Definition: Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes</li> </ul>	
<ul style="list-style-type: none"> <li>■ <b>Outreach</b> Definition: Educational interventions generally conducted by peer or paraprofessional educators face to face with high-risk individuals</li> </ul>	
<ul style="list-style-type: none"> <li>■ <b>Prevention case management (PCM)</b> Definition: Promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs</li> </ul>	
<ul style="list-style-type: none"> <li>■ <b>Partner counseling and referral services (PCRS)</b> Definition: A systematic approach to notifying sex and needle-sharing partners of HIV+ persons of their possible exposure to HIV</li> </ul>	
<ul style="list-style-type: none"> <li>■ <b>Health communication/public information (HC/PI)</b> Definition: The delivery of planned HIV/AIDS prevention messages that are designed to build general support for safe behavior among target audiences</li> </ul>	

# Worksheet 13

## Determine Factors for Interventions

### PURPOSE:

To select specific factors to consider when assessing how well an intervention will reduce HIV infections in a target population.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Check off those factors** that your group will use to choose interventions. (The factors are recommended for consideration by the *Guidance*.)
- **Fill in the data source column** in the first table to show where your group will find data for each factor you choose.
- Use your understanding of the local community to make thoughtful assessments if a data source can't easily back up an intervention factor.

FACTOR	QUESTIONS TO CONSIDER	DATA SOURCES
<input type="checkbox"/> <b>Targets a specific population</b>	Is the intervention specifically designed to reach the target population?	
<input type="checkbox"/> <b>Targets a specific behavior</b>	Is the intervention specifically designed to change the target behavior?	
<input type="checkbox"/> <b>Effectiveness</b>	What evidence exists to show that this intervention is effective in averting or reducing high-risk behavior?	

FACTOR	QUESTIONS TO CONSIDER	DATA SOURCES
<input type="checkbox"/> <b>Sound theoretical basis</b>	Was behavioral and/or social science research and theory used as a basis for designing the intervention?	
<input type="checkbox"/> <b>Norms, values, consumer preferences</b>	Is the intervention acceptable to the target population? Did members of the intended audience either develop the intervention themselves or provide input into its development?	
<input type="checkbox"/> <b>Intervention feasibility</b>	The factors listed below may be used to evaluate whether an intervention is feasible.	
<ul style="list-style-type: none"> <li>• <b>Capacity</b></li> </ul>	Does the capacity exist to develop the interventions? Is the intervention practical, given available expertise, funding, and implementation time? Who can do this work? How much will it cost? How long will it take to be implemented?	
<ul style="list-style-type: none"> <li>• <b>Sustainability</b></li> </ul>	Is the intervention sustainable over time? If federal dollars were not available, how might this intervention be sustained?	
<ul style="list-style-type: none"> <li>• <b>Resources</b></li> </ul>	What are these resources? Are other resources available to assist delivery of the intervention?	
<ul style="list-style-type: none"> <li>• <b>Legality</b></li> </ul>	Is this intervention legal? Do federal, state, or local laws or ordinances prohibit implementation of the intervention? If so, what are your funding sources?	
<input type="checkbox"/> <b>Ability to have the greatest impact on decreasing new infections</b>	When choosing between two interventions for the same population, which one will reduce new infections for less money?	
<input type="checkbox"/> <b>Other considerations based on state or local needs</b>	(Depends on state/local issues.)	



# Worksheet 14

## Weight Factors for Interventions

### PURPOSE:

To assign weights to intervention factors to indicate the relative importance of each factor.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Decide as a group** which system of weighting factors you prefer and create a scale.
- **List the factors** your CPG decided upon from Worksheet 13 in the table below. Then assign weights to these according to your opinion about how well the factor demonstrates an intervention's potential for reducing the number of new HIV infections.
- **Discuss the weights** with your CPG and come to an agreement on how to weight each factor.

### WEIGHTING SCALE: \_\_\_\_\_

FACTOR	WEIGHT

FACTOR	WEIGHT
<p>Comments:</p>	

# Worksheet 15

## Rate Factors for Interventions

### PURPOSE:

To create a rating scale for assessing each factor and then rate each intervention according to the developed scale.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Make enough copies** of this sheet for each of your interventions for all target populations.
- **Label the chart** with the target population and intervention you plan to rate.
- **List the factors** you chose from Worksheet 13 in the column to the left.
- **Decide which questions** to pose for each factor by examining data. Write these in the section for rating information.
- **Develop a scale** for rating each factor. Write it in the space allocated.
- **Rate the factors** for each intervention.
- **Proceed** with the same steps for each additional intervention.

TARGET POPULATION: _____		INTERVENTION: _____	
FACTOR	RATING INFORMATION	RATING SCALE	RATING
<b>Example:</b> Outcome effectiveness	Is there evidence to show that the intervention is effective in averting or reducing HIV risk behaviors?	1: No outcome data, but based on theory and acceptable to target audience. 3: Intervention maintains core elements of an evaluated intervention. 5: An outcome evaluation demonstrates significant reduction in risk behavior.	3

TARGET POPULATION: _____		INTERVENTION: _____	
FACTOR	RATING INFORMATION	RATING SCALE	RATING

# Worksheet 16

## Score Interventions Using Factors

### PURPOSE:

To determine a final score for each intervention.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Make enough copies** of this sheet for each of your interventions for all target populations.
- **Label the chart** with the target population and intervention you plan to score.
- **List the factors** that your group decided on Worksheet 13.
- **List the weights** that you assigned to each factor on Worksheet 14.
- **List the ratings** that you assigned to each factor on Worksheet 15.
- **Multiply the weight** by the rating for each factor to obtain the final score.
- **Add the scores** for all the factors to obtain the overall score for the intervention.
- **Proceed** with the same steps for each additional intervention.

TARGET POPULATION: _____		INTERVENTION: _____	
FACTOR	WEIGHT	RATING	SCORE (WEIGHT x RATE)
<b>Example:</b> Outcome effectiveness	1	3	3



# Worksheet 17

## Rank-Order Interventions

### PURPOSE:

To determine the overall rank for each intervention (by target population).

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

- **Make enough copies** of this sheet to use for each target population.
- **Label the chart** with the particular target population for which you plan to rank interventions.
- **Place interventions** in the chart in order of their scores (either highest to lowest or lowest to highest, depending on the rating scale).
- **Decide on a ranking system:** numerical or non-numeric. For example, a numerical system ranks interventions by numerical order; a non-numeric system ranks interventions by associating them with words such as low, medium, and high.
- **Rank interventions.**

### TARGET POPULATIONS:

TARGET POPULATIONS:		
RANK	INTERVENTION	OVERALL SCORE





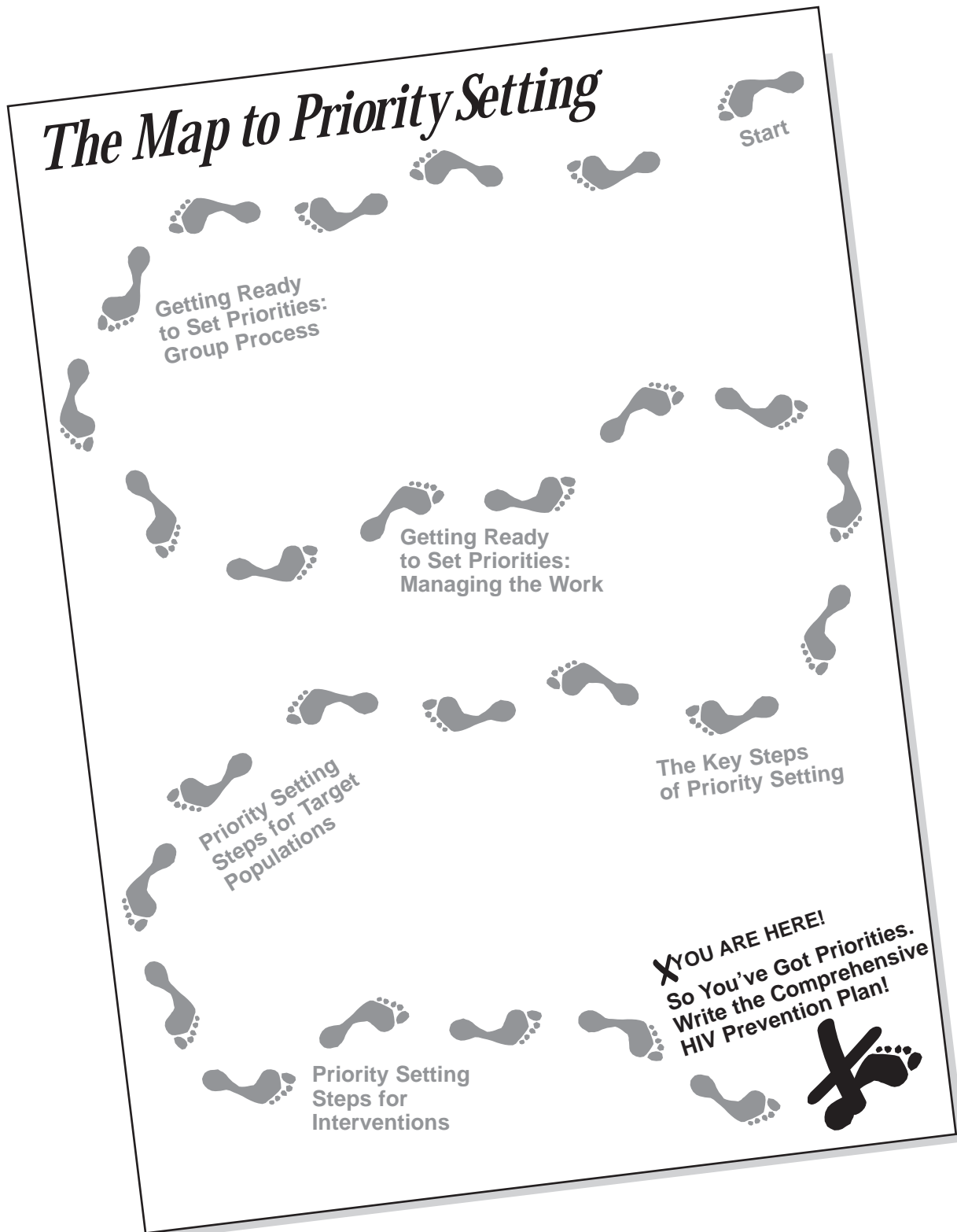
# 6

## Notes



# 7

## So You've Got Priorities. Now What?



# The Continuing Adventures of the *Better the Second Time Around CPG*

## **Situation**

Now that target population and intervention priorities are set, a consultant, hired by the health department with the assistance of the CPG, writes the comprehensive HIV prevention plan. The health department incorporates the priorities recommended by the CPG into its application for funding and sends the application to the community co-chair for review. Paula, the health department co-chair, is concerned the group might not concur.

## **Action**

The CPG had developed a plan to examine the health department application for concurrence. The plan is to circulate a synopsis of the health department's application to the full CPG. The group agrees that comments are due to Kim, the community co-chair, in two weeks. If there are concerns about the application, Kim will convene a conference call to discuss the actions needed.

Kim receives many comments, all positive. He signs the letter of concurrence signifying that the application reflects the priorities the group spent so much time and effort developing.

The CPG decides to use its next meeting to celebrate its hard work, to talk about how to publicize the plan, and to develop a plan for plugging the information gaps the group identified during the process. Everyone agrees that setting priorities was hard work but the final product is worth the effort.

# 7

## So You've Got Priorities. Now What?

### The Comprehensive HIV Prevention Plan and Concurrence

Congratulations! Your CPG has completed the process of setting priorities for target populations and for recommending interventions for each population. Your next tasks are writing the comprehensive HIV prevention plan and determining concurrence — how well the health department's application agrees with your CPG's priorities.

**W** Use Worksheet 18 on page 151 to make sure your plan is complete.

### Writing the Plan

The comprehensive plan is the major product of the entire HIV prevention community planning process. Based on the outcome of the priority setting process, the plan recommends specific, high-priority HIV prevention activities and interventions for defined populations.

### What Does the Plan Include?

As described in the “Comprehensive HIV Prevention Plan and Key Products” section of the *Guidance*, the plan should include the following:

- Epidemiologic profile
- Community services assessment (needs assessment, resource inventory, and gap analysis)
- Prioritized (rank-ordered) target populations
- Appropriate science-based prevention activities/interventions
- Letter of concurrence, concurrence with reservations, or nonconcurrence

## How Often Is the Plan Written?

CPGs are required to develop a new plan at least once every five years. Some CPGs develop a plan annually, and others write multiple-year plans. Regardless of the length of the planning cycle, all CPGs must review and update the plan every year.

The *Guidance* says:

*Before choosing a timeline for developing a comprehensive plan, it may be important to determine the scope and amount of time that will be necessary to develop and/or review these products [epidemiologic profile and community services assessment] and then to set priorities among target populations and prevention interventions/activities. In determining the planning cycle, health departments and CPGs may choose either one- or multiple-year planning processes (from one to five years), and submit a Comprehensive HIV Prevention Plan depending on their planning time frame.*

The *Guidance* provides more detail on one-, two-, and multiple-year processes on page 11 of that document.

### THE PLAN'S PURPOSE

The comprehensive HIV prevention plan serves many important purposes. It:

- Identifies the specific prevention needs and resources of a jurisdiction
- Includes information that is current, evidence-based, and updated on a regular basis
- Represents the diverse perspectives of CPG members in order to provide the most effective prevention efforts in a specific area
- Provides a road map for prevention that providers in each jurisdiction can use
- Is distributed to programs and stakeholders throughout the project area
- Can be used as a basis for additional fundraising

## What Is the Difference Between the Plan and the Application?

The comprehensive HIV prevention plan provides an overview of all HIV prevention programs and activities in a jurisdiction supported by federal, state, local, and private resources. The CPG and the health department work together to develop the plan. In some project areas, the health department writes the plan while the CPG reviews each draft and advises. In some project areas, a consultant develops the plan, and both the health department and CPG provide oversight and input. In other cases, the CPG members share responsibility for writing different portions of the plan, in collaboration with the health department.

In contrast, the application focuses solely on prevention programs and activities supported by CDC resources. The health department is solely responsible for developing the application. It includes a proposed program plan, based on the CPG's recommendations, and budget allocations for a specific set of prevention programs and interventions. Your CPG must review the final application, particularly the proposed allocation of HIV resources, to determine whether it reflects the priorities set forth in the comprehensive plan.

## Writing the Prioritized Populations and Recommended Interventions Section of the Plan

The results of your CPG's priority setting process form a key component of the comprehensive plan. The priority setting section of the plan should carefully document all the steps of priority setting so that the process and its results are clear. Worksheet 18, page 151, will help you keep track of all the essential elements to include in the plan. In addition, the worksheets in this guide can help your CPG develop and document the priority setting section of its plan. Your group may want to attach the completed worksheets to its comprehensive plan.

A complete priority setting section of the plan should include:

- A description of the participants in the priority setting process, including their committee structures and memberships and priority setting roles and responsibilities
- A review of the methods used, including a description of the priority setting model and decision making procedures
- A summary of conflict-of-interest policies used during the priority setting process
- A complete description of the target populations considered
- A list of factors (and weights) used to rate target populations
- A list of prioritized target populations
- A list of factors (and weights) used to rate interventions
- A list of recommended interventions for each target population
- An evaluation of the priority setting process and recommendations for enhancing the process

## Concurrence

This section provides basic information about concurrence as CDC defines it in the *Guidance*.

### **Q: What is concurrence?**

**A:** In general, “concurrence” means “agreement” or “union in action.” In community planning, “concurrence” refers to the CPG’s belief that the health department’s application to CDC for HIV prevention funds reflects the CPG’s priorities. The health department should base its application on the CPG’s comprehensive HIV prevention plan, and there should be a clear link between the priorities your group has set and the allocation of HIV prevention resources.

**However, resource allocation may not correspond directly with the rank-ordered target populations for such reasons as the following:**

- Different types of interventions vary in cost.
- Levels of effort may be different for different interventions.
- Number of persons needing the service may vary.
- Geographic location(s) of service can affect cost.
- Availability of other resources to address these services varies.

### **Q: Why is concurrence important?**

**A:** Concurrence is an essential component of the community planning process. That process requires setting priorities that correspond to resource allocation. However, as noted above, some circumstances justify resource allocation that does not directly correspond to prevention priorities. The CPG checks the health department’s responsiveness to priorities by reading its application. If the health department has disregarded some of your priorities, concurrence gives you an opportunity to tell that to CDC.

### **Q: What are letters of concurrence, concurrence with reservations, or nonconcurrence?**

**A:** As part of the CDC application, every health department must include a letter of concurrence, concurrence with reservations, or nonconcurrence from each planning group in the jurisdiction. This letter is the planning group’s way of formally telling CDC to what extent it agrees with the health department’s application. The letter may range from one page to several pages, and the best ones are specific about reasons for concurrence, concurrence with reservations, or nonconcurrence. For sample letters, see Appendix H on page 183.



The letters should indicate the:

- Degree to which the health department has responded to the priorities in the comprehensive HIV prevention plan in its application to CDC for federal HIV prevention funds
- Degree to which the health department and CPG(s) have worked together in developing, reviewing, or revising the plan
- Process used for concurrence, including:
  - A description of the process used by the CPG to review the application
  - The time the CPG had to review the application
  - Which CPG members reviewed the application
  - The degree of concurrence (your group may choose concurrence, concurrence with reservations, or nonconcurrence)

A letter of concurrence may include a statement of reservations (see sample letter #3 in Appendix H on page 186). If your CPG submits such a letter, CDC requests that the health department address the reservations in an attachment to the HIV prevention application.

A letter of nonconcurrence tells CDC that the CPG disagrees with the program priorities identified in the health department's application and that the health department is proposing to implement activities or allocate federal resources based on priorities that are not the CPG's. The letter should cite specific reasons for nonconcurrence. If a health department disagrees with the CPG's priorities and recommends funding different HIV prevention activities, the health department must include an explanation for that disagreement with its application. The health department must justify disregarding the CPG's priorities.

**Q: Who signs the letter?**

**A:** At a minimum, the co-chairs of each CPG in the project area should sign the letter(s) on behalf of the CPG(s). Your group also may have all members sign.

**Q: How does the planning group decide on concurrence?**

**A:** That's up to the group, but you should carefully review the comprehensive HIV prevention plan and the health department's entire application to CDC, including the proposed budget. CPG members don't review and comment on internal health department issues, such as salaries of individual staff.

The CPG and the health department should work together to determine the process for negotiating concurrence. The CPG's workplans with timelines should outline concurrence-related activities, responsible parties, and deadlines. The application to CDC can be a long, complex document, so your CPG needs to have enough time to complete a thorough review. The amount of time to review the application is up to the CPG and the health department and may vary with the number of peo-

ple who will be reviewing the application. The review may take more than a month or as little as two weeks. Your CPG should be certain to document its process in reviewing the application.

The CPG may use consensus, modified consensus, voting, or a combination of these decision-making methods to decide concurrence. In some project areas, the executive committee is charged by the full CPG with reviewing the application and making a recommendation to the full group regarding concurrence. Usually, CPG members either achieve consensus or vote on concurrence, and the CPG co-chairs report on this in the letter to CDC.

**Q: What will CDC do if the CPG does not concur?**

**A:** CDC will assess and evaluate instances of nonconcurrence on a case-by-case basis and determine the appropriate actions. A letter of nonconcurrence does not necessarily mean that the project area will lose any portion of its CDC funding. For example, CDC may decide to obtain more information about the situation, meet with the health department and co-chairs, request a plan of corrective action, and/or place conditions or restrictions on the award of health department funds pending a future submission by the applicant.

# Worksheet 18

## Write the Plan

### PURPOSE:

To ensure that the priority setting section of the plan is complete.

### CLARIFY ROLES:

Who will complete this worksheet?

By what date?

How will this information be presented to the group?

### DIRECTIONS:

Use this worksheet as a checklist to ensure that the priority setting section of the plan is complete.

The results of your CPG's priority setting process are a key component of the comprehensive HIV prevention plan. The worksheets your group completed from the previous chapters should document the information below.

### ELEMENTS OF THE COMPREHENSIVE HIV PREVENTION PLAN

- A description of the participants in the priority setting process, including their committee structure and memberships and their priority setting roles and responsibilities
- A review of the methods used, including a description of the priority setting model and decision-making procedures
- A summary of conflict-of-interest policies used during the priority setting process
- A complete description of the target populations considered
- A list of factors (and weights) used to rate target populations
- A list of prioritized target populations, including high- and low-priority needs

<input type="checkbox"/> A list of factors (and weights) used to rate interventions
<input type="checkbox"/> A list of recommended interventions for each target population
<input type="checkbox"/> A review of the final prioritization process, including justifications for any differences between scores and final priorities and recommendations
<input type="checkbox"/> A description of the CPG's expectations of how resources should be allocated based upon the priorities
<input type="checkbox"/> An evaluation of the priority setting process and recommendations for enhancing the process
<b>Comments:</b>

# 7

## Notes





# Glossary

**Accountability:** A framework for how a group and its members will be responsive and responsible to itself and the community as it carries out its mission.

**Application:** The health department's application to CDC for funding. It contains a proposed budget to support a specific set of prevention programs and interventions.

**Behavioral interventions:** Programs to change individual behaviors without an explicit or direct attempt to change the norms (social or peer) of the community (e.g., geographically defined area) or the target population (e.g., drug users or men having sex with men). Example: risk reduction counseling.

**Capacity building:** An activity that increases a community's ability to deliver effective HIV prevention programs. Some CPGs lack enough capacity to design, implement, and sustain a full range of HIV prevention interventions. Helping them to acquire the necessary skills, personnel, or other resources is a capacity-building activity.

**Centers for Disease Control and Prevention (CDC):** The federal agency responsible for monitoring diseases and conditions that endanger public health and for coordinating programs to prevent and control the spread of these diseases. Based in Atlanta, it is an agency of the U.S. Department of Health and Human Services.

**Community-based organization (CBO):** An organization offering services to a specific group of people in a defined area. Usually nonprofit, CBOs are governed by a board of directors and staffed by a combination of employees and volunteers.

**Community-level interventions (CLI):** Programs designed to reach a defined community and to increase community support of the behaviors known to reduce the risk for HIV infection and transmission by working with the social norms or shared beliefs and values held by members of the community. CLIs aim to reduce risky behaviors by changing attitudes, norms, and practices through community mobilization and organization, including community-wide events.



**Community mobilization:** The process by which a community's citizens are motivated to take an active role in defining, prioritizing, and addressing issues in their community. This process focuses on identifying and activating the skills and resources of residents and organizations while developing linkages and relationships within and beyond the community in order to expand the current scope and effectiveness of HIV/STD prevention.

**Community Services Assessment (CSA):** A description of the prevention needs of people at risk for spreading and becoming infected with HIV, the prevention interventions/activities implemented to address these needs (regardless of funding source), and service gaps. The CSA is comprised of the Resource Inventory, Needs Assessment, and Gap Analysis.

**Community planning group (CPG):** The official HIV prevention planning body that follows the *Guidance* to develop the comprehensive HIV prevention plan for the project area.

**Comprehensive HIV prevention plan:** An overview of all HIV prevention programs and activities occurring in the jurisdiction. The plan is developed through a participatory planning process.

**Concurrence:** Refers to the CPG's belief that the health department's application for HIV prevention funds reflects the CPG's target population and intervention priorities.

**Conflict of interest:** A circumstance in which a person's self-interest might be served by that person's official actions or influence.

**Consensus model:** A decision-making method in which a group holds one or more discussions on an issue and arrives at a decision as a group. The group agrees without voting. Since consensus requires all members to accept (though they may not fully agree with) the group's decision, significant compromise is often necessary.

**Cost-effectiveness:** Available information about the relative costs and effectiveness of proposed strategies and interventions, either demonstrated or probable.

**Counseling and testing:** The voluntary process of client-centered, interactive information sharing in which an individual learns basic information about HIV/AIDS, testing procedures, how to prevent the transmission and acquisition of HIV infection, and takes a test.

**Counseling, testing, referral, and partner notification (CTRPN):** Voluntary HIV/AIDS counseling and testing, referral to appropriate medical and social services, and anonymous or confidential notification of sex or needle-sharing partners by health department staff.

**Cultural competence:** The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

**Delphi technique:** A decision-making method that uses written questionnaires developed and tabulated by a planning committee and distributed among a group for completion. The technique is particularly useful where participants are widely scattered.

**Demographics:** The statistical characteristics of human populations, such as age, race, ethnicity, and sex, that can provide insight into the development, culture, and sex-specific issues that the intervention will need to account for.

**Epidemic:** The occurrence of cases of an illness, specific health-related behavior, or other health-related events in a community or region in excess of normal expectancy.

**Epidemiologic profile:** A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.

**Epidemiology:** The study of factors associated with health and disease and their distribution in the population.

**Factors:** The various types of information that may be considered in decision making.

**Focus group:** A method of information collection involving a carefully planned discussion among a small group of individuals from the target population led by a trained moderator.

**Gap analysis:** A comparison of the needs of high-risk populations, as determined by the needs assessment, to existing services as described in the resource inventory.

**Group-level interventions (GLI):** Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. These use peer and non-peer models involving a wide-range of skills, information, education, and support.

**Group process:** The manner in which a group behaves and functions and its members interact.

**Guidance:** The CDC document that gives information and rules for receiving funds for HIV prevention programs and defines the process of HIV prevention community planning.

**Health communications/public information (HC/PI):** The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences. The messages are designed to build general support for safe behavior, support personal risk-reduction efforts, and inform people at risk for infection how to get specific services. Channels of delivery include electronic media, print media, hotlines, clear-inkhouses, and presentations/lectures.

**Health education and risk reduction interventions (HE/RR):** Organized efforts to reach people at increased risk of becoming HIV-infected or, if already infected, of transmitting the virus to others. The goal is to reduce the risk of infection. Activities range from individual HIV prevention case management to broad community-based interventions.

**HIV prevention community planning:** The cyclical, evidence-based planning process in which authority for identifying priorities for funding HIV prevention programs is vested in one or more planning groups in a state or local health department that receives HIV prevention funds from CDC.

**Icebreaker:** A structured activity or exercise that relaxes people and encourages them to talk to each other. It can also break down barriers to interpersonal communications.

**Implementation:** Putting into effect a precise plan or procedure (e.g., collecting information about the interventions identified in the HIV prevention comprehensive plan).

**Incidence:** The number of new cases of a disease diagnosed in a defined population in a specified period, often a year.

**Incidence rate:** The number of diagnoses of new cases of a disease diagnosed in a defined population in a specified period, divided by that population. It is often expressed per 100,000 population.

**Individual-level interventions (ILI):** Health education and risk-reduction counseling provided to one person at a time. ILIs assist clients in making plans to change individual behavior and to appraise regularly their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (i.e., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV. Interventions also help clients plan to obtain these services.

**Injection drug users (IDU):** People who are at risk for HIV infection through the shared use of equipment used to inject drugs with an HIV-infected person (e.g., syringes, needles, cookers, spoons).

**Intervention:** An activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common strategy of delivering the prevention message. An intervention has distinct objectives and a protocol outlining the steps for implementation.

**Intervention plan:** A description of a planned intervention strategy for a target population.

**Jurisdiction:** An area or region that is the responsibility of a particular governmental agency. This term usually refers to an area where a state or local health department monitors HIV prevention activities (i.e., Jonestown is within the jurisdiction of the Jones County Health Department).

**Justification:** An explanation of why the intervention in the intervention plan will or won't lead to the specified outcomes.

**Key informant interview:** An information collection method involving in-depth interviews with a few individuals carefully selected because of their personal experiences and/or knowledge. An interview guide or checklist guides the discussion. This is also called a key person interview.

**Men who have sex with men (MSM):** Men who have sexual contact with other men (i.e., homosexual contact or bisexual contact).

**Met need:** A requirement for HIV prevention services within a specific target population that is currently being addressed through existing HIV prevention resources. These are available to, appropriate for, and accessible to that population (as determined through the resource inventory and assessment of prevention needs). For example, a project area with an organization for African American gay, bisexual, lesbian, and transgendered individuals may meet the HIV/AIDS education needs of African American men who have sex with men through its outreach, public information, and group counseling efforts.

An unmet need is a requirement for HIV prevention services within a specific target population that is not currently being addressed through existing HIV prevention services and activities, either because no services are available or because available services are either inappropriate for or inaccessible to the target population. For example, a project area lacking Spanish-language HIV counseling and testing services will not meet the needs of Latinos with limited English proficiency.

**MSM/IDU:** Men who report both sexual contact with other men and injection drug use as risk factors for HIV infection.

**Needs assessment:** The process of obtaining and analyzing findings to determine the type and extent of unmet needs in a particular population or community. The methods of collecting information and data may vary.

**Nominal group technique:** A decision-making method in which groups consider a series of questions. The process is designed to limit communication and thereby reduce premature evaluation, social pressures, etc. Group members develop responses individually before the group shares and discusses results.

**Nonconcurrence:** A CPG's disagreement with the program priorities identified in the health department's application for CDC funding. Nonconcurrence also may mean that your CPG thinks that the health department has not fully collaborated in developing the plan.

**Outcome evaluation:** The use of rigorous methods to assess whether the prevention program has affected the predetermined set of goals. This allows you to rule out factors that might otherwise appear responsible for the changes. For example outcome evaluation determines whether a particular intervention had a desired effect on the targeted population's behavior — typically whether the intervention made a difference in knowledge, skills, attitudes, beliefs, behaviors, or health outcomes.

**Outreach:** HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials.

**Partner counseling and referral services (PCRS):** A systematic approach to notifying sex and needle-sharing partners of HIV+ people of possible exposure to HIV so the partners can avoid infection or, if

already infected, can prevent transmission to others. PCRS help partners gain early access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

**Prevalence:** The total number of people living with a specific disease or condition in a defined population on a specified date.

**Prevalence rate:** The number of people living with a disease or condition in a defined population on a specified date, divided by that population. It is often expressed per 100,000 population.

**Prevention case management (PCM):** Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.

**Prevention need:** A documented necessity for HIV prevention services within a specific target population. The documentation is based on numbers, proportions, or other estimates of the impact of HIV or AIDS among this population from the epidemiologic profile. It also is based on information showing that members of this population are engaging in behaviors that place them at high risk for HIV transmission from the epidemiologic profile and needs assessment.

**Prevention program:** A group of interventions designed to reduce disease or other negative results among individuals whose behavior, environment, and/or genetic history place them at high risk.

**Prevention services:** Interventions, strategies, programs, and structures designed to change behavior that may lead to HIV infection or other disease. Examples of HIV prevention services include street outreach, educational sessions, condom distribution, and mentoring and counseling programs.

**Primary source data:** Original data that you collect and analyze yourself. Primary data are collected to answer a specific question. Example: survey results about women's sexual risk behavior.

**Priorities:** In community planning, a rank-ordered set of target populations and recommended interventions for those populations.

**Process evaluation:** A descriptive assessment of the implementation of program activities — what was done, to whom, how, when, and where. It involves assessing such things as an intervention's conformity to program design, how it was implemented, and the extent to which it reached the intended audience.

**Program evaluation:** The systematic assessment of the means and ends of some or all of the action program stages, including program planning, implementation, and outcomes, in order to determine the value of and to improve the program.

**Public health surveillance:** An ongoing, systematic process of collecting, analyzing, and using data on specific health conditions and diseases in order to monitor these health problems to detect changes in

trends or distribution. Example: CDC's surveillance system for AIDS.

**Qualitative data:** Data presented in narrative form, describing and interpreting the experience of individuals or groups. Example: A focus group report relating the experience of Latino teens in getting HIV prevention services.

**Quantitative data:** Data reported in numerical form. Example: The numbers of reported AIDS cases by population group and method of transmission, provided by CDC in its AIDS Surveillance reports.

**Rank-order:** A list of priorities in order of importance.

**Referral:** A process by which an individual or client is connected with a provider who can serve that person's need (usually in a different agency). For example, individuals with high-risk behaviors and those infected with HIV are guided towards prevention, psychosocial, and medical resources needed to meet their primary and secondary HIV prevention needs.

**Relevance:** The extent to which an intervention plan addresses the needs of affected populations in the jurisdiction and of other community stakeholders. As described in CDC's *Guidance*, relevance is the extent to which the population targeted in the intervention plan is consistent with the target population in the comprehensive HIV prevention plan.

**Reliability:** The consistency of a measure or question in obtaining very similar or identical results when used repeatedly. For example, if you repeated a blood test three times on the same blood sample, the test would be reliable if it generated the same results each time.

**Representative:** Term used to indicate that a sample is similar to the population from which it was drawn and, therefore, can be used to make inferences about that population.

**Resource inventory:** The existing community services for HIV prevention. It consists of the current HIV prevention and related resources and activities in your project area, regardless of the funding source. A comprehensive resource inventory includes information regarding HIV prevention activities within your project area and other education and prevention activities that are likely to contribute to HIV risk reduction.

**Risk factor or risk behavior:** Whatever places a person at risk for disease. For HIV/AIDS, this includes such factors as sharing injection drug use equipment, unprotected male-to-male sexual contact, and commercial unprotected sex.

**Scale:** A tool used when rating items to evaluate the extent to which each factor applies or is met.

**Secondary analysis:** Re-analysis of data or other information that someone else collected. For example, you might get data on AIDS cases in your metro area from your state health department and carry out additional analysis of those data.

**Secondary source data:** Existing data you can use or re-analyze and use. These data are usually gathered to detect changes in disease distribution among the population. Example: Youth Risk Behavior Surveillance Survey (YRBSS).

**Seroprevalence:** The number of people in a population who test HIV+ based on serology (blood serum) specimens. Seroprevalence is often presented as a percent of the total specimens tested or as a rate per 1,000 persons tested.

**Seroprevalence reports:** Reports providing information about the percent or rate of people in specific testing groups and populations who have tested positive for HIV.

**Serosurveillance:** The ongoing and systematic collection of blood samples for the purpose of surveillance. As part of a surveillance system to monitor the HIV epidemic in the United States, CDC, in collaboration with state and local health departments, other federal agencies, blood collection agencies, and medical research institutions, conducts standardized HIV seroprevalence surveys in designated subgroups of the U.S. population.

**Supermajority vote:** Sometimes used in the voting decision-making method in which a specified proportion of votes cast — e.g., three-fifths (60%) or two-thirds (66%) — is required to reach a decision.

**Surveillance:** The ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition.

**Surveillance reports:** Documents on the number of reported cases of a disease, nationally and for specific locations and subpopulations. CDC issues such reports, providing both cumulative cases and new cases reported during a specific reporting period, such as each of the last two years.

**Target populations:** Groups of people who are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior. Groups are often identified using a combination of behavioral risk factors and demographic characteristics.

**Technical assistance (TA):** The provision of direct or indirect support to build capacity of individuals or groups to carry out programmatic and management responsibilities with respect to HIV prevention. CDC funds a National Technical Assistance Providers' Network to assist HIV prevention community planning groups in all phases of the community planning process.

**Transmission categories:** In describing HIV/AIDS cases, the same as exposure categories. The categories are based on how an individual may have been exposed to HIV, such as injecting drug use.

**Unmet need:** See *Met need*.

**Weighting:** A method for determining the level of importance of two or more options relative to one another. In priority setting, weighting is used to compare factors for populations and interventions.









# A

## CDC National Technical Assistance Providers' Network

The Centers for Disease Control and Prevention has created a network of technical assistance (TA) providers to support HIV prevention community planning across the CDC-funded project areas. The organizations funded by the CDC to provide TA to HIV prevention community planning groups are listed below. Contact your CDC project officer.

### **Academy for Educational Development**

1825 Connecticut Avenue, NW

Washington, DC 20009

Contact: Nickie Bazell

Tel: (202) 884-8149

E-mail: nbazell@aed.org

Web sites: [www.healthstrategies.org](http://www.healthstrategies.org) or [www.hivaidsta.org](http://www.hivaidsta.org)

### **Asian and Pacific Islander American Health Forum (APIAHF)**

450 Sutter, Suite 600

San Francisco, CA 94108

Contact: ManChui Leung or Ed Tepporn

Tel: (415) 568-3307 or (415)568-3309

E-mail: [etepporn@apiahf.org](mailto:etepporn@apiahf.org)

Web site: [www.apiahf.org](http://www.apiahf.org)

### **Behavioral and Social Science Volunteer (BSSV) Program**

Office on AIDS, American Psychological Association

750 First Street, NE

Washington, DC 20002-4242

Contact: E. Duane Wilkerson, MPH

Tel: (202) 218-3993 or 1-877-754-1404

E-mail: [dwilkerson10@comcast.net](mailto:dwilkerson10@comcast.net)

Web site: [www.apa.org/pi/aids/bssv.html](http://www.apa.org/pi/aids/bssv.html)

**Inter-Tribal Council of Arizona, Inc. (ITCA)**

2214 North Central Avenue, Suite 100  
Phoenix, AZ 85004  
Contact: Michelle Sabori  
Tel: (602) 302-1557  
E-mail: michelle.sabori@itcaonline.com  
Web site: www.itcaonline.com

**National AIDS Education & Services for Minorities (NAESM)**

2001 Martin Luther King, Jr. Drive, Suite 602  
Atlanta, GA 30310  
Contact: Donato C. Clarke  
Tel: (404) 753-2900  
E-mail: dclarke@naesmonline.org  
Web site: www.naesmonline.org

**National Alliance of State and Territorial AIDS Directors (NASTAD)**

444 North Capitol Street, NW, Suite 339  
Washington, DC 20001  
Contact: Connie Jorstad  
Tel: (202) 434-8090  
E-mail: cjorstad@nastad.org  
Web site: www.nastad.org

**National Association of People with AIDS (NAPWA)**

1413 K Street, NW, Suite 700  
Washington, DC 20005  
Contact: Joseph Lovato or Charles Debnam  
Tel: (202) 898-0414  
E-mail: jlovato@napwa.org or cdebnam@napwa.org  
Web site: www.napwa.org

**US-Mexico Border Health Association (USMBHA)**

5400 Suncrest Drive, Suite C-5  
El Paso, TX 79912  
Contact: Maria Chaparro  
Tel: (915) 833-6450 x20  
E-mail: chaparrm@usmbha.org  
Web site: www.usmbha.org

## Other Resources for HIV Prevention Community Planning Groups

**CDC project officer** — Your CDC project officer is a key person for successful TA. CDC project officers can help you diagnose your TA needs and link you to other resources (e.g., the CDC National TA Providers' Network, national and community-based organizations, and CDC resources). Contacting your CDC project officer is easy. If you don't have his or her direct number, or are unsure who your project officer is, call the main number, (404) 639-5230.

**CDC National Center for HIV, STD, and TB Prevention Web site** — You can access CDC resources via the Internet: [www.cdc.gov/nchstp/od/nchst.html](http://www.cdc.gov/nchstp/od/nchst.html).

**CDC National Prevention Information Network (NPIN)** — NPIN can provide you with information and materials related to HIV prevention needs assessment, strategies and interventions, priority setting, and other topics related to HIV prevention community planning. Call (800) 458-5231 Monday through Friday from 9:00 a.m. to 6:00 p.m. Eastern Time, or access NPIN on the Internet at [www.cdcpin.org](http://www.cdcpin.org) or [info@cdcpin.org](mailto:info@cdcpin.org). Any publication in the bibliography with an NAC identification number is available free from NPIN.

**Center on AIDS & Community Health at the Academy for Educational Development Web site** — You can access and download a variety of technical assistance materials via the Internet: [www.healthstrategies.org](http://www.healthstrategies.org).

**Center on AIDS & Community Health and the National Alliance of State and Territorial AIDS Directors Joint Web site** — You can access and download HIV prevention community planning materials, peer samples, and hot links to other CPGs via the Internet: [www.hivaidsta.org](http://www.hivaidsta.org).

**National Alliance of State and Territorial AIDS Directors Web site** — You can access information about state HIV/AIDS programs, HIV prevention fact sheets, and other resources via the Internet: [www.nastad.org](http://www.nastad.org).

**A**

APPENDIX

# B

## Sample Ground Rules for Planning Groups

1. **Every planning group member will treat everyone else with respect** — as an intelligent person with a legitimate right to be a part of discussions and decision making. All members will have the opportunity to speak — and to be listened to — without interruptions. There will be no personal attacks. Disagreements will focus on issues, not individuals.
2. **The co-chair or facilitator will establish procedures for discussion** and may limit the length of individual presentations and set reasonable time limits on discussion or debate. A primary responsibility of the co-chair or facilitator will be to assure that everyone is enabled and encouraged to participate in the discussion. The group may select a parliamentarian or timekeeper to assist with this process.
3. **Decision making will occur in an agreed-upon manner, and every member will accept and support the decisions regardless of his/her personal position.** The group will determine a method to be used for decision making — whether majority rule, some form of super majority (e.g., two-thirds vote), consensus, etc. — before discussions and debates begin. Unless the group specifically determines another method, decision making will be by majority rule. The group may want to agree ahead of time that certain critical decisions will require a super majority vote.
4. **Information presented in confidence will be held in confidence**, not discussed outside the meeting. This includes matters related to assessments of particular prevention programs or other information about specific communities or organizations.
5. **Members will behave in a manner that reflects their responsibility to represent a community or constituency** and that benefits it rather than themselves or their organizations.
6. **All members will accept and follow the planning group's policies and procedures regarding conflict of interest** and will work actively to prevent both real and perceived conflicts of interest.

7. **All members will take responsibility for helping to prevent and resolve conflicts within the group.** Recognizing that disagreements are inevitable, all members will help to focus on the issues rather than personalities, to accept the need for compromise, and to help find mutually acceptable solutions wherever possible.
8. **All members will accept shared responsibility for determining the highest priority needs for various populations or groups,** recognizing that resources are not sufficient to meet all legitimate needs and that critical needs of many different groups must be met.
9. **Any participant who feels he or she cannot support the mission, policies, processes, and /or leadership of the planning group** as agreed upon by the members should leave the group rather than disrupt its proceedings.
10. **Every participant in the group will take responsibility** not only for following these ground rules but also for speaking out to assure that all other members follow them.



# C

## Decision-Making Methods

This appendix provides an overview of various types of decision-making methods.

### Group Consensus

**In a group consensus model, a group holds one or more discussions for each decision to be made and arrives at a decision as a group.** A decision is made based on discussion and without voting. Since group consensus requires all members to accept (though they may not necessarily agree with) the decision the group makes, significant compromise is often necessary.

An advantage of the group consensus model is that you minimize dissent and, because everyone is involved in the process, enhance the credibility of the decisions. A disadvantage of the consensus model is that difficult or complex decisions can be extremely time consuming, and your group may never reach consensus. As a result, some CPGs operate by consensus when possible, and revert to voting when consensus cannot be achieved. If your group chooses to take such an approach, it may be helpful to establish parameters that define when decision making will move from the consensus model to voting.

One strategy for streamlining the consensus process is to use straw polls. You can take such polls before and during group discussions to identify issues of disagreement. If there is no disagreement, your group can move quickly to consensus. Where there is disagreement, additional discussions can sometimes produce a compromise. In many cases, minor changes are sufficient to overcome objections.

## Voting

**In a voting model, your members discuss the issue at hand and then vote for one or more outcomes.**

In most cases, a majority rule is used, and the option receiving the most votes passes. Some groups require a super majority, where a specified proportion of votes cast — e.g., three-fifths (60%) or two-thirds (66%) — is required to reach a decision.

One advantage of voting is its familiarity. Most CPG members are comfortable with the process. Another advantage is that it's almost always possible for your group to reach a decision.

A disadvantage of voting is that, barring a unanimous vote, you will have dissent. Another disadvantage is that you may need to vote many times to resolve ties. You must apply some sensitivity to the voting process to assure that a majority does not totally disregard the needs of the minority. For example, some groups may decide that if all representatives of a particular community are in the minority in a majority-rule decision, the group will revisit the decision with either a consensus process or a clear super-majority vote (e.g., 75%).

There are many variations on the voting model. In the simplest form — often used for decisions with a single outcome, like voting up or down on an issue — each participant casts one vote. In more complicated variations — used when decisions require multiple outcomes, like electing a five-person board of directors — individuals sometimes cast multiple votes. For example, in a thirty-person group that must select a five-person board from among twelve candidates, the following voting models could be used.

- Each group member casts a single vote. Candidates with the first-, second-, third-, fourth-, and fifth-highest numbers of votes would make up the board.
- Each group member casts five votes, each of which must be cast for a different candidate. Candidates with the first-, second-, third-, fourth-, and fifth-highest numbers of votes would make up the board.
- Each group member casts a total of five votes, but group members are permitted to cast more than one vote for a single candidate. Candidates with the first-, second-, third-, fourth-, and fifth-highest number of votes would make up the board.

## Complex Decision-Making Methods

Sometimes there are too many choices for a group to use a technique like voting or asking for consensus. Priority setting is a good example. Two additional methods for making decisions among large numbers of choices in a group setting are described below.

### Nominal Group Technique

**The nominal group technique is a small-group discussion method that results in priority ranking of options.** This method allows individual judgments to be gathered and examined with balanced input from all group members. Basic steps in using the technique include the following.

- Prepare specific questions for the planning group to consider (e.g., what are the important factors to consider in evaluating prevention needs/possible interventions).
- Use one (or more) individual(s) to facilitate the process.
- Ask planning group members to take a few minutes to think individually and write down their responses to the question posed.
- Using the facilitator, ask the members to share their responses with the group without discussing the relative merits of these responses. You may want to use index cards, flipcharts, or stick-on notes to list the responses.
- Once everyone has participated fully, the facilitator leads the group in a discussion to ensure all members understand the responses. A result may be that you can group similar responses.
- Ask the planning group to identify which responses are most important to them by voting. Sometimes each member receives an equal number of colored stick-on dots to use to “vote” on posted responses. A show of hands may do.
- Finally, begin a facilitated discussion of the voting results to bring about group consensus on the priority items. Avoid simply adding up all scores. If time permits, the group may want to clarify items and vote again.
- Careful planning, preparation of planning group members, and any follow-up feedback to the group can minimize potential misunderstandings from the use of this structured process.

### Delphi Technique

The Delphi technique uses written questionnaires that are developed and tabulated by a planning committee and distributed to the decision makers. The technique allows respondents to remain anonymous and does not require group discussion. The technique is particularly useful when participants have scheduling problems or are scattered in a large project area. When decision making involves multiple stages or when the number of decision makers is large, this method works well.

Final target population and intervention priorities should not be set with this method, but it may help in some initial phases of the process. This method can also be used as a first step before discussing results in person.

- A planning committee should develop a clear, concise statement of the central issue to be addressed (e.g., to rank-order target populations).
- A small group selects members to participate. Because the process is not conducted in person, participants may be widely dispersed.
- The small group develops an initial questionnaire that clarifies the central issues for participants and instructs them how to respond in an open-ended format by a deadline (e.g., two weeks). For example, an instruction might be: “Indicate on the enclosed form the top priority target populations in rank-order.”
- A committee collates responses into appropriate categories and redistributes these to participants on a second questionnaire (with space for responses). By a deadline, participants are to rank or assign a value to the top (e.g., seven) categories and to add comments to any of the categories.
- Values assigned by group members in the previous step are combined and indicated next to the appropriate category on a third questionnaire, along with a summary of participants’ comments for any category that received votes. Participants vote a final time.
- The committee counts the votes and ranks categories in priority order. (If necessary, develop additional questionnaires and conduct votes to resolve outstanding disagreements.)

# D

## Sample Conflict-of-Interest Disclosure Form

### Iowa HIV Prevention Community Planning Group

The Iowa CPG has members who are professionally or personally affiliated with organizations that have, or may request, or receive funds for HIV prevention activities. Because of the potential for conflict of interest, the CPG has adopted this Disclosure Sheet, which all current and future CPG members must complete and provide to the CPG record-keeper.

The reputation and credibility of the CPG rests on its ability of make fair, objective, and impartial decisions. Accordingly, it is essential to avoid situations where a conflict of interest may influence, or appear to influence, the decision-making process. There are two types of conflict-of-interest situations:

1. Where a member (or a relative or partner, etc.) has a financial interest, or appears to have a financial interest, in the outcome of a decision and,
2. Where a member has an affiliation or other conflict of loyalties that may lead to or suggest influence over the outcome of a decision.

The following guidelines are intended to help the CPG avoid both types of conflicts.

#### General

From time to time, a member may serve as an officer, staff member, director, trustee, active volunteer or consultant to an organization with a vested interest in the outcome of the decision-making process. Situations may also arise where a member's business or personal interests may be affected by the outcome of a decision. In all such cases, the potential for conflict should be recognized and disclosed, and appropriate steps taken to prevent influence or favoritism by such members in the decision-making process.

## Disclosure

Each member is under an obligation to the CPG and to the other CPG members to inform them of any position they and/or a family member and/or household member serve or have served in the past twelve (12) months in a staff, consultant, officer, board member, advisor capacity, and the investment in any business, or any volunteer activities that may result in a possible conflict of interest with the following organizations that received, may seek, and/or are eligible for HIV Prevention funding within the scope of CPG influence. A member should also disclose any activity or interest that may cause bias for or against a particular action or policy being considered by the CPG. **Each member is asked to file a Disclosure Statement.**

Organization: \_\_\_\_\_

Title: \_\_\_\_\_ Period of Affiliation: \_\_\_\_\_

Group Member Name (Please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date Form Received by the Planning Group: \_\_\_\_\_

# E

## Keeping Your Committee Focused and Efficient

As a committee chair, it's your responsibility to recognize everyone's (including your own) busy schedule and to conduct effective meetings through good planning, appropriate meeting agendas, and a thorough orientation of committee members. The following approach can help you keep your committee running smoothly and effectively.

- **Overview of committee work** — include how it relates to the work of the full planning body and what action the planning body or staff has taken that relates to or affects the committee's work
- **Minutes or summary from the previous meeting** — read, review, and adopt
- **Summary of past actions** — remind the committee of the decisions it has made. This helps update committee members and avoids renewed discussion of completed work.
- **Review of progress toward objectives** — focus discussion of what has been done since the last meeting in the context of the work plan
- **Action items** — identify areas that require discussion and decision making, including presentations by various members on their work and recommendations, with a clear understanding of what action needs to be taken or decisions made based on their work
- **Problem solving** — discuss work that is behind schedule, unexpected problems encountered, other difficulties, and committee action to resolve them
- **Task assignments** — assign new or expanded tasks, always with deadlines specified
- **Other business** — cover anything not already addressed
- **Reminder of next meeting and subcommittee meetings**, with changes in scheduling when this is unavoidable





# F

## Structuring an Effective Committee

Experience suggests that an effective committee has the following characteristics.

1. **It has a written “charge”** that clearly specifies the tasks to carry out, products to prepare, deadline, and issues of particular concern.
2. **It knows exactly which decisions it can make** and which the full planning group will make.
3. **Its membership is appropriate to its charge in size, diversity, and capability.** A very large committee is hard to manage and difficult to get together, but a very small committee may not have among its members the diversity of knowledge, personal experience, community experience, and contacts needed. Given the disparate impact of HIV/AIDS in specific communities, committees need diverse representation, including members from disproportionately affected populations. At least one health department employee usually staffs the committee. This staff role varies depending on the health department’s HIV prevention resources. If the health department has sufficient administrative staff, the staff liaison usually is responsible for handling logistics, providing background materials, attending and participating in meetings, and sometimes preparing written materials the committee requests. Usually the liaison is not a voting member.
4. **It has a strong, enthusiastic, capable, reliable chair** who is committed to assuring the success of the committee and to involving all members. The chair should be good at motivating, listening to, using the talents of, and working with other members — at building the committee into an effective, cooperative team.
5. **It has basic organizational support** — professional staff support, information and assistance from the full planning group, a place to meet, and secretarial help. If the health department’s HIV prevention unit is small and has limited resources, this must be made clear at the outset, and the committee membership must include individuals who have explicitly agreed to provide support either

personally or through their own organizations — providing meeting space, preparation of minutes, secretarial help, photocopying, mailings, etc.

6. **The committee members feel confident that good work will make a difference** — that the committee's recommendations or products will be used for the benefit of the planning body and the community. The planning body can help instill in the committee a sense of its importance through its written charge to the committee and the scheduling of regular committee reports as part of planning group meetings. Most important, it must seriously review and then act on committee recommendations. If the planning body rejects committee recommendations, the body should explain why.
7. **Committee problems are addressed promptly.** If the full planning group consistently ignores or reverses committee recommendations, the problem may lie within either the planning group or the committee. The two committee and group chairs should lead a careful review of both entities and their relationship.

# G

## Icebreakers, Energizers, and Team Builders

These icebreakers, energizers, and team builders have produced positive results for several community planning groups.

Icebreakers allow members to get to know one another and reduce group tensions.

### Find Someone Who . . .

Find someone in the room who meets these criteria, and have that person sign the sheet with his/her first name. Try to get as many signatures as you can!

Find Someone Who . . .	Signed by:
Has traveled to another country	
Is a grandparent	
Has met a celebrity	
Has more than three pets	
Had a job at a restaurant	
Was sent to detention in high school	
Listens to the Backstreet Boys	
Knows how to snowboard	
Can bench press over 250 lbs.	
Was a hippie	
Can dunk a basketball	
Is a chocoholic, etc.	

**Story Time**

The facilitator starts a story by saying a sentence. The story then goes around in a circle, with each person adding a sentence to the story — after repeating each sentence that's come before.

Energizers perk up a group when fatigue sets in.

**Air Pen**

The facilitator tells the group that each person is holding an “air pen.” Group members are told to hold the pen with their teeth and to write the name of their favorite movie star in large letters. The facilitator then tells members to put the air pen in their belly button, and with their hands in the air, to write the name of their childhood sweetheart.

Team builders help to develop unity, understanding, motivation, and commitment among group members.

**Yarn Toss**

Everyone stands or sits in a circle, with the facilitator holding a ball of yarn. Hanging on tightly to the tail of the yarn, the facilitator tosses the ball to someone else while completing the sentence, “I appreciate you for...” That person does the same. After the ball of yarn has been tossed to everyone in the circle, group members slowly raise and lower their part of the yarn to reveal the intricate web of relationships in the group.

# H

## Sample Letters of Concurrence, Concurrence with Reservations, and Nonconcurrence

**SAMPLE 1 - Statewide Community Planning Group: LETTER OF CONCURRENCE**

Date \_\_\_\_\_  
 Mr./Ms. \_\_\_\_\_  
 Grants Management Officer  
 Procurement and Grants Office  
 Centers for Disease Control and Prevention  
 290 Brandywine Road  
 Room 300, Mailstop E-15  
 Atlanta, GA 30341

Dear Mr./Ms. \_\_\_\_\_:

The \_\_\_\_\_ HIV community planning group confirmed by consensus at its meeting August 8-9, 2003, its concurrence with the state of \_\_\_\_\_'s application to CDC for HIV prevention funds under program announcement 04012. The planning group has reviewed the state's proposed 2004 objectives, activities, and budget and finds them to be responsive to the priorities identified by the planning group and expressed in the \_\_\_\_\_ HIV prevention plan, 2003-2005.

The planning group met \_\_\_\_\_ (frequency) during 2003 and through a series of full-group and subcommittee meetings planned the content of meetings, defined needs established in the existing plan, and developed a schedule to review the state's HIV prevention application. Members were asked to review materials (the HIV prevention plan 2003-2005 and the state's 2004 AIDS/STD program plan objectives) and be prepared to discuss them at the September meeting. Thirteen of the 16 planning group members reviewed progress on the state's 2003 objectives, the planning group priorities, the HIV prevention plan 2003-2005, and the state's draft 2004 program plan and objectives. At the August planning group meeting, members gave AIDS/STD program staff considerable feedback on content for the 2004 CDC application. Based on a review of the draft program plan, the planning group easily reached consensus on its concurrence that the priorities and strategies proposed for the state's application reflected the priorities expressed in the planning group's plan.

The two community co-chairs, along with the health department co-chair, have been designated as signatories to the letter of concurrence.

Sincerely,

**SAMPLE 2 - Statewide Community Planning Group, with Regional Community Planning Groups:  
LETTER OF CONCURRENCE**

Date \_\_\_\_\_  
Mr./Ms. \_\_\_\_\_  
Grants Management Officer  
Procurement and Grants Office  
Centers for Disease Control and Prevention  
290 Brandywine Road  
Room 300, Mailstop E-15  
Atlanta, GA 30341

Dear Mr./Ms. \_\_\_\_\_:

On behalf of the statewide HIV/STD community planning group (CPG), we are confirming our concurrence with the 2004 \_\_\_\_\_ prevention plan and grant application. We believe that these documents address the prevention needs of priority populations and are being supported through the funding commitments of the health department. We feel strongly that the 2005 Plan and grant application reflect the planning efforts of the statewide HIV/STD community planning group and that a thorough review process was used to ensure concurrence. Our process included:

- The statewide resources development committee reviewed the proposed budget for 2005 at the June 2004 statewide meeting. All members of the statewide CPG received time to provide input (until early June). No one voiced opposition to the committee.
- A presentation of all regional plans to the statewide CPG ensured that the statewide CPG was aware of regional priorities. A review team composed of the statewide community co-chair, regional representatives, at-large members, and gallery participants read the plan and the regional plans to ensure that the state plan was based on the regional plans.
- A second-review team composed of the statewide community co-chair, a new set of regional representatives, at-large members, and gallery participants, read the application and reviewed regional plans to ensure that the application met CDC guidelines.
- At the September meeting of the Statewide CPG, the Resource Development Committee presented the budget, reporting that the budget adequately reflected the priorities presented in the comprehensive plan. The plan review team followed the same process. The statewide CPG voted to accept the plan. The grant application review team followed the same process, and the CPG voted to accept the application.

We look forward to implementing the plan to reduce the spread of HIV in \_\_\_\_\_.

Sincerely,

State Health Department Co-Chair State Community Co-Chair  
Region X Co-Chairs, Region X Co-Chairs  
Region X Co-Chairs, Region X Co-Chairs

2004–2008 HIV PREVENTION COMMUNITY PLANNING GUIDANCE

**SAMPLE 3 - Statewide Community Planning Group:  
LETTER OF CONCURRENCE WITH RESERVATIONS**

Date  
 Grant Management Officer  
 Grants Management Branch  
 Procurement and Grants Office  
 Centers for Disease Control and Prevention  
 290 Brandywine Road  
 Room 300, Mailstop E-15  
 Atlanta, GA 30341  
 Re: LETTER OF CONCURRENCE WITH RESERVATIONS

Dear Mr./Ms. \_\_\_\_\_:

We concur with our health department's application with one major exception. We are concurring with concerns to the health department's application for funding. As a CPG, we feel that the health department has consistently failed to implement effective programs for Men who Have Sex with Men (MSM). We recognize that this is a difficult population to reach, however, this is the jurisdiction's number one target population (as documented in both the epidemiologic profile and our priority setting process). The CPG has stated both the need and the types of interventions that are most needed (see the Comprehensive HIV Prevention Plan, Target Populations: MSM).

Despite our reservations about the application, we feel proud of how the \_\_\_\_\_ community planning group came together with the health department and accomplished so much with such a diverse group of individuals. The \_\_\_\_\_ community planning process is truly community driven. This was reflected in the review of the health department's application. The health department distributed copies of the application to all members and each member had ten days to review the application and to respond with comments. The community co-chairs collated comments and then participated in a conference call to make the decision to concur with concerns with the health department application.

We remain united in the struggle for healthy communities!

The \_\_\_\_\_ Community Planning Group



**SAMPLE 4 - Statewide Community Planning Group:  
LETTER OF NONCONCURRENCE**

Date  
Grants Management Officer  
Procurement and Grants Office  
Centers for Disease Control and Prevention  
290 Brandywine Road  
Room 300, Mailstop E-15  
Atlanta, GA 30341  
Re: LETTER OF NONCONCURRENCE

Dear Mr./Ms. \_\_\_\_\_:

After careful consideration of the health department's application, we have decided not to concur with that application. The application does not reflect our priorities for target populations or interventions directed to those populations. Instead, the health department application proposes funding for programs directed at the general public and a broadly targeted HIV counseling and testing program. We do not make this decision lightly.

Our group spent many hours reviewing epidemiologic data and the results of our needs assessment to form our population priorities. We also consulted with behavioral scientists and conducted an extensive literature review to support our intervention priorities. The health department application appears not to have recognized our efforts or recommendations.

We also want to register our dismay at the health department's lack of cooperation with the review process. Initially the CPG was informed that we would have 24 hours to review the application and that budget tables would not be included in the draft copy sent for review. We were able to negotiate three days for the review, still an inadequate amount of time.

We would greatly appreciate your help in resolving this matter.

Sincerely,

Community Co-chair

2004-2008 HIV PREVENTION COMMUNITY PLANNING GUIDANCE



# Interventions for HIV Positive People

These interventions have been identified by CDC's HIV/AIDS Prevention Research Synthesis Project (PRS) as having used rigorous study methods and demonstrated evidence of effectiveness in reducing sex- and drug-related risk behaviors and/or improving health outcomes.

**Partnership for Health (PfH)** is a brief provider-delivered counseling program for individual men and women living with HIV/AIDS. This individual-level intervention takes place at clinics providing primary medical care to HIV-positive persons. The program is designed to improve patient-provider communication about safer sex, disclosure of serostatus, and HIV prevention. PfH is based on a social cognitive model that uses message framing, repetition, and reinforcement to increase the patient's knowledge, skills, and motivations to practice safer sex.

Results from the original study indicated that male and female patients who had two or more sex partners or at least one casual partner and who received consequences-framed messages were significantly less likely to engage in unprotected anal or vaginal sex.

**Healthy Relationships** is a five-session small-group intervention for men and women living with HIV/AIDS. It is based on social cognitive theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. The sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

**Teens Linked to Care (TLC)** is a group-level intervention targeting HIV+ youth, age 13-29. The preferred setting is clinical care sites in which youth are receiving treatment for HIV related conditions. TLC is delivered in small groups using cognitive-behavioral strategies to change behavior. Young people meet regularly to provide social support, learn and practice new skills, and socialize. This program helps

young people identify ways to improve the quality of their lives by setting new habits and daily social routines. They set goals regarding their health, sexual relationships, drug use, and daily peace. The project's intentions are to increase health-enhancing behaviors, to reduce high-risk behaviors, and to reduce risks to others with whom the youth come in contact.

**Holistic Harm Reduction Program (currently in the process of adopting a new name, *Holistic Health Recovery Program [HHRP]*)**, is a group-level intervention for HIV+ Injection Drug Users, preferably those who are in treatment for addiction. The primary goal of HHRP is to provide group members with the resources (i.e., knowledge, motivation, and skills) they need to make choices that reduce harm to themselves and others. The intervention is based on the information, motivation, behavior (IMB) model of behavior change. In addition to providing substance abuse treatment, HHRP addresses medical, emotional, and social problems that may impede harm reduction behaviors. Treatment goals could include abstinence from illicit drugs or sexual risk behavior, but reduced drug use, reduced risk of HIV transmission, and improved medical, psychological, and social functioning are also acceptable. HHRP activities are designed to address clients as complex human beings in search of physical, emotional, social, and spiritual well-being.

**Women involved in Life Learning from Other Women (WiLLOW)** is a small group-level effective intervention targeting HIV positive African American women ages 18-50. WiLLOW's premise is that women have learned about life and how to cope with life's challenges by forming relationships with other women. Participants meet weekly to discuss issues such as self-esteem, stress management, condom use, unhealthy relationships, communication skills and the importance of female social networks. The intervention is grounded in the theories of social cognition and gender and power and complements the intervention SISTA for heterosexually African American women. WiLLOW is highly recommended for agencies already implementing SISTA.

**OPTIONS** is an intervention based on the IMB model (information, motivation, behavior) and uses motivational interviewing techniques. The intervention is delivered by clinic staff to HIV positive patients at each visit to the clinic. The intervention significantly reduced unprotected receptive and insertive anal and vaginal intercourse and unprotected insertive oral sex.

**CLEAR** (adapted as a PCM model) is an 18-session individual-level intervention that can be adapted for PCM providers. The intervention deals with illicit drug use and compliance with medical recommendations, safer sex and needle cleaning, risk reduction, depression, social support, coping, and mental health. The intervention was found to significantly increase HIV risk reduction behaviors in HIV positive people ages 16-29.

## INTERVENTIONS FOR PEOPLE AT HIGH RISK FOR HIV INFECTION

**Many Men, Many Voices (3MV)** is a group-level STD/HIV prevention intervention for gay men of color. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia. It is designed to be facilitated by a peer in groups of six to twelve clients. The two- to three-hour sessions aim to foster positive self-image, educate participants about their STD/HIV risk, and teach risk reduction and partner communication skills. The sessions are highly experiential, incorporating group exercises, behavioral skills practice, group discussions, and role play.

**The Mpowerment Project** was developed by and for young gay men ages 18-29. The intervention is run by a core group of ten to fifteen young gay men from the community and paid staff. The young gay men, along with other volunteers, design and carry out all project activities. Ideally, the project has its own physical space where most social events and meetings are held and where young men can meet and socialize during specified hours.

**Popular Opinion Leader (POL)** is a four-session community-level intervention that involves identifying, enlisting, and training key opinion leaders to encourage safer sexual norms and behaviors within their social networks through risk-reduction conversations. The program targets men who frequent gay bars, male sex workers, adolescents, and business owners who cater to gay men.

**Community PROMISE** (Peers Reaching Out and Modeling Intervention Strategies for HIV/AIDS Risk Reduction in their Community) is an effective, community-level HIV prevention intervention that relies on role model stories and peers from the target community. The intervention is based on the Stages of Change theory and other behavioral theories. PROMISE can serve any community or population, since the messages come from and are communicated within the community. It has been tested with African American, Anglo, and Latino communities, including IDUs and their sex partners, non-gay identified men who have sex with men, high-risk youth, female sex workers, and high-risk heterosexuals. It is also being developed for other populations and for individuals living with HIV.

**Real AIDS Prevention Project (RAPP)** is a community mobilization program designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. This intervention relies on peer-led activities, including: outreach and one-on-one brief conversations, referrals, and condom distribution; small-group safer sex discussions and presentations. There is also peer interaction with community businesses, who participate in media campaigns with distribution of role model stories and prevention and health information newsletters and brochures. RAPP is based on the transtheoretical model of behavior change.

**Safety Counts** is an intervention aimed at reducing high risk drug use and sexual behaviors of injecting and noninjecting drug users that are related to transmission of HIV and viral hepatitis. The intervention is a behaviorally focused seven-session intervention that includes both structured and unstructured activities in group and individual settings over four to six months. It employs a stages-of-change frame-

work and draws on behavior change principles articulated in the theory of reasoned action, social cognitive theory, and the health belief model. With HIV testing as a core element of the intervention, Safety Counts works well with CDC's Advancing HIV Prevention initiative as staff discusses the importance of knowing your status upon program enrollment and in each session offers testing and counseling services. The intervention addresses the needs of both HIV-negative and HIV-positive clients.

**The SISTA project** is a group-level, culturally and gender relevant social skills training intervention designed to increase condom use among African American women. It's comprised of five two-hour sessions delivered by peer facilitators in a community-based setting, focuses on ethnic and gender pride, HIV knowledge, and skills training around sexual risk-reduction behaviors and decision making. The intervention is based on social learning theory as well as the theory of gender and power.

**Street Smart** is an HIV/AIDS and STD prevention skills-building program for runaway and homeless youth to reduce their unprotected sex acts, number of sex partners, and substance use. It is based on social learning theory, which links feelings, attitudes, and thoughts to behavior change. Agency staff also provide individual counseling and trips to community health providers.

**VOICES/VOCES (Video Opportunities for Innovative Condom Education & Safer Sex)** is a group-level single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Participants, grouped by gender and ethnicity, view an English or Spanish video on HIV risk behaviors and condom use and take part in a facilitated discussion.

<b>CDC-VALIDATED INTERVENTIONS</b>		
<b>Intervention Name</b>	<b>Intervention Type</b>	<b>Target Audience</b>
Partnership for Health	ILI	HIV + men and women in clinic settings
Healthy Relationships	GLI	HIV + men and women
Teens Linked to Care (TLC)	GLI	HIV + youth 13-29
The Holistic Health Recovery Program (HHRP)	GLI	HIV+ IDU
WILLOW	GLI	HIV+ African American women, 18-50
Options		HIV+ patients in clinic settings
CLEAR	ILI	
Many Men Many Voices	GLI	Gay men of color
Mpowerment	GLI	Young gay and bisexual men, 18-29
Popular Opinion Leader (POL)	CLI	Men who frequent bars, male sex workers, adolescents, and business owners who cater to gay men
Community PROMISE	CLI	African American, Anglo, Latino IDU and their sex partners, non-gay identified MSM, high risk youth, female sex workers, high risk heterosexuals
Real AIDS Prevention Project (RAPP)	CLI	Sexually active women of reproductive age and their male partners
Safety Counts	GLI	Individuals who are currently using drugs, injectors and non-injectors
SISTA	GLI	Sexually active African American women
Street Smart	GLI	Runaway and homeless youth, 11-18
VOICES/VOCES	GLI	African American and Latino adult men and women clinic clients







# Bibliography

## Community Planning and CDC Initiatives

Includes *Guidance* and general community planning resources.

*HIV Prevention Community Planning: An Orientation Guide*. 2004. Washington, DC: Academy for Educational Development, Center on AIDS & Community Health.

Describes the community planning initiative in basic language. A good document for those considering membership on a planning group or for people needing an overview of HIV prevention community planning. Explains the CDC 2004-2008 *HIV Prevention Community Planning Guidance* and describes technical assistance and technical resources helpful to CPGs.

**Availability:** [www.healthstrategies.org](http://www.healthstrategies.org). Or telephone: CDC's National Prevention Information Network (NPIN) at 1-800-458-5231

2004-2008 *HIV Prevention Community Planning Guidance*. Atlanta, GA: Centers for Disease Control and Prevention.

The *Guidance* defines the Centers for Disease Control and Prevention's (CDC) expectations of health departments and HIV prevention community planning groups (CPGs) in implementing HIV prevention community planning. The *HIV Prevention Community Planning Guidance* provides a blueprint for HIV prevention planning and provides flexible direction to CDC grantees receiving federal HIV prevention funds to design and implement a participatory HIV prevention community planning process.

**Availability:** [www.cdc.gov/hiv/pubs/hiv-cp.htm](http://www.cdc.gov/hiv/pubs/hiv-cp.htm). Or telephone: CDC's National Prevention Information Network (NPIN) at 1-800-458-5231 for publication ID#D051.

*Advancing HIV Prevention: New Strategies for a Changing Epidemic*, Centers for Disease Control and Prevention (CDC)

CDC's initiative is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services for those diagnosed with HIV. The program's emphasis is: 1. incorporate HIV testing as a routine part of care in traditional medical settings; 2. implement new models for diagnosing HIV infections outside medical settings; 3. prevent new infections by working with people diagnosed with HIV and their partners; and 4. further decrease mother-to-child HIV transmission.

**Availability:** <http://www.cdc.gov/hiv/partners/ahp.htm>

*Bright Ideas: Innovative or Promising Practices in HIV Prevention*. 3rd ed. 2002. Washington, DC: National Alliance of State and Territorial AIDS Directors.

Presents an inclusive, descriptive inventory of HIV prevention practices identified as noteworthy or promising. Practices are listed by state with contact information provided.

**Availability:** [www.cdc.gov/hiv/PUBS/2002410Brightideas2002nnovativeorPromisingPracticesinHVPre.pdf](http://www.cdc.gov/hiv/PUBS/2002410Brightideas2002nnovativeorPromisingPracticesinHVPre.pdf).

Rose VJ, Gomez CA, et al. 2003. "Do Community Planning Groups (CPGs) Influence HIV Prevention Policy? An Analysis of California CPGs." *AIDS Education and Prevention* 15(2): 172-83.

Examines the roles of California community planning groups (CPGs) in systems change and policy making in HIV prevention and identifies factors that either promote or inhibit systems and policy change by CPGs.

Kaplan EH, Merson MH. 2002. "Allocating HIV-Prevention Resources: Balancing Efficiency and Equity." *American Journal of Public Health* 92(12): 1905-7.

The authors contrast two allocation models for HIV prevention: 1) current practice of federal resources granted to states in proportion to reported AIDS cases and 2) a cost effectiveness approach where activities that prevent more HIV infections per dollar are favored over those that prevent fewer. They propose a middle ground for allocating federal HIV-prevention resources.

Zaric GS, Brandeau ML. 2001. "Optimal investment in a portfolio of HIV prevention programs." *Medical Decision Making* 21(5): 391-408.

The authors present a resource allocation model to determine the allocation of HIV prevention funds that maximizes quality-adjusted life years (or life years) gained or HIV infections averted in a population over a specified time horizon. The model is applied theoretically to three types of HIV prevention programs and the authors estimate a production function that relates the amount invested to the associated change in risky behavior. They discuss the factors to be considered for optimal allocation of funds and argue that simpler allocation methods (e.g., based on HIV incidence or notions of equity among population groups) may not maximize health benefit.

## Group Process

Includes general resources on managing groups/committees, specific resources on community planning, evaluation of the community planning process and CDC information on community planning evaluation guidelines.

*Evaluating CDC-Funded Health Department HIV Prevention Programs, Volume 1, Guidance, and Volume 2, Supplemental Handbook.* Atlanta, GA: Centers for Disease Control and Prevention.

Describes the types of standardized evaluation data needed by the CDC to be accountable for its use of federal funds and to conduct systematic analysis of HIV prevention to improve HIV prevention policies and programs. The document has two primary purposes: 1) to describe each type of evaluation as it applies to CDC requirements and 2) to explain types of data to be collected and mechanisms for reporting the data to CDC. Volume 1, Chapter II is Evaluating the HIV Prevention Community Planning Process.

**Availability:** [www.cdc.gov/hiv/aboutdhap/perb/hdg.htm](http://www.cdc.gov/hiv/aboutdhap/perb/hdg.htm)

Kreuter MW, Lezin NA, Young LA. 2000. "Evaluating Community-Based Collaborative Mechanisms: Implications for Practitioners." *Health Promotion Practice* 1(1): 49-63.

The literature on community-based coalition strategies offers marginal evidence that these strategies lead to health status/health systems change. The authors summarize useful tools for evaluating collaborative efforts and suggest that more realistic expectations and asking the right questions is the way to determine the effectiveness of collaborative mechanisms and consortia.

*Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability.* David M. Fetterman, Shakeh J. Kaftarian, Abraham Wandersman, Eds. 1995. Thousand Oaks, CA: Sage Publications. 424p.

The book addresses the theoretical and philosophical framework of empowerment evaluation, using evaluation concepts and techniques to foster improvement and self-determination, in a variety of settings including non-profits, academia, federal and local governments, community prevention coalitions and foundations. Also discusses tools, training and technical assistance. Chapter authors Cynthia Gomez and Ellen Goldstein address the HIV Prevention Evaluation Initiative.

Dearing JW, Larson RS, et al. 1998. "Local Reinvention of the CDC HIV Prevention Community Planning Initiative." *Journal of Community Health* 23(2): 113-26.

HIV prevention community planning in Michigan, with its decentralized approach to HIV prevention community planning, is presented as a case study. The authors conclude that drawing a distinction between centrally coordinated information-seeking tasks and decentralized decision-making tasks most fully achieves the potential of HIV prevention community planning.

Butterfoss, FD, RM Goodman, et al. 1996. "Community Coalitions for Prevention and Health Promotion: Factors Predicting Satisfaction, Participation, and Planning." *Health Education Quarterly* 23(1): 65-79.

An examination of the key characteristics of coalitions found that community leadership, shared decision making, linkages with other organizations, and a positive organizational climate were key determinants of coalition-member satisfaction and participation although they were not related to the quality of coalition plans. The authors discuss the significance of coalitions for community empowerment and health promotion.

## Epidemiology and Community Services Assessment

Includes data gathering and interpretation, evaluation and assessment.

*Rapid Assessment and Response Technical Guide: Chapter 9.10. Estimation techniques.* 2003. Stimson GV, Donoghoe MC, Fitch C and Rhodes TJ, with A. Ball and G. Weiler. Geneva: World Health Organization (Department of Child and Adolescent Health and Development, and Department of HIV/AIDS).

Estimation techniques are used to estimate the size of an affected population or group when its size cannot be measured directly. These techniques generally use combined data from routine information systems and agencies to develop overall estimates. This chapter covers relative trends, case finding, multiplier techniques, nomination techniques and capture-recapture.

**Availability:** [www.who.int/docstore/hiv/Core/Chapter\\_9.10.html](http://www.who.int/docstore/hiv/Core/Chapter_9.10.html)

*Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning.* Atlanta, GA: Centers for Disease Control and Prevention.

The Guidelines were developed by the Centers for Disease Control and Prevention and the Health Resources Services Administration for people who compile and interpret HIV prevention and care data for state, territorial, or local HIV/AIDS epidemiologic profiles. The guidelines help profile writers produce integrated epidemiologic profiles and advise them on ways to interpret epidemiologic data that are consistent and useful in meeting prevention and care planning needs. An integrated epidemiologic profile from Louisiana is used as an example. Appendix D provides available data sources by jurisdiction.

**Availability:** [www.cdc.gov/hiv/epi\\_guidelines.htm](http://www.cdc.gov/hiv/epi_guidelines.htm)

*Assessing the Need for HIV Prevention Services: A Guide for Community Planning Groups.* 1999.

Washington, DC: Academy for Educational Development, Center for Community Based Health Strategies. 132p.

In-depth guide to help HIV prevention community planning groups design, implement, update and manage useful needs assessments.

**Availability:** [www.healthstrategies.org/pubs/publications/needs\\_assessment\\_all.pdf](http://www.healthstrategies.org/pubs/publications/needs_assessment_all.pdf). Or telephone: CDC's National Prevention Information Network (NPIN) at 1-800-458-5231 for publication ID#D153.

*Making Sense of Focus Group Findings: A Systematic Participatory Analysis Approach.* 2003. de Negri B, Thomas E. Washington, DC: Academy for Educational Development. 168p.

A practical, how-to handbook on analyzing focus group findings geared toward researchers, program managers, technical officers and others working in developing countries. Useful for those who use focus groups to plan, monitor, and/or assess their programs. The emphasis is on gathering practical information for planning and/or improving programs. Systematically explains the analysis process and includes examples, a case study and hands-on exercises.

**Availability:** [www.aed.org/publications/Making%20Sense\\_final.pdf](http://www.aed.org/publications/Making%20Sense_final.pdf)

American Psychological Association, *HIV Prevention Program Evaluation*

Provides tools for the development and evaluation of HIV prevention programs for HIV prevention and technical assistance providers. Topics include evaluation planning, types of evaluation and research methods, data sources, and links to descriptions of effective HIV prevention programs.

**Availability:** [www.apa.org/pi/aids/introprogrameval.html](http://www.apa.org/pi/aids/introprogrameval.html)

## Target Populations

Includes descriptions of specific populations and settings.

Needle RH, Trotter RT, Singer M, Bates C, Page JB, Metzger D, Marcelin LH. 2003. "Rapid Assessment of the HIV/AIDS Crisis in Racial and Ethnic Minority Communities: an Approach for Timely Community Interventions." *American Journal of Public Health* 93(6): 970-9.

An initiative of the US Department of Health and Human Services, in collaboration with the Congressional Black Caucus, deployed technical assistance teams to introduce rapid assessment and response methodologies and train minority communities in their use. Data from the first three eligible cities (Detroit, Miami, and Philadelphia) provides critical information about changing the dynamics of the HIV/AIDS epidemic through program and policy changes and infrastructure redeployment targeted at the most serious social and environmental conditions.

Vernon IS, Jumper-Thurman P. 2002. "Prevention of HIV/AIDS in Native American Communities: Promising Interventions." *Public Health Reports* 117 Suppl 1: S96-103.

Presents data on trends in AIDS prevalence among Native American men and women with a model for building effective prevention and intervention strategies. The problems of classification, data collection and factors that contribute to high risk (including poverty, homophobia, denial, and mistrust) are discussed along with factors that affect prevention and intervention.

- Bau I. 1998. "Asians and Pacific Islanders and HIV Prevention Community Planning." *AIDS Education and Prevention* 10(A): 77-93.

Highlights HIV prevention plans from 29 states, five local governments, and six Pacific Island jurisdictions to show the lack of HIV prevention programs for Asians and Pacific Islanders and provides recommendations for obtaining additional data to support the need for these programs.

- The State of Latinos in HIV Prevention Community Planning*. 2002. Academy for Educational Development Center for Community-Based Health Strategies, Centers for Disease Control and Prevention, National Alliance of State & Territorial AIDS Directors, National Association of People with AIDS, National Minority AIDS Council, U.S.-Mexico Border Health Association. 26p.

A compilation of information on the Latino experience in community planning from meetings, conferences and other sources. It was created to serve as a tool to help CPGs, health departments, and other stakeholders understand the issues behind Latino participation in community planning and to increase Latino participation in HIV Prevention Community Planning.

**Availability:** [www.cdc.gov/hiv/pubs/SLCP/slcp.htm](http://www.cdc.gov/hiv/pubs/SLCP/slcp.htm)

## Interventions

Includes types of interventions, theory, evaluation (effectiveness), cost effectiveness.

- REP+, Replicating Effective Programs, Centers for Disease Control and Prevention (CDC)

The programs in REP are tested, science-based behavioral interventions with demonstrated evidence of effectiveness in reducing risky behaviors, such as unprotected sex, or in encouraging safer ones, such as using condoms and other methods of practicing safer sex. The interventions are translated into everyday language and put into user-friendly packages designed, developed, and field-tested by researchers collaborating with community-based partners. The products can guide prevention providers in replicating effective risk-reduction programs in their own settings and communities. The REP+ site also provides an overview of other CDC/DHAP initiatives.

**Availability:** [www.cdc.gov/hiv/projects/rep/default.htm](http://www.cdc.gov/hiv/projects/rep/default.htm)

- Center for AIDS Intervention Research (CAIR), Medical College of Wisconsin

CAIR develops, conducts and evaluates new interventions to prevent HIV among persons most vulnerable to the disease. CAIR's Partners in Prevention manuals were developed to attempt to

fill the gap between HIV prevention research findings and applied practice in community settings. The Men's and Women's editions are downloadable from the site. Website also includes searchable database of articles related to HIV/AIDS prevention and links.

**Availability:** [www.cair.mcw.edu](http://www.cair.mcw.edu)

*Compendium of HIV Prevention Interventions with Evidence of Effectiveness.* Atlanta, GA: Centers for Disease Control and Prevention, HIV/AIDS Prevention Research Synthesis Project, November 1999, Revised August 2001.

The Compendium provides state-of-the-science information about interventions with evidence of reducing sex- and/or drug-related risks and the rate of HIV/STD infections. Provides summaries of effective prevention interventions. An Intervention Checklist, derived from many successful prevention interventions, can guide assessment of other existing or new interventions.

**Availability:** <http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm>. Or telephone: CDC's National Prevention Information Network (NPIN) at 1-800-458-5231 for publication ID#D275.

Kelly JA, Somlai AM, DiFranceisco WJ, Otto-Salaj LL, McAuliffe TL, Hackl KL, Heckman TG, Holtgrave DR, Rompa D. 2000. "Bridging the Gap between the Science and Service of HIV Prevention: Transferring Effective Research-Based HIV Prevention Interventions to Community AIDS Service Providers." *American Journal of Public Health* 90(7): 1082-8.

Compares the effectiveness of three dissemination strategies for transferring HIV prevention models from researchers to community providers of HIV prevention services. A dissemination strategy with implementation manuals, staff training workshops, and follow-up consultation resulted in more frequent adoption and use of the research-based HIV prevention intervention. The collaboration between researchers and service agencies appears to result in more successful program adoption than distribution of implementation packages alone.

*Procedural Guidance for Selected Strategies and Interventions for Community Based Organizations, Funded under Program Announcement 04064*

The *Guidance* is divided into three sections, which match the three major activities that will be funded through Program Announcement 04064. Section 1 describes procedures for targeted outreach and health education/risk reduction for high-risk individuals. Section 2 describes procedures for targeted outreach and counseling, testing, and referral services for high-risk individuals. Section 3 describes procedures for prevention interventions for people living with HIV and their partners of negative or unknown status. Section 3 also describes interventions for person at very high risk for HIV infection.

**Availability:** <http://www.cdc.gov/search.do?action=search&queryText=Procedural+Guidance>



### Diffusion of Effective Behavioral Interventions (DEBI) project

The Diffusion of Effective Behavioral Interventions project is a national-level strategy to provide high quality training and on-going technical assistance on selected evidence-based HIV/STD prevention interventions to state and community HIV/STD program staff.

The Centers for Disease Control and Prevention Divisions of HIV/AIDS Prevention (DHAP), Capacity Building Branch is committed to enhancing the capacity of individuals, organizations, and communities to conduct more effective and efficient HIV prevention services. Staff of CDC/DHAP Capacity Building Branch, HIV/STD Prevention Training Centers, state-level health departments, Capacity Building Assistance providers, and the Behavioral and Social Scientist Volunteers program (BSSV) may offer training and technical assistance on the interventions.

**Availability:** [www.effectiveinterventions.org](http://www.effectiveinterventions.org)

Holtgrave DR, Valdiserri RO, and West GA. 1994. "Quantitative Economic Evaluations of HIV-Related Prevention and Treatment Services: A Review." *Risk: Health Safety & Environment* 5:29-47.

Gives an economic evaluation (cost-benefit and cost-effectiveness analysis) of HIV-related prevention and treatment services.

Pinkerton SD, Holtgrave DR, DiFranceisco WJ, Stevenson LY, and Kelly JA. 1998. "Cost-Effectiveness of a Community-Level HIV Risk Reduction Intervention." *American Journal of Public Health* 88(8): 1239-1242.

Describes a cost-effective analysis of a community-level intervention that used peers to educate gay men.

The Center for AIDS Prevention Studies (CAPS), University of California–San Francisco.

CAPS conducts HIV/AIDS prevention research and disseminates knowledge, skills, and effective research and prevention models. Information on model programs, intervention curricula, CAPS survey instruments available. CAPS collaborative community research disseminates research findings to inform community services. Descriptions of community projects and links to other resources available from the website.

**Availability:** [www.caps.ucsf.edu](http://www.caps.ucsf.edu)

Valdiserri RO, West GR, Moore M, Darrow WW, Hinman AR. 1992. "Structuring HIV Prevention Service Delivery Systems on the Basis of Social Science Theory." *Journal of Community Health*. 17(5): 259-69.

Provides information about ways that prevention programs can use behavioral theory to design prevention interventions.

## Project Area Web sites

Includes links to project area websites and specific planning tools available for download.

### HIV Community Planning Group Web Sites

*University of California San Francisco HIV InSite*

The web site provides links to a wide variety of community planning, treatment and prevention resources. Also provides links to specific HIV community planning web sites.

**Availability:** [hivinsite.ucsf.edu/InSite?page=li-07-12#S2X](http://hivinsite.ucsf.edu/InSite?page=li-07-12#S2X)

*HIV Prevention Toolbox*, The University of Texas Southwestern Medical Center at Dallas

The Toolbox provides both downloadable materials and links to intervention and assessment strategies, planning and priority setting guides, evaluation models and manuals and other resources related to HIV prevention.

**Availability:** [www3.utsouthwestern.edu/preventiontoolbox](http://www3.utsouthwestern.edu/preventiontoolbox)

*Community Planning Toolkit*, Massachusetts Department of Health

The Toolkits include operational manuals describing community planning processes implemented and evaluated in Massachusetts through the Behavioral Data Grant.

**Availability:** [www.mass.gov/dph/aids/toolkits/toolkits.htm](http://www.mass.gov/dph/aids/toolkits/toolkits.htm)

