Evaluation of Montana's HIV prevention community planning process

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EVALUATION OF MONTANA’S HIV PREVENTION COMMUNITY PLANNING PROCESS

by

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The purpose of this study was to conduct an evaluation of Montana’s HIV prevention community planning process. The evaluation was designed to explore barriers and challenges to planning, as well as the factors that facilitate planning. Additionally, this project sought to explore Montana’s CPG members’ perception of the HIV prevention community planning process as well as members’ motivations to join the CPG. The study was descriptive in nature; both qualitative and quantitative data was utilized as the basis of methodology. A Community Planning Membership Survey, developed by the CDC, was given to current community planning group members at the August 2004 CPG meeting in Helena, MT. Two focus groups and three interviews were conducted to provide further insight into the members’ motivations for joining the CPG and their perceptions of community planning efficacy.

A combination of descriptive statistics and chi square tests were run on survey data. The interview and focus group data were analyzed qualitatively. The results indicated that, in general, Montana’s CPG members felt positive about the process of HIV prevention community planning in 2004. Analysis of all three data sources revealed that Montana’s CPG is, for the most part, meeting all of the community planning goals and objectives. Additionally, the results revealed numerous factors facilitating community planning including: 1) the presence of diversity and inclusion on the CPG; 2) the valuable work done by the CPG’s four standing committees; 3) the effectiveness of the recruitment process; 4) the use of the independent facilitator at the CPG meetings and 5) the contributions of the DPHHS staff in the planning process. Concern for the community was identified as the most important factor motivating members to join the CPG as well as to continue their membership.

The results of this study will assist the Montana Department of Health and Human Services in improving the community planning process.
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CHAPTER 1: INTRODUCTION OF THE STUDY

Since 1986, the Centers for Disease Control and Prevention (CDC) has provided Federal funds for HIV/AIDS prevention to all fifty states (Holtgrave, Harrison, Gerber, Aultman & Scarlett, 1996). From the beginning of HIV fund provision, the CDC provided guidance regarding the use of the funds and encouraged grantees to involve members of their communities in the planning process. However, many barriers to the planning process were discovered upon the evaluation of HIV programs (Holtgrave et al., 1996; Valdiserri, Aultman & Curran, 1995).

Therefore, in 1993 the CDC required that the 65 health department grantees receiving HIV prevention funding, engage in a comprehensive community planning process (Johnson-Masotti, Pinkerton, Holtgrave, Valdiserri & Willingham, 2000). A Supplemental Guidance on HIV Prevention Community Planning was issued by the CDC in 1993 (CDC, 1993). This document detailed the CDC’s requirements for the community planning, including: the involvement of affected communities in prevention decision making; an increase in the use of epidemiological data to target HIV prevention resources; and the use of scientific information in the planning process, particularly regarding the effectiveness and efficiency of HIV interventions (Johnson-Masotti, et al., 2000).

Initially, the CDC detailed five core objectives for the community planning process. In 2003, the core objectives were revised and now consist of three goals, including: (1) the community planning process will support broad-based community participation in HIV prevention planning; (2) the community planning process will identify priority HIV prevention needs in each jurisdiction, and (3) the community
planning process will ensure that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan (CDC, 2003).

HIV prevention community planning plays an important role in achieving the goals of the CDC’s “HIV Prevention Strategic Plan Through 2005” (CDC, 2003). The CDC’s overarching national goal for HIV prevention in the United States is to reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by 2005, focusing particularly on eliminating racial and ethnic disparities in new HIV infections (CDC, 2003).

In order to meet the goals and the purpose of community planning, the CDC requires that each grantee create one community planning group (CPG). The CPGs are comprised of individuals who represent the diversity of the HIV epidemic in that jurisdiction, as well as individuals who specialize in program evaluation, behavioral science and epidemiology (Holtgrave et al., 2000).

Montana’s CPG membership, when fulfilled, consists of thirty-five members, five from each of the six communities. The six communities represented by CPG members include: 1) High Risk Heterosexuals (HRH), 2) HIV Prevention Services Providers, 3) HIV-Positive Individuals, 4) Injection Drug Users (IDU), 5) Men who have Sex with Men (MSM), and 6) Native Americans. The remaining five members include: three community co-chairs (past, current, and elect), one Health Department appointed co-chair and the HIV prevention planning coordinator. The major task of Montana’s CPG is to create a comprehensive HIV plan intended to improve the effectiveness of the Department of Health and Human Services (DPHHS) HIV prevention programs.
The mission of the CPG is to reduce the number of Montanans who become HIV positive or re-infected with HIV.

**STATEMENT OF THE PROBLEM**

Many barriers exist to meeting the community planning goals, objectives and attributes set forth by the CDC. Therefore, evaluating the current planning process will allow Montana’s CPG to discover barriers and challenges to planning, as well as the factors that facilitate planning. The focus of this project is to explore Montana’s CPG members’ perception of the HIV prevention community planning process. This evaluation provides the CPG with valuable information which allows them to enhance the community planning process.

**PURPOSE OF THE STUDY**

The purpose of this study was to evaluate Montana’s HIV prevention community planning process. The CDC’s goals, objectives and attributes were used as criterion for the assessment of the process of HIV prevention community planning. This evaluation of the current community planning process provides information that can be used to improve and enhance Montana’s CPG.

**RESEARCH QUESTIONS**

The following research questions were developed based on the CDC’s goals and objectives for the community planning process. The questions were designed to examine the planning process as well as CPG members’ perceptions of planning efficacy.

1. What methods are used in the recruitment of CPG members?
   - What are the CPG members’ perceptions of the recruitment process?
2. What strategies does the CPG employ to ensure a representative membership?
   • What are CPG members' perceptions of the representativeness of Montana's at risk populations on the CPG?
   • What are CPG members' perceptions of inclusion and parity in the CPG planning process?

3. What methods were used to prioritize population-specific prevention needs?
   • What are members' perceptions of the prioritization process?

4. What strategies were used to develop HIV prevention activities/interventions for identified priority populations?
   • What are members' perceptions of the strategies used to develop prevention/interventions?

5. How does the CPG ensure that there is a direct relationship between the Comprehensive HIV prevention plan and the health department progress report?

6. What motivated the Community Planning Group (CPG) members to become involved with CPG?

7. What motivates CPG members to continue participating in the CPG?

8. What are the barriers, if any, to participation in the community planning process?

9. What are the factors that facilitate participation in the community planning process?

**DELIMITATIONS**

• This study was delimited to current Community Planning Group members in Montana.

• Data was collected through existing documents, a survey, two focus groups and interviews.

• Data was restricted to participants' self-report on the survey, during focus groups and interviews.

• Participants in this study were volunteers.
LIMITATIONS

- Responses were limited to the voluntary completion of the survey by CPG members.
- Data gathered from the focus groups and interviews was limited to what the participants were able and willing to share.
- Focus group, interview, and survey data was limited to the honesty and accuracy of participants’ responses.

DEFINITION OF TERMS

**Acquired Immune Deficiency Syndrome (AIDS):** the late stage of HIV infection. AIDS involves the loss of function of the immune system. The CDC defines AIDS as an HIV positive individual who has a CD4 cell count which is lower than 200 CD4 cells/mm³ or the presence of at least one opportunistic illness (AIDS Foundation, 2004).

**High Risk Heterosexuals (HRH):** includes but is not limited to, individuals with HIV+ partners, individuals with sexually transmitted diseases (STD); females who have sex with MSMs; individuals who are sex workers (exchange sex for resources, survival or drugs); individuals who are substance abusers; individuals who are sexual partners of IDUs or; youth who engage in high-risk sexual behaviors (Montana HIV prevention planning CPG bylaws, 2003).

**Human Immunodeficiency Virus:** a slow-acting blood-borne retrovirus believed to be the sole or primary cause of AIDS. The two major types are: HIV-1 and HIV-2 (AIDS Foundation, 2004).

**Inclusion:** meaningful involvement of members in the process with an active voice in decision making (CDC, 2003).
**Injection Drug Users (IDUs):** a person who uses a drug that is administered with a needle and syringe (AIDS Foundation, 2004).

**Men Who Have Sex With Men (MSM):** Men who report sexual contact with other men and men who report sexual contact with both men and women, whether or not they identify as “gay” (Montana HIV prevention planning CPG bylaws, 2003).

**Parity:** the ability of members to equally participate and carry-out planning tasks/duties (CDC, 2003).

**Representation:** the act of serving as an official member reflecting the perspective of a specific community (CDC, 2003).

**IMPORTANCE OF THE STUDY**

Montana’s CPG will use the information from this study to enhance their HIV prevention community planning process. The evaluation process provides feedback about the community planning process in order to eliminate barriers to planning, to identify strengths and weaknesses, and to determine ways to improve the planning process.
CHAPTER 2: REVIEW OF RELATED LITERATURE

HIV/AIDS IN THE UNITED STATES

HIV/AIDS continues to be a serious public health problem in the United States. Since the first AIDS cases were reported in the United States in 1981, the number of cases and deaths among persons with AIDS increased rapidly during the 1980s. This was followed by substantial declines in new cases and deaths in the late 1990s (CDC, 2001). However, it is important to recognize that since the use of highly active antiretroviral therapy (HAART) became widespread during 1996, trends in AIDS incidence have become less reflective of underlying trends in HIV transmission. Despite breakthroughs in treatment in recent years, and less deaths among individuals living with AIDS, the prevalence of HIV continues to increase (CDC, 2002). It is estimated that a total of 859,000 persons are living with AIDS in the United States (CDC, 2002). Additionally, it is estimated that 40,000 new HIV infections occur annually in the U.S. (CDC, 1999).

According to the World Health Organization (WHO), women account for an increasing proportion of people living with HIV/AIDS in the United States (WHO, 2002). The proportion of AIDS cases attributed to heterosexual contact has continued to increase and accounted for 22% of recently diagnosed cases (WHO 2002). The diagnosis of HIV/AIDS has increased each year from 1999-2002 among men who have sex with men (MSM) (CDC, 2002). Male to male sexual contact accounted for 41% of new AIDS diagnoses, while injection drug use accounted for 30% of all recently diagnosed AIDS cases (WHO, 2002).

Increases in newly diagnosed HIV cases among MSM and heterosexuals have created concern (CDC, 2001). Communities are therefore recognizing a need for new
prevention strategies. To meet this need the CDC has developed a new *HIV Prevention Strategic Plan through 2005*. Their new national goal is to reduce the number of new HIV infections in the United States from an estimated 40,000 annually to 20,000 by the year 2005 (CDC, 2001). Additionally by 2005, they seek to strengthen the nationwide capacity to successfully evaluate prevention programs, monitor the epidemic and implement effective HIV prevention interventions. The planning of effective interventions is a key component in the CDC’s goal to reduce the number of new HIV infections.

**HIV/AIDS IN MONTANA**

As of September 30, 2003, a total of 347 persons were living with HIV/AIDS in Montana. Forty of the fifty-six counties in Montana have reported at least one or more HIV/AIDS case since 1985 (Montana HIV/AIDS cases, 2003). Considering the primary exposure categories, MSM account for 59% of the total HIV/AIDS cases, IDUs account for 13%, MSM/IDU account for 13%, and heterosexual contact accounts for 4% (Montana HIV/AIDS cases, 2003). The remaining HIV/AIDS cases are associated with blood transfusions due to hemophilia/coagulation disorder (2%), transfusions with blood or blood products (1%) or are currently under investigation (8%) (Montana HIV/AIDS cases, 2003).

**COMMUNITY PLANNING GROUP HISTORY**

Since 1986, the CDC has provided Federal HIV prevention funds to health department grantees. The grantees receiving HIV funds are the 50 states, 8 U.S. territories, the District of Columbia, and six local health departments (Chicago, Houston, Los Angeles, New York City, and San Francisco (Johnson-Masotti et al., 2000). From the beginning of
HIV fund allocation, the CDC has provided the grantees guidance regarding the use of Federal funds. The CDC encouraged the grantees to include members of their community in the development and planning of HIV prevention efforts (Holtgrave et al., 1996). However, a number of barriers were identified as hindering the prevention planning efforts, which eventually led to the development of community planning (Valdiserri & West, 1994).

Among the identified barriers to the planning process, were limited and insufficient funds. The CDC required dispersion of limited funds to specific programs, such as counseling and testing, which ultimately diluted the impact of a comprehensive planning process (Holtgrave et al., 1996). A survey conducted in 1993 (ASTHO, 1994 as cited in Johnson-Masotti et al., 2000) revealed that 75% of states surveyed, cited insufficient funds as an impediment to planning. Additionally, 48% reported a need for training and technical assistance in the HIV prevention planning process. Interviews conducted in May 1993 with senior HIV program administrators revealed that environmental complexity, technical deficits, and resource deficits were frequently cited as barriers to planning (Valdiserri, Aultman, & Curran, 1995). Valdiserri, Aultman and Curran (1995), noted that this same group of program administrators recognized that the development of coalitions would be a means to facilitating HIV prevention planning.

Furthermore, an external review of CDC’s HIV prevention partnership was conducted in 1993, involving site visits and public hearings in seven geographically and ethnically diverse communities across the U.S. This review exposed the community’s belief that it is “imperative to develop a partnership between and among persons with AIDS, nongovernmental organizations, state and local health departments, populations at
increased risk, and the CDC in order for HIV prevention programs to be successful” (CDC, 1993). Moreover, The Blueprint for Reforming Federal AIDS Prevention Programs (1993, as cited in Rogers, Doino-Ingersoll, Hayes-Cozier & Weisfuse, 1996) stated that “behavior change will only occur and be sustained if the education effort emerges from the individual’s own community and if the individual’s social environment supports that change.”

Therefore, in 1993 the CDC mandated that the 65 health department grantees receiving funds for HIV prevention interventions begin implementing a single specified approach to comprehensive HIV prevention planning (Valdiserri, Aultman & Curran, 1995). HIV Prevention Community Planning was developed as a partnership between health departments and community representatives (Holtgrave, Thomas, Chen, Edlavitch, Pinkerton & Fleming, 2000). HIV community planning was designed to serve as a building block for all HIV prevention efforts within jurisdictions across the country (CDC, 2000).

The CDC issued a Supplemental Guidance on HIV Prevention Community Planning, which was developed through the input of governmental and nongovernmental organizations (CDC, 1993). This document outlined the planning process in order to revise publicly funded HIV prevention programs nationwide by promoting representative community input, and the application of scientific principles and behavioral theory (Valdiserri, Aultman & Curran, 1995). The CDC’s Guidance (1993) defined community planning as:

“an ongoing process whereby grantees share responsibilities for developing a comprehensive HIV prevention plan with other state and local agencies, nongovernmental organizations, and representatives of communities and groups at risk for HIV infection or already infected.”
Additionally, the CDC Guidance requires that each grantee create one community planning group (CPG) (Dearing, Larson, Randall & Pope, 1998). The CPGs are comprised of persons who represent the diversity of the HIV epidemic in that jurisdiction, and include people who specialize in program evaluation, behavioral science and epidemiology (Holtgrave et al., 2000).

In order to promote successful community planning the CDC developed five core objectives for the CPGs including: (1) fostering an open and participatory nature in the community planning process; (2) ensuring that the members of the CPGs reflect the diversity of the HIV epidemic in the jurisdiction, and that experts in epidemiology, behavioral science, health planning, and evaluation are included in the process; (3) ensuring that priority HIV prevention needs are determined based on a epidemiologic profile and a needs assessment; (4) making certain that interventions are prioritized based on explicit consideration of the priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values and (5) encouraging strong, logical linkages between the community the community planning process, plans, applications for funding, and the allocation of CDC HIV prevention resources (CDC, 2000).

In 2003, the core objectives were revised, and currently consist of three goals including: (1) broad-based community participation in the HIV prevention planning; (2) identification of HIV prevention needs in each jurisdiction; and (3) ensuring that the HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan (CDC, 2003).
COMMUNITY PLANNING SUCCESSES

In theory, community planning has extreme potential for success across many dimensions in terms of local HIV/AIDS policies (Takahashi & Smutny, 1998). In regards to prevention, community planning's strategies and interventions could reduce the transmission of HIV (Takahashi & Smutny, 1998). The CPG's aim is to influence HIV/AIDS prevention messages and strategies, as well as the allocations of HIV federal funding in their jurisdiction. However, the review of the literature revealed limited nationwide data regarding the achievements of CPGs. However, following are several examples of state and local evaluation results.

Schietinger, Coburn and Levi (1995), conducted an evaluation of nine CPGs after the first year of planning and discovered numerous positive perceptions of the planning process. Most respondents in their evaluation reported that their views and the views of other community representatives were taken seriously by other members of the CPG. In addition, the majority of the respondents felt that the perspectives of the different communities played a role in the development of the HIV comprehensive plan.

Likewise, Rogers et al. (1996), in their evaluation of the community planning process in New York, found that the process encouraged empowerment of the members and discouraged an "us vs. them" attitude. It was evident that the CPG members controlled the meetings rather than the representatives from the Department of Health Resources. Rogers et al. (1996) also found that the CPG was highly effective in establishing collaboration among members. An enormous amount of work was accomplished in a short period of time due to the effort of all members of the group.
Additionally, Roger's et al. (1996) evaluation in New York demonstrated an extensive outreach to the community in order to recruit members for the CPG. The community outreach included a diverse mailing list to 6,000 individuals and agencies. The actual selection process was based on objective criteria and the final membership nominations were evaluated by a panel, which Rogers et al. (1996) describes as being fair and unbiased.

Finally, concerns have been raised in some jurisdictions that in certain circumstances, the CPGs and health departments are not prioritizing funds in a way that reflects the actual HIV/AIDS epidemiology (Holtgrave et al., 2000). To evaluate this concern, Holtgrave, et al. (2000) conducted an analysis of HIV/AIDS epidemiology, budget information, and information about the delivery of services to those affected by HIV/AIDS in fifty-nine jurisdictions. The results revealed that HIV prevention community planning is doing a better job of allocating resources in a manner that reflects the HIV/AIDS epidemic. The researchers found that the overall relationship between budgetary data and HIV/AIDS prevalence is strong.

CHALLENGES TO COMMUNITY PLANNING

Although there are numerous potential benefits from the community planning process many challenges have been identified in the literature including: (1) barriers to the needs assessment process (Valdiserri & West, 1994), (2) difficulties in promoting cooperation and participatory planning (Valdiserri, Aultman & Curran, 1995; Valdiserri & West, 1994; Takahashi & Smutny, 1998), (3) challenges in prioritizing HIV prevention needs (Johnson-Masotti et al., 2000), and 4) challenges in achieving adequate representation...
from the community (Schietinger, Coburn & Levi, 1995; Takahashi & Smutny, 1998). A
discussion of each barrier follows.

Assessing Unmet Needs: The assessment of unmet needs has been recognized as
an essential component of planning (Valdiserri & West, 1994; CDC, 1993). The process
of revealing unmet needs should involve the appropriate community groups and
organizations in order to assess availability and accessibility of prevention services for
underserved populations (Valdiserri & West, 1994). Additionally, this process should
identify barriers to the access of needed services by populations at risk for HIV infection.

Although this process is an essential component, it has been fraught with barriers
which may in turn influence the implementation of HIV prevention programs. First, there
is pressure to allocate limited resources to existing HIV prevention services (Valdiserri &
West, 1994). Consequently, these organizations face opposition from program staff if
suggestions are made regarding the use of limited resources in the assessment of unmet
needs.

Second, technical challenges may arise in the planning and conducting of needs
assessments. Valdiserri and West (1994) noted the need for convergent analysis in the
assessment of HIV prevention needs, due to the ongoing changes in the epidemic, and the
continuing development of new approaches to interventions. However, methodologically
this requires specialized expertise not often found in health departments and
nongovernmental organizations (Valdiserri & West 1994). Many of these technical
barriers exist due to limited resources, such as the inability to employ full-time or part-
time planning or analyst staff.
Finally, organizational barriers may also exist which impede comprehensive needs assessments. This may be due to the diversity of staff from different organizations with different values, perceptions of the problem and different experiences with those in need of the program services (Valdiserri & West, 1994). Furthermore, it is essential to involve the communities in need as part of the assessment process (Hibbard, 1984). Although considered essential, community involvement can further increase the environmental complexity. The more voices and opinions involved in the assessment process, the more cumbersome it becomes (Valdiserri & West, 1994). This may be due to the fact that program administrators may not possess the group process and consensual decision making skills needed in the collaborative assessment process.

**Participatory Planning:** Cooperation and the ability to deal with numerous voices and opinions can become an issue in the community planning process. The need for participatory planning among nongovernmental and governmental agencies increases the complexity of the planning process (Valdiserri, Aultman & Curran, 1995). Often tensions are inherent when government and nongovernmental agencies participate in planning (Takahashi & Smutny, 1998). Nongovernmental participants, particularly those representing socioeconomically marginalized groups have their own significant concerns (Valdiserri, Aultman & Curan 1995).

The HIV epidemic has instigated a substantial mistrust by the gay community and communities of color for governmental authorities, including the public health department (National Minority AIDS Council, 1992, as cited in Valdiserri, Aultman & Curran, 1995). In some communities there is the potential for the fear of disclosing personal information such as sexual orientation, drug use or HIV serostatus (Valdiserri,
Aultman & Curran, 1995). Schietinger, Coburn and Levi (1995), detail in their evaluation, the apprehension of some respondents in identifying themselves as people living with HIV, or as gay people, or as members of other stigmatized groups. This uneasiness is understandable; however, it poses a problem when it may potentially impede the HIV planning of prevention for specific populations in need.

**Prioritization Process:** The difficulties between governmental and nongovernmental organizations may present themselves when dealing with technical matters, particularly in the prioritization process. Governmental officials may assume that community participants have no voice on technical issues (Valdieserri, Aultman & Curran, 1995). This problem is exemplified in the technical complexity of the priority setting used to select target groups and set funding priorities. Community members not accustomed to systems of priority setting may find them incomprehensible (Takahashi & Smutny, 1998). Schietinger, Coburn and Levi’s (1998) study revealed that the prioritization process was poorly understood by most members, and that many disagreed with the results of prioritization.

The technical consideration in the prioritization of prevention needs is just one of the barriers to the prioritization process. Prioritization requires the cooperation of multiple individuals with different backgrounds and aims (Johnson-Masottie et al., 2000). Validiserri, Aultman and Curran (1995), describe components required in successful priority setting, including: ability to interpret qualitative and quantitative findings, and the integration of information from a variety of sources. Utilizing these components is difficult, as Johnson-Masotti et al. (2000) point out, the information-deficient environment in which properties of interventions (such as their cost or effectiveness) are
unknown, make prioritization complex. Schietinger, Coburn and Levi (1995), found that most of the respondents in their study poorly understood the process of prioritization and felt that the results were arguable. Additionally, Holtgrave et al. (2000) discovered that some CPG members refused to vote for particular populations over others for fear of offending other members or becoming ostracized. Finally, comparing different interventions for different populations may seem arbitrary, like comparing apples to oranges (Johnson-Masotti et al., 2000).

**Community Representation:** Finding representatives from respective communities to be a part of the CPG can be an ongoing challenge. HIV/AIDS prevention planning is a complex process involving many actual and potential participants and special interests, which makes the recruitment and selection of persons to be members of the CPG problematic (West & Valdisseri, 1994). As aforementioned, members of groups traditionally marginalized by mainstream society may be averse to becoming involved in the planning process for fear of publicizing their HIV status, drug use, sexual behavior or sexual orientation (Valdiserri, Aultman & Curran, 1995). In addition, institutional apathy in the delivery of funding and services may make community members reluctant to spend their time and energy on planning (Cain, 1995).

**EVALUATION OF COMMUNITY PLANNING**

Due to the persistence of the HIV epidemic and the necessity to identify and overcome challenges, much attention has been paid to the evaluation of the HIV community planning process. The CDC mandates that the health department grantees report the CPGs composition and allocation of Federal funds to particular interventions and populations (CDC Guidance, 2001). In the spring of 1994, the CDC began delivering the
health department grantees a binder with technical assistance material to aid them in the evaluation process (Holtgrave et. al., 1996).

The evaluation process is required to examine: 1) the extent to which community representation was achieved, 2) the degree to which community representatives felt included in the decision-making process, 3) the extent to which the community planning process identified HIV priority needs in each jurisdiction, and 4) the degree to which HIV prevention resources targeted priority populations and prevention activities determined in the comprehensive HIV prevention plan (CDC. 2003).

The evaluation of the community planning process is useful to both the CDC and the grantees, in that it provides information about barriers to the planning process as well as ways to enhance the process (Holtgrave et al., 1996). Additionally, the evaluation process allows the CDC and the grantees to monitor the progress and make adjustments to increase the likelihood that community planning will improve HIV prevention in the United States.

COMMUNITY PLANNING IN MONTANA

Montana’s CPG underwent major restructuring in 2003. The entire community planning process, including structure, mission, guiding principles, bylaws, and membership were reviewed. As a result, the membership was distributed geographically and of the CPG changed dramatically. Previously, membership consisted of approximately forty individuals: two representatives from each of the six regional advisory committees; fourteen at-large members; CPG co-chairs, relevant DPHHS staff, and several representatives from organizations such as the Office of Public Instruction.
In contrast, the current membership, when fulfilled, consists of thirty-five individuals. There are six communities represented by five members each. Communities include individuals who are infected and affected by the epidemic as well as HIV prevention providers. The six communities are defined as follows: 1) High Risk Heterosexuals, 2) HIV Prevention Services Providers, 3) HIV-Positive Individuals, 4) Injection Drug Users (IDU), 5) Men who have Sex with Men (MSM), and 6) Native Americans. In addition there are three community co-chairs (past, current and elect), one Department appointed co-chair, the HIV prevention planning coordinator and the STD supervisor. Other staff in the STD/HIV Section share in the community planning process by providing information, technical assistance and playing supportive roles as appropriate.

The mission of Montana’s CPG is to reduce the number of Montanans who become HIV positive or re-infected with HIV (Montana HIV Prevention CPG Bylaws, 2003). The CPG is organized to create a comprehensive HIV plan intended to improve the effectiveness of the DPHHS HIV prevention programs. All thirty-five members of the CPG are involved in the planning process which includes: (1) implementing an open recruitment process that ensures the representation of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, (2) determining the highest priority, population-specific prevention needs based on the epidemiologic profile, (3) planning prevention activities/interventions for identified priority target populations based on behavioral and social science, outcome effectiveness, and cultural appropriateness, relevance and acceptability and (4) demonstrating a direct relationship.
between Comprehensive HIV Prevention Plan and DPHHS’s application for federal HIV prevention funding (CDC, 2003).

COMMUNITY INVOLVEMENT

The majority of the members of the CPG volunteer their time and energy to the community planning process with little material return. Therefore, an important question to ask when evaluating the community planning process is: what motivates individual’s to become involved with community agencies or organizations? Much of the participation literature examines the individual motivations to volunteer. Different theoretical models have been developed to predict why people volunteer or become involved with their community, and what motivates them to continue volunteering.

VOLUNTEER PROCESS MODEL

One such model is the Volunteer Process Model which was developed by Snyder and Omoto (1992a) from research on AIDS volunteers. This model considers the antecedents of volunteering and what happens to volunteers over time. More specifically, this model identifies an inventory of motivations to suggest reasons for volunteerism. Snyder and Omoto (1992a) have found that different motivations bring people to donate their time and also lead to different selection of volunteer roles in an organization.

Omoto and Snyder (1993) discuss five primary motivations associated with volunteerism. These motivations include: (1) community concern - the sense that one is obligated to, or an advocate for, certain communities, (2) values motive - a feeling of humanitarian obligation to others because of personal values or beliefs, (3) understanding motive - includes the desire to learn (in this research particularly about AIDS), (4) personal development - the motive to get to know people who are similar to oneself and
also to challenge and test one's skills, and (5) esteem enhancement - the need to feel less lonely as well as to feel better about oneself.

Omoto and Snyder's (1993) motivation inventory was examined to determine each motives relationship to role selection. They found that AIDS volunteers working in direct service capacities were more likely to strongly endorse personal development motivations. Whereas, volunteers not providing direct service more strongly endorsed the understanding motivation. Omoto and Snyder (1993) posit that volunteers' motivations represent their needs and expectations. Those volunteers whose needs are being met will be satisfied with their experience. For example, volunteers with needs to enhance their self-esteem would be likely to function best if they were part of a team, which frequently provides positive feedback. Therefore, Snyder and Omoto (1992a) emphasize the importance of understanding volunteers' motivations in order to place them in appropriate roles.

Additionally, Snyder and Omoto (1992a) examined volunteer retention. They found, after re-contacting AIDS volunteers, that there was no difference between the quitters and the stayers in reported satisfaction and commitment to the mission of their organization. However, they did discover that the people who espoused esteem enhancement reasons for their work were more likely to still be active. Esteem enhancement and understanding motivations proved valuable as predictors of total length of service of these volunteers. Consequently, volunteer attrition was not so much associated with the "selfless" or community-focused motivations, but rather with the more "selfish" desires of feeling good about oneself and acquiring knowledge (Snyder & Omoto, 1992a).
ROLE IDENTITY THEORY

A second model that attempts to explain volunteer motivation is the Role Identity Model, which is a more sociological approach than the volunteer process model. The Role Identity Model posits that as people continue to volunteer their commitment to the organization increases (Penner & Finkelstein, 1998). This model suggests that one of the best predictors of future volunteerism is the past level of the individual’s volunteer activity.

Role Identity theory also argues that the volunteer role becomes a part of an individual’s personal identity. The role identity directs the volunteer’s behavior in order to make their behavior consistent with their role as volunteer (Penner & Finkelstein, 1998). In support of this argument is Piliavin’s (1991, as cited in Penner & Finkelstein, 1998) discovery that past volunteering led to the development of a volunteer role identity, which predicted volunteer retention. Moreover, both organizational commitment and role identity predicted volunteer retention rate.

The Volunteer Process and Role Identity theories overlap in a number of ways (e.g., the emphasis they place on organizational commitment). Therefore, understanding both the initial decision to volunteer and long-term commitment may require constructs from both models. For example, Penner and Finkelstein (1998), in their research on AIDS volunteers, found that organizational commitment was not significantly associated with length of service, but satisfaction was. The researchers also discovered that the motives identified by Omoto and Snyder (1993) were positively correlated with length of volunteer service, particularly the community concern motivation.
SENSE OF COMMUNITY

Community provides an important backdrop for individuals and groups to undertake volunteer activities which target the promotion of social change and that contribute to societal cooperation and civic involvement (Omoto & Snyder, 2002). Community organizations are comprised of individuals, often volunteers, who take action to change other settings or their communities (Hughey, Speer & Peterson, 1999). Many volunteer service organizations developed out of attempts to improve or change aspects of the community, such as providing services that were not previously available in the community (Omoto & Snyder, 2002). Other volunteer service organizations began as attempts to alter the social climate in the community. Often the driving force behind these services is community members who have chosen to volunteer their time.

Therefore, in order to understand community participation it is essential to explore the components of volunteerism in the context of community. Community organizations are settings in which individuals bring their concerns to the table, form attachments to one another and often develop a sense of community (Hughey, Speer & Peterson, 1999). Sense of community may develop as a result of working through issues of belonging, emotional vulnerability or sharing of personal pain, as well as resolving shared interests or different agendas.

Sense of community has been described by McMillan and Chavis (1986) and is composed of four crucial elements including: membership, influence, integration and need fulfillment, and shared emotional connection. Membership is associated with a feeling of belonging and acceptance in a group. Influence refers to the attraction to a group based on an expectation that one will have influence over the group. The third
component encompasses the reinforcement members receive by having their needs met as well as through being successful and being protected from shame by the community. Lastly, emotional connection refers to the value of a shared experience by the community members.

Omoto and Snyder (2002) propose that sense of community may influence an individual’s decision to join a community. Members are more attracted to communities which they feel they may potentially influence (McMillan & Chavis, 1986). Furthermore, individuals are attracted to organizations which provide a voice for their concerns in order to generate community change (Hughey, Speer & Peterson, 1999). Support for the salience of community in motivating volunteerism can be found in Omoto and Snyder’s (1993) discussion of the Volunteer Process Model. They revealed that one of the main impetuses for volunteering was the motivation of concern for the community. They discovered, among AIDS volunteers, that community motivation ratings were highest among new volunteers who came from communities that were particularly concerned about HIV and AIDS. For example, they discovered that gay volunteers gave higher ratings than heterosexual volunteers on the indicators of community concern.

Omoto and Snyder (2002) have also found that a greater sense of community plays a role in the retention of members. Sense of community increases the confidence of individuals, feelings of social support, and self esteem. When communities are successful individuals can feel a sense of accomplishment by being a part of that community (Hughey, Speer & Peterson, 1999). Individuals who feel that they are part of a group will invest in the group and therefore, membership will be more meaningful and valuable (McMillan & Chavis, 1986). The sense of belonging that comes with community also
enhances one's worth as an individual as well as a member of the group (Omoto & Snyder, 2000). Thus, Hughey, Speer and Peterson (1999) posit that it would be beneficial for community organizations to intentionally promote a sense of community. The benefits received from the development of a sense of community are likely to influence member retention and satisfaction.
CHAPTER 3: METHODOLOGY

DESCRIPTION OF TARGET POPULATION

The target population for this study included all Community Planning Group members as well as one DPHHS staff who is not a member of the CPG. The CPG membership is structured around six communities including: 1) High Risk Heterosexuals, 2) HIV Prevention Services Providers, 3) HIV-Positive Individuals, 4) Injection Drug Users (IDU), 5) Men who have Sex with Men (MSM), and 6) Native Americans. Five individuals represent each of the communities. Additionally, three community co-chairs (past, current, and elect), one Department appointed co-chair, and one HIV prevention planning coordinator.

STUDY DESIGN

This study utilized a descriptive research design. Secondary data was gathered from existing documents including the CPG Policies and Procedures Manual and written minutes from statewide meetings. Primary data was gathered through the CPG membership survey, focus groups, and interviews. The research took place in Montana in the summer and fall 2004.

INSTRUMENTATION

SURVEY

The survey, which was developed by the CDC, gathered information regarding the goals, objectives and attributes presented in the CDC’s 2003-2008 HIV Prevention Community Planning Guidance (Appendix B). It was designed to elicit members’ perceptions about the planning process and the group’s success in accomplishing the CDC’s required goals and objectives for HIV prevention community planning.
The survey was divided into two parts. The first part of the survey gathered demographic data. Part two asked members’ opinions about adherence to the goals and objectives of community planning during their most recent year of involvement. This section of the survey was separated into goals with the related objective(s) listed below each goal. The statements following the objective(s) touch on specific actions or tasks related to the objective(s) and overarching goal. The CPG members were asked whether they “agree” or “disagree” with each statement. Additionally, a “don’t know” response was provided.

PROCEDURES

The survey was administered at the August, 2004 CPG meeting. All CPG members at the meeting were asked to complete the survey. Members were reminded that completion of the survey was voluntary, the survey was anonymous and that they should not put their name anywhere on the survey. In addition, they were told that all data was to be reported as group data. The survey was given to members at the end of the meeting on Saturday prior to the focus groups. After completion of the survey, members were asked to place it in a bag that was placed in the front of the room.

Six members were not present at the August CPG meeting. Surveys were mailed to the absent members. A cover letter, as well as the instructions provided by the CDC, were attached to the survey detailing the voluntary nature of the survey. The members were reminded not to put their name on the survey and to return it in the envelope provided.
FOCUS GROUPS

At the March, 2004 CPG meeting members were informed about the impending focus groups planned for the August 2004 meeting in Helena, Montana. At the August meeting CPG members were reminded on Friday about the focus groups that were to occur the following day. All of the members attending the meeting were asked to attend the focus groups.

The focus group questions were developed based on a review of the literature, the CPG membership survey, and the goals and objectives set forth by the CDC (Appendix C). The opening focus group question served as an icebreaker. Questions one through four were designed to supplement the survey data and cover the goals and objectives of community planning. The next five questions were created to gather information regarding the motivations of the CPG members. These questions looked more closely at why CPG members became involved with community planning and what motivates them to continue being involved. The literature on community involvement and volunteerism provided the theoretical basis for the development of questions five through nine.

Questions eight and nine covered the needs and expectations of the members. This relates to Omoto and Snyder's (1993) finding that volunteers' motivations often represent their needs and expectations. Additionally, those volunteers whose needs are being met will be more satisfied with their experience, and are likely to remain volunteers for a longer period of time (Omoto & Snyder, 1993). Thus, it is important to find out what the members' needs and expectations are in order to more clearly understand their motivation to be a part of the CPG. The last question provided participants with the opportunity to express final thoughts regarding Montana’s CPG process.
Additionally, the questions are designed to provide information on how the CPG could be made more attractive to potential members, as well as how the CPG can build an environment that will promote the continued involvement of current members.

PROCEDURES

Two focus groups were performed at the August, 2004 CPG meeting in Helena, Montana. Friday morning members were reminded about the focus groups, which were to occur on Saturday morning. The agenda for the CPG meeting included the focus groups. The focus groups were conducted after the members filled out the CPG Membership Survey. Both focus groups were conducted at the same time. The two primary researchers facilitated one focus group with the aid of an assistant. All seventeen members present at the meeting on Saturday, excluding DPHHS staff, were invited to participate in the focus groups. A total of fifteen individuals participated in the focus groups, including thirteen current members as well as two prospective members. The focus groups took place in two private rooms in the hotel where the CPG meeting was held. Members were told that two door prizes would be drawn at each focus group.

At the beginning of each focus group, participants were given a general idea of the focus group procedure, topic and agenda. A verbal script was read to participants prior to the focus groups reminding them that their participation was voluntary and that they could leave at any time (Appendix C). They were reminded that their responses would remain confidential and that all information was to be summarized as group data. Members were asked not to discuss the content or process of the focus groups outside of the room. Subsequently, participants were asked to discuss freely their opinions regarding the community planning process.
An assistant helped in taking notes during each focus group. Notes were taken on newspaper print for ease of discussion. Each focus group session was tape recorded and notes checked for accuracy. Focus group tapes were transcribed. Tapes were destroyed upon transcription. Members were not identified by name in the transcription or in results section of this study.

INTERVIEWS

Interviews were conducted in June and July in Helena, MT. Three interviews were conducted with DPHHS staff. The interview responses were summarized and compared to the focus group responses. Additionally, the first five question responses were combined with the focus group responses. Therefore, the interview questions are similar to the focus group questions (Appendix D). However, the questions related to members' motivations were changed. They were created to examine DPHHS staffs' thoughts about what motivates individuals to become involved with the CPG. As well as, what factors they felt motivated members to continue participating in the CPG. The overall purpose of the interviews was to explore any differences that might exist between DPHHS members' opinions and the opinions of the CPG community members. In addition, the information was used along with focus group responses to identify barriers as well as factors facilitating the community planning process.

PROCEDURES

Three interviews were conducted with DPHHS staff members during July and August in Helena, Montana. The interviewer arranged to meet with the staff members during July at the DPHHS office.
Two of the interviews took place in a private office at the DPHHS building in Helena, MT. The third interview took place in a quiet hallway in the hotel at the August CPG meeting in Helena, MT. At the beginning of each interview, a verbal script was read reminding participants that the information obtained would be confidential (Appendix D). The interviews were tape-recorded and notes were taken. After each interview observations and thoughts about the interview were written. The interviews were then transcribed, and the tapes subsequently destroyed.

DATA ANALYSIS

Data for this study came from written documents, a survey, two focus groups and three interviews. Quantitative and qualitative data analysis was completed on the data.

SURVEY ANALYSIS

Survey data was analyzed using the SPSS computer program. Descriptive statistics were used to report the CPG members’ perceptions of the community planning process. Frequencies are reported by actual count and are represented by charts and graphs. Cross-tabs were conducted to note differences in responses across demographics, specifically number of years on the CPG. When deemed appropriate, Chi-squares, with an alpha level of 0.05, were run to determine differences between number of years on the CPG and members’ perceptions of the CPG’s efficacy.

FOCUS GROUPS AND INTERVIEW ANALYSIS

Focus group and interview data was analyzed qualitatively. Interviews and focus groups were taped and notes were taken. The tapes were transcribed completely and compared to the notes taken during focus groups and interviews to check for accuracy.
Analysis of the focus groups and interviews was based on qualitative research techniques (Creswell, 1998). The first part of the analysis involved reading the transcriptions through numerous times and taking notes in the margins. The notes were used to identify themes, patterns, perceptions and concerns presented by the participants. Furthermore, this step included the identification of unusual and significant information.

Second, each important participant comment was cut from the transcriptions and placed in piles with related comments. The emergent themes and concepts were organized into files on the computer. Thirdly, the emergent themes were compared and condensed into overall themes and sub-themes. Fourth, the themes and concepts from the interviews were compared to that of the focus group to look for similarities and differences. Lastly, the information about CPG members’ motivations was compared to information from the review of literature on community involvement and volunteerism.

Information from all three data sources was compared and synthesized. The information from all three sources was analyzed for themes and patterns. Conclusions regarding the community planning process were drawn from the comprehensive analysis.
CHAPTER 4: RESULTS

The purpose of this study was to conduct an evaluation of Montana’s HIV Prevention Community Planning process. The evaluation included data from the following sources: the CPG Membership Survey, DPHHS staff interviews, focus groups, meeting minutes and CPG Policy and Procedures.

SURVEY RESULTS

The CPG membership survey was developed by the CDC (Appendix B). The survey was distributed at the August CPG meeting in Helena, MT. A total of 22 CPG members filled out the survey at the meeting. The remaining six members, who were not present at the meeting, were mailed the survey the first week of September 2004. Two weeks later all six members were sent an e-mail reminding them to return the survey. Two surveys were returned, a total of twenty-four surveys were included in this analysis.

DEMOGRAPHIC INFORMATION

Table 1: Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency (n=24)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>n=2</td>
<td>8.3</td>
</tr>
<tr>
<td>25-34</td>
<td>n=5</td>
<td>20.8</td>
</tr>
<tr>
<td>35-44</td>
<td>n=6</td>
<td>25.0</td>
</tr>
<tr>
<td>45+</td>
<td>n=11</td>
<td>45.8</td>
</tr>
</tbody>
</table>

Table 2: Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency (n=24)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>n=10</td>
<td>41.7</td>
</tr>
<tr>
<td>Female</td>
<td>n=14</td>
<td>58.3</td>
</tr>
</tbody>
</table>
Chart 1: Sexual Orientation

Graph 1: Race

Table 3: Geographic Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Frequency (n=24)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>n=6</td>
<td>25.0</td>
</tr>
<tr>
<td>Urban Non-Metropolitan</td>
<td>n=16</td>
<td>66.7</td>
</tr>
<tr>
<td>Urban Metropolitan</td>
<td>n=1</td>
<td>4.2</td>
</tr>
<tr>
<td>Frontier</td>
<td>n=1</td>
<td>4.2</td>
</tr>
</tbody>
</table>
Members’ Primary and Secondary Area of Expertise on the CPG

Survey participants were asked to report their primary and secondary area of expertise. Approximately forty-six percent of CPG members’ reported community representation as their primary area of expertise. Person living with HIV/AIDS (16.7%, n=4), Intervention Specialist/Service Provider (20.8%, n=5) and health planner (12.5%, n=3) were reported by members as primary areas of expertise. Approximately 21% of respondents did not report a secondary area of expertise. The majority of respondents noted community organization (25%, n=6), Intervention Specialist/Service Provider (20.8%, n=5) and community representation (16.7%, n=4) as their secondary area of expertise.

**Graph 2: Primary Area of Expertise**

**Graph 3: Secondary Area of Expertise**
Primary and Secondary HIV Perspective

Survey participants were asked to note the primary and secondary HIV risk population’s perspective which they represent through personal life experiences, work responsibilities or other affiliations. Each risk group had at least one member representing them on the CPG. The at risk group with the most members represented (50%, n=12) was the MSM population at risk for HIV infection through unsafe sex as their primary perspective. The second most represented at risk group (17%, n=4) was men and women at risk for HIV infection through unsafe heterosexual sex with an infected person as their primary perspective.

<table>
<thead>
<tr>
<th>HIV Perspective</th>
<th>Frequency (n=24)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM at risk through unsafe sex</td>
<td>n=12</td>
<td>50.0</td>
</tr>
<tr>
<td>MSM at risk through unsafe sex and unsafe injection drug use</td>
<td>n=1</td>
<td>4.2</td>
</tr>
<tr>
<td>Men and women at risk through unsafe injection drug use</td>
<td>n=3</td>
<td>12.5</td>
</tr>
<tr>
<td>Men and women at risk through unsafe heterosexual sex with infected partner</td>
<td>n=4</td>
<td>16.7</td>
</tr>
<tr>
<td>Men and women not part of a specific HIV risk population</td>
<td>n=3</td>
<td>12.5</td>
</tr>
<tr>
<td>Missing Data</td>
<td>n=1</td>
<td>4.2</td>
</tr>
</tbody>
</table>
### Table 5: Secondary HIV Perspective

<table>
<thead>
<tr>
<th>HIV Perspective</th>
<th>Frequency (n=24)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM at risk through unsafe sex</td>
<td>n=3</td>
<td>12.5</td>
</tr>
<tr>
<td>MSM at risk through unsafe sex and unsafe injection drug use</td>
<td>n=6</td>
<td>25.0</td>
</tr>
<tr>
<td>Men and women at risk through unsafe injection drug use</td>
<td>n=4</td>
<td>16.7</td>
</tr>
<tr>
<td>Men and women at risk through unsafe heterosexual sex with infected partner</td>
<td>n=1</td>
<td>4.2</td>
</tr>
<tr>
<td>Men and women not part of a specific HIV risk population</td>
<td>n=1</td>
<td>4.2</td>
</tr>
<tr>
<td>Missing Data</td>
<td>n=9</td>
<td>37.5</td>
</tr>
</tbody>
</table>

### HIV/AIDS Status

Survey respondents were asked to report their HIV/AIDS serostatus. Additionally, participants were asked to report whether they have a relative, partner or close friend who is living with HIV/AIDS or who has died from HIV/AIDS. Twenty-five percent (n=6) of the survey respondents reported living with HIV/AIDS. Sixty-seven percent (n=16) of respondents reported having a relative, partner or close friend who is living with HIV/AIDS.

### Chart 2: HIV Serostatus

- Living with HIV/AIDS (n=6)
- Not Living with HIV/AIDS (n=17)
- Unknown (n=1)
Agency Representation

The survey participants were asked to report the type of organization they primarily represent or are affiliated with. The majority of respondents reported that they represent a health department HIV/AIDS division (37.5%, n=9) or a non-minority community based organization (33.3%, n=8).
HIV Prevention Funding

The majority of respondents (62.5%, n=15) reported that their primary organization received HIV prevention funding from state/city/territory health department.

<table>
<thead>
<tr>
<th>Funding</th>
<th>Frequency (n=24)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>n=15</td>
<td>62.5</td>
</tr>
<tr>
<td>No</td>
<td>n=6</td>
<td>25.0</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>n=3</td>
<td>12.0</td>
</tr>
</tbody>
</table>

GENERAL INFORMATION ABOUT THE CPG

The survey participants were asked to report the number of meetings they attended in the last year as well as the year in which they joined the CPG. Nearly half of the participants attended all four of the CPG meetings. The year they joined is described below as the number of years on the CPG. The years have been reduced to two years or less and more than two years for ease of analysis.

Chart 4: # of CPG Meetings Attended in the Last Year
Over 60% (n=7) of the individuals who have been on the CPG for more than two years are over the age of forty-five.
Graph 6: Years on the CPG and Meetings Attended

* It should be noted that meetings have been reduced to less than four or all four meetings for ease of analysis.

Nearly 70% (n=6) of members who have been on the CPG for more than two years attended all four meetings.

COMMUNITY PLANNING GOALS AND OBJECTIVES

Survey participants were asked to respond to questions relating to the goals and objectives of the community planning process. Chi-Square tests of significance were run to compare responses to questions across demographics. The tests revealed no statistically significant differences (p≤ .05); the lack of statistical significance may be attributed to the small sample size. However, it should be noted that differences in percentages, when comparing number of years on the CPG and member responses, suggest practical significance.
GOAL 1: Community Planning supports broad-based community participation in HIV Prevention Planning.

OBJECTIVE A: Implement an open recruitment process for CPG membership.

Table 7: Responses to Questions Relating to Objective A

<table>
<thead>
<tr>
<th>Please rate your agreement with the following statements:</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t Know</th>
<th>Missing Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CPG has written procedures for nominations to the CPG.</td>
<td>83.3% (n=20)</td>
<td>0% (n=0)</td>
<td>12.5% (n=3)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>The CPG uses the written procedures (above) for nominations to the CPG.</td>
<td>79.2% (n=19)</td>
<td>4.2% (n=1)</td>
<td>12.5% (n=3)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>The CPG has established a nominations/membership committee.</td>
<td>95.8% (n=23)</td>
<td>0% (n=0)</td>
<td>0% (n=0)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>CPG nominations target membership gaps identified by the members of the CPG.</td>
<td>83.3% (n=20)</td>
<td>0% (n=0)</td>
<td>12.5% (n=3)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>Both CPG members and health department staff participate in membership decisions.</td>
<td>87.5% (n=21)</td>
<td>0% (n=0)</td>
<td>8.3% (n=2)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>The CPG has written procedures for how to select CPG members.</td>
<td>79.2% (n=19)</td>
<td>0% (n=0)</td>
<td>16.7% (n=4)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>The CPG uses the written procedures (above) in selection of CPG members.</td>
<td>75% (n=18)</td>
<td>4.2% (n=1)</td>
<td>16.7% (n=4)</td>
<td>4.2% (n=1)</td>
</tr>
</tbody>
</table>

A strength of the CPG appears to be in its recruitment process. The majority of respondents agreed that written procedures for nominations exist, that the CPG has established a membership committee and that both the CPG members and the health department staff participate in decisions about membership.

Survey Participant Comments Related to Objective A

- *Since I am very new I am tentative about my answers I personally did not know I was a member till March 04 and was unable to attend 2 meetings because I did not know I was a member and made previous commitments.*
- *Membership committee has done a great job in selecting community representatives for the CPG!*
OBJECTIVE B: Ensure that the CPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction and includes key professional expertise and representation from key governmental and non-governmental agencies.

<table>
<thead>
<tr>
<th>Table 8: Responses to Questions Relating to Objective B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please rate your agreement with the following statements:</strong></td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>The CPG includes members who represent each population of the current and projected epidemic as documented in the epidemiologic profile.</td>
</tr>
<tr>
<td>The CPG has expert perspective available from behavioral/social science on issues related to the community planning process.</td>
</tr>
<tr>
<td>The CPG has expert perspective available in epidemiology on issues related to the community planning process.</td>
</tr>
<tr>
<td>The CPG has expert perspective available in evaluation on issues related to the community planning process.</td>
</tr>
<tr>
<td>The CPG has expert perspective available in service provision on issues related to the community planning process.</td>
</tr>
<tr>
<td>The CPG has expert perspective available from health department HIV/AIDS Program staff on issues related to the community planning process.</td>
</tr>
<tr>
<td>The CPG has expert perspective available from state/local health department STD program staff on issues related to the community planning process.</td>
</tr>
<tr>
<td>The CPG has expert perspective available from state/local substance abuse treatment facilities on issues related to the community planning process.</td>
</tr>
<tr>
<td>The CPG has expert perspective available from state/local HIV Care and Social Services, on issues related to the community planning process.</td>
</tr>
<tr>
<td>The CPG has expert perspective available from correctional facilities, on issues related to the community planning process.</td>
</tr>
</tbody>
</table>

The majority of members agreed that the CPG includes individuals who represent each at-risk population identified in the epidemiologic profile. The respondents also noted the
strengths in expertise in the areas of Social Services, the health department STD program staff and the health department HIV/AIDS Program staff. However, approximately 21% (n=5) of participants seemed to believe there was a lack of expert perspective from state/local substance abuse treatment facilities and approximately 30% (n=7) believed there was a lack of expert perspective from correctional facilities related to the community planning process. Additionally, regarding to both of these areas of expertise 25-30% of members reported not knowing whether or not these perspectives are available during the community planning process.

“Older” vs. “Newer” Members Perceptions of Expertise on the CPG

The above results suggest that there is disagreement among members about the existence of expert perspective from correctional facilities and substance abuse facilities on the CPG. Therefore, the following comparisons were conducted to determine whether there were differences between “older” and “newer” members’ perspectives regarding expertise on the CPG.

Graph 7: Years on the CPG and Perceptions of Expertise in Substance Abuse

Approximately 33% (n=3) of respondents who have been on the CPG for more than two years did not believe that the CPG has expert perspective on substance abuse issues
related to the community planning process. Whereas, only 14% (n=2) of the “newer” members disagreed with statement: the CPG has expertise on substance abuse issues related to the community planning process.

**Graph 8: Years on the CPG and Perceptions of Expertise from Correctional Facilities**

In regards to the presence of expert perspective from correctional facilities, 57% (n=8) of “newer” members agreed that this perspective is present on Montana’s CPG. Whereas, only 11% (n=1) of “older” members agreed that there was expert perspective available from correctional facilities on issues related to community planning.

**Survey Participant Comments Related to Objective B**

- *To me it seems like the expert perspective is anecdotal comments made by CPG members who happen to also work in the field of expertise.*
- *Although there is expert perspective on the CPG, those people often do not speak up.*
- *More involvement with corrections and substance abuse agencies would be great.*
- *Overall, CPG has expert perspective from a variety of disciplines needed for HIV prevention planning. When necessary, CPG is able to bring in expert perspective that may be missing from the current membership.*
**OBJECTIVE C:** Foster a community planning process that encourages inclusion and parity among community planning members.

<table>
<thead>
<tr>
<th>Table 9: Responses to Questions Relating to Objective C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please rate your agreement with the following statements:</strong></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>The CPG uses various methods to gain input from high-risk groups or individuals who would be hard to recruit and/or retain as CPG members.</td>
</tr>
<tr>
<td>The CPG undertakes efforts to assist members in their continued participation in the CPG, particularly those who face challenging barriers.</td>
</tr>
<tr>
<td>The CPG has formal procedures for making decisions and resolving disagreements among members.</td>
</tr>
<tr>
<td>Throughout the planning year, the CPG provides a process for training for all CPG members.</td>
</tr>
<tr>
<td>The CPG provides orientation and/or other appropriate support to new CPG members.</td>
</tr>
<tr>
<td>CPG meetings are open to the public and allow time for public comment.</td>
</tr>
</tbody>
</table>

The survey results revealed that the CPG is making progress towards fostering an environment that encourages inclusion and parity among the CPG members. Eighty-seven percent (n=21) of respondents believed that the CPG meetings were open to the public and 83% (n=20) of participants believed that the CPG undertook efforts to ensure the continued participation on the CPG of individuals who face challenges. All participants (n=24) agreed that the CPG has a formal policy for resolving disagreements. It should be noted that 17% (n=4) of survey respondents did not believe that the CPG used various methods to gain input from high-risk groups who would be hard to recruit and/or retain as CPG members.
Survey Participant Comments Related to Objective C

- The meetings are technically open but public participation is not encouraged adequately.
- The travel policy for CPG members is an important way the CPG uses to reduce barriers to attendance.
- Meetings are not advertised, public not always made to feel welcome. Gay community shunned at times!

GOAL 2: Community planning identifies priority HIV prevention needs in each jurisdiction.

OBJECTIVE D: Carry out logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

Table 10: Responses to Questions Relating to the Epidemiological Profile

<table>
<thead>
<tr>
<th>Please rate your agreement with the following statements:</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The epidemiologic profile used in the prioritization process contains the most updated information as provided by the health department.</td>
<td>79.2% (n=19)</td>
<td>12.5% (n=3)</td>
<td>8.3% (n=2)</td>
</tr>
<tr>
<td>The epi-profile provides information about defined populations most at risk for HIV infection for the CPG to consider in the prioritization process.</td>
<td>87.5% (n=21)</td>
<td>8.3% (n=2)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>Strengths and limitations of data sources used in the epi-profile are described.</td>
<td>83.3% (n=20)</td>
<td>4.2% (n=1)</td>
<td>12.5% (n=3)</td>
</tr>
<tr>
<td>The epi-profile contains a written explanation of the data presented.</td>
<td>91.7% (n=22)</td>
<td>4.2% (n=1)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>The epi-profile was presented to the CPG members prior to voting on priorities.</td>
<td>91.7% (n=22)</td>
<td>4.2% (n=1)</td>
<td>4.2% (n=1)</td>
</tr>
</tbody>
</table>

The members’ had a positive perception of the CPG’s use of the epi-profile in the prioritization process. The majority of respondents, seventy-nine percent or above felt that the epi-profile used the most updated information; it defined the populations most at risk for HIV infection and was presented to the CPG members prior to voting on priorities.
Table 11: Responses to Questions Related to the Community Services Assessment (CSA)

<table>
<thead>
<tr>
<th>Please rate your agreement with the following statements:</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CSA focuses on one or more most at risk populations identified in the epi-profile.</td>
<td>70.8% (n=17)</td>
<td>0% (n=0)</td>
<td>29.2% (n=7)</td>
</tr>
<tr>
<td>The CSA contains data that define populations’ needs in terms of knowledge, skills, attitudes, and norms.</td>
<td>62.5% (n=15)</td>
<td>0% (n=0)</td>
<td>37.5% (n=9)</td>
</tr>
<tr>
<td>The CSA contains data that define populations’ needs in terms of access to services.</td>
<td>66.7% (n=16)</td>
<td>0% (n=0)</td>
<td>33.3% (n=8)</td>
</tr>
<tr>
<td>The CSA describes the target populations being served.</td>
<td>70.8% (n=17)</td>
<td>0% (n=0)</td>
<td>29.2% (n=7)</td>
</tr>
<tr>
<td>The CSA describes the interventions provided to each target population.</td>
<td>66.7% (n=16)</td>
<td>0% (n=0)</td>
<td>33.3% (n=8)</td>
</tr>
<tr>
<td>The CSA describes the geographic coverage of the interventions or programs.</td>
<td>66.7% (n=16)</td>
<td>0% (n=0)</td>
<td>33.3% (n=8)</td>
</tr>
<tr>
<td>The CSA specifically identifies both met and unmet needs.</td>
<td>62.5% (n=15)</td>
<td>0% (n=0)</td>
<td>37.5% (n=9)</td>
</tr>
<tr>
<td>The CSA identifies the portion of needs being met with CDC funds.</td>
<td>66.7% (n=16)</td>
<td>4.2% (n=1)</td>
<td>29.2% (n=7)</td>
</tr>
<tr>
<td>The CSA was presented to the CPG members prior to voting on priorities.</td>
<td>70.8% (n=17)</td>
<td>0% (n=0)</td>
<td>29.2% (n=7)</td>
</tr>
<tr>
<td>The CSA was utilized in demonstrating linkages between the plan and the application.</td>
<td>70.8% (n=17)</td>
<td>0% (n=0)</td>
<td>29.2% (n=7)</td>
</tr>
</tbody>
</table>

It is important to note that 29% (n=7) of the respondents reported that they “did not know” whether or not the CPG was using the Community Services Assessment (CSA) as defined in the statements above. Almost 40% (n=9) of participants stated that they “did not know” whether the CSA specifically identified both met and unmet needs. The remaining 60-70% of respondents agreed that the CSA was being utilized as defined by the statements above.
"Newer" vs. "Older" Members' Responses to Questions Regarding the CSA

The preceding results revealed that a large proportion of CPG members “do not know” whether the CSA is being utilized appropriately during the community planning process. Therefore, the responses to all of the statements regarding the use of the CSA were analyzed to determine whether differences existed between “newer” and “older” members. The following tables contain results from this analysis.

Table 12: “Newer” vs. “Older” Members’ Responses to the Statement: CSA Data Defines Access to Service Needs

<table>
<thead>
<tr>
<th>Years on the CPG</th>
<th>Agree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two years or less</td>
<td>53.3% (n=8)</td>
<td>46.7% (n=7)</td>
</tr>
<tr>
<td>More than two years</td>
<td>88.9% (n=8)</td>
<td>11.1% (n=1)</td>
</tr>
</tbody>
</table>

Approximately 47% (n=7) of “new” members reported that they “did not know” whether the CSA contained data that defined the populations’ needs in terms of access to services. Only 11% (n=1) of “older” members endorsed the “do not know” response for this statement.

Table 13: “Newer” vs. “Older” Members’ Responses to the Statement: CSA Describes Interventions Provided to each Population

<table>
<thead>
<tr>
<th>Years on the CPG</th>
<th>Agree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two years or less</td>
<td>53.3% (n=8)</td>
<td>46.7% (n=7)</td>
</tr>
<tr>
<td>More than two years</td>
<td>88.9% (n=8)</td>
<td>11.1% (n=1)</td>
</tr>
</tbody>
</table>

The majority (88.9%, n=8) of “older” members agree that the CSA describes the interventions provided to each at-risk population. However, approximately 47% (n=7) of “newer” members reported that they “did not know” whether the CSA described the interventions provided, whereas only 11% (n=1) of “older” members endorsed the “do not know” response.
Table 14: “Newer” vs. “Older” Members’ Responses to the Statement: CSA Describes Geographic Coverage of Interventions

<table>
<thead>
<tr>
<th>Years on the CPG</th>
<th>Agree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two years or less</td>
<td>60.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>(n=9)</td>
<td>(n=6)</td>
<td></td>
</tr>
<tr>
<td>More than two years</td>
<td>77.8%</td>
<td>22.0%</td>
</tr>
<tr>
<td>(n=7)</td>
<td>(n=2)</td>
<td></td>
</tr>
</tbody>
</table>

Forty percent (n=6) of “newer” members endorsed the “don’t know” response relating to whether the CSA describes geographic coverage of interventions. The majority (77.8%, n=7) of “older” members agreed with this statement.

Table 15: “Newer” vs. “Older” Members’ Responses to the Statement: CSA Identifies both Met and Unmet Needs

<table>
<thead>
<tr>
<th>Years on the CPG</th>
<th>Agree</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two years or less</td>
<td>53.3%</td>
<td>46.7%</td>
</tr>
<tr>
<td>(n=8)</td>
<td>(n=7)</td>
<td></td>
</tr>
<tr>
<td>More than two years</td>
<td>77.8%</td>
<td>22.2%</td>
</tr>
<tr>
<td>(n=7)</td>
<td>(n=2)</td>
<td></td>
</tr>
</tbody>
</table>

Nearly half (46.7%, n=7) of the “newer” members reported that they “did not know” whether the CSA identifies both met and unmet needs.

Survey Participant Comments Related to Objective D

- *I have no clue what the CSA is. I asked a co-chair, they did not know either*
- *I feel that the epi-profile may not accurately reflect what is going on with certain populations because not enough testing or attention is focused on that population compared to others.*
- *I’ve never seen one of these [referring to the CSA] and I am being hurried by the meeting.*
- *Epidemiologist needs to be at EVERY MEETING for both days.*
- *I feel there is bias with the epi-profile.*
- *Jim Murphy does a great job with the presentation of the epi-data!*
- *We could probably do a better job on identifying unmet needs.*
**OBJECTIVE E:** Ensure that priority target populations are based on an epidemiologic profile and a community services assessment.

<table>
<thead>
<tr>
<th>Table 16: Responses to Questions Relating to Objective E</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please rate your agreement with the following statements:</strong></td>
</tr>
<tr>
<td>The CPG considers available information on the size of the most at risk populations.</td>
</tr>
<tr>
<td>The CPG considers the level of disease burden in the most at risk populations.</td>
</tr>
<tr>
<td>The CPG considers the prevalence of risky behaviors in the most at risk populations.</td>
</tr>
<tr>
<td>The CPG considers the priority needs of the most at risk populations.</td>
</tr>
</tbody>
</table>

The survey results revealed that the majority of members believed that the CPG was meeting Objective E. Ninety-one percent (n=22) of respondents reported that the CPG considered information on the size of the most at-risk populations. However, 16.7% (n=4) of participants felt that the CPG did not consider the priority needs of the most at-risk populations. Overall, it appears that a strength of the CPG is its effort to ensure that prioritization is based on the epi-profile.

**Survey Participant Comments Related to Objective E**

- Yes, as far as the epi-profile. I don’t know if it is based on more than the epi-profile.
- Nothing other than “MSM” is ever stated!
OBJECTIVE F: Ensure that prevention activities for identified priority populations are based on behavioral and social science, outcome effectiveness and/or have been adequately tested with intended consumers for cultural appropriateness, relevance and acceptability.

Table 17: Responses to Questions Relating to Objective F

<table>
<thead>
<tr>
<th>Please rate your agreement with the following statements:</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CPG considers whether the prevention activities are culturally appropriate and acceptable for the most at risk populations.</td>
<td>83.3% (n=20)</td>
<td>12.5% (n=3)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>The CPG considers whether implementation of the prevention activity is possible for its intended populations and in its setting.</td>
<td>79.2% (n=19)</td>
<td>16.7% (n=4)</td>
<td>4.2% (n=1)</td>
</tr>
<tr>
<td>The CPG considers whether the prevention activities were developed by or with input from the most at risk population.</td>
<td>83.3% (n=20)</td>
<td>8.3% (n=2)</td>
<td>8.3% (n=2)</td>
</tr>
<tr>
<td>The CPG considers the known effectiveness of prevention activities in averting or reducing HIV infection.</td>
<td>91.7% (n=22)</td>
<td>0% (n=2)</td>
<td>8.3% (n=2)</td>
</tr>
</tbody>
</table>

The majority of respondents believed that the CPG ensures that prevention activities are based on behavioral and social science and are culturally appropriate and acceptable. Ninety-one percent (n=22) of the respondents felt that the CPG considered the known effectiveness of prevention activities. However, it should be noted, that 16.7% (n=4) of the respondents did not believe that the CPG considered whether implementation of a prevention activity is possible with a population or within a setting.

Survey Participant Comments Related to Objective F

- *It seems like prevention activities are mostly for more populated areas and maybe not for different racial groups.*
- *Community representation of the target population is one of the primary strengths of the Montana CPG.*
- *We need more input from actual high risk community members to develop new and innovative prevention activities; there is a huge amount of resistance from major Community Based Organizations to try new things.*
GOAL 3: Community planning ensures that HIV prevention resources target priority populations and prevention activities set forth in the comprehensive HIV prevention plan.

OBJECTIVE G: Demonstrate a direct relationship between the Comprehensive HIV prevention plan and the health department application for federal HIV prevention funding.

OBJECTIVE H: Demonstrate a direct relationship between the Comprehensive HIV prevention plan and funded interventions/services delivered.

Table 18: Responses to Questions Relating to Objectives G and H

<table>
<thead>
<tr>
<th>Please rate your agreement with the following statements:</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of correspondence between the comprehensive plan and the health department application to CDC for federal funding was provided to the CPG.</td>
<td>83.3% (n=20)</td>
<td>8.3% (n=2)</td>
<td>8.3% (n=2)</td>
</tr>
<tr>
<td>Evidence of correspondence between the comprehensive plan and funded interventions/services delivered in the prior year was provided to the CPG.</td>
<td>83.3% (n=20)</td>
<td>12.5% (n=3)</td>
<td>4.2% (n=1)</td>
</tr>
</tbody>
</table>

The CPG appears to be providing evidence that they are meeting objective G and H.

Eighty-three percent (n=20) of the respondents agreed that the CPG provided evidence of correspondence between the application for funds and the HIV Comprehensive plan.

Survey Participant Comments Related to Objective G and H

- No room for Discussion. Group is impatient in discussing issues, wanting rather to just be finished. Overworked state staff reacts the same way. Easiest to just go along and not question anything.
- Have different contractors present at meetings.
- This year’s IPR was confusing for CPG members, especially new members.
FOCUS GROUP RESULTS

Focus group interviews were used as a data collection instrument in this study (Appendix C). Focus group questions were designed to answer original research questions. Several themes emerged upon analysis of the focus group transcriptions. Each theme reflects the perceptions of the CPG members related to the community planning goals and objectives, and their perceptions of members’ motivation to join and continue to be a part of the community planning group. Representative participant comments are reported in conjunction with each theme in order to increase understanding and further illustrate the theme. These themes are presented and explored below.

THEMES DERIVED FROM FOCUS GROUPS RELATED TO THE COMMUNITY PLANNING GOALS AND OBJECTIVES

Theme 1: Diversity and Inclusion on the CPG: What is Working?

Diversity, as it was described by the focus group participants, referred to the presence of a wide variety of individuals at the table who represented all of the populations most at-risk for HIV infection. Inclusion was described as the ability of all populations in the planning process to participate equally. Sub-themes related to diversity and inclusion included the organization of the CPG into smaller groups of individuals representing at-risk populations. These small groups are known as “communities”. A second sub-theme was related to the process for recruiting members.

A. Organization of the CPG into Communities

The CPG is organized into six communities which represent the populations most at-risk for HIV infection. The six communities include: 1) High Risk Heterosexuals (HRH), 2) HIV Prevention Services Providers, 3) HIV-Positive Individuals, 4) Injection Drug Users (IDU), 5) Men who have Sex with Men (MSM),
and 6) Native Americans. During CPG meetings the communities come together to
discuss meeting topics. This allows each community to bring its perspective back to
the group as a whole. Focus group participants discussed the process of breaking into
communities as important to the inclusion of all target populations in the planning
process.

The focus group participants described breaking into small groups as an
opportunity for individuals who are uncomfortable speaking in the larger group to
discuss important issues. This process allows the entire CPG to hear the perspective
of each community.

Additionally, each community appoints an individual to represent them on one of
the four standing committees of the CPG. The committees meet outside the CPG
meetings to work on projects for the planning process. These committees include the
membership committee, the effective interventions committee, the executive
committee and the budget committee. Committees meet at designated times during
the state meetings and between meetings to carry out their roles and responsibilities.
Again, having an individual represent each of the six communities on these
committees ensures that each high risk population perspective is heard when
decisions are made. The focus group participants believed that this representation was
a strength in the planning process.

- I think that the community group work is a strength.
- Seeing what other people feel is important, and seeing what IDU feels is
  important, what each population feels is important.
- Our different populations had the representatives there, the committee had
  our populations so represented, there wasn’t one population that was left
  out. So we had the targeted groups there.
- I think that the strengths are that we have a person from each of the
  communities in there to put in input and that’s a good idea.
• Breaking down into groups into communities. We've grown so much we came to this point where we can go into our different communities. I for people who can't speak in the bigger groups that is where people actually speak, in the community
• I was not used to speaking in big groups but when we went to do the small groups that is when I felt comfortable.

B. Process for Recruiting Members

The recruitment process involves finding new members to fill gaps in the representation of the at-risk populations on the CPG. A membership committee has been established that is responsible for assessing and implementing the recruitment process as it is defined in the Policy and Procedures manual. The application has been formatted such that the potential members must note where they are from, what population they represent and what specific skills, if any, they would bring to the table. The application in itself helps to ensure diversity and representation. The focus group participants reported the CPG’s recruitment process as important to ensuring representation and diversity in community planning.

In addition, the focus group participants discussed the importance of the current members in the recruitment process. Current members are often involved in referring individuals whom they believe would be an asset to the community planning process. The members are more likely than the DPHHS staff to have access to individuals within the at-risk populations.

• That is a strength that there is diversity in the recruitment process, that there seems to be that diversity, even though it is hard to reach some people you can see it sitting at the table.
• The application sets it all up into age group and geographic, into frontier, rural, it lets us know what people are bringing to the table. I think the application itself is a piece of work.
• I believe that one of the big strengths is the fact that if we believe in what we're doing than we can recruit others that will work just as hard in the process.
Theme 2: Diversity and Inclusion on the CPG: What are the Barriers?

Several sub-themes emerged as barriers to diversity and inclusion: 1) lack of representation on the CPG from the eastern region of the state; 2) recruitment being limited to individuals who are known by current members and 3) fear of possible repercussions to voicing an unpopular opinion.

A. Lack of Representation from the Eastern Region of the State

Representation from the far eastern region of Montana is lacking according to some of the focus group participants. The nature of the state makes it difficult to reach these individuals as well as to encourage them to join the CPG. Participants discussed the long travel distance as a deterrent to potential members. However, members noted the importance of including these individuals on the CPG. The focus group participants were concerned that the CPG has little understanding of the population from the eastern region of the state and therefore, an important perspective is not being heard.

- A big weakness is getting the people from the real eastern side of the state. Getting those people, we have three up in the north eastern part but there is NOBODY from the Miles City part.
- I think that is a weakness, I think reaching those areas because I think they need a voice, they need to be heard too. Because we don’t know what is going on over in Miles City, it’s hard to know what is actually being done in those areas.
- The application and the information are disseminated well, in reaching contractors and parties who may be interested. It can also be a weakness, that it isn’t reaching more rural areas, I think there are both sides to that.

B. Recruitment is Limited to Individuals who are Known by Current Members

A strength to diversity and inclusion, as aforementioned, was the involvement of the current members in the recruitment process. However, some participants described member referral as a weakness in the recruitment process. Due to the fact
that current members are recruiting individuals they know it may be leaving important voices out of the planning process. Additionally, focus group participants discussed overrepresentation of certain organizations on the CPG due to current members recruiting only individuals they know.

Lastly, members described the lack of knowledge about the CPG within the community as a contributing factor to members relying on recruiting individuals they know. Focus group participants pointed out that without their participation in the recruitment process there would potentially be less diversity on the CPG.

- I think it (recruitment) is limited because it is just around people you know or people involved in HIV work, or if there is someone in the community that knows someone involved in HIV work that is when you can have access to these populations.
- There are not many people who know that there is a community planning group in MT.
- The CPG is not well advertised.
- So if we could expose the whole lot I think people would know what the CPG does and be interested in joining.

C. Fear of Possible Repercussions to Voicing an Unpopular Opinion

A few members discussed a fear of repercussions to speaking up as a barrier to the inclusion of all members in the planning process. Participants reported name calling as a result of speaking out during a previous meeting. Therefore, a few participants noted reluctance to speak out during meetings for fear of “fall out”. Additionally, participants discussed being a new member as a barrier to speaking out at meetings. Members suggested that not understanding the policies or the history of the CPG were barriers to participating in the planning process.

- There is no validity in what you’re saying, there is worry that if you do speak up you are going to be completely off and people are just going to be like what was she thinking you know or that was the dumbest question ever
• I think the voices being heard, one of the problems is there is always fear of the fall out and I think that's one of the weaknesses because in the last couple of meetings name calling has resulted and bitterness. It's not personal, its work and working on the issues but then it disintegrates into name calling. Then boy it's hard to talk and say anything because now what are you going to be called.

• It's kind of hard to talk if you're pretty new you just feel like you don't know the history enough so I tend not to talk because I didn't read the policy....

Theme 3: The Influence of DPHHS's Efforts in the Planning Process

Members brought to the forefront the influence of the State’s efforts in the overall planning process. Sub-themes included DPHHS’ role in making the planning process clear; the effort of the state to provide expertise and information; and suggestions for improving the meeting process with the help of DPHHS.

A. DPHHS’ role in Making the Planning Process Clear

Focus group participants discussed the role the State plays in making sure that all members are clear on the processes of planning. A few members noted the State staffs’ genuine interest in the members’ understanding of the planning process, particularly changes to the process presented by the CDC. The State staff allowed time for question and discussion to further aide in the members’ understanding. The State’s efforts play a positive role in the overall planning process and in the relationship between the State and the CPG members.

• I think another strength is that the state genuinely tries to help us understand the new things that come about from the CDC, like Ginny did that with all of her copies we each got a copy of what we were supposed to look at and tried to explain to us what it means whether we understand it or not, they have a genuine effort in helping us understand it.

• They allow time for questions and discussion.
B. The Effort of the State to Provide Expertise and Information

Focus group participants noted the State's effort in providing information and expertise as a strength to the planning process. Meetings were thought to run smoother when participants were provided with information from the State prior to the meetings.

Additionally, members noted the strength of having experts at the meetings in order to make important decisions regarding planning. The participants specifically noted the epidemiological data as important to the prioritization process. Participants reported that this information was presented in a manner that made sense allowing them to appropriately prioritize the target populations.

- We get the information well before hand in advance so that we have prior knowledge of what we are going to be discussing in the small groups, because they (the State) send the information to us.
- They (the State) brought in other people besides us to help select interventions. I am thinking of IDU, you know they brought in Vicki and she is not a part of the CPG right now, but that information is valuable, so the expertise was helpful.
- There was also a lot of information made available about the interventions.
- We're really lucky to have Jim pull the epi-data together for us because that is an incredible strength for us to prioritize, because we're so different from the rest of the country.

C. Suggestions for Improving the Meeting Process with the Help of DPHHS

Focus group participants suggested ideas for the State employees that would aide in strengthening the planning process. Suggestions included, providing e-mail reminders detailing what needs to be read prior to the meeting. Participants believed that this would help the meetings run more smoothly. Additionally, participants suggested that hard copies of lengthy documents should be provided to members prior
to meetings. Participants reported that it was difficult for them to print the materials sent from the State via e-mail.

- Maybe that needs to be put out in e-mail, please read material several times.
- The CPG needs to see the final copy before it is sent to the CDC.
- I had to read the plan at work, and I'm not allowed to print it off because it is so long. So maybe what we need to do is provide a hard copy.
- Maybe if we just hard copied the stuff that is changing....that way you don't have to print out that much. You could just get six and seven pages.
- I think one of the weaknesses is that we should have the epidemiologist at all of our meetings.

Theme 4: Committee Work: What is effective?

As aforementioned, each of the six communities has an individual who represents them on the four standing committees of the CPG. These committees include the membership committee, the effective interventions committee, the executive committee and the budget committee. Focus group participants discussed the importance of the work done by the committees throughout the entire planning process. They reported that the work the committees complete outside of the meetings is a time saving process.

- The committee process worked.
- Doing the face-to-face (effective interventions committee meeting) this year I think was one of the best things that we’ve done this year.
- It’s relying on the committee, you know I can see at the table who is being included in the diversity and so I do see that results of their work. I think that is good.
- I think the committee process all the way through is a good idea. It is so time saving to have the committee come back and report.
- I think it was incredibly helpful that the effective interventions committee went and met outside and put it all together and brought it in and saved a hell of a lot of time.
Theme 5: Geographic Challenges to the Community Planning Process

Focus group participants suggested that the geographical nature of the state of Montana poses a challenge to the community planning process. Sub-themes included the vastness of the state and a lack of proven effective interventions for rural areas.

A. The Vastness of the State

As previously discussed, participants noted the challenge of recruiting members from the far eastern part of the state. Members from eastern Montana have a difficult time traveling all of the way to Helena for every meeting. Some participants reported that individuals do not have a way to get to the meetings.

- When you are trying to get people that live on the reservations that are not employed by the reservations and trying to get them to be on the CPG, it's almost impossible because they don't have ways to get here. So it makes it really frustrating. It isn't just we can all pay for it, that person's life is there and to be that far away from home all of the time, it makes it frustrating.
- It's a long way, it's three and a half hours from Billings, and so you're talking Miles City or far Eastern, who's going to drive.

B. Adapting Interventions not Proven Effective for Rural Areas

Focus group participants noted that the CDC requires the use of effective interventions, yet very few interventions have been tested and proven to work in rural states. This was reported as a barrier to planning due to the fact that very few interventions have been proven to work in rural states. The participants discussed the challenge of taking interventions developed for metropolitan areas and trying to adapt them to a rural state.

- Just that it (CDC interventions) doesn't apply to rural area.
- Maybe one of the weaknesses at the same time is kind of the DEBI and the "in the box" kind of limited ability for that creativity and having to try and conform to interventions created for metropolitan areas.
- They (CDC interventions) are all set for metropolitan areas, well that leaves us out. What works there is never going to work here.
Theme 6: Time is a Challenge to the Community Planning Process

Focus group participants discussed lack of time as a barrier to the planning process. Participants reported feeling rushed for time when meeting in their communities. A few participants noted the pressure of having to speed read important documents provided by the DPHHS and then make quick decisions without being allotted enough time to process the information.

Additionally, focus group participants noted the timelines set by the CDC as adversely affecting DPHHS staff, which in turn affects the planning process. Focus group participants felt that the short timelines place stress on the DPHHS staff. Consequently, the staff may not respond favorably to questions brought forward by members. Thus, resulting in members feeling excluded from the process or uniformed about the important decisions they are being asked to make.

- *I think that* (short timelines) *contributes to the tension and stress level of the state’s staff... and any kind of input or questioning is just like, would you just agree and forget about it. But that isn’t even a criticism of them when you’re so overworked and overstressed and trying to meet those timelines it makes it impossible for any discussion or input.*
- *It seems like every year we are going right up to the last minute. To when it’s got to be sent in and we’re just struggling like crazy to try and get it all done.*
- *It seems like things are really rush. Like when we break into little groups and you have to speed read stuff, and that you’re not familiar with, and I’m a type of person that has to read it pretty thoroughly to be able to comment on it.*
- *From a CPG membership standpoint too, that is definitely something that if I were a new member the race for time would make me burn out.*
- *More timely on CDC’s end. They are way out of line with their delays and their nonsense.*
Theme 7: Gaps in Needs Assessment Data

The participants believed that the epidemiologic data does not tell the whole story about the target populations. In order to have a complete picture of the populations most at-risk for HIV infection, needs assessment data must be examined. However, focus group participants noted a lack of needs assessment data for some of the target populations. They felt that this lack of data results in an inaccurate picture of at-risk populations which may ultimately affect the ranking of populations in the prioritization process.

- I think not everything is based on his (epidemiologist) report. I think like in our area there is not a lot of testing done. So you don't have accurate information about what is going on in our area. And then if you use that then only seven percent of Native Americans have this so we're only going to get this much money, but maybe we need a lot more because there hasn't been enough testing to give us those big numbers.
- Lack of information or research (prioritization process).
- We don't have a needs assessment for each group.

THEMES DERIVED FROM FOCUS GROUPS RELATED TO MEMBERS' MOTIVATIONS

The majority of members felt that their expectations for the community planning group and their motivations to join the CPG matched. Therefore, the CPG members' expectations are not described in depth below. For example one participant described expecting to learn about the CPG process, he also described being motivated to join the CPG by an opportunity to learn. The participants in one of the focus groups all agreed that their motivations and expectations were in line with one another. Additionally, the majority of members felt that their expectations were being met. If their expectations were not met, their perceived barriers have been represented in the analysis above.

The four motivations that emerged from the analysis of the focus group responses include: 1) concern for the community; 2) social networking; 3) to increase knowledge
and 4) the ability to influence the community planning process. Each one of these motivations was described by focus group participants as a motivation to initially join the CPG as well as a motivation to continue participating in the planning process.

**Theme 1: Concern for the Community**

The focus group participants discussed concern for the community as a reason to become a CPG member as well as a reason to continue participating in the CPG. The community concern motivation was characterized by focus group participants as a desire to help the populations they serve. Some focus group participants described this as a need to be a voice for their community or the community they represent. Additionally, concern for the community is the motivation to make a difference and to lend a helping hand to the community, in this case those at risk for HIV infection or those living with HIV.

- For me it was for the population that I represent to have a voice.
- We seem to be expanding and doing more for the populations that we have chosen to represent and that is encouraging.
- Living with the disease kind of changes, no matter how well you’re doing with the disease, it changes everything about every aspect of your life. And you like to contribute in some way and make a difference.
- I think the belief that a few voices can still make a difference and this is what motivates me to continue coming.
- The only thing that motivates me to come is the population, and caring about the people, absolutely nothing else. I couldn’t say that more firmly. NOTHING ELSE MOTIVATES ME TO COME HERE, if I didn’t care about the people that we’re serving in the populations, you couldn’t drag me here.
- For me it’s that there isn’t anyone from my area that is coming, I feel like they need some representation.
- I think for me it was seeing so many people die of AIDS and being sick and finding out what I could do to help make a difference. This was a group that I felt I had that opportunity to make a difference in prevention.
Theme 2: Social Networking

The social networking motivation was characterized by the need to be a part of a group working toward a similar goal, to share ideas with others and to meet new people and develop new friendships. The social networking motivation played a role in initial motivation as well as continued motivation to be a part of the CPG. More specifically, the progress of the group as a whole and being a part of a successful community was noted as a motivating factor in continued participation.

- *I just wanted companionship of people that were working in the same direction. Just to I guess have a big support group.*
- *The other members. The friendships, you realize that you are going to see these people.*
- *We are productive now. After we meet here going back to Missoula I always feel like that was productive.*
- *One of my motivations a hundred years ago when I started and I’d just moved into Montana I wanted to meet gay people.*
- *For me it is the fact that I see progress in what we do and I see change and we’ve been getting along better*
- *Being a part of a group like this with good intentions and looking out for people in the state and people in different communities.*
- *I enjoy seeing everybody. So this is my chance every three months to reunite with everybody.*
- *Why I joined was to be able to network with other people that are doing the same things.*

Theme 3: Increase Knowledge

Some of the focus group participants discussed a desire to increase knowledge as a motivation for joining the CPG. This motivation encompassed a desire to learn more about the disease and the community planning process. A few participants discussed the desire to get ideas from individuals working in the same field as a reason they continue to participate in the CPG.

- *The reason that I joined the CPG to begin with was because I knew absolutely nothing about the disease that I found out that I had.*
- *Get some ideas for interventions, things like that.*
• So for me to actually be learning about the process is just, has fascinated me that has just blown me away, I never would have thought I would be interested in such a process.

Theme 4: Ability to Influence the Community Planning Process

A few focus group participants reported being motivated to join the CPG in order to have a say in what happens with HIV prevention planning in the state. A small number of participants wanted to have a personal role in the outcome of the planning process.

• I just kind of wanted to have some input in what happens with the interventions and stuff.
• I think being able to have input in what happens in our state and have some say over that.
INTERVIEW RESULTS

Interviews were used as a data collection instrument in this study (Appendix D). The interview questions were similar to the focus group questions and were designed to answer original research questions. Several themes emerged after analyzing the interview transcriptions. These themes reflect the perceptions of the DPHHS staff members regarding the community planning goals and objectives. Additionally, these themes reflect their perceptions of members’ motivations to join and continue to be a part of the community planning group. Participant comments are reported in order to further support and demonstrate each key finding. These themes are presented and explored below.

THEMES DERIVED FROM INTERVIEWS RELATED TO THE COMMUNITY PLANNING GOALS AND OBJECTIVES

Theme 1: Diversity and Inclusion on the CPG: What’s working?

Diversity was described by interview participants as the presence of all of the at-risk populations at the table. Inclusion was characterized by the respondents as the participation of all of the populations in every aspect of the community planning process. Four sub-findings emerged that relate to diversity and inclusion: 1) the process for recruiting members; 2) the organization of the CPG into communities; 3) the organization of the CPG into committees and 4) having an independent facilitator.

A. Process for recruiting members

Interview respondents stressed the importance of the recruitment process in ensuring diversity and community representation on the CPG. It was noted that current members play a crucial role in the recruitment process. One participant noted that without the recruitment by current members the CPG would lack representation...
from closed communities, such as the IDU community. The members are able to access communities that would otherwise be closed to DPHHS.

Furthermore, respondents believed that the membership committee was important to the recruitment process and consequently essential to diversity on the CPG. Each of the six communities has a representative on the membership committee, thus ensuring equal weight and equal voice in the decisions made about membership. In addition, the committee looks for gaps in representation of at-risk populations, age groups and geographic locations.

- I think it is a pretty closed community (IDU) so in order to really make them a part of this process it requires other members of their community to go out and recruit from within.
- They (the membership committee) look at where the gaps are. We not only have the populations but we look at geographic distribution, age groups and we bring in their life experiences so they really get to be a part of the process.
- I think a really good thing is that the members are doing the recruiting. That we do get community representation.
- I think that is a real strength of the recruitment process in that other members are actively recruiting. It is not the state health department that is out trying to recruit people because I think we would fail miserably if that was the case.

B. Organization of the CPG into Communities

The respondents believed that breaking into communities (small groups of individuals who represent one of the at-risk populations) during the state meetings allows all of the members to be a part of the planning process. Members not comfortable speaking within the large group are provided an opportunity to do so while meeting with their community.

- Our Native American representatives it seems they tend to be quieter...so when the whole group is meeting we don't hear from them as much, which is a real deficit. When they meet separately as a community I have noticed that they are very vocal and they have a lot to say.
• They broke into groups, so in smaller groups people are more apt to talk possibly and then come back as a larger group and have open group discussion.
• I have been amazed as we have broken into the communities when we come up with what the needs are and the way that they put their heads together and come up and articulate it, it is just absolutely amazing. It really feels like a community planning process.

C. Organization of the CPG into Committees

Each at-risk population has one representative on each of the four CPG standing committees. The interview respondents believed that this representation ensures that committee decisions are made with equal voice from all of the populations’ perspectives.

• We do have the effective intervention work group...made up of all communities, there was equal voice or equal weight amongst the communities and so I feel like we had a pretty comprehensive package when it came forward in the recommendations.
• I think a strength is that we have an actual membership committee that’s made up of all the populations. So, there is equal weight amongst the decisions that are made.

D. Having an Independent Facilitator

The interview participants also stressed the importance of the facilitator in ensuring inclusion in the planning process. Participants discussed the facilitator’s ability to draw people out during discussion, as well as her ability to ensure that one person was not dominating the meeting.

• We have a professional facilitator which I think is absolutely essential. She does a phenomenal job of trying to make sure everybody has an opportunity to speak and tries to draw people out.
• One of the things the CPG does is having the independent facilitator to kind of oversee the meetings and help facilitate that process. Somebody who is neutral and can see if a voice isn’t being heard or is being overpowered and facilitate that process. I think that helps ensure that all of the voices are being heard.
Theme 2: Diversity and Inclusion on the CPG: What are the Barriers?

There were three sub-findings related to this issue: 1) the limiting of recruitment to individuals who are known by current members; 2) the lack of geographic diversity on the CPG and 3) the tendency for some individuals to dominate the meetings.

A. Recruitment is Limited to Individuals who are Known by Current Members

The respondents discussed the potential for overrepresentation of agencies due to members recruiting only people they know. Additionally, participants noted that with the reliance on current members for recruitment the highest risk individuals are not being reached. Consequently, important perspectives are potentially being left out of the community planning process.

- It seems like a lot of members are asking people that they know.... Which could be a weakness because it tends to want to start being too heavy with one organization being overrepresented.
- We don’t know if we’re missing a perspective or a population. I think that’s always a potential. One of the weaknesses I think is because it is contingent upon the members recruiting.... we may not be getting the highest risk individuals or we may not be hearing some perspectives because people tend to hang out with people that have similar beliefs, behaviors and attitudes.

B. Lack of Geographic Diversity on the CPG

Participants believed that only the major towns in Montana are being represented on the CPG. Respondents discussed the challenge of finding individuals from smaller communities willing to travel from far eastern Montana to Helena for meetings. Therefore, this perspective is not being heard during the planning process.

- A weakness is trying to get diversity geographically and definitely the major towns in MT are getting represented, there’s only about three or four (towns) who have high representation.
- The rest of them (towns) are very sparse so trying, you know just because we’re a big state and finding someone who works in this field in those smaller communities.
• I think it is hard, the travel piece and the meeting locations are challenging.

C. Tendency for Some Individuals to Dominate

Respondents believed that the tendency for some individuals to dominate during meeting discussions was a barrier to inclusion in the planning process. Another barrier to inclusion was believed to be members’ unwillingness or discomfort to participate in the larger group discussions

• I don’t know that we always do a good job of that (ensuring that voices are heard). I think there are people that tend to dominate always.
• I think that our facilitator does the best that she can and some people just aren’t comfortable speaking up in that large of a group especially when it gets really emotionally heated and intense.

Theme 3: What does DPHHS Bring to the Table?

The DPHHS staff members develop the application for funds, which is sent to the CDC. This application is based on the HIV Prevention Comprehensive Plan. One of the responsibilities of the community planning group members is to assist DPHHS in the development of the Comprehensive Plan. Therefore, the role of DPHHS is to write an application to the CDC that represents what has been outlined in the Comprehensive Plan.

Interview participants believed that by cutting and pasting from the plan to the application they have honored the CPG members. Consequently, DPHHS staff felt that they have developed a good working relationship with CPG members.

Additionally, the DPHHS staff believed that bringing outside expertise to CPG meetings enhances the planning process. More specifically, one interview respondent discussed the importance of bringing in the disease surveillance coordinator to ensure that
all members have equal understanding of the epidemiological data for the prioritization process.

- I think that the biggest strength is that we have a good working relationship between the CPG members and the State and that we truly do try to honor the interventions as is.
- The strength is the epi-profile and having our disease surveillance coordinator, Jim Murray, explain the epi-profile. I think he does it in a way that everyone is on a level playing field.
- We (DPHHS staff) have really honored, or tried to honor, the CPG by RFPing for only things that are in the Comprehensive Plan.
- I think one thing that has been really strong in our state, and before I started, they had copied the plan and application in almost dual papers it was two documents that looked exactly the same.

Theme 4: Potential Conflict of Interest among CPG Members

Conflict of interest was characterized as “CPG members having their own agendas” or wanting their own organization to profit from their membership on the CPG. Respondents believed that conflict of interest was a potential barrier to planning due to the nature of the CPG. Respondents stressed that many of the members are contractors from HIV/AIDS prevention organizations, thus putting them in a situation where they may make decisions during the community planning process that benefit their organization.

- I think that conflict of interest is there, you know you have people representing their own organization and then they don’t want to see other groups getting too much.
- I am concerned, I do think there is a lot of conflict of interest. I know they have to sign those conflict of interest disclosure forms, and they are supposed to remove themselves if they come to a point of conflict of interest.
- We’re such a small state too, of course we have contractors on the planning group. It just becomes a little; it’s not bad it just comes up sometimes.
- Whenever there’s money tied to things that’s when things start to get a little more tense, when they see the dollar amounts that are actually attached to the different interventions and populations.
- If you have a tool or a scoring thing, people can always answer it to make it come out the way they want. If enough people do it then it would maybe skew our process and we would have to deal with that when it happens.
Theme 5: Level of Understanding among CPG Members

CPG members come to the planning process with different levels of understanding of the community planning process. The members represent diverse backgrounds and experiences; therefore, each individual understands the planning process differently. One respondent noted the challenge of asking members to examine interventions that are sound when some members do not have experience with developing or researching interventions.

Another concern expressed by interview respondents was the way members are forced to figure out and “just o.k.” the decisions made during the planning process. The respondents felt they may be requiring members to make decisions they are not comfortable with because they are not allowed enough time to process the information.

- One of the weaknesses is the peer groups or community member representation, they don’t necessarily have that background or have the knowledge related to choosing those or to knowing all the intricacies of how much it’s going to cost, how much effort and staffing and training and all of those things. So we may pick interventions that aren’t realistic in our state.
- When we’re asking the members to look up interventions that are sound and have research......then whatever they bring to the table is what we go with. That’s hard because you have someone representing a population who doesn’t have experience with interventions, they may be really good at outreach but they don’t have the education and background, it’s hard.
- It is very unfair to ask the individuals who are fairly new to this process to kind of figure it out and just o.k. it and just write us this letter so that we can get funds.
- I feel like we’re not fully allowing the community to absorb and process information in a way that they can make a comfortable decision.
Theme 6: Gaps in Research on Effective Interventions

The CDC requires the CPG to select interventions which have been proven effective in preventing HIV infection. However, the participants articulated their concern about the lack of research on effective interventions, particularly for rural states. The participants discussed the difficulty of adapting interventions which have been proven effective in metropolitan areas to a rural frontier state.

- Yet again the CDC is basically mandating that we have to use interventions that have been proven effective and have a scientific basis although they have only been proven effective in urban communities.
- Another thing with selecting interventions that have been proven effective, there’s not very many that have been done actually in a rural frontier state. So the adapting of them, how far can we adapt them?
- If we have a very small pot of money, limited resources, we really need to be directing that money towards interventions that work, that are effective.
- We need to start moving in that direction….we need to be able to say we are implementing interventions that have proven to be effective rather than saying we are implementing interventions that everybody likes and makes them feel good.

Theme 7: The Influence of the CDC on the Community Planning Process

The interview respondents discussed the impact the CDC has on planning. The respondents viewed the CDC’s influence as a barrier to current planning as well as the determining factor for the future of planning. Two sub-findings relating to the CDC’s influence emerged: 1) the CDC’s mandates limit the influence of the CPG members; and 2) the future of community planning: what will it look like?

A. The CDC’s Mandates Limit the Influence of the CPG Members

The respondents noted that the CDC has dictated which at-risk population is to be ranked as the number one population, thus limiting the CPG members’ involvement in the prioritization of populations. Additionally, as aforementioned, the interview respondents felt that the CDC has mandated the use of effective interventions, thereby
forcing the CPG to use interventions which have only been proven effective in metropolitan areas.

Lastly, respondents believed that the CDC has already decided what they want from community planning, thus, reducing the planning process to ensuring that members come to the same conclusion as the CDC.

- The CDC has basically dictated who our number one priority target population is going to be. The other target populations follow the epidemiological profile.
- It seems like a waste of time and a waste of resources because... we already know who the priority populations are, one of them has been mandated by the CDC the other ones are going to follow the epidemiological profile.
- The CDC is really dictating how this money is going to be spent and then the community planning process becomes all about trying to get them to come to the conclusion that we need them to come to. It feels disingenuous to me at times.

B. The Future of Community Planning: What will it look like?

The direction in which the CDC is heading has made the participants uncertain about the future of the CPG. Moreover, one participant expressed doubt about whether community planning is the most effective use of resources in Montana. In addition, the respondents reported ambiguity about the future roles and responsibilities of the CPG members.

- If that’s the case, if CDC isn’t going to honor the real purpose of community planning than I think the money could be spent in a better way in our state. So I don’t know what the future of community planning will look like.
- The future is going to be very interesting. I am not sure what it’s (CPG) role is going to be or how it’s going to play out. What are the expectations, it is going to be very interesting.
- I really value our CPG members, I value their commitment and their dedication and the process and I think in theory it is a really good process, but I don’t know that it is actually working the way that it is supposed to in theory because everything is being dictated basically.
- I think that especially with the changes with CDC, we need to be able to clearly articulate what members’ responsibilities are and how their role is
going to impact the disease in the state. With the changes I don’t know that I can answer that.

THEMES DERIVED FROM INTERVIEWS RELATED TO MEMBERS’ MOTIVATIONS

The interview participants expressed difficulty with the question regarding members’ motivations. They shared a few ideas about what might motivate individuals to become members of the CPG. The two motivations that emerged from the analysis of interview responses include concern for the community, and the ability to influence the community planning process. These motivations are explored below.

Motivation 1: Concern for the Community

The interview respondents reported that concern for others within their community was the strongest motivator for joining the CPG. The respondents characterized concern for the community as a motivation to join the CPG in order to make a difference in HIV prevention. The participants also described concern for the community as the motivation to volunteer because of a common connection with individuals affected by HIV/AIDS. Additionally, community concern encompassed the motivation to help those people affected by HIV/AIDS or to see that it doesn’t affect someone else in their community.

- *I think the majority are truly motivated by their commitment to HIV prevention in the state. I think that is the bottom line for the majority of members.*
- *I think one because of the cause; I mean the people who are obviously involved have some connection to it."
- "I think one of the biggest motivators is the people that are impacted by the disease. I really think they want to make a difference with this disease in their communities. I think that is probably the single biggest motivator, is how they’ve been impacted or how their communities have been impacted and they want to see that that doesn’t happen to somebody else."
Motivation 2: Ability to Influence the Community Planning Process

The interview respondents also noted a desire to influence the community planning as a reason for individuals to join the CPG. This motivation was also characterized by interview respondents as the desire to join the CPG in order to play a role in the decisions made about State HIV prevention funding.

- *I think some people are motivated to be a part because of the funding that comes to the state.*
- *People get involved because they are a contactor and they want to be a part of this group to help guide us where we are going to spend the money, which would ultimately benefit them in their minds. I think.*
CHAPTER 5: DISCUSSION

The purpose of this study was to evaluate Montana’s HIV prevention community planning process. Both Qualitative and quantitative data were collected. Quantitative data was collected via the Community Planning Group Membership Survey, while qualitative data was collected via interviews and focus groups with CPG members.

DISCUSSION OF RESULTS

SURVEY SUMMARY

The majority of survey respondents agreed with the statements representing each of the eight community planning objectives. On forty-six of the forty-eight statements, sixty to one hundred percent of the respondents endorsed the “agree” response. The survey results revealed that the majority of Montana’s CPG members believed that the community planning process was meeting the objectives set forth by the CDC. Several of those strengths are outlined below.

Community Planning Strengths

Five crucial community planning strengths were identified after analyzing the survey data. Those strengths are discussed below.

1) The Recruitment Process: Approximately 75% or more of survey respondents agreed with the statements regarding the CPG’s use of an open recruitment process (Objective A). The recruitment strengths included the CPG’s use of written procedures for nominations, the establishment of a membership committee, the participation of both CPG members and health department staff in membership decisions and the use of written procedures to select CPG members.
2) **Inclusion and Parity:** Montana’s CPG members believed that the community planning process included individuals who represent each at-risk population as documented in the epidemiologic profile. The survey results revealed that the CPG is making progress towards fostering an environment that encourages inclusion in the community planning process. In fact, 70% or more of the survey respondents agreed with the statements related to inclusion and parity among CPG members (Objective C).

3) **Epidemiologic Profile:** Montana’s CPG members reported a favorable perception of the CPG’s use of the epi-profile in the prioritization process. The majority of respondents believed that the CPG ensures that the prioritization of the at-risk populations is based on an epidemiologic profile (Objective E). In regards to the statements related to prioritization, approximately 80-91% of survey respondents agreed. The results suggest that the members viewed the prioritization process as successful.

4) **Intervention Prioritization:** The majority of respondents believed that the CPG ensures that prevention activities are based on behavioral and social science and are culturally appropriate and acceptable (Objective F). Eighty to ninety percent of respondents agreed with statements related to intervention appropriateness.

5) **Relationship between the Plan and the Application:** The DPHHS’ efforts toward ensuring a direct relationship between the Comprehensive HIV Prevention Plan and the health department application for federal HIV funding was viewed as a factor which facilitated planning. Approximately 80-91% of participants responded positively to statements regarding the health department application and the Comprehensive Plan.
Barriers to Community Planning

A few challenges to community planning also emerged during survey analysis. Three of those challenges are discussed below.

1) Lack of Input from Substance Abuse Facilities: Approximately, 21% of respondents disagreed with the statement relating to expert perspective from substance abuse facilities, and 25% endorsed the “do not know” response.

2) Lack of Input from Correctional Facilities: Twenty-nine percent of participants did not believe that expert perspective from correctional facilities was present on the CPG. Additionally, twenty-nine percent of participants reported that they “did not know” if this perspective existed on the CPG. It should be noted that only 11% of “older” members agreed with the statement pertaining to expert perspective, whereas 57% of “newer” members agreed.

3) Lack of Knowledge about Community Services Assessment: Twenty-nine to thirty-seven percent of respondents endorsed the “don’t know” response for all of the statements relating to the use of the Community Services Assessments (CSA). The results revealed a general lack of knowledge among CPG members about the CSA. Additionally, the results suggested that the “newer” members are less familiar with the CSA than the “older” members. Forty to fifty-three percent of the “newer” members responded that they “did not know” whether the CSA was used during the planning process, whereas, only 11-22% of “older” members responded similarly. These findings were not statistically significant; however the results are practically significant. The results suggest that “newer” members need to be provided with more information about the use of the CSA during the planning process.
INTERVIEW AND FOCUS GROUP SUMMARY

COMMUNITY PLANNING GOALS AND OBJECTIVES

Similarities in Perceptions between DPHHS Staff and CPG Members

Four key similarities emerged between CPG members’ and DPHHS staff perceptions of the planning process. These similarities are described below.

1) Diversity and Inclusion: One similarity was the belief by participants that diversity and inclusion are key elements in the community planning process. Both members and DPHHS staff reported the process for recruiting new members and the organization of the CPG into communities representing at-risk groups as factors that facilitate planning. Additionally, the participants believed that the independent meeting facilitator played a crucial role in ensuring the participation of all members in the planning process.

2) Challenges to Diversity and Inclusion: Both CPG members and DPHHS staff reported challenges to ensuring diversity and inclusion in the planning process. The respondents noted that one barrier to diversity is the limitation of recruitment to individuals who are known by current members. The participants believed that a perspective is potentially being left out of the planning process. In addition, members and DPHHS staff reported a lack of representation from the Eastern Region of the state as a barrier to diversity and inclusion. It should be noted that West and Valdisseri (1994), in their evaluation of community planning, found both the recruitment and selection process to be major challenges to participatory planning.

3) DPHHS Staff Effort in the Planning Process: Both the State staff and the CPG members believed that the influence and contributions of DPHHS staff was a strength in Montana’s community planning process. Both groups discussed the effort by DPHHS
staff to ensure that expertise and information are provided to CPG members in order for them to make informed decisions about planning. More specifically, the focus group participants noted that the DPHHS staff creates an environment conducive to understanding through their efforts to answer questions and clearly explain the planning process.

4) Gaps in Research: Gaps in research on effective interventions were viewed by the DPHHS staff and CPG members as a barrier to planning. The participants discussed the difficulty in attempting to adapt interventions that have not been proven effective for rural areas.

Differences in Perceptions between DPHHS Staff and CPG Members

Five key differences emerged between CPG members’ and DPHHS staff perceptions of the planning process. The differences are discussed below.

1) Conflict of Interest: The interview participants’ believed that CPG members may potentially experience a conflict of interest while being involved in the community planning process. In other words, the DPHHS staff felt that members might join the CPG in order for their organization to profit. The CPG members did not report conflict of interest as a concern for the community planning process.

2) Levels of Understanding about the Community Planning Process: The DPHHS staff expressed concern regarding the different levels of understanding about the community planning process among the members. They discussed the challenge of asking members to select sound interventions when they have little experience with developing or researching interventions. Valdiserri, Aultman and Curran (1995) noted that there is the tendency for Governmental officials to assume that community participants have little
understanding about technical issues. Interestingly, the CPG members themselves did not report a similar concern.

3) CDC’s Influence on the Community Planning Process: The DPHHS staff discussed the CDC’s influence on the community planning process. The State staff believed that the CDC’s mandates limit the influence of the CPG members in the planning process. For example, the DPHHS staff believed that the CDC dictates what interventions are to be used as well as the number one priority population, thus limiting the role of CPG members. Additionally, the interview respondents expressed a sense of uncertainty about the future of community planning due to the current direction the CDC seems to be heading. Concern about CDC’s increasing influence on community planning and uncertainty about the future of community planning were not issues raised by the CPG members.

4) Challenges to Inclusion: CPG members believed that ensuring inclusion in the community planning process is challenged by a fear of possible repercussions to voicing an unpopular opinion. “Name calling” was discussed by CPG members as a potential result of expressing an unfavorable view. The DPHHS staff did not describe this as a barrier to ensuring inclusion on the CPG.

5) Gaps in Needs Assessment Data: The CPG members believed that there are gaps in needs assessment data for some of the at-risk populations. The members discussed how these gaps might potentially affect the prioritization of target populations. Moreover, Valdiserri and West (1994) have reported the existence of many barriers to the needs assessment process which may in turn influence prioritization process as well as the
implementation of HIV prevention programs. DPHHS staff did not raise concerns regarding the quality of needs assessment data.

MEMBERS’ MOTIVATIONS

The CPG members’ foremost motivating factor to join the CPG was described as their concern for the community and the populations they serve. Additionally, concern for the community was noted as a reason to continue participating in the CPG. The DPHHS staff participants also believed that individuals join the CPG in order to be a voice for their community and to be involved with the fight to prevent the spread of HIV/AIDS.

The majority (62.5%) of members have been on the CPG for two years or less. This may have played a role in the identification of concern for the community as a motivating factor to join the CPG. Omoto and Snyder (1993), in their research on AIDS volunteers, discovered that concern for the community was the most endorsed motivation among new volunteers who came from communities that were particularly concerned about HIV/AIDS. It should also be noted that Penner and Finkelstein (1998), in their research on AIDS volunteers, discovered a positive correlation between the community concern motivation and length of volunteer service.

The ability to influence the community planning process was described by both DPHHS staff and CPG members as a motivation for individuals to join the CPG. CPG members reported being motivated to join the CPG in order to have a say in what happens with HIV prevention planning in the state. DPHHS staff believed that individuals join the CPG in order to be involved in the decisions made about State HIV
prevention funding. McMillan and Chavis (1986) have noted that members are more likely to join groups or communities that they believe they may potentially influence.

CPG members discussed a desire to learn as a motivation to join the CPG. A few participants discussed joining the CPG in order to learn more about HIV/AIDS as well as the community planning process. Omoto and Snyder's (1993) motivation inventory includes an understanding motive which is characterized by a desire to learn.

Finally, the CPG members described being a part of a group and networking with others working toward the same goal as a motivation to join the CPG. Moreover, participants believed that they are motivated to continue participating in the planning process because the group is making progress. Not only did the participants join the CPG to be a part of a group with similar goals but they continue to participate because they believe that the group is successful. When communities are successful individuals feel a sense of accomplishment by being a part of that community, thus are more likely to remain a member of the group (Hughey, Speer & Peterson, 1999).
RECOMMENDATIONS

RECOMMENDATIONS FOR THE COMMUNITY PLANNING PROCESS

Based on the analysis of the data and the review of the literature, recommendations for Montana’s community planning process have been developed. These recommendations will assist DPHHS and Montana’s CPG in improving the community planning process. The recommendations are explored below.

1) Increase CPG Members’ Knowledge about the Community Services Assessment

The survey results revealed a general lack of knowledge among the CPG members about the CSA. Additionally, the results suggested that the “newer” members are less familiar with the CSA than the “older” members. Montana’s CPG would benefit from a review of the use of the CSA in the planning process.

2) Increase the Member Representation from the Eastern Region of the State

Both the CPG members and the DPHHS staff discussed the lack of representation from the Eastern Region of the State as a barrier to diversity on the CPG. Reaching out to individuals from the Eastern Region of the State will provide a perspective that CPG members and State staff do not believe currently exists.

3) Address the Issue of Gaps in Research

The CPG members and the DPHHS staff believed that the gaps in research on effective interventions were barriers to the planning process. It would be useful for the DPHHS staff to discuss this concern with the CPG members. Additionally, continued evaluation of current interventions would aid in decreasing these research gaps.
4) **Address the CPG Members’ Fear of Voicing their Opinions During CPG Meetings**

The CPG members believed that being fearful of repercussions to voicing an unpopular opinion was a barrier to inclusion in the planning process. In order to develop inclusion in the planning process it is essential that all members feel safe in expressing their opinions during the CPG meetings. This concern should be addressed by the DPHHS staff in order to increase inclusion in the planning process.

5) **Conduct Needs Assessments for all of the At-Risk Populations**

The CPG members believed that there are gaps in needs assessment data for some of the at-risk populations. The assessment of unmet needs has been recognized as an essential component of the planning process (Valdiserri & West, 1994; CDC, 1993). The needs assessment data assists in the proper prioritization of target populations, as well as the development of HIV prevention interventions.

Montana’s community planning process could be improved, particularly the prioritization process, by conducting needs assessments for all of the at-risk populations.
RECOMMENDATIONS FOR RETAINING CPG MEMBERS

The literature on volunteerism and membership as well as the analyses of the focus group and interview results were used to develop the following recommendations for Montana's CPG.

1) Increase Sense of Community

Hughey, Speer and Peterson (1999) posit that it would be beneficial for community organizations to intentionally promote a sense of community. The benefits received from the development of a sense of community are likely to influence member retention and satisfaction. Sense of community includes: 1) a feeling of belonging and acceptance in a group; 2) attraction to a group based on an expectation that one will have influence over the group; 3) reinforcement members receive by having their needs met as well as by being a part of a successful group and 4) the value of a shared experience by the community members. Some of the CPG members have expressed their continued involvement in the community planning process as a result of feeling a sense of belonging to the group. It would be ideal to continue to promote a sense of togetherness among the group members. Additionally, the DPHHS staff should aim to develop a belief among members that they play an influential role in the planning process. Lastly, the CPG can retain current members by understanding their needs and successfully meeting those needs.

2) Focus on Community Planning Group Successes

Not only did the CPG members join the CPG to be a part of a group with similar goals but they believed that they continue to participate because they feel that the...
group is successful. When communities are successful individuals feel a sense of accomplishment by being a part of that community, thus are more likely to remain a member of the group (Hughey, Speer & Peterson, 1999). By focusing on the progress and success of the community planning group members will be likely to continue to participate in the planning process.
CONCLUSION

Analysis of data from this evaluation suggests that Montana’s CPG members, in general, felt positive about the process of HIV prevention community planning in 2004. The focus group and interview results were supported by the results of the survey. The majority of the respondents (60-80%) agreed on 46 of 48 statements relating to the community planning goals and objectives. More specifically, the strengths expressed in the focus group and interview results, such as diversity and inclusion, the process for recruitment and the presence of expert perspectives on the CPG were supported by participants’ responses to the survey statements.

Additionally, analysis of all three data sources revealed that Montana’s CPG is, for the most part, meeting all of the goals and objectives set forth by the CDC for community planning. Numerous factors facilitating community planning were identified during focus group, interview and survey analyses. These included: 1) ensuring diversity and inclusion on the CPG; 2) the effective work done by the CPG’s standing committees; 3) the successful recruitment process; 4) the use of the independent facilitator during meetings and 5) the contributions of the DPHHS staff.

Lastly, all three data sources suggest that concern for the community is the most important motivating factor for members’ to join the CPG as well as to continue participation in the planning process. The survey results revealed that sixty-seven percent of respondents have . The DPHHS staff and the majority of CPG members believed that individuals join the CPG to help their community and to make a difference in the fight to prevent the spread of HIV/AIDS. It is clear, through the comprehensive analysis, that
living with, or being close to someone living with HIV/AIDS, has played a role in members' choice to join the CPG.
REFERENCES


Centers for Disease Control and Prevention. (2002). Cases of HIV infection and AIDS in


Journal of Community Psychology, 14, 6-21.


The University of Montana

INSTITUTIONAL REVIEW BOARD (IRB)

Submit one completed copy of this Checklist, including any required attachments, for each project involving human subjects. The IRB meet every other month to evaluate proposals, and approval is usually granted for one year. See IRB Guidelines and Procedures for details.

Project Director: Meg Woltring  Dept.: HHP  Phone: 4211
E-mail: mwoltring@aol.com
Signature: ___________________________ Date: 6-5-04

Co-Director(s): K. Ann Sondag  Dept.: HHP  Phone: 5215
Project Title: Evaluation of Montana's HIV Prevention Community Planning Process

Project Description: The purpose of this project is to provide an evaluation report to the Department of Public Health and Human Services regarding the HIV prevention community planning process in Montana. The evaluation will determine whether the planning process met the goals and objectives established by The Centers for Disease Control for community planning groups.

All investigators on this project must complete the self-study course on protection of human research subjects, available at the UM IRB website: http://www.um.edu/research/irb.htm.

Certification: I have completed the course - (Use additional page if necessary)

Signature: ___________________________ Date: ____________

Students Only:
Faculty Supervisor: K. Ann Sondag  Dept.: HHP  Phone: 5215
Signature: ___________________________ Date: ____________
(My signature confirms that I have read the IRB Checklist and attachments and agree that it accurately represents the planned research and that I will supervise this research project.)

IRB Determination:

Approved Exemption from Review — Exemption # ____________
Approved by Expedited/Administrative Review

Full IRB Determination:

Approved
Conditional Approval (see attached memo)
Resubmit Proposal (see attached memo)
Disapproved (see attached memo)

Signature IRB Chair: ___________________________ Date: ____________
INSTRUCTIONS FOR COMPLETING
THE COMMUNITY PLANNING MEMBERSHIP SURVEY

Purpose
The community planning membership survey is designed to gain input from community planning groups (CPGs) on their perspectives regarding the implementation and quality of the community planning process within their jurisdictions. Its purpose is to provide CDC with a picture of what is occurring in HIV Prevention Community Planning across the country and to serve as a useful tool for CPGs in improving community planning processes at the local level. The opinions of CPG members are very important for both purposes. Input from you and other CPG members will be used to guide improvements to the community planning process nationwide as well as to identify unique strengths and potential training needs within your own CPG.

Before you begin, here are a few things you should know:

- Completion of the survey should take approximately 30-40 minutes.
- If you are a member of more than one CPG, please fill out a survey for each CPG.
- A “comments” section follows each group of items in the survey for you to provide additional thoughts regarding your responses or questions about particular sections of the survey.
- Your participation in this survey is voluntary, and you may choose not to answer any one or more questions.
- The information you provide will be kept confidential. Survey responses will be presented in an aggregate format and your individual information will not be linked to your responses.
- If during the survey you have particular questions or come across items that are unclear, it’s okay to ask for clarification from your CPG Co-chairs or other individuals who are administering the surveys. However, please also note your questions in the comments section. Your feedback is valuable and will help us make these items clearer in the future.
- When you are finished, please return the survey to the designated individual within your CPG (i.e., CPG Co-Chair, Community Planning Coordinator, Evaluator).
- We greatly appreciate your time! Your participation in this survey will help to improve the quality of the community planning process and will ultimately contribute to the development of a system to assess HIV prevention community planning nationwide.

Please note that the Office of Management and Budget (OMB) requires CDC to follow certain standards when collecting data on race and ethnicity. The standards have five categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There are two categories for data on ethnicity: “Hispanic or Latino,” and “Not Hispanic or Latino.” The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies. (Statistical Policy Office Directive No. 15, Race and Ethnic Standards for Federal Statistics and Reporting, 1997). For more information, see also OMB guidance entitled Implementation of the 1997 Standards for Federal Data on Race and Ethnicity (2000) or visit the OMB website at http://www.whitehouse.gov/omb/fedreg/ombdir15.html.

Thank You for Participating!
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<thead>
<tr>
<th>Name of the HIV Prevention CPG: ___</th>
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<tr>
<td>Type of HIV Prevention CPG:</td>
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<tr>
<td>☑ Statewide planning group</td>
<td>☑ Directly-funded city planning group</td>
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<td>☑ Regional planning group</td>
<td>☑ Other (__________________________)</td>
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<td>☑ Local planning group</td>
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<td>Age (choose one):</td>
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<td>☐ 18-24</td>
<td>☑ 25-34</td>
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<tr>
<td>Gender (choose one):</td>
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<td>Sexual orientation</td>
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<td>☑ Unknown</td>
<td>☑ Other (specify):</td>
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<td>☑ Hispanic/Latino</td>
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<td>Race (Choose more than one if applicable):</td>
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<td>☑ American Indian or Alaska Native</td>
<td>☑ Native Hawaiian or Other Pacific Islander</td>
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<td>☑ Black or African-American</td>
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Community Planning Membership Survey
April 2004
8. Type of geographic location in which you live (choose one):

- **Rural**: An area with a population of less than 2,500 (typically a small town or a community with a population that is widely dispersed or spread out)
- **Urban non-metropolitan**: An area with a population of between 2,500 and 100,000 (small to mid-size city)
- **Suburb**: A residential area around or outskirts a city
- **Urban metropolitan**: An area with a population of greater than 100,000 (large city, densely populated such as New York, Los Angeles, Houston)
- **Other (please specify):**

9. Primary areas of expertise (Select up to two, placing a "1" next to your primary expertise area and "2" next to your secondary area):

- **Community Representative**
- **Community Organization**
- **PLWHA (person living with or affected by HIV/AIDS)**
- **Intervention Specialist/Service Provider**
- **Behavioral or Social Scientist**
- **Evaluation**
- **Health Planner**
- **Epidemiologist**
- **Other (please specify):**

10. HIV risk populations whose perspectives you represent through personal life experiences, work responsibilities, or other affiliations. (Select up to two, placing a "1" next to your primary and "2" next to your secondary perspective):

- Men who have sex with men and are at risk through unsafe sex
- Men who are at risk from both unsafe sex with other men and unsafe drug injection practices
- Men and women who are at risk through unsafe injection drug practices
- Men and women who are at risk through unsafe heterosexual sex with an infected partner
- Men and women who are at risk through unsafe sex with a transgender
- Men and women who are at risk from both unsafe sex with a transgender and unsafe injection drug practices
- Men and women not part of a specific population at risk for HIV

11. What is your HIV serostatus?

- Living with HIV/AIDS
- Not living with HIV/AIDS
- Unknown
- No Response

12. Do you have a relative, partner, or close friend who is living with HIV/AIDS or who has died from HIV/AIDS?

- Yes
- No
- Don't know

13. Type of organization you represent or are affiliated with (Select up to two, placing a "1" next to your primary affiliation and "2" next to your secondary affiliation). If you do not represent an agency, please check "Non-Agency/Community Representative."

- **Faith Community**
- **Minority CBO**
- **Non-minority CBO**
- **Other Nonprofit**
- **Business and Labor**
- **Other (please specify):**

*Minority CBO – Provides HIV prevention services to members of racial/ethnic minority communities who are at risk for HIV infection (≥ 85% of persons served in each of the last three years were of racial/ethnic minority populations)*
<table>
<thead>
<tr>
<th>Question</th>
<th>Option</th>
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<tr>
<td>14. Does your primary organization receive HIV prevention funding from the state/city/territory health department?</td>
<td>□ Yes □ No □ Not applicable</td>
</tr>
<tr>
<td>15. Does your secondary organization receive HIV prevention funding from the state/city/territory health department?</td>
<td>□ Yes □ No □ Not applicable</td>
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**General Information about the CPG**

16. During the past planning year, how many CPG meetings (of the general membership) did you attend?  

17. In what year did you become a member of the CPG you currently belong to? (i.e., 1999, 2001)

End of Part I
INTRODUCTION

This next series of items asks your opinion regarding whether the objectives of community planning were met in your CPG during the most recent year of planning. Each objective is followed by a series of items that ask you to indicate your agreement or disagreement with the presence of a specific attribute or key step in the community planning process. If you are unsure about a particular item, please indicate "Don’t Know.”

Goal 1: Community Planning supports broad-based community participation in HIV Prevention Planning

Objective A: Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.

| A1. The CPG has written procedures for nominations to the CPG. |  |  |  |
| A2. The CPG uses the written procedures (above) for nominations to the CPG. |  |  |  |
| A3. The CPG has established a nominations/membership committee. |  |  |  |
| A4. CPG nominations target membership gaps identified by the members of the CPG. |  |  |  |
| A5. Both CPG members and health department staff participate in membership decisions. |  |  |  |
| A6. The CPG has written procedures for how to select CPG members. |  |  |  |
| A7. The CPG uses the written procedures (above) in selection of CPG members. |  |  |  |

Comments/Questions:

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Objective B: Ensure that CPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction and includes key professional expertise and representation from key governmental and nongovernmental agencies.

<table>
<thead>
<tr>
<th>Objective B</th>
<th>Description</th>
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<tbody>
<tr>
<td>B1.</td>
<td>The CPG includes members who represent each population of the current and projected epidemic as documented in the epidemiologic profile.</td>
</tr>
<tr>
<td>B2.</td>
<td>The CPG has expert perspective available from behavioral/social science on issues related to the community planning process.</td>
</tr>
<tr>
<td>B3.</td>
<td>The CPG has expert perspective available in epidemiology on issues related to the community planning process.</td>
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<tr>
<td>B4.</td>
<td>The CPG has expert perspective available in evaluation on issues related to the community planning process.</td>
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<tr>
<td>B5.</td>
<td>The CPG has expert perspective available in service provision (i.e., intervention specialists, medical providers, counselors) on issues related to the community planning process.</td>
</tr>
<tr>
<td>B6.</td>
<td>The CPG has expert perspective available from health department HIV/AIDS Program staff on issues related to the community planning process.</td>
</tr>
<tr>
<td>B7.</td>
<td>The CPG has expert perspective available from state/local health department STD program staff on issues related to the community planning process.</td>
</tr>
<tr>
<td>B8.</td>
<td>The CPG has expert perspective available from state/local substance abuse treatment facilities on issues related to the community planning process.</td>
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<tr>
<td>B9.</td>
<td>The CPG has expert perspective available from state/local HIV Care and Social Services (i.e., Ryan White Care clinics), on issues related to the community planning process.</td>
</tr>
<tr>
<td>B10.</td>
<td>The CPG has expert perspective available from correctional facilities, on issues related the community planning process.</td>
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Comments/Questions:

[Blank space for comments]
Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.

| C1. The CPG uses various methods (i.e., focus groups, panels, or committees) to gain input from high-risk groups or individuals who would be hard to recruit and/or retain as CPG members. |
| C2. The CPG undertakes efforts to assist members in their continued participation in the CPG, particularly those who face challenging barriers. |
| C3. The CPG has formal procedures for making decisions and resolving disagreements among members. |
| C4. Throughout the planning year, the CPG provides a process for training (i.e., presentations, speakers, capacity building workshops) for all CPG members. |
| C5. The CPG provides orientation and/or other appropriate support to new CPG members. |
| C6. CPG meetings are open to the public and allow time for public comment. |
Goal 2: Community planning identifies priority HIV prevention needs in each jurisdiction.

Objective D: Carry out logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

| D1. The epidemiologic profile (referred to here as the "epi-profile") used in the prioritization process contains the most updated information as provided by the health department. | &lt;seen suggestions for updating the profile in "Integrated Guidelines for Developing Epidemiologic Profiles." HIV Prevention and Ryan White Care Act Community Planning. DRAFT

| D2. The epi-profile provides information about defined populations most at risk for HIV infection for the CPG to consider in the prioritization process. | 

| D3. Strengths and limitations of data sources used in the epi-profile are described. | 

| D4. The epi-profile contains a written explanation of the data presented. | 

| D5. The epi-profile was presented to the CPG members prior to voting on priorities. | 

| Comment/Question | 

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Community Planning Membership Survey  
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06. The community services assessment (referred to here as the CSA) focuses on one or more most at risk populations identified in the epi-profile.

07. The CSA contains data that define populations' needs in terms of knowledge, skills, attitudes, and norms.

08. The CSA contains data that define populations' needs in terms of access to services.

09. The CSA describes the target populations being served (i.e., age, gender, race).

10. The CSA describes the interventions provided to each target population (i.e., types of activities, number of sessions).

11. The CSA describes the geographic coverage of interventions or programs.

12. The CSA specifically identifies both met and unmet needs.

13. The CSA identifies the portion of needs being met with CDC funds.

14. The CSA was presented to the CPG members prior to voting on priorities.

15. The CSA was utilized in demonstrating linkages between the plan and the application.
Objective E: Ensure that priority target populations are based on an epidemiologic profile and a community services assessment.

<table>
<thead>
<tr>
<th></th>
<th>Consider Available Information on the Size (Estimated Total Number) of the Most at Risk Populations.</th>
<th>Consider the Level of Disease Burden in the Most at Risk Populations.</th>
<th>Consider the Prevalence (Frequency of Occurrence or Amount) of Risky Behaviors in the Most at Risk Populations.</th>
<th>Consider the Priority Needs of the Most at Risk Populations (Access to Services, Cultural/Language Barriers, Special Health Care Needs).</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>E2</td>
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<td>E3</td>
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<tr>
<td>E4</td>
<td>☐</td>
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</tr>
</tbody>
</table>

Comments/Suggestions:
Objective F: Ensure that prevention activities for identified priority populations are based on behavioral and social science, outcome effectiveness and/or have been adequately tested with intended consumers for cultural appropriateness, relevance, and acceptability.

<table>
<thead>
<tr>
<th>Question</th>
<th>Agree</th>
<th>Disagree</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1. The CPG considers whether the prevention activities are culturally appropriate and acceptable for the most at risk populations (i.e., through focus groups, pilot testing, reviewing studies).</td>
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</tr>
<tr>
<td>F2. The CPG considers whether implementation of the prevention activity is possible (achievable) for its intended populations and in its setting.</td>
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</tr>
<tr>
<td>F3. The CPG considers whether the prevention activities were developed by or with input from the most at risk population (i.e., key informant interviews, focus groups, surveys).</td>
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</tr>
<tr>
<td>F4. The CPG considers the known effectiveness of prevention activities in averting or reducing HIV infection (Examples may include those listed or based upon the programs in the Compendium of HIV Prevention Programs with Evidence of Effectiveness).*</td>
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</tr>
</tbody>
</table>

*Exact replication of programs is not always appropriate within a given jurisdiction given regional and/or population-based circumstances. "Consideration of known effectiveness" includes reviewing the literature and applying a reasonable amount of tailoring to fit local circumstances.

**Comments/Questions**

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Community Planning Membership Survey  
April 2004
Goal 3: Community planning ensures that HIV prevention resources target priority populations and prevention activities set forth in the comprehensive HIV prevention plan.

Objective G: Demonstrate a direct relationship between the Comprehensive HIV prevention plan and the health department application for federal HIV prevention funding.

Objective H: Demonstrate a direct relationship between the Comprehensive HIV prevention plan and funded interventions/services delivered.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Evidence (Comprehensive Plan)</th>
<th>Evidence (Application)</th>
<th>Evidence (Prior Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G-H1</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>G-H2</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Community Feedback:

[Blank space for comments]

Community Planning Membership Survey
April 2004
Thank You Very Much for Taking the Time to Complete this Survey
VERBAL SCRIPT FOR FOCUS GROUP PARTICIPANTS

PURPOSE
The purpose of this project is to evaluate Montana’s HIV prevention community planning process. Information gathered from this project will be made available to Montana’s Department of Health and Human Services (DPHHS) as well as the Center’s for Disease Control and Prevention (CDC). By participating in this focus group you will help provide valuable information, which will be used to improve HIV prevention community planning.

PROCEDURES
Participation in this focus group is voluntary. If you agree to participate you will be asked to respond to questions covering topics related to HIV prevention community planning. The focus group will last approximately 1 hour. The session will be audio recorded and transcribed for accuracy of responses. Once the tape recordings have been transcribed they will be destroyed. All data will be kept in a locked filing cabinet, in a locked office in the project director’s office and the project assistant’s office. In no way will we link your identity with the transcribed materials. At any time, if you feel uncomfortable and no longer want to participate in the focus group, you may leave.

CONFIDENTIALITY
All of the information we collect here today is confidential. We will not identify any of the participants. We will not use your name, or any other identifying information in the reports or other materials related to this project. Due to the fact that we are tape recording the focus groups, we ask that you not use other members’ names in the course of the discussion. In addition, we ask that focus group participants to keep all information exchanged in the group confidential. Please do not discuss the content or process of the focus groups outside of this room.

We greatly appreciate you taking part in this focus group. We will now begin our discussion.
Focus Group Questions

Ice Breaker: How did you become involved with the CPG?

Questions related to community planning goals and objectives:

1. What are the strengths of the CPG’s recruitment process?
   - What are the weaknesses of the recruitment process?

2. How does the CPG ensure that all voices are heard at the table?

3. What are the strengths of the process for prioritizing target populations?
   - What are the weaknesses of the prioritization process?

4. What are the strengths of the process for selecting interventions?
   a. What are the weaknesses of the selection process?
   b. In what way could this process be improved?

5. How does the CPG ensure that there is a relationship between the Comprehensive HIV prevention plan and the health department progress report?
   a. What are the strengths of this process?
   b. In what way could this process be improved?

Questions related to members’ motivations:

6. What motivated you to become a member of the community planning group?

7. What could make the community planning group more attractive to potential members?

8. What motivates you to continue participating in the CPG?

9. What were you’re expectations coming into the community planning group?
   a. Have your expectations been met? If so in what ways?
   b. If not, how has the CPG fallen short?

10. What other thoughts do you have regarding Montana’s HIV community planning process?
VERBAL SCRIPT FOR INTERVIEW PARTICIPANTS

PURPOSE
The purpose of this study is to evaluate Montana’s HIV prevention community planning process. Information gathered from this project will be made available to Montana’s Department of Health and Human Services (DPHHS) as well as the Center’s for Disease Control and Prevention (CDC). By participating in this interview you will help provide valuable information, which will be used to improve HIV prevention community planning process.

PROCEDURES
Participation in this interview is voluntary. If you agree to participate you will be asked to respond to questions covering topics related to HIV prevention community planning. The interview will last approximately 45 minutes. The session will be tape recorded and transcribed for accuracy of responses. Once the tape recordings have been transcribed they will be destroyed. All data will be kept in a locked filing cabinet, in a locked office in the project director’s office and the project assistant’s office. In no way will we link your identity with the transcribed materials. You may choose not to answer any one or more questions.

I greatly appreciate you taking the time to let me ask you a few questions about the community planning group process.
Interview Questions

**Ice Breaker:** How did you become an employee of the Department of Health and Human Services?

**Questions related to community planning’s goals and objectives:**

11. What are the strengths and weakness of the recruitment process?

12. How does the CPG ensure that all voices are heard at the table?

13. What are the strengths and weaknesses of the process for prioritizing target populations?

14. What are the strengths and weaknesses of the process for selecting interventions?

15. How does the CPG ensure that there is a direct relationship between the Comprehensive HIV prevention plan and the progress report?
   a. What are the strengths of this process?
   b. In what way could this process be improved?

**Questions related to members’ motivations:**

16. What do you think motivates individuals to become a part of the CPG?

17. What could make the CPG more attractive to potential members?

18. What are your expectations for the community planning group?

19. Have your expectations been met? If so, in what ways? If not, how has the CPG fallen short?

20. What other thoughts do you have regarding Montana’s HIV community planning process?