



PENNSYLVANIA HIV PREVENTION COMMUNITY PLANNING UPDATE

A quarterly publication of the Pennsylvania Department of Health, Division of HIV/AIDS

2004 HIV Prevention Plan and CDC Grant Application

At the 16 July 2003 Committee meeting the CPG and health department discussed the Planning Cycle and agreed upon submitting a one-year Plan for 2004 and then two subsequent Plans for years 2005 and 2006 as well as 2007 and 2008. The primary rationale for this adoption was to align the HIV Prevention Plan with the local county and municipal health departments contracting process. Hence, Plan recommendations will be incorporated into the county and municipal contracts in their next three-year contract period commencing on 1 July 2006 through 30 June 2009.

The 2004 HIV Prevention Plan and CDC grant application have been completed by the HIV Prevention Community Planning Committee and the Pennsylvania Department of Health Division of HIV/AIDS. The full document is to be submitted to the CDC on Monday 6 October. At the September and November meetings the Committee is already examining the timelines to complete the 2005 and 2006 two-year Plan that will be developed in 2004 for submission next Fall.

The Committee will continue meeting at the Best Western Inn and Suites of Middletown/Harrisburg on the following dates in **2004**:

New Member Orientation

Tuesday

20 January

CPG meetings

Wednesday

21 January

Wednesday/Thursday

17 & 18 March

19 & 20 May

21 & 22 July

Wednesday

18 August

15 September

17 November

New Committee Members Sought

The current Calendar Year 2003 Pennsylvania HIV Prevention Community Planning Committee (Committee), the CDC funded Community Planning Group (CPG) for Pennsylvania not including Philadelphia, is composed of 39 members. The Committee appoints some voting members based on their unique expertise in prevention planning, policy experience, or familiarity with systems.

Members from the Pennsylvania Departments of Education and Corrections are appointed to the Committee. Two members from the Ryan White HIV/AIDS Regional Planning Coalitions have been appointed. The Young Adult Roundtable Executive Committee elects four young adults. Consultants from the Pennsylvania Department of Health Bureaus of Drug & Alcohol Programs, Epidemiology and Communicable Diseases Division of HIV/AIDS regularly attend and participate at Committee meetings.

The CY 2004 Committee is expected to remain in the 40-member range. Attrition will require new members to ensure maintenance of the identified categories. Following the September 2003 meeting Co-Chairs and the Nominations Committee will review attendance and participation records of Committee members. Those no longer able to participate will be removed.

Members not in attendance are sent all materials distributed at each meeting. Reminders are sent to members to communicate to Co-Chairs if they are experiencing problems with participation. CPG

members can serve two consecutive three-year terms as dictated through bylaws.

Committee members volunteer at the September meeting for an ad hoc nominations committee to nominate new members to the Committee. In early October the Department of Health, following input from the Committee, widely distributes nominating forms to the seven Ryan White HIV/AIDS Regional Planning Coalitions for distribution to their subcontractors and community representatives, the ten local county and municipal health departments, Committee members, posts the application on the stophiv.com web site in a downloadable fashion, and special mailings to other pertinent groups particularly those representing target and sub-populations.

The Pennsylvania Prevention Project analyzes the current composition of the Committee to determine representation within several categories. These include racial/ethnic categories in relation to both the epidemic and Epidemiological profile in Pennsylvania not including Philadelphia, gender, geographic representation, and HIV-infected persons by transmission categories in accordance with the most recent surveillance data. Committee member attendance

for the current year is reviewed to determine any vacancies.

Nominations are reviewed and scored by the Nominations Committee. Nomination Committee members contact potential new Committee members for a brief interview emphasizing the commitment of time necessary for the community planning process. Once the potential members have completed the interview process the Nominations Committee has a final vote.

New Members are notified in writing that they have been selected and are invited to attend a one-day orientation and reception the day preceding their first meeting in January. In addition, they are assigned a Committee member who will mentor them through the community planning process.

Preliminary results indicate a need for more HIV positive individuals in HIV risk-related categories of men who have sex with men (MSMs), injection drug users, (IDUs), men who have sex with men who are also injection drug users (MSM/IDUs), from all race/ethnic categories as well as women. In particular members need to be from the more populated counties around Philadelphia (Montgomery, Bucks, Delaware and Chester), South

Central and South Western Pennsylvania.

Community Planning Groups and HIV Prevention Policy

Since 1994, the Centers for Disease Control and Prevention has required its 65 public health department grantees to develop and implement a collaborative planning process with state and local communities as a condition of continued HIV prevention funding. In a recent AIDS Education and Prevention journal article, study authors argue that policy making for local priorities and systems change within government institutions are consequences of the core objectives. CPGs, through their expertise and advocacy for change, have the potential to shape public policy for HIV prevention whether they perceive this or not.

The five core objectives of HIV prevention of HIV prevention community planning are to (a) foster an open and participatory planning process; (b) recruit and retain a membership reflective of the local epidemic whose expertise include epidemiology, behavior/social science, health planning, and evaluation, (c) establish HIV prevention needs based on an epidemiological profile and needs assessment; (d) give explicit consideration to outcome effectiveness, cost effectiveness, theory and community norms and values in selecting HIV prevention

interventions and (e) demonstrate clear linkages among the planning process, the health department's application for CDC funding, and the allocation of federal dollars.

The study aims were to measure the perceptions, experiences, and actions of CPG members to understand the factors that facilitate or inhibit policy-making activities by CPGs. HIV prevention policy was defined as, "developing solutions or agreed upon course of actions while balancing conflicting views." A semistructured survey was administered to all identified CPG members (n=1,058) from 56 CPGs in California who participated in HIV prevention community planning during the calendar or fiscal years 1998 and 1999.

Fifty-one of the 56 California counties with HIV prevention CPGs participated in the survey for a total of 400 participants. Seventeen of the 56 counties were considered rural according to the California State Office of AIDS. CPG members who participated in community planning in California during 1998 and 1999 were largely Caucasian (67%), female (59%), and heterosexual (64%), with an average age of 46. CPG members were highly educated with 80% reporting a bachelor's degree or higher. Nearly 50% earned annual incomes of \$46,000 or more. Eleven-

percent of the respondents were HIV positive.

Nearly half (48%) reported the authority of the CPG was a combination of advisory and decision making, 33% indicated that their CPG was solely advisory to the health department, and 20% reported having decision-making authority. Seventy-percent of CPG members thought they should have the authority to make decisions about funding and resource allocations, and 50% indicated that the CPG had this authority during 1998 and 1999.

The majority of respondents (86%) agreed that a function of planning was to promote change in public policy, and 80% thought that HIV prevention planning groups should be able to influence local legislative policies related to HIV. Two-thirds indicated that the health department should involve the CPG in all HIV prevention decisions, and 73% were somewhat or very confident that the health department involved the CPG in HIV prevention decisions during the years under study.

Eighty-percent of respondents indicated that the CPG and the health department enjoyed a positive relationship. This was further supported by the 64% of CPG members who disagreed or strongly disagreed that the CPG

served as a "rubber stamp" for decisions that were already made by the health department.

The top five factors that facilitate policy making were: 1) support from the health department, 2) effective leadership among the co-chairs, 3) adequate funding for planning process, 4) diverse members and 5) clear definition of roles and responsibilities. The top five factors that inhibit policy making were: 1) ineffective leadership among co-chairs, 2) uncertainty of planning group role, 3) inadequate funding of planning process, 4) lack of support from the health department and 5) lack of support from politicians, or an advisory only role authority.

Rural counties resembled the urban counties in their responses to most of the research questions. Rural and urban CPGs differed on what CPGs *should* do and similarly, urban and rural CPGs differed on what the CPG was *supposed* to do. Rural and urban counties agreed on the factors that promote policy making; however, the rank order was different indicating that while they agreed on the same five promoting factors they assigned different weights to each factor. Rural CPGs differed from urban on the factors that interfere with policy making, placing more emphasis on political support

and funding than leadership and role clarity, but differences were not significant.

CPGs in California have made profound changes in government systems and these experiences position them for policy making in HIV prevention. The writers further suggest that health department and other leaders in the community planning process need to enhance communication with CPGs to ensure that CPG members are aware of system and policy changes resulting from the planning process and so they recognize the significance and potential of their influence.

Rose VJ, Gomez CA, Valencia-Garcia D (2003) Do Community Planning Groups (CPGs) Influence HIV Prevention Policy? An Analysis of California CPGs. AIDS Education and Prevention, 15, 2 172-183.

How Pennsylvania Measures Up-State Rankings

The following selected information from the Pennsylvania State Data Center provides a partial picture of Pennsylvania as it compares to the other 50 states:

- Pennsylvania is 5th in population while California is first and Wyoming last.

- PA is 10th in population density while New Jersey is first and Alaska last.
- PA is 44th in population growth, but first in rural population (%).
- PA is 3rd in median age of population with Florida first and Utah last.
- PA is 15th in per capita income while Connecticut is first and Mississippi last.
- PA is 17th with number of farms while Texas is first and Alaska last.
- PA is 33rd with an unemployment rate (number one is low) while North Dakota is first and Alaska is last.
- PA is 4th with union membership while New York is first and South Carolina last.
- PA is 5th with federal funding while California is first and Wyoming last.
- PA is 40th with voter registration while North Dakota is first and Hawaii last.
- PA is 46th with its birth rate while Utah is first and Maine last.
- PA is 2nd with death rate while Alaska is first and West Virginia is last.
- PA is 6th with physicians per 100,000 population while Massachusetts is first and Idaho is last.
- PA is 14th with AIDS rates while New York is first and Wyoming last.

- PA is 50th with k-12 school enrollment while Texas is first.
- PA is 2nd with the number of hazardous waste sites while New Jersey is first and Nevada and North Dakota tie for last
- PA is 3rd with hunters while Michigan is first and Hawaii last.

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