

LOCAL REINVENTION OF THE CDC HIV PREVENTION COMMUNITY PLANNING INITIATIVE

James W. Dearing, PhD; R. Sam Larson, PhD; Liisa M. Randall, MA; and
Randall S. Pope, BS

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

INTRODUCTION

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

James W. Dearing is Associate Professor, Department of Communication, Michigan State University, R. Sam Larson is Principal, Applied Research, Liisa M. Randall is Consultant, and Randall S. Pope is Chief, HIV/AIDS Prevention and Intervention Section, Michigan Department of Community Health.

Requests for reprints should be addressed to James W. Dearing, PhD, Department of Communication, Michigan State University, East Lansing, Michigan 48824-1212.

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

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

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

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

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

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

IMPLEMENTING THE CDC COMMUNITY PLANNING INITIATIVE

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

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

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

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

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

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

Grantees responding to the CDC *Guidance* exhibited considerable

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

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

This planning process was communicated to RCPG leadership and members through a planning workbook distributed by HAPIS, through

annual skill building conferences, through direct technical assistance provided to each region, and through extensive correspondence between HAPIS and the regional planning groups. In addition, the planning process was reviewed at several SCPG meetings where members from each RCPG were present.

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

PROCESS EVALUATIONS OF HIV PREVENTION COMMUNITY PLANNING

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

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

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

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

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

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

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

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

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

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

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

REINVENTION OF COMMUNITY PLANNING IN MICHIGAN

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

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

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

REFERENCES

1. Valdiserri RO, Aultman TV, and Curran JW. Community planning: A national strategy to improve HIV prevention programs. *J Community Health* 1995; 20:87-100.
2. U.S. Centers for Disease Control and Prevention. *Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects*. Atlanta: U.S. Centers for Disease Control and Prevention, 1993.
3. Green LW and Kreuter MW. Health promotion as a public health strategy for the 1990s. *Ann Rev of Public Health* 1990; 11:319-334.
4. Aggleton P, O'Reilly K, Slutkin G, and Davies P. Risking everything? Risk behavior, behavior change, and AIDS. *Science* 1994; 265:341-345.
5. Dearing JW, Rogers EM, Meyer G, et al. Social marketing and diffusion-based strategies for com-

- municating with unique populations:: HIV prevention in San Francisco. *J of Health Communication* 1996; 1:343-363.
6. Federal Facility Environmental Restoration Dialogue Committee. *Final Report of the Federal Facilities Environmental Restoration Dialogue Committee: Consensus Principles and Recommendations for Improving Federal Facilities Cleanup*. Keystone, CO: The Keystone Center, 1996.
 7. Rogers EM. Re-invention during the innovation process. Presented at the Workshop on Assessment of Current Developments on the Diffusion of Innovations, Northwestern University. November 15-16, 1978.
 8. Rice RE and Rogers EM. Reinvention in the innovation process. *Knowledge: Creation, Diffusion, Utilization* 1980; 1:499-514.
 9. Eveland JD. Diffusion, technology transfer, and implementation. *Knowledge: Creation, Diffusion, Utilization* 1987; 8:303-322.
 10. Dearing JW and Rogers EM. *Agenda-Setting*. Thousand Oaks, CA: Sage, 1996.
 11. AIDS Action Foundation and AIDS Action Council. *Blueprint for HIV Prevention*. Washington, DC: AIDS Action Foundation, 1993.
 12. U.S. Centers for Disease Control and Prevention Advisory Committee on the Prevention of HIV Infection. *External Review of CDC's HIV Prevention Strategies*. Atlanta: U.S. Centers for Disease Control and Prevention, 1994.
 13. Association of State and Territorial Health Officials, National Alliance of State and Territorial AIDS Directors, and Council of State and Territorial Epidemiologists. *State Health Agency Vision for HIV Prevention*. Washington, DC: 1993.
 14. Nancy Pelosi. *House of Representatives 1538: Comprehensive HIV Prevention Act of 1993*. Washington, DC: U.S. Congress, 1993.
 15. Valdiserri RO and West GR. Barriers to the assessment of unmet need in planning HIV/AIDS prevention programs. *Public Administration Rev* 1994; 54:25-30.
 16. U.S. Centers for Disease Control and Prevention. *Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects*. Atlanta: U.S. Centers for Disease Control and Prevention, 1993.
 17. Academy for Educational Development. *Handbook for HIV Prevention Community Planning*. Washington, D.C.: Academy for Educational Development, 1994.
 18. Holtgrave DR. Setting priorities and community planning for HIV-prevention programs. *AIDS & Public Policy J* 1994; 9:145-151.
 19. U.S. Council of Mayors. *HIV Prevention Community Planning Profiles: Assessing Year One*. Washington, DC: U.S. Council of Mayors, 1995.
 20. U.S. Council of Mayors. *HIV Prevention Community Planning Profiles: Assessing the Impact*. Washington, DC: U.S. Council of Mayors, 1996.
 21. Academy for Educational Development and National Alliance of State and Territorial AIDS Directors. *HIV Prevention Priorities: How Community Planning Groups Decide*. Atlanta: U.S. Centers for Disease Control and Prevention, 1996.
 22. Shadish Jr WR, Cook TD, and Leviton LC. *Foundations of Program Evaluation*. Thousand Oaks, CA: Sage, 1991.
 23. Valdiserri RO and West GR. Barriers to the assessment of unmet need in planning HIV/AIDS prevention programs. *Public Administration Rev* 1994; 54:25-30.
 24. Siegel LM, Attkisson CC, and Carson LG. Need identification and program planning in the community context. In FM Cox, JL Erlich, J Rothman, and JE Tropmen, (Eds), *Strategies of Community Organization*. Itasca, IL: FE Peacock, 1987, pp.71-97.
 25. von Winterfeldt D, and Edwards W. *Decision Analysis and Behavioral Research*. New York: Cambridge University Press, 1986.
 26. Bosin MR. Priority setting in government. *Evaluation and Program Planning* 1992; 15:33-43.
 27. Holtgrave DR. Setting priorities and community planning for HIV-prevention programs. *AIDS & Public Policy J* 1994; 9:145-151.
 28. Applied Research. *Evaluation of the 1995 Michigan HIV Prevention Community Planning Process*. Report prepared under contract to the HIV/AIDS Prevention and Intervention Section, Michigan Department of Public Health, 1995.
 29. Valdiserri RO, and West GR. Barriers to the assessment of unmet need in planning HIV/AIDS prevention programs. *Public Administration Rev* 1994; 54:25-30.