

Longitudinal Observation of an HIV Prevention Community Planning Group (CPG)

Roberto Mejia, PhD
Richard A. Jenkins, PhD
James W. Carey, PhD, MPH
Hortensia Amaro, PhD
Allison C. Morrill, PhD
Laura Krech, MPH
Jennifer A. Logan, MS
Kevin Cranston, MDiv

HIV prevention community planning groups were formed to increase stakeholder participation and develop evidence-based comprehensive HIV prevention plans. To date, it is not well understood what factors affect group behavior as the planning group prepares for data-informed decision making. In this observational case study, the authors videotaped 18 meetings of a community planning group (CPG) to observe how a group's behavior changes over time in response to modifications in its structure and function. Discussions on authority and conflict were common, particularly during presentations on prioritized populations and interventions. Changes in the frequency of data-informed discussions were not statistically significant. Observed group conflict may have been an unintended consequence of efforts to improve equity. The authors suggest that formal and informal mechanisms to manage conflict and agreed-on procedures for decision making should be incorporated into the technical assistance offered to CPGs. Future studies should address whether data-informed decisions increase once contentious issues are resolved.

Keywords: *community planning group; CPG; organizational development; group behavior; HIV/AIDS prevention; HIV community planning*

On December 30, 1993, the Centers for Disease Control and Prevention (CDC) issued supplemental guidance to revise the process of HIV prevention community planning. Based on input from governmental and nongovernmental organizations, the creation of community planning groups (CPGs) was required by publicly funded HIV prevention programs in 65 health departments (Academy for Educational Development [AED] 1994; CDC, 1993, 1998, 2003). State and local health departments were requested to share responsibilities with CPGs for assessing present and future HIV epidemics, community resources, identifying unmet needs, and developing comprehensive HIV prevention plans. The planning process was not guided by a particular theoretical or program framework, but instead, was meant to be a general set of principles for improving the scientific basis of program decision making (i.e., make it evidence based) as well as to provide more input from at-risk or affected populations (Valdiserri, Aultman, & Curran, 1995). This process encourages CPG members to use epidemiological and behavioral data for the core HIV prevention planning objectives of population and intervention prioritization.

A health department's application for CDC federal HIV prevention funding is based in part on a comprehensive

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The Authors

Roberto Mejia, PhD, is a public health analyst at Prevention Research Branch, Division of HIV/AIDS Prevention (DHAP), Centers for Disease Control and Prevention, Atlanta, Georgia.

Richard A. Jenkins, PhD, is currently health scientist administrator at Prevention Research Branch, National Institute on Drug Abuse, Bethesda, Maryland.

James W. Carey, PhD, MPH, is a behavioral scientist and is the team leader for the Operational Research Team within the Prevention Research Branch, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia.

Hortensia Amaro, PhD, is distinguished professor of health sciences at the Bouve College of Health Sciences and director of the Institute on Urban Health Research at Northeastern University, Boston, Massachusetts.

Allison C. Morrill, PhD, is president of Capacities, a research firm in Watertown, Massachusetts, and serves as director of research and evaluation for Vida Health Communications in Cambridge, Massachusetts.

Laura Krech, MPH, is a program manager for the United States Pharmacopeia Drug Quality and Information program in Rockville, Maryland.

Jennifer A. Logan, MS, is the president of Catalyst Consulting, a research, training, and technical assistance firm located in Norwell, Massachusetts.

Kevin Cranston, MDiv, is the director of the HIV/AIDS Bureau, Massachusetts Department of Public Health, Boston, Massachusetts.

prevention plan developed by the health department and the CPG. At the time of this study, the comprehensive HIV prevention plan was expected to include: an epidemiological profile for HIV in the funded jurisdiction, a needs assessment, a resource inventory of HIV prevention programs in the jurisdiction, and a gap analysis that documents unmet needs (CDC, 1993, 1998). The CPG also prioritizes populations and interventions to address the needs of those populations. The CPG participates in the preparation of the final document sent to CDC by the jurisdictional health department by offering its concurrence or nonconcurrence with the final plan's recommendations for populations and interventions. Not all of these tasks have to be completed in every year (e.g., population and intervention prioritization occur during separate planning cycles).

CPGs have encountered a variety of barriers to effective evidence-based planning. Local data on HIV cases

and high risk populations are often limited, and the utility of available data may be constrained by factors such as data collection methods, presentation, and the quality of available technical assistance (Jenkins, Cranston, et al., 2005). As a result, CPG members may be unsure how to make the best use of data, creating "decision making under uncertainty" (Hammond, 1996; Kahneman & Tversky, 1982). These conditions promote the use of suboptimal decision strategies and tendencies toward personal bias in decision making, even among "experts."

Capacity building for CPGs has tended to concentrate on technical aspects of planning such as recruitment of at-risk and affected populations (Valdiserri, 1996) and the construction of epidemiological profiles (Neal & McNaghten, 1998), as opposed to the social-organizational dynamics of group decision making. The published guidance (AED, 1994; CDC, 1993, 1998, 2003) addresses organizational aspects of CPGs in general terms, encouraging representation from affected populations and seeking open nomination of members along with equitable procedures for conducting meetings but does not describe how to conduct the meetings. Available data suggest that establishing CPGs is a time-consuming process even under optimum conditions (Dearing, Larson, Randall, & Pope, 1998). Organizational dynamics also can undermine evidence-based planning where groups are poorly facilitated (Amaro et al., 2005; Batchelor, Freeman, Robbins, Dudley, & Phillips, 2005).

Surprisingly few studies have looked at group process and decision making in public policy planning groups such as CPGs, even though these kinds of bodies have become a popular way of planning and allocating resources for a variety of health and human service issues. Most of the available literature discusses results from surveys that addressed perceptions and experiences of members regarding systems change and policy making (e.g., Valerie, Gomez, & Valencia-Garcia, 2003) or qualitative case studies based largely on focus groups or interviews (e.g., Butterfoss, Houseman, Morrow, & Rosenthal, 1997).

The current study was part of a CDC-funded effort to improve behavioral data availability, quality, and use within CPGs in Texas and Massachusetts (Jenkins, Robbins, et al., 2005). Meetings of the Massachusetts CPG were videotaped, as the group underwent changes in its structure and function prior to making informed decisions based on sound and reliable data. Briefly, decision-making authority at the outset had been concentrated in a steering committee which many members viewed as being dominated by health department agendas. In response to this, the CPG modified its membership recruitment process and decision-making structure (see Table 1).

TABLE 1
Code Definition of Observations of Routine Tasks, Organizational Structure, and Data Input for the Massachusetts Community Planning Group (CPG)

<i>Code</i>	<i>Definition</i>
Routine tasks	
Team building	Group exercises to strengthen and/or restore group bonds.
Training of CPG Members	CPG effort to better prepare new members with an orientation curriculum that included the history and purpose of community planning, member roles and responsibilities, group norms, decision-making timelines, an assessment of new members' training needs, and other introductory topics.
Organizational structure	
Consensus issues	Discussions regarding procedures and policies (e.g., co-chair's consistency), member's confusion about consensus voting (e.g., "thumbs-up motion," "let's just vote on this" statements).
Group independence/questioning authority	Issues of control around the facilitator, the agenda, and department of public health (e.g., complaints about changes in agenda, DPH control on cooperative agreement, and issues around DPH's completion of recommendations on population and intervention prioritization).
Individual conflict	Discussions leading to conflict among CPG members (e.g., confusion over the roles of members and leaders) and instances in which members expressed disagreements about specific population groups.
Data input	
Data results	Discussion of outcomes such as effective interventions for prevention and education (e.g., community outreach, behavioral change counseling for Latino men who have sex with men, injection drug users, sex workers, CDC categories, DPH Epi-Profile).
Department of health DPH data	Discussion of DPH data presentations (e.g., HIV surveillance data, effective interventions for partner counseling and referral services, CDC prioritization tool, DPH gap analysis data, DPH allocation of dollars).
Outside source data	Discussion of data presentations by non-DPH members (e.g., academic study to assess a gender specific and culturally appropriate empowerment model of HIV prevention).
Emerging populations	Discussion included presentations on homelessness and HIV, deaf and hard of hearing. (Greater change in discussions related to emerging populations normally would be expected during population prioritization.)

The membership committee began to select and train new members with an intentionally broader representation of affected populations and more diverse levels of educational attainment. This led to a significant reduction of members with advanced degrees (65% to 43%), although there were no changes in relative representation of government employees, providers, or consumers (Amaro et al., 2005; Morrill et al., 2005). Decision making was redistributed to three new leadership groups, each of which had different areas of jurisdiction (policy and procedures, membership, and work plans). In addition, smaller "population groups" were formed to provide forums for people whose interests and expertise were related to specific priority populations

(e.g., injection drug users, men who have sex with men). The "population groups" met near the end of each CPG meeting to process the data and other presentations that had been presented.

The purpose of this article is to examine how the Massachusetts CPG's attempts to improve its own structure and function affected its observable behavior, especially those behaviors related to evidence-based decision making. Prior to the study, we expected to see the group develop more cooperative types of behavior following efforts to better distribute decision making responsibility in the group (Cherniss & Deegan, 2000) and expected that more consideration would be given to the discussion of data. We also assumed that the normal life of the group

would invoke cycles of greater and lesser discussion of data in relation to the prioritization tasks, which would affect the observed behavior of the group.

► METHOD

Participants

At baseline, CPG members ranged in age from 19 to 60 with 50% female participation. Of the members, 13% had participated one year or less on CPG activities, 35% had some college or less education, and 65% held advanced degrees. Providers represented 71% of membership followed by public agencies (16%) and consumers (13%). After reorganization of the group, there was a decline in the proportion of members who held advanced degrees (65% to 49%, $p < .05$), and the remainder displayed a nonsignificant increase in the proportion of college or less (35% to 51%, $p > .05$). There were no changes in relative representation of government employees, providers, and consumers as a consequence of reorganization (Amaro et al., 2005; Morrill et al., 2005).

Procedures

Researchers from Northeastern University videotaped a total of 18 meetings of the Massachusetts CPG (with the group's consent) from May 2000 through June 2002 to observe the group's deliberations. The investigators developed an initial codebook to qualitatively code the activities observed in the videotapes. The codes we have included in this article represent nonparticipant observations about organizational structure and function, and situations where the group discussed or used HIV-related data during their meetings. These included: routine tasks, organizational structure, and data input (see Table 1). Data input codes included the activities themselves (e.g., data presentations), and time spent discussing them. The selected codes do not account for all the total time spent in CPG activities, as infrequent codes and codes for purely administrative processes (e.g., calling meetings to order) were excluded. The reliability of the codes was tested by CDC investigators in Atlanta who used a number of "test" tapes (e.g., the June 2001 video was used as a test meeting) to become familiar with the codebook and to ensure that coders applied the codes in the same way. The CDC investigator reconciled his codes with those of the Northeastern investigators, with conceptual input from senior CDC and Northeastern staff. The resulting codes were then used to establish onset and offset times (frequency in minutes) of particular behaviors or patterns of behavior, and the amount of time associated with each code was computed.

In addition to the videotaping, data collection included face-to-face interviews and self-report questionnaire data from CPG members, and reviews of archival planning documents. Findings from those data are described elsewhere (Amaro et al., 2005; Morrill et al., 2005).

As shown in Table 2, we organized the observations from the 18 meetings into four periods, based on (a) the group's focus on specific programmatic tasks and (b) modifications to the CPG's organizational structure and function. These modifications were based on formative data (Amaro et al., 2005) and both the data collection and the specific modifications are described in detail elsewhere (Jenkins, Cranston, et al., 2005; Morrill et al., 2005). This sequence facilitated our interpretation of changes in the group's structure and function and modifications to data input that occurred during the normal planning cycle of the group.

The time periods differed in length, as meetings were not held monthly. Because the total meeting time varied, time spent on coded behaviors during each period was standardized as a percentage of the total meeting time (i.e., sum of the time of a particular code) during that period. Because of the timeline of the project and the cyclical nature of the CPG's work, we were not able to look at the intermediate or long-term effects of all the changes in the group because some were introduced very late in the observations, or were not fully implemented during the observation period.

Statistical Analysis

The primary goal of this analysis was to see whether time spent on certain topics varied as modifications in group structure and function were implemented. First, we describe the percentage of time spent on each category of CPG behavior during each of the periods before that change to the percentage of time spent on the same behavior during each of the periods following that change. Second, we use the Kruskal-Wallis test for independent samples (Kruskal & Wallis, 1952), to test whether the four periods significantly differ. Tests of significance used an alpha of .05.

► RESULTS

Modifications of Organizational Structure

As shown in Figure 1, once the revised recruitment and selection process was implemented in Period 1, the proportion of time spent discussing training new committee members declined in Period 2, but gradually increased during Periods 3 and 4, but the change was not significant. Team-building exercises proceeded

TABLE 2
Massachusetts Community Planning Group (CPG) Timeline of Routine Data Collection, Planning Tasks, and Changes to Organizational Structure and Function, Period 1 to Period 4

<i>Data Collection Dates</i>	<i>CPG Tasks</i>	<i>Changes to CPG Structure or Function</i>
Period 1 (Baseline Data Collected) May 2000 June 2000 July 2000	Assessment of population needs	Membership task force created
Period 2 September 2000 October 2000 December 2000 February 2001 March 2001	Presentations focusing on interventions for the various populations that had already been prioritized (e.g., injection drug users, sex workers) and interventions (e.g., partner counseling)	Interim leadership plan by consensus of CPG New members selected and oriented Structural changes introduced: work plan committee, steering committee, population groups Team-building activities
Period 3 April 2001 May 2001 June 2001 July 2001 August 2001 September 2001 (Note: Massachusetts HIV Prevention Planning Group meeting cancelled because of news of September 11)	Gap analysis and epidemiological profile reviewed Interventions prioritized, using CDC intervention categories	Floating technical assistants began providing support to population groups as needed
Period 4 October 2001 November 2001 December 2001 February 2002 June 2002	Reviewed comprehensive plan, cooperative agreement, and concurrence Because of a number of factors, including severe budget cuts that occurred in December 2001 (news of cuts began in November 2001) and an unexpected number of meeting cancellations because of September 11 and the budget cuts, the population prioritization process was postponed. Members felt that they would not have sufficient time to complete the prioritization process before the required concurrence process in September. In lieu of population prioritization process, members voted to develop population description chapter beginning in June 2002. They also voted to develop a "more authentic population prioritization process" for the future. January meeting was cancelled because of meetings about the budget cuts, and the new bimonthly schedule (instituted mainly because of budget cuts) was implemented in February 2002. After February 2002, meeting schedule alternated between large-group meetings and committee meetings. Observations occurred only during large-group meetings.	New data request system implemented Templates and technical assistance for data providers initiated

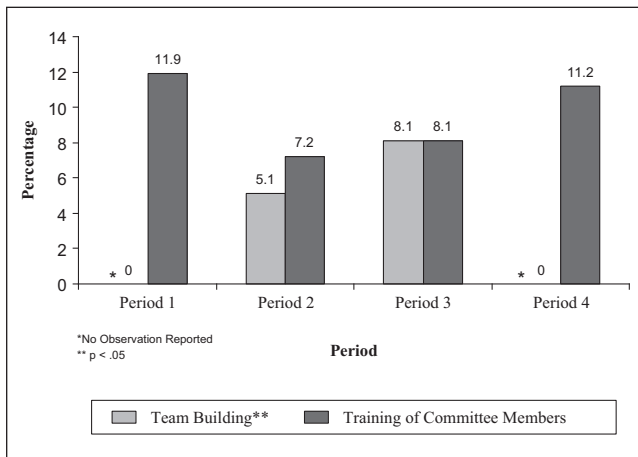


FIGURE 1 Proportion of Time Spent in Community Planning Group's Team Building and Training, May 2000 to June 2002

recruitment activities (see Table 2). Time spent in team-building exercises significantly increased from Period 1 to Periods 2 and 3. These exercises were absent during Period 4 (Figure 1).

The change in CPG organization was followed by increased time spent in discussion of group consensus and authority during Periods 3 and 4. Increased conflict among individual members also was observed over this period (Figure 2). Although the observed changes were not statistically significant, it appeared that both conflict within the group and efforts to reach consensus were features of the prioritization process.

Modifications of Data Presentations and Use

During Periods 3 and 4, procedural and technical changes were implemented to improve the relevance of data presentations for the planning process. Standardized formats for data presentations were implemented and an effort was made to organize presentations around specific topics of themes (e.g., devoting all presentations at a single meeting to different aspects of injection drug use, including surveillance findings, program data, and evaluation data). During Period 4, a data request system was implemented to increase the availability of data.

Although discussion of data presentations from sources outside the department of public health appears to have diminished after Period 1 (when population needs were being assessed), there were no significant changes in the proportion of time spent on data-related discussions during the four time periods (Figure 3).

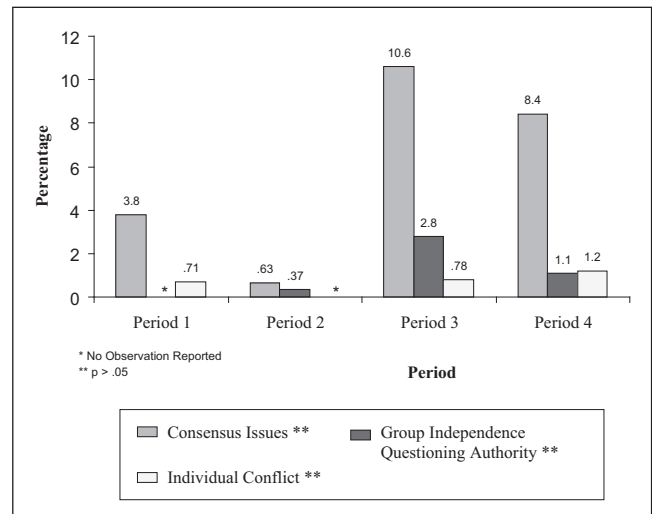


FIGURE 2 Proportion of Time Spent in Community Planning Group's Organizational Behaviors, May 2000 to June 2002

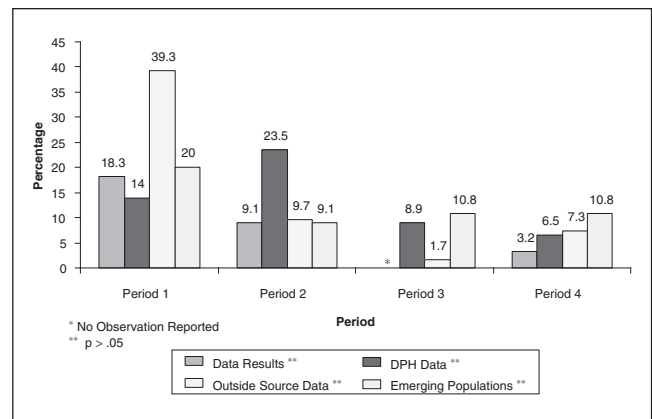


FIGURE 3 Proportion of Time Spent in Community Planning Group's Data-Related Behaviors, May 2000 to June 2002
NOTE: DPH = department of public health.

DISCUSSION

This study provides a direct observational picture of a planning group during a period of time when the group was attempting to implement organizational and procedural changes. Our study provides preliminary findings for understanding the integration of group behavior and decision making into HIV community planning efforts, particularly with respect to time spent in capacity building, consensus and conflict within the

group, and discussion of data. We observed that training activities decreased once the new membership criteria were implemented even though a fair amount of attention had been devoted to training new members during the period when the membership committee was instituted. Group activities and technical assistance aimed at increasing participation and knowledge of community planning decreased over time as a result of receiving data-related concepts (Jenkins & Carey, 2005). We found that changes in structure were followed by discussions of consensus and authority, and instances of conflict before decision making activities using data were introduced to the CPG.

Despite the efforts to improve data availability and presentation, we actually observed nonsignificant declines in the frequencies of activities and discussions related to various data sources and topics (e.g., emerging populations). This pattern occurred during periods where presentations focused on prioritized populations and during the lead-up to the prioritization of interventions. Only data discussions that occurred during the large group presentations were videotaped and there was a significant upheaval during Periods 1 and 2 as the group went through the restructuring process. Upheaval occurred again in 2001 (Period 4) as a result of the statewide budget cuts. Hence, group discussion during Periods 1, 2, and 4 became focused on contentious issues, as opposed to the data-driven decision-making mission of the CPG. After the CPG's restructuring was complete, the group may have become better able to handle similar contentious issues related to interpersonal conflict within the group when they occurred in the future. Alternatively, it may be that the group spent more time in discussion of data when the presentations were less satisfactory, and once the quality has improved, less discussion was necessary. Periodic questionnaires collected from CPG members over roughly the same period found more favorable assessments of the CPG's group decision-making structure and leadership, and more satisfaction with the decision-making process than at baseline (Morrill et al., 2005). This suggests that planning groups may be responsive to changes in structure, even when they coincide with periods of conflict within the group and that these changes may even facilitate more comfort in people raising difficult issues within the group.

The present study illustrates the strengths and weaknesses of using direct behavioral observation as a method for understanding the operation of planning groups. This kind of observation provides a way of understanding group process that is not accessible from questionnaires or interviews. Still, observational data need to be understood in terms of a group's programmatic tasks, and it is useful to supplement observation with other data sources

such as questionnaires. By their nature, planning groups do not lend themselves to evaluation by experimental or quasi-experimental designs (Koepsell et al., 1992) and alternative designs such as longitudinal observation are necessary. Most of the patterns of change in behavior over time did not attain statistical significance, perhaps in part because of the small number of meetings observed. It is also likely that our codes, although reliable and useful for statistical analysis, were insufficiently refined to capture relevant subtleties. The nature of groups blurs the onset times of interventions because they have to be blended into the normal work cycle of a planning group's tasks and may take time to be fully integrated into the group process. The nonlinear quality of change in planning groups is common to many group settings (White, 1984). Another problem was the presence of smaller, concurrent "population groups" that occurred during the latter portions of the CPG, as part of the changes in group structure and function. These subgroups were designed to facilitate discussion of data-based presentations and could not be feasibly videotaped. The decline we observed in data-related discussions may have been an artifact of this change in the group structure.

► CONCLUSION

We observed changes in the behavior of the Massachusetts CPG that suggested that modifications of the group structure led to changes in group behavior that were sometimes counterintuitive. Although the group gained more structure and capacity building activities were put in place, conflict also increased. Some of the patterns we observed in CPG behavior may reflect the normal planning cycle, rather than organizational and procedural changes. Some CPG-type groups adopt an unstructured approach to minimize conflict or facilitate openness, but this approach can also create a lack of equity within the group. The results here suggest that increased discord might be an unintended consequence of efforts to improve equity. This article represents the first efforts to directly and prospectively observe planning groups rather than infer process from questionnaires, or from cross-sectional retrospective qualitative accounts. The effort to develop reliable and frequent codes that can be subjected to statistical analysis may sacrifice some of the nuance of group process and individual behavior.

► IMPLICATIONS AND RECOMMENDATIONS

Further research is needed to systematically study how groups for HIV prevention programs and other planning

tasks function in real time. Parallel to this is the need for better theoretical models, conceptual frameworks, and technical assistance for guiding the group processes aspects of these planning bodies. In practice, many groups adopt a permissive, laissez-faire approach to minimize conflict or facilitate openness, but this approach can create a chaotic atmosphere or otherwise create a lack of equity in a group. The guidance for these groups needs to make better use of organizational theories that consider the role and significance of context in shaping decision processes and the process of change (Pettigrew, 1985; Rajagopalan, Rasheed, Datta, & Spreitzer, 1997). Given the statistical power limitations that occurred with our observational methodology, it may be useful to supplement systematic observation with ethnographic methods, such as participant observation, that often have been applied in organizational settings (White, 1984). In addition, researchers need to take into account how their designs can capture the routine patterns of the group and isolate factors related to these, apart from any interventions that take place.

In practice, persons charged with facilitating planning groups need to recognize the dynamic nature of groups and the difficulties in providing enough structure to promote equity, while also tolerating conflict. In this regard, formal and informal mechanisms to appropriately manage conflict and formal agreed-on procedures to assure real equity and attention to the group's mission (Cherniss & Deegan, 2000) should be incorporated into the group's technical assistance so that it can improve the group's decision-making process. The original guidance for CPGs did not address organizational factors and purposely tried to encourage diverse structures that fit local needs (AED & CDC, 1994). This study and the available published literature (e.g., Dearing et al., 1998) make clear that additional guidance should be provided so that people starting or entering groups better understand how to create environments that meet the objectives of community planning.

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