

CHAPTER 1

Introduction and Overview of the Community Planning Process



Iowa HIV Community Planning Process Introduction and Overview

The Iowa Department of Public Health (IDPH) HIV/AIDS Program initiated an HIV prevention community planning process in January 1994. In 2001, the HIV Community Planning Group (CPG) merged prevention and care planning. The Iowa Planning Process embraces a community participatory planning process as an essential component for building an effective statewide HIV prevention and care program.

The evidence-based planning process specified by the national Centers for Disease Control and Prevention (CDC) in the “HIV Prevention Community Planning for HIV Prevention Cooperative Agreement Recipients” were followed to initiate the Iowa Planning Process. When care and prevention planning merged, the CPG incorporated guidance from the Human Resources Services Administration (HRSA) into the planning process. The IDPH is committed to developing and implementing a planning process that incorporates the views and perspectives of providers of HIV prevention and care services and HIV affected groups for whom the programs are intended.

ORIGINS AND PURPOSE OF HIV PREVENTION COMMUNITY PLANNING

In 1993, the CDC directed states and localities that receive funding for HIV prevention to conduct a community planning process. HIV Prevention Community Planning was built around the following principles:

1. HIV prevention community planning reflects an open, candid, and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valued.
2. HIV prevention community planning is characterized by shared priority setting between health departments administering and awarding HIV prevention funds and the communities for whom the prevention services are intended.
3. Priority setting accomplished through a community planning process produces programs that are responsive to high priority, community-validated needs within defined populations. Persons at risk for HIV infection and persons with HIV infection play a key role in identifying prevention needs not adequately met by existing programs and in planning for needed services that are culturally appropriate. HIV prevention programs developed with input from affected communities are likely to be successful in garnering the necessary public support for effective implementation and in preventing the transmission of HIV infection.

In 2003, the CDC set three major goals for HIV Prevention Community Planning. The three major goals are:

1. Community planning supports broad-based community participation in HIV prevention planning.
2. Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

3. Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

Comprehensive Planning Process: Prevention

To ensure that the HIV prevention community planning process is carried out in a participatory manner, the CDC expects CPGs to address the following *Guiding Principles of HIV Prevention Community Planning*:

1. The health department and community planning group must work collaboratively to develop a comprehensive HIV prevention plan for the jurisdiction.
2. The community planning process must reflect an open, candid, and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valued.
3. The community planning process must involve representatives of populations at greatest risk for HIV infection and persons living with HIV (PLWHA).
4. The fundamental tenets of community planning are parity, inclusion, and representation (often referred to as PIR).
 - *Representation* is defined as the act of serving as an official member reflecting the perspective of a specific community.
 - *Inclusion* is defined as meaningful involvement of members in the process with an active voice in decision making.
 - *Parity* is defined as the ability of members to equally participate and carryout planning tasks and duties.
5. An inclusive community planning process includes representatives of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics such as varying educational backgrounds, professions, and expertise.
6. The community planning process must actively encourage and seek out community participation.
7. Nominations for membership should be solicited through an open process, and candidate selection should be based on criteria established by the health department and the community planning group.
8. An evidence-based process for setting priorities among target populations should be based on the epidemiological profile and the community services assessment.
9. Priority setting for target populations must address populations for which HIV prevention will have the greatest impact.
10. The set of prevention interventions and activities for prioritized target populations should have the potential to prevent the greatest number of new infections.

ORIGINS AND PURPOSE OF HIV CARE PLANNING

The Ryan White CARE Act requires IDPH to develop a comprehensive plan for the organization and delivery of HIV care and support services to be funded under Title II. The CARE Act of 1996 requires States to coordinate the development of a Statewide Coordinated Statement of Need (SCSN). The IDPH is expected to provide the following planning-related information in describing its use of Title II funding:

1. The purposes for which the State intends to use the funds, including the services and activities to be provided, and an explanation of how the State would maximize the quality of health and support services available to all PLWHA

2. How funded services will be coordinated with related services for individuals with HIV disease
3. How the allocation and use of resources are consistent or not with the SCSN, developed in partnership with other Ryan White CARE Act grantees

Under Title II, Iowa provides funds to HIV care consortia for assistance in planning, developing, and delivering comprehensive services for individuals and families affected by HIV disease. To be eligible for State assistance, the CARE Act requires consortia to conduct the following planning activities:

1. Carry out an assessment of need within their geographic area
2. Develop a plan, in consultation with PLWHA and public health and community-based providers, to ensure the delivery of services to meet identified needs

Comprehensive Planning Process: Care

Building upon epidemiological data and other needs assessment information, the comprehensive planning process examines HIV care needs for the State and assesses the resources available to meet those needs and to overcome barriers to service provision. The comprehensive plan sets long-term goals while addressing the vision and values that guide Iowa's development of a system of care.

IDPH must develop a planning process and outline planning tasks. A sound comprehensive planning process and plan do the following:

1. balance openness and inclusiveness with timely creation of a final product
2. are developed in a coordinated manner
3. build upon and are coordinated with the needs assessment process.

OBJECTIVES OF COMMUNITY PLANNING

HIV community planning is an ongoing comprehensive planning process that is intended to improve the effectiveness of state, local and territorial health departments' HIV programs by strengthening the scientific basis, community relevance and population or risk-based focus of prevention interventions and care services.

Prevention

The following Goals and Objectives of HIV prevention community planning provide a framework for monitoring and measuring progress in achieving a reduction of new HIV infections and reduced HIV-related morbidity. Brief responses to attributes for each objective provide an overview of the Iowa Community Planning Group's (CPG) approach to achieving each objective.

GOAL ONE – 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.***

Nominations

Nominations for membership to the CPG are solicited through an open process and candidates are selected based on criteria (page 5) established by the CPG and the IDPH. The nomination and selection of new community planning group members by the Selection Committee occurs in a timely manner to avoid vacant positions or disruptions in planning. In addition, the recruitment process for membership in the HIV prevention community planning process is proactive to ensure that socio-economically marginalized groups and groups that are underserved by existing HIV prevention programs are represented.

Selection

Criteria for selection of members were developed by an Implementation Advisory Group established in 1994. The Implementation Advisory Group consisted of representatives from a variety of affected communities, persons with expertise in health promotion and disease prevention, local health departments, community based organizations, HIV/AIDS coalitions, HIV care providers and persons living with HIV.

A Selection Committee was established in 1994. The selection committee consists of representation from the health department, community based organizations, local health departments, and persons living with HIV.

Nomination packets are distributed to all HIV prevention and care providers through mailings and at meetings. During the annual HIV/AIDS Conference, sponsored by the Iowa Department of Public Health, Iowa Department of Education, and the CPG, nomination packets are widely distributed to reach many more potential candidates. Along with a "Call for Nomination," potential members are sent a nomination form, complete description of the CPG, and overview of the CPG process, a CPG member job description, and an order form for the current Comprehensive Plan.

- ***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.***

Representation

The CPG actively recruits new members who represent the diversity of perspectives of those affected by HIV and includes racial/ethnic, age, and geographic diversity of the state. Members represent the affected community in terms of race/ethnicity, gender/gender identity, sexual orientation, and geographic distribution.

A wide variety of areas of expertise are available to the CPG, both through its membership and IDPH technical assistance staff and consultants involved in the planning process.

Members are selected using the following criteria:

- The nominee reflects the characteristics of the current and projected epidemic (as documented by the epidemiologic profile) in terms of age, gender, race, ethnicity, and socioeconomic status, geographic distributions (urban and rural residence) and risk for HIV infection.
- The nominee represents one or more of the following constituencies:
 - a. state and local health departments, including HIV prevention and STD treatment programs;
 - b. state and local education agencies;
 - c. other relevant government agencies (e.g. substance abuse, mental health, corrections);

- d. epidemiology;
 - e. behavioral and social sciences;
 - f. program evaluation;
 - g. health planning;
 - h. key non-governmental and governmental organizations providing HIV prevention and related services to persons with or at risk of HIV infection (e.g., STD, TB, substance abuse prevention and treatment, mental health services, homeless shelters, HIV care and social services); and
 - i. key non-governmental organizations relevant to, but who may not necessarily provide HIV prevention services (e.g., representatives of business, labor and faith communities).
- The nominee is able to fulfill commitments to the CPG's work.
 - The nominee is able to relay pertinent information between the CPG and his/her constituency in the community.

The CPG's membership ranges from 17 to 33. The HIV/AIDS Program provides technical support as needed. In 1995, the State Epidemiologist and IDPH Medical Director, Patricia Quinlisk, M.D., agreed to serve in an advisory role to the CPG. In 1998, Kent Sandstrom, Associate Professor of Sociology, Department of Sociology at the University of Northern Iowa, agreed to serve in an advisory capacity. In 1999, Cortland Lohff, M.D., Assistant State Epidemiologist, agreed to serve in an advisory role to the CPG. In 2003, Scott Clair joined the CPG as a voting member. He is part of the National Behavioral Social Science Volunteer Program with a Ph.D in Social Psychology.

To assure needed input without the CPG becoming too large to function; the CPG seeks additional avenues for obtaining input on community HIV prevention needs/care and priorities such as conducting focus groups and key informant interviews.

In the latter part of 1999, Young Adult Roundtables (YARTs) was implemented to secure input from high-risk youth. Selected sites for YARTs are Davenport, Des Moines, Mason City, and Sioux City. Each YART consists of approximately fifteen youth between the ages of 13-24. Youth represent a wide variety of backgrounds, cultures, identities, and experiences. Each YART has a facilitator and a mentor who is a CPG member. The youth participate in CPG work but the primary interest and goal is to get youth voices heard and youth needs addressed. A summary of the YART discussions can be found in Chapter 3, Page 155.

➤ ***Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.***

Inclusion

An inclusive process assures that the views, perspectives, and needs of all affected communities are actively included. The CPG gains input through the following methods: key informant interviews, focus groups, and a statewide prevention resources inventory. To ensure that all interested parties beyond the community planning membership are encouraged to participate, the CPG routinely and informally shares and collects information from the constituencies that they represent. Members are reimbursed for travel expenses incurred when attending meetings. In consideration of the need for representation of persons with HIV, those individuals are exempt from the termination clause, which states that automatic removal results when a member misses three consecutive meetings or four meetings in a 12-month period.

To achieve parity, representatives are provided with opportunities for orientation and skills building to participate in the planning process and to have equal voice in voting and other decision-making activities.

Parity

New members receive a thorough orientation, using an interactive outline developed in 1999 and updated in 2002. The Membership/Orientation/Bylaws Committee completes the orientation, and is responsible for the implementation of the CPG Mentor Program that provides ongoing support to new members.

The orientation includes the following:

- review of information sent at the time of “Call for Nominations”
- review of Iowa’s Comprehensive Plan
- a detailed explanation/discussion of the roles and responsibilities of CPG members
- specific policies, procedures and ground rules
 - 1) decision making within the CPG
 - 2) conflict(s) of interest for members of the CPG
 - 3) resolving disputes within CPG
 - 4) differences between health department and CPG regarding prioritization and implementation of programs and services
 - 5) resolving conflicts/disputes in a timely manner
- understanding the history of the CPG and its decisions to date
- understanding the three Community Planning Goals and the ten guiding principles
- understanding HIV prevention interventions and the comprehensive prevention plan
- understanding HIV care priorities and expectations

CPG member orientation has been further enhanced by the following developments:

- The video developed by CDC and the Academy for Education Development (AED) entitled *HIV Prevention Community Planning: Partners in Prevention* is used during orientation of new members.
- The MOB Committee uses an outline developed to facilitate discussion with new members during orientation. Three months after a member completes orientation, they are asked to complete an orientation evaluation and changes are made accordingly.
- The Co-chairs periodically review committee norms as a refresher for continuing members and as an introduction for the new members joining the CPG. A laminated poster describing the CPG’s code of ethics/norms is posted at each meeting.

The orientation process is ongoing. Any member may choose to take part in the mentoring program implemented in Fall 1997.

GOAL TWO – Community planning identifies priority HIV prevention process (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

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

Epidemiological Profile

The epidemiological profile (Chapter 2) provides information about defined populations at high risk for HIV infection for the CPG to consider in prioritization. Strengths and limitations of data sources, data gaps, and a narrative interpretation of data are presented in the epidemiologic profile. The epidemiologic profile was presented to the CPG members prior to the 2003 prioritization process.

Community Services Assessment

Community services assessment information provided to the CPG has included reports from focus groups, key informant interviews, a review of literature, and results of a survey of existing HIV prevention services in Iowa (Chapter 3). In 1998, the Needs Assessment/Community Resources Committee conducted a mass mailing to 425 organizations/individuals to solicit data collected regarding any target populations (surveys, curriculum evaluation, reports, committee findings, service reports, and case studies) that would be beneficial to the CPG and its work.

In 2002, the committee was instrumental in updating the provider resource inventory. Focus groups were conducted in 1999 to gather information from male and female IDUs and female sex workers. Most recently focus groups were conducted with HIV positive MSM, and high-risk youth. Surveys, focus groups, reports, case studies, and key informant interviews provided information about the knowledge, skills, attitudes, access to services, and norms of persons at risk for transmission or retransmission of HIV.

The community services assessment details the target populations being served, the interventions provided to each target population, the geographic coverage of interventions or programs, and linkages between IDPH's application and funded interventions. The community services assessment was presented to the CPG members prior to the 2003 prioritization process.

Gap Analysis

In 2000 and 2003, the Needs Assessment/Community Resources committee extensively revised the ongoing inventory of documents used to review existing needs and possible gaps in prevention services (chapter 3).

The gap analysis includes data from the epidemiologic profile and community services assessment. It identifies both met and unmet needs, and the portion of needs being met with CDC funds. The CPG was presented with a summary of the gap analysis prior to the 2003 prioritization process. The gap analysis was used by the CPG in demonstrating linkages between the application and funded interventions.

- ***Objective E: Ensure that prioritized target populations are based on an epidemiological profile and a community services assessment.***

Target Populations

Detailed epidemiological data are provided to the CPG to foster decision-making about the allocation of HIV prevention resources to priority populations (Chapter 3). The size of at-risk populations, HIV and AIDS incidence, HIV and AIDS prevalence, and prevalence of risky behaviors in the population, were all considered in setting priorities for target populations.

Transmission risk, HIV status, age, and incarceration status define target populations. In 2003 target populations were re-prioritized. Populations are ranked by priority, in terms of their contribution to new HIV infections.

- ***Objective F: Ensure that prevention activities and interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness,***

and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

Prevention Activities/Interventions

Epidemiological information, programmatic experience, and the perspectives of affected communities and persons are used in the development of effective HIV prevention strategies. The CPG engaged in a process focusing on effective prevention strategies for target populations by completing an extensive literature search and prioritizing interventions for the target populations (Chapter 4).

Behavioral science, pre- and post-test outcome evidence, and evaluation data were used to show intervention effectiveness in reducing high-risk behavior within the target populations. Other criteria used in selecting interventions included evidence that the prevention intervention is acceptable to the target population, evidence that the intervention is feasible to implement for the intended population in the intended setting, and evidence that the intervention was developed with input from the target population.

Prevention activities and interventions are characterized by focus, level, factors expected to affect risk, setting, frequency and duration. Intervention sets were chosen based on their ability to have the greatest impact on decreasing new infections.

GOAL THREE – Community planning ensures that HIV prevention resources target priority populations and interventions 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.***

Comprehensive Plan

Linkages between the comprehensive HIV prevention plan and the health department application to CDC for federal funding are provided in Chapter 6. The CPG provided a letter concurring with priorities identified in the application.

➤ ***Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.***

Comprehensive Plan

The Cooperative Agreement between the IDPH HIV/AIDS Program and the CDC, Iowa's grant application for federal funds, is largely based upon the partnership of IDPH and the CPG. The CPG has used, and will continue to use the community services assessment to determine whether interventions were funded according to the comprehensive HIV prevention plan.

Care

The comprehensive care plan should guide the consortia in the development of a coordinated system of care for PLWHA. It should include clear goals, objectives and strategies for action, and mechanisms for assessing progress. The planning information must be organized in a logical format to best help decision-making about HIV service priorities and funding allocations.

The plan describes the status of HIV services within Iowa and the care needs of PLWHA.

1. An epidemiologic profile (Chapter 2)
2. The assessed needs of the affected population (Chapter 3)

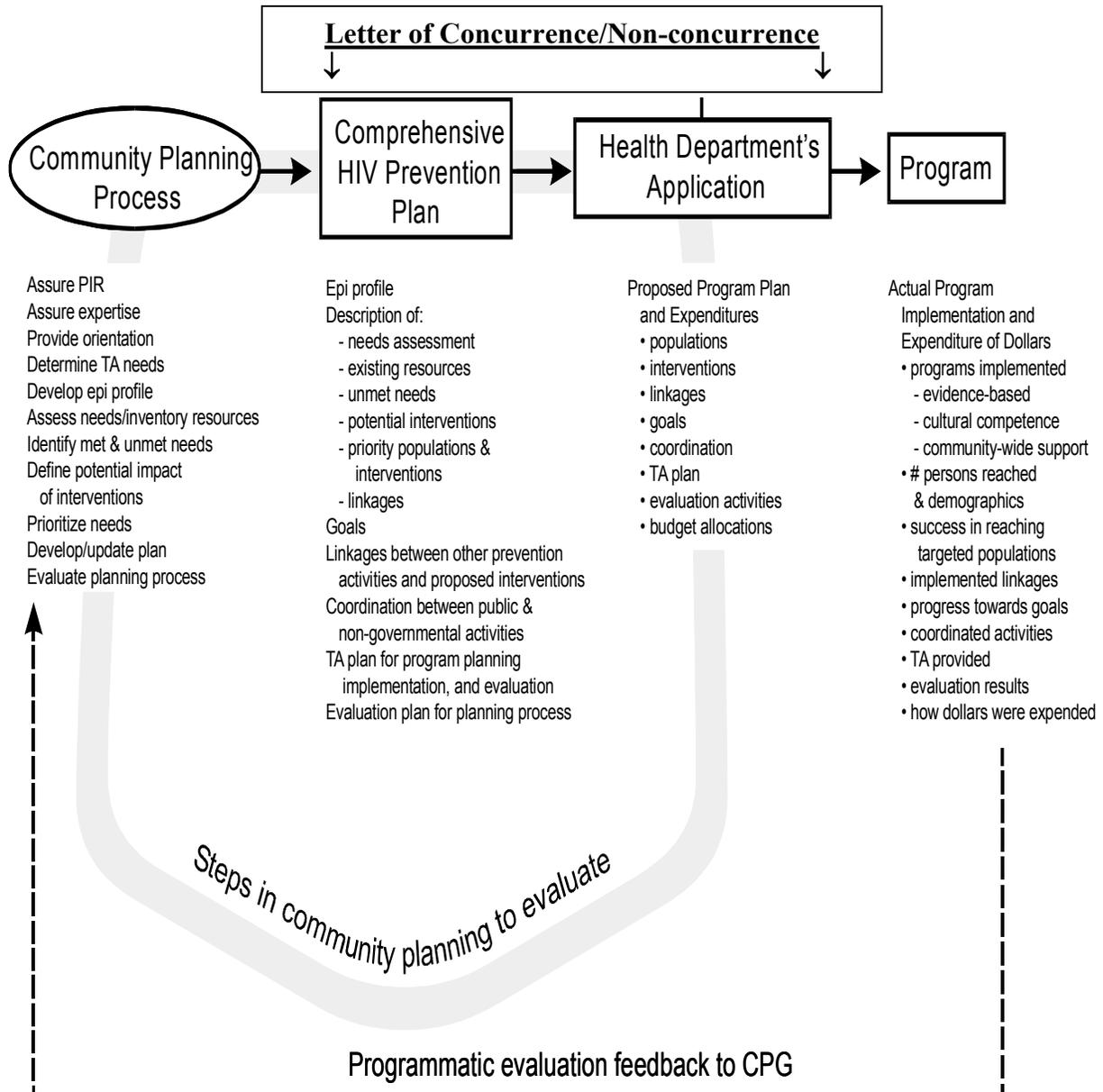
3. An inventory of community resources, including availability of non-Title II funds (Chapter 3)
4. An assessment of provider capacity and capability (expertise and infrastructure of current providers) (Chapter 3)
5. An assessment of service gaps (Chapter 5)

The plan outlines goals for a comprehensive continuum of care, and an action plan to help reach those goals.

1. An operational definition of a “continuum of care” that addresses the SCSN and the coordination of Title II services with other services available to PLWHA (Chapter 5).
2. Guiding principles and shared values that shape the HIV system of care in Iowa (Chapter 5).
 - Cost-effectiveness
 - High-quality services
 - Role of the consortium as the payer of last resort
3. Goals and objectives stated in specific, measurable terms (chapter 5)
 - Systems planning and evaluation
 - Services (reviewed every 3 years)
 - Care and treatment (reviewed annually)

It is necessary to strike a balance between naming the service needs and acknowledging the limited resources likely to be available to meet those needs. IDPH may have to choose among competing needs when setting service goals and outline strategies. To negotiate differences of opinion regarding the continuum of care and the most critical core services, clear guidelines for planning and decision-making are necessary to sustain an efficient process.

HIV Prevention Community Planning



Development of Bylaws

Charter/Bylaws were developed in 1994, and have been revised yearly to date. All members have written descriptions of their roles and responsibilities, and agree to the procedures, ground rules, and code of ethics used in all deliberations and decision making. Each member must sign a “Letter of Commitment” and a “Conflict of Interest Disclosure Form” (Attachment #1).

Process Used to Conduct Business

The CPG has held monthly meetings since August 1994. To accomplish the tasks identified by the CPG’s Workplan, it was important to divide the tasks among smaller working committees that could examine issues and develop recommendations more productively. Thus the committee structure was changed for more efficiency:

- 1996 Six main committees were established:
 - Epidemiologic Profile Committee
 - Needs Assessment/Community Resources Committee
 - Membership/Orientation/Bylaws Committee
 - Strategies for Prevention Intervention and Community Endeavors Committee
 - Workplan/Evaluation/Technical Assistance Committee
 - Public Relations Committee
- 1998 Conference Workgroup
- 1999 Young Adult Roundtables
- 1999 Healthy Iowans 2010 STD/HIV Chapter (Attachment #2)
- 2003 Care Committee

The committee descriptions follow.

Committee Descriptions

Epidemiologic Profile Committee (EPIC)

- Review the epidemiological information/data presented by the HIV/AIDS Program Surveillance staff.
- Provide oversight for and contribute to the collection and presentation of epidemiologic data.
- Review and comment on the epidemiology section of the plan.

Needs Assessment/Community Resources Committee (NARC)

- Review behavioral studies, Knowledge, Attitude, Behavior and Belief (KABB) studies and other information about the needs of the groups at risk.
- Develop an unprioritized list of target populations.
- Review needs assessment information and identified gaps in knowledge/services.
- Select populations for focus groups.
- Assist and comment on the needs assessment section of the Iowa Plan.
- Design, conduct, and summarize a provider resource inventory.

Membership/Orientation/Bylaws Committee (MOB Squad)

- Review membership composition.
- Call for nominations.
- Make recommendations to Selection Committee.
- Provide orientation to new members.
- Review and update bylaws and job descriptions as necessary.
- Assist with overview of the planning process.

Strategies for Prevention Interventions and Community Endeavors Committee (SPICE)

- Develop an unprioritized list of prevention strategies (intervention effectiveness).
- Provide oversight for and contribute to a literature review of strategies/ interventions.
- Review information about intervention effectiveness.
- Assist with intervention assessment and prioritization section of the plan.

Workplan/Evaluation/Technical Assistance Committee (WET Ones)

- Develop a workplan/timeline for the CPG.
- Review technical assistance (TA) needs and make recommendations for TA.
- Identify the technical assistance needs of the STD/HIV Prevention Program, local government agencies, and community based providers in the area of community planning, implementation of prevention programs, and evaluation.
- Assist with evaluation of the community planning process.
- Assist with priority setting development of criteria/defining terms and recommended weighting factors.

Public Relations Committee (PR)

- Assist Iowa Department of Public Health with the development of a process for disseminating the plan or a summary of the plan among the affected communities and the general public.

Young Adult Roundtables Committee (YARTs)

- Convey relevant information from the CPG to the YARTs
- Convey relevant information from the YARTs to the CPG
- Provide YARTs accurate information about HIV prevention.
- Assist in identifying new recruits to the roundtables.
- Recommend future activities for planning needs assessment.

Care Committee

- Provide oversight and contribute to the development of the Statewide Coordinated Statement of Need.
- Develop a provider questionnaire in conjunction with the NARC to identify reasons why an HIV-infected person is not in care.
- Assist with the development of the “Care” Section of the plan (Chapter 5).

IOWA HIV COMMUNITY PLANNING GROUP COMPOSITION

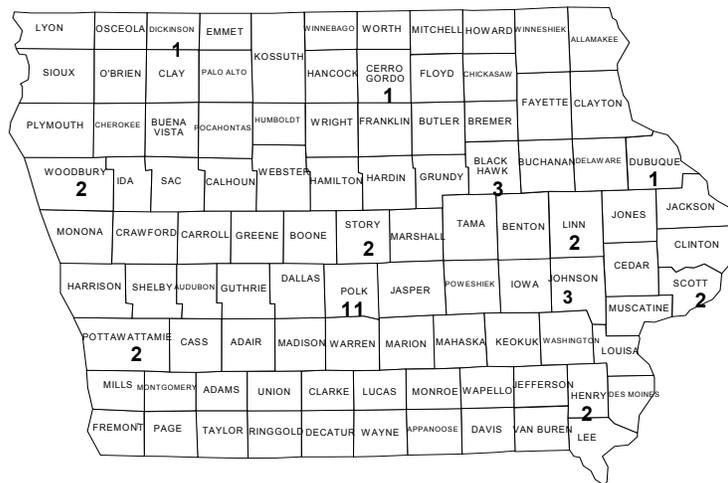
Date: August 2003

Total number of voting members: 32

| Gender | |
|-------------|----|
| Males | 13 |
| Females | 18 |
| Transgender | 1 |

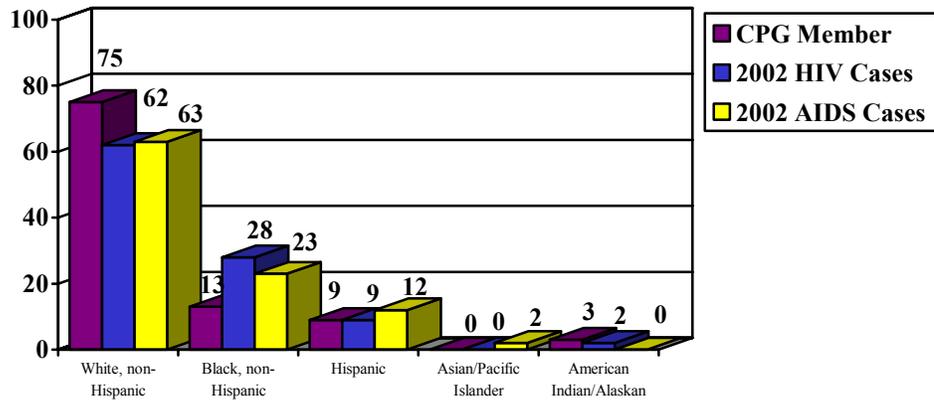
| Age | |
|----------------------|----|
| <19 | 0 |
| 20-24 | 1 |
| 25-29 | 3 |
| 30-49 | 18 |
| 50+ | 11 |
| Unknown/Not Reported | 0 |

Geographic Distribution



4 members represent statewide organizations

Racial/Ethnic Representation



| Sexual Orientation (CPG Members) | |
|---|-----|
| Men Who Have Sex With Men (MSM) | 25% |
| Women Who Have Sex With Women (WSW) | 4% |
| Bisexual Male | 7% |
| Bisexual Female | 4% |
| Heterosexual | 60% |
| Unknown/Not reported | 0% |

Members may represent more than one category in the following tables.

| Representation of Affected Communities | |
|---|----|
| Current/Former Injection Drug User (IDU) | 2 |
| Sex Partner of MSM/IDU | 1 |
| HIV Positive | 11 |
| Spouse/Partner/Relative of PLWA/HIV | 8 |
| Youth at Risk | 1 |
| Current/Former Sex Worker - Survival Sex | 2 |
| Alcohol/Substance Abuser | 3 |
| Gay Men of Color | 4 |
| Current/Former Homeless | 2 |
| Migrant Population | 0 |

| Prevention Expertise | |
|---|---|
| Epidemiology | 3 |
| Behavioral and Social Sciences | 3 |
| Evaluation Research | 0 |
| Health Planning | 2 |
| Mental Health Services | 2 |
| Correctional Facilities | 2 |
| Migrant Population | 1 |
| Homeless | 0 |
| Front-line provider of prevention services such as: outreach educator, community educator, community education and/or counselor | 9 |
| Substance Abuse Treatment Services | 3 |
| Social Marketing | 2 |

Agency Representation

| State or Local Government Representation | |
|---|---|
| State/Local Health Agency | 6 |
| State/Local Education Agency | 2 |
| Social Services | 0 |
| Law Enforcement | 0 |
| Youth Services | 0 |
| Mental Health | 1 |
| Corrections | 1 |
| Substance Abuse | 1 |
| Other | 0 |

| CBO and Non-Governmental Representation | |
|--|---|
| HIV/AIDS Prevention | 7 |
| Medical/HIV/AIDS Care | 4 |
| Substance Abuse | 1 |
| Youth Services | 0 |
| Clergy/Faith Community | 0 |
| Academic Institutions | 1 |
| Voluntary Organizations | 0 |
| Family Planning | 1 |
| Business/Union | 0 |
| Community | 2 |
| Mental Health | 2 |
| Migrant Population | 1 |
| Homeless | 1 |
| Other 1 = Insurance, Medical Society | 1 |