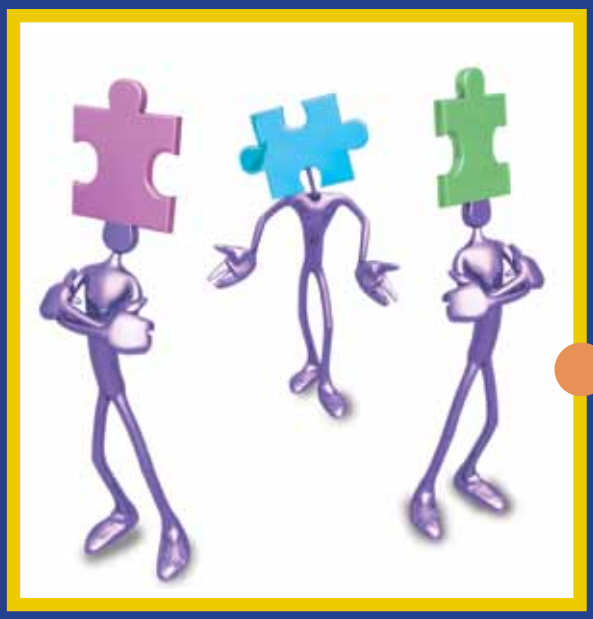
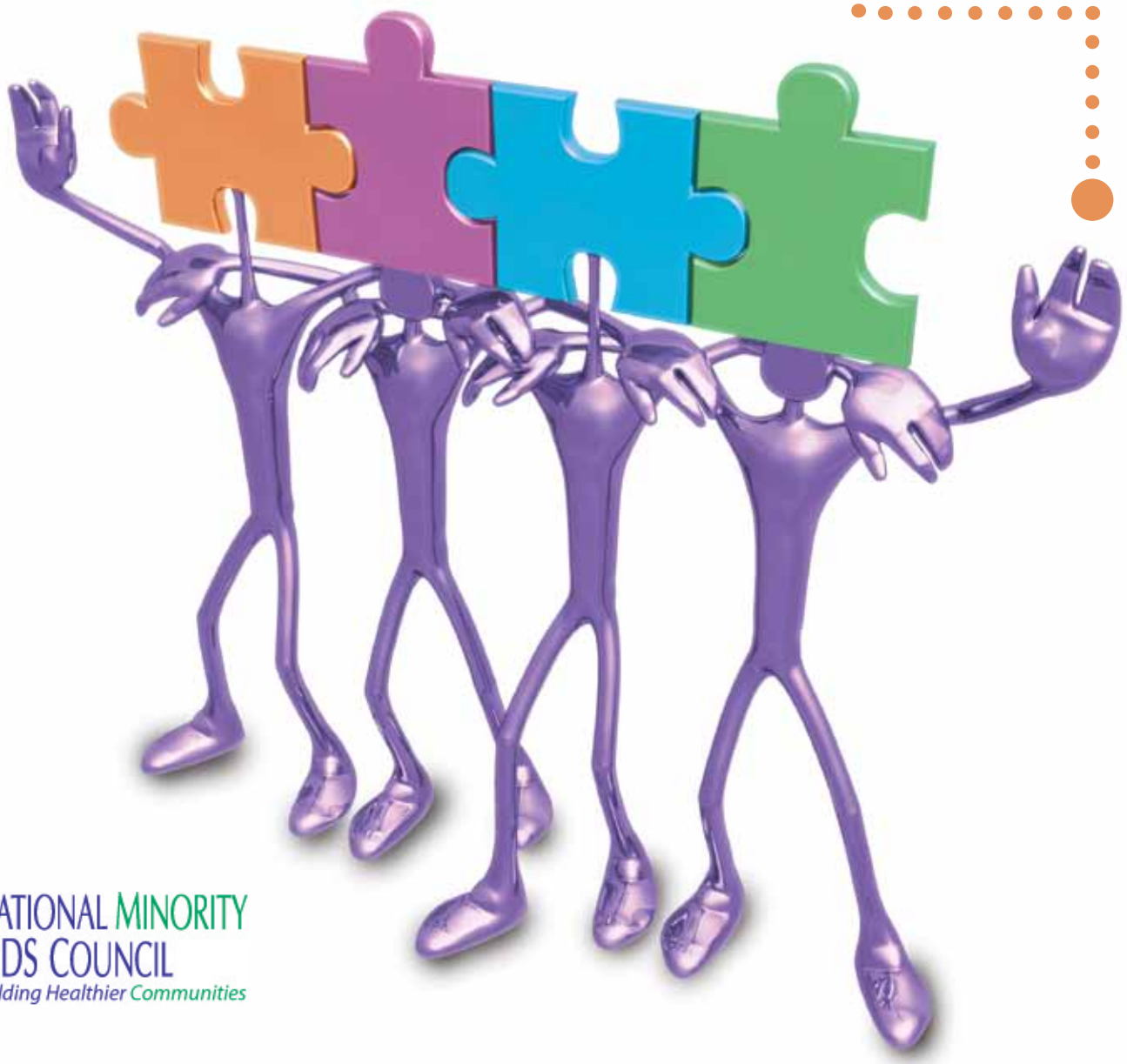


Conflict Management
in Community Planning Groups

A guide to help prevent and expedite conflict resolution among sexual health Community Planning Groups



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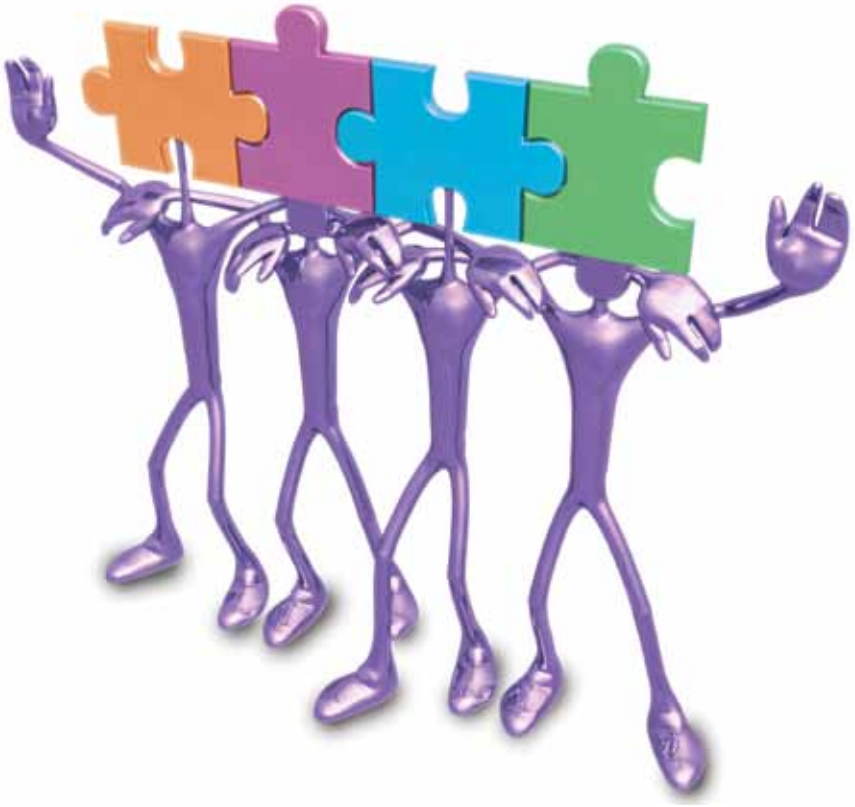

Conflict Management in Sexual Health Community Planning Groups

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ACKNOWLEDGEMENTS

This publication was supported by cooperative agreement #5U65PS0001736 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

The main author was Randall H. Russell, LCSW, PIP of Healthcare Responses under contract with the National Minority AIDS Council. Editing and supplemental materials were contributed from multiple community planning groups across the United States and the author would like to thank all of those who helped and provided guidance for this publication.

INTRODUCTION

The *Conflict Management in Sexual Health Community Planning Groups* guide is designed to help all members of sexual health community planning groups (CPGs) across the United States **prevent** avoidable conflict and **resolve** conflict that will naturally arise.

Sexual health community planning groups are formed to prevent disease. Effective methods to truly reduce the number of new infections depend upon the environment where prevention work is to be done, the existing surveillance data, skilled provider resources, and the input and experiences of persons living with disease.

The goals shared by all CPG members are to[1]

1. Work with territorial, state, or local health departments to develop a comprehensive prevention plan based on scientific evidence and community needs;

2. Work together to assess the impact of sexually transmitted infections in their localities (known as the Epidemiologic Profile);

3. Describe the prevention needs of populations living with or at risk of sexually transmitted infections (STIs), the prevention activities and interventions underway to address these needs, and the gaps identified (known as the Community Services Assessment);

4. Prioritize target populations due to high infection rates, risky behaviors, and gaps in interventions; and

5. Define a set of prevention activities and interventions that are evidence-based for these high-incidence target populations.

Despite their common goals, there are several factors that can lead to conflict:

1. The number of partners and their levels of experience with CPGs
    a. Some partners have been involved in a CPG for many years and are experienced in the process
    b. Other partners are new to the table and do not receive funding or any direct benefit from the CPG, but are invested in disease prevention activities
    c. Others have been tapped by their organization to attend, but may or may not have a comprehensive understanding of the process or the various roles of participation roles
2. Political challenges due to the funding decisions that may result from the recommendations of these entities
3. Unclear or unstated agenda items from participants
4. Participants' desired outcomes
5. The desire to develop more programs and methods of disease prevention than there are available funds.
6. The evolution and culture of an existing working group.[2]

It is managing these sources of conflict and staying focused on the overriding principle of participating in a work group – ***preventing disease*** – that will allow the CPG to have the highest impact.

This guide includes a description of community planning for sexual health, theories of conflict, a focus on how controlling stigma in the CPG can reduce conflict, conflict prevention, and conflict management, as well as recommendations and templates to utilize to avoid conflict when possible. However, conflict is inevitable, and this guide will present some objective methods to addressing it when it occurs.

"The easiest, the most tempting, and the least creative response to conflict within an organization is to pretend it does not exist." — Lyle E. Shaller

1

Chapter 1: Background

A sexual health CPG operates in a very challenging environment. There are at least three different communities typically represented at the community planning table:

1. Persons living with HIV or other sexually transmitted diseases (STDs)
2. Persons who are employed by a governmental entity such as a state health department, city or county government
3. Persons who are employed by community-based nonprofit organizations who receive funding and/or who are involved with prevention activities

Representatives from each of these groups have different desired outcomes from the community planning process. Conflict arises most often when there is poor communication regarding those differences in expectations.[3]

Tip: Consider asking one CPG member at each meeting (or using a sign-up sheet in advance) to talk about why they were interested and willing to serve in this capacity. Ask them to provide a brief history of their involvement that led them to have interest in participating. By alternating between consumers, agency personnel, and representatives from government settings, different points of view can be heard and appreciated.

View

An important component of conflict prevention is to consider the viewpoints of other members of the CPG. The group is likely to arrive at the best decision for the communities at risk if all perspectives are heard and considered.

"Be kind, for everyone you meet is fighting a hard battle." — Plato

Persons living with HIV or other STDs

People who are infected with an STD often come from social situations where they are judged and stigmatized merely due to a sexual encounter that transmitted a disease to their body. General culture communicates that if a person has obtained a disease from sex, he or she is unclean or unworthy of attention.[4] This can instill a harsh and unwarranted self-perception and perpetuates discrimination and stigma.

Persons employed by governmental entity

One of the most challenging positions to understand is the role of the government employees involved with sexual health community planning. During their tenure to represent the government it is inappropriate for them to share their personal views. It is their role to staff the prevention programs based on the federal, state, and local guidelines and to fulfill the overall funding goal. Since CPGs are required for many of the existing funding streams, sometimes the most government participants can do is to be sure the group has met and to take group input back to their employer.

Persons employed by nonprofit and/or community representatives

Employees of community-based organizations (CBOs) represent the providers of prevention, testing, and care services for people living with or at risk of STIs. These organizations are also quite often the recipients of the funds that come through the state or local governmental entity as guided by the CPG. The type of providers involved

with CPGs can be an AIDS Service Organization, a faith-based entity that focuses on community health including STDs, a university or academic setting with community programs of various kinds, and/or a clinic that serves persons with STDs with a vested interest in prevention activities. The views represented among these participants vary widely and include[5]:

- Mid-level staff representation from a large organization with limited ability to speak for the organization, but with high levels of what works and what does not work in prevention services
- Executive directors of nonprofit organizations supported with funds guided by a CPG, who have multiple programs and often a clear interest in both maintaining funding and reducing new disease
- Trained, professional, talented people who are experts (and sometimes researchers) driven to reduce new HIV infections
- Clinicians (social workers, mental health professionals, nurses, physicians) who have a strong interest in seeing reduction in new disease

Bias

The experiences from our own lives shape our beliefs and values. It is sometimes a challenge to understand the views of others when sexual health is the topic due to its overcharged nature[vi]. The feelings, moral beliefs, personal sexual experiences, and prevailing social norms all shape our opinions about sex. In a group with a responsibility to reduce disease, it is more helpful to give voice to an idea that addresses the tasks put before us, than an opinion. The simple expectation of all who participate in a CPG is: to *stay focused on disease prevention, not how we feel.*

Power

Power is sometimes affiliated with control, knowledge, and money. But every member of the CPG has equal status. The basis for community planning related to health interventions is designed to include diverse representatives from various groups to achieve the best outcome. It is critical that each participant asserts their right to more information, history, background and any other missing information to make them equal partners. If each person is not clear why they are there, what the group's purpose is for, and perhaps most importantly that they are equal members of the group, the results of the group will be tainted by those who either take or are given power.

"He who talks incessantly, talks nonsense." — African Proverb

Some of us think out loud

Some people in a group are comfortable and able to verbalize their thoughts quickly and easily. Brainstorming aloud can help the entire group think through issues. By listening to one person's thought process, others can reach their own conclusions. However, a single person dominating a meeting can inhibit other participants and/or cause conflict based on the group's dynamic.

Some of us prefer not to speak in public

A great loss to group outcome is members at the CPG table who choose not to participate. To some people, talking in public is painful, unpleasant, anxiety producing, and frightening. It is important to find productive ways to gain insights from all participants. Often persons who say little have much to say.

BIAS

Cognitive biases within groups are the tendencies for individuals to systematically make decisions based on ones own beliefs, values, and other cognitive factors rather than evidence[6].

Tip: If you, as a member of the CPG, notice that some persons aren't saying much, encourage them in kind ways to share their thoughts, opinions, and ideas. Quiet people often observe a great deal and have great insights.

"I don't like that person. I'm going to have to get to know them better."
— Abraham Lincoln

"The means by which we live have outdistanced the ends for which we live. Our scientific power has outrun our spiritual power. We have guided missiles and misguided men." — Martin Luther King, Jr.

Self-serving

Sometimes we need an outcome to occur from a meeting, rather than listening to others to arrive at a decision supported by the entire group.

Arriving at a meeting with a desired outcome can also lead to conflict through bias. For example, if a participant comes to a meeting and is invested in the top ranked priority for the vote to be men of color who have sex with other men, then their ability to listen to others can be limited and limiting. Outcomes based on surveillance and epidemiological data better serve the goal of disease prevention than appeasing a strong voice or personal agenda.

Public Health and Prevention

Prevention of disease has been a cornerstone of public health's role for centuries[7]. The protection of the public's health became a partnership between the government, the public, and the private sector as early as Roman times when dealing with human waste. Modern day approaches to prevention continue to involve these collaborations.

An example may include public health messages about screening for diabetes, cardiovascular disease, and cancers, with linkages to community groups who offer free screenings, which are sometimes funded by private entities. This model has survived because it works and is replicated by many CPGs.

All CPGs are guided to include people who live with or are at risk of STIs, public health officials, nonprofit CBOs, and private sector resources (for-profit hospitals, clinics, and/or manufacturers or developers of screening, testing, and/or care, and treatment options) when appropriate and available. The challenge for sexual health CPGs is to determine whose role or function it is to bring these various groups to the table. Public health, in this case, is often the state health department division or branch responsible for HIV, hepatitis, and other STDs. While their infrastructure can support and help administer the CPGs, input is desired from outside the health department. Therefore, it is sometimes counter-intuitive to have the health department host meetings where the are the listeners to the advice from all the other partners. Those invited to the table ar sometimes reticent to share information du to fears either real or imagined.

Origination of Conflict

Conflicts within the CPG often arise[8] from

1. Disagreements about how meetings, processes, or results from the group are handled;

2. Turf issues among CPG members, whether newly formed within the CPG or pre-existing;

3. Inadequate communication among membership; and/or

4. Misunderstanding the role and purpose of the CPG.

These conflicts are natural, expected, and occur in multiple settings in various disease states. Whether the CPG has been in existence for a long period of time, is new, or being reformed, the purpose of this guide is to help identify the areas of conflict that occur, and to provide various approaches to avoid conflict where possible and manage it when it occurs.

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Chapter 2 – Group Conflict Management Theory

According to Webster's dictionary conflict is defined as a violent dispute or an incompatibility of positions. For the purpose of this guide and as it relates to sexual health CPGs, we will define conflict as the latter. The theoretical models of conflict began to be interdisciplinary fields of study in the late 1950s and have accelerated in the last twenty years across the globe[9].

As policy shifts in the distribution of government resources continue to require more inclusive decision making around how limited resources can best meet their stated outcomes at the local level, resolving conflict becomes more critical.

Conflict Example: There is science to inform the CPG about the effectiveness of various interventions to prevent STIs. The epidemiological data from the health department shows, for example, that 55% of the HIV infections in the previous year were among African-Americans. The determination is therefore that 55% of the funding should be focused on that population.

But this data alone is an incomplete view of the situation. Questions arise such as: Do we have prevention, testing, counseling, and screening services for this population already? If we do, are they adequate? How do we know if they are adequate? And, have we applied a geographical picture of where those 55% infections occur (for example, within urban environments or rural environments)? What about age groups, or gender? Interventions would be different for different characteristics of this group, so why are we not looking at that level?

During this process, participants in the CPG may disagree with the data being reviewed, or how the formula for understanding the epidemiological data is interpreted. *Does the CPG strive to solve this conflict? What methods are in place for processing and resolving these conflicts when they occur?*

Conflict Resolution Possibility: One of the working groups of the CPG (data committee, epidemiological committee, target populations workgroup) could be assigned the responsibility of recommending to the full CPG the target areas suggested by the data. The full committee would be requested to be in agreement with the recommendations, and/or disclose the area of differences to the full group.

If the conflict will impact the group's ability to prioritize populations, then it is wise to establish a conflict resolution approach that offers a content expert and representatives from conflicting viewpoints. The content expert would be nominated and agreed upon by the community and state co-chairs, and accepted by those who have different points of view. The results would be binding, and that moves the conflict into mediation with the results of the content expert in dialogue with the opposing views coming to an understanding of what will be presented to the full group.

Group conflict management has theoretical and practical uses when planning for health promotion and disease prevention. This chapter will focus briefly on conflict theories to help provide a context for the conflicts that occur within CPGs in the United States. A pervasive conflict management theory was established in the late 1970s and has been analyzed and improved over subsequent decades. Kenneth Thomas and Ralph Kilmann present evidence that, in general, people have five preferred approaches to resolving conflict; any one of these approaches could be appropriate for CPGs depending upon the scenario.

Conflict Styles

The five styles[10] are:

		Style Description	Style Usage
1	Competitive	People who prefer taking a firm stand because they know what they want Usually operate from a position of power (role in CPG, persuasive ability)	Can leave people feeling bruised, unsatisfied, resentful Helpful style in an emergency when fast decision making matters more than involvement and process
2	Collaborative	People who try to meet the needs of everyone involved Tend to be highly assertive and cooperative valuing all input	Very helpful style when a variety of views exist and a solution is needed Good style when previous conflicts have existed in the group
3	Compromising	People who try to at least partially satisfy all involved Participants are all expected to give up something Compromiser also tends to relinquish something	A useful style when the disruption of conflict is greater than the loss of some accomplishments hoped for Helpful when a deadline is at hand and opponents are not in agreement
4	Accommodating	Person operates with a willingness to meet the needs of others over their own Can 'give in' to others and can be persuaded to surrender a position even if it is not warranted	Useful style when peace is more valued than winning Helpful approach when an issue matters more to the other party Used to gain favor with opposing group/ individual
5	Avoiding	People who avoid conflict Typified by people who delegate or assign committees to study a difficult or charged issue, rather than dig into it and resolve it	Useful when resolving a conflict appears not possible Useful is someone treats a controversy as vital when it is trivial

The general management theory is quite applicable to CPGs given the likelihood for conflict to occur. These theories are presented as a way to view conflict when it arises. The ability to classify and/ or categorize conflict, label it when it occurs, and then determine the best style to use is helpful for the leadership of the CPG to utilize whenever conflict of any kind occurs.

How are a variety of diverse opinions, experiences, and beliefs supposed to be merged into streamlined thinking and recommendations to the health department? We can start with *drop the me*. *Drop the me* implies that the group process is about more than what one person believes. The goal is always to document and hear what the group thinks as a whole. To achieve this result, each CPG participant has to ask, "What part of the input that I provide is helping just me, and what is helping prevent disease based on solid data?" *Drop the me* is a reminder to the entire group and ourselves that we all have a responsibility to take a view that is broader than just our own experiences.

Most helpful to the CPG process are the individual experiences and histories of all the participants at the table. Those experiences can help everyone focus on and shape disease prevention within the environment where the CPG is geographically assigned. Most unhelpful in that process is sharing those experiences and histories solely from an individual perspective.

3

Chapter 3 – Conflict within stigmatized populations

Articles from just one hundred years ago defined, for the first time in human development, adolescence[11]. G. Stanley Hall wrote a two-volume book to discuss young people post-puberty who were still too young to marry. The next hundred years (1904 to 2004) advanced this topic to public schools addressing sex education with a range of moral, fear-based, and emotional reactions.

Race, income, employment, and geography in the United States continue to serve as social determinants of health disparities. If a person is any combination of young, poor, of color, living in a less urban setting, who is unemployed, their risk of testing positive for an STI is higher. The rate of infections for STIs is even higher among men who have sex with other men, persons of color, persons living in a low socioeconomic class, persons living in the south, and young people. Due to the stigmas that stem from these circumstances, CPGs have multiple challenges in addition to conflict management that they must overcome to fulfill their ultimate duties to prevent disease.

Defense Mechanisms

The CPG becomes a place where people who have been traumatized often first have an opportunity to be heard without consequence. It makes it a rich environment for emotional release and for defensive expression. Psychological defenses are inborn in us; they are there to protect us. However, without stopping to recognize their existence, conflict can arise.

Projection

The theory of psychological projection is relevant when considering how to understand conflict among community health planning groups that involve stigmatized populations. The basic theory in its simplest form is seeing one's own traits in other people[12]. One may not like something about oneself, and blame someone else for it. For example, a person may not have accepted that they are gay. So, their internalized fear about their own situation may be expressed in direct and indirect ways toward other people who are gay. Defense mechanisms, like projection, are more pronounced in settings where people confront moral, ethical, and spiritual beliefs; especially those situations where the responsibility for financial resource allocations exist. Topics like abortion, homosexuality, sexual addiction, chemical dependency, and other very relevant topics to STIs can evoke defensive responses from any one person around a sexual health CPG. The acceptance that stigma and defensive reactions exist in these settings will help the CPG avoid conflicts that are personal in nature and not relevant to the group decision-making process about disease prevention[xii].

Stigma

Stigma also exists inside the CPG setting. It is made more challenging to address because it exists throughout most settings within our culture. At a community level, sometimes the CPG is the safest place one has to express frustration to being treated in a stigmatized way because it is safer than showing frustration in other settings.

Take a real experience shared here with permission, Gerald L. Gerald L. is a person living with HIV, who happens to be black, unemployed, uninsured, and addicted to crack. Gerald seeks regular medical care and has not missed appointments. However, the clinic where the person goes has nurses and social

workers that patronize Gerald person by talking down to him. He is thirty-six years old, has a college degree, and, due to compulsive behavior, has been trapped in addiction for a few years. The clinic staff treats him differently, as documented by longer wait times, less face time with clinic staff, and fewer referrals than the average patient. Gerald has been put on a "behavior plan" that suggests if he misses an appointment due to drug use, they may suspend his free access to antiretroviral treatment. He wants to keep taking his HIV-related medication, but this judgment of his behavior has him so angry, he's not sure what he will do next.

At the next community planning group meeting, he lashes out at people from the state, at colleagues on the CPG who he has known for years, and is a bit mystified himself that he is so angry at these folks who are all there trying to do the same thing. When he talks with a therapist about it, he realizes he has been transferring his anger at the way the clinic staff treats him to a group of people who cannot withdraw services from him; the anger he felt at being put on a behavior plan in order to maintain his medication regimen was not safe to show in the clinic setting; they might remove him from his life-sustaining medicine. So, he vented in the only other venue where there is no risk of being denied services.

This environment, handled well, can be both therapeutic and can untangle some of the needed elements about how to curb disease. Being reminded, regularly, that the CPG setting is one where the sole focus is on disease prevention for the community, can take these individual experiences of persons who are living with STIs and turn them into information that can help people like Gerald improve their own situation and reduce the risk for others.

Stigma disproportionately impacts persons in minorities; in Gerald's case, race, addiction, and poverty have created multiple life traumas. These social determinants have to be considered, and at least acknowledged as traumatic, in order to support Gerald as he decides to reduce the harm to himself and improve his quality of life. The clinic staff, due to ridiculously high work burdens, and long-term careers, may need to be reminded that people believe, whether it is true or not, that they are being treated differently if they have experienced discrimination and/or been stigmatized in the past.

Stigma, discrimination, and trauma sadly go together. When they are repeated in life patterns, being emotionally overwhelmed by them easily leads to defensive postures.

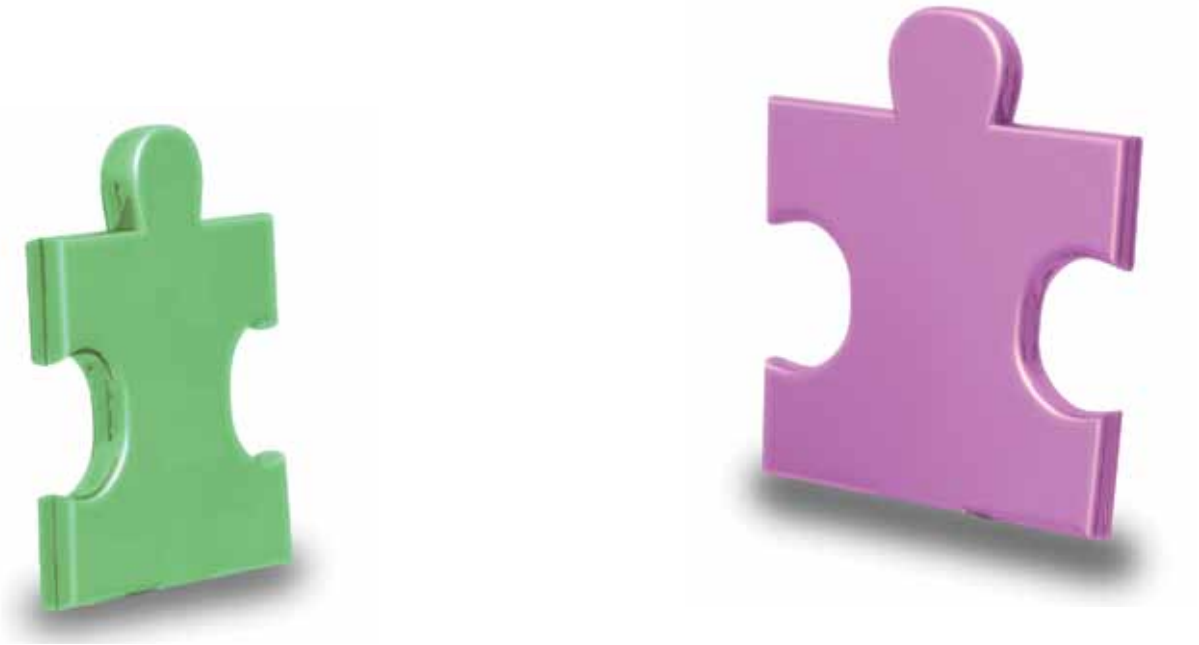
Persons who are stigmatized, are less likely to access health screenings, healthcare, and are more likely to report feeling discriminated against[iv]. Stigma can exist inside the community of persons who are living with a sexually transmitted infection, providers, and within many small group settings. Stigma can include[13] identifying the differences between:

Category	Description
Race	Assumptions exist around majority and minority participation of CPGs – if more persons of color participate with a white minority, whites perceive they are stigmatized.
Socioeconomic class	Those with means assume those without means who participate have less to offer.
Education completed	Those who have college degrees value the input of participants without college degrees less.
Sexual orientation	Persons who have sex with same gender can be perceived by heterosexuals as the 'cause' of so much disease given high incidence among same gender sexual infections.
Gender orientation	Persons who identify opposite their own birth gender are perceived as less mentally stable, therefore have less important input.
Employment status	Those who are unemployed confront feelings of worthlessness if they are able to work; those who are employed value the input of those unemployed less.
Employment setting	Persons who work for the government, perceive themselves as having more power at times; persons who work for nonprofit providers who have contracts for funding perceive they have more "rights" to input than unfunded entities.
Sexual activity level	Persons who may identify as having many annual sexual partners and are known to be positive, may be looked upon as "responsible" for the spread of infection and be ostracized from participation.
Age	Persons who are both young and old are devalued as either being immature, or too out of it to be relevant.
Urban versus rural settings	Persons living in less urban settings are more likely to be dismissed when considering urban-related interventions.
Monolingual Spanish or other	Persons who are not fluent in English are devalued as not understanding.
Years since HIV/STI diagnosis	Persons who were infected 20 years ago, may feel that someone infected one year ago should have "known better."
Currently taking antiretroviral medicines	Those who take medications are perceived as cooperative and helpful, especially since it is known it makes a person less infectious. Those who choose not to take medication, are sometimes portrayed as responsible for spreading more infection.
Health insurance coverage	Persons who are covered by some form of health insurance are seen as more responsible than those who have no insurance.
Co-Conditions	Those who have no other diagnoses can also stigmatize persons who live with HIV or other STIs who also have another chronic diagnosis such as a mental illness, kidney disease, physical mobility issue, and/or obesity. (Todd F. Heatherton 2000)

It is important that health promotion and disease prevention CPGs not perpetuate the harm done by the discrimination and stigma faced by certain groups[ii]. Procedural justice can be utilized by community-based coalitions and planning bodies to control for stigma Operating procedures, bylaws, and conflict resolution processes can all be designed with two distinct values employed: (1) protecting a discriminated and stigmatized group fron any additional harm where possible will help reduce normal, defensive reactions; and (2 the purpose of all work completed by the CPGs is disease prevention.

CPGs must operate fairly, with reduced conflict, and achieve reductions in new STIs. One clear way to aim toward this outcome is by considering justice and protection from harm for all CPG participants in part through the mutually development of conflict resolution processes.

"You can't shake hands with a clenched fist." — Indira Gandhi



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Chapter 4 – Conflict Prevention in Community Planning Groups

Throughout the past thirty years, responses to sexual health planning have developed and evolved with significant direction from the Centers for Disease Control and Prevention (CDC).

Conflict prevention in the CPG setting involves:

1. Role clarity for the CPG and all of the members
2. Orientation to stigma, discrimination, and life with HIV disease
3. Evidence-based priority setting to maximize disease prevention
4. Conflict of interest policy in writing known by all members with an annual review
5. Specific conflict management policies that outline approaches to managing conflict when it occurs

One of the best ways to prevent conflict is to remind participants how conflict is handled by the CPG at each meeting. Observational studies indicate a reduction in overall conflict with the implementation of clearer guidance as to the role of the CPG and the various roles of the CPG members[14]. This practice is most effective when there has been a history of or recent difficult and/or contested decisions.

Guidelines to address conflict prevention may need to include the following topics in the CPG Conflict Prevention Policy:

Potential Conflict Categories	Descriptions
Definition	Define the opposing views that naturally occur in diverse small groups designed to address volatile issues.
Expectation	Conflict is expected, the policy could openly describe what has been done to prevent avoidable conflict.
Prevention	Communication related to how to prevent conflict is known to reduce conflict, along with clarity about roles and function.
Resolution	Address conflict management and resolution in the conflict policy.
Types of Conflict	Address the types of conflicts likely to occur
• Needs Assessment agreement	Different perspectives may exist on what community needs are. *What plans are in place to avoid these conflicts?*
• Adoption of disease-related data	While the data is objective, the interpretation can be subjective. *What happens in cases such as this?*
• Adoption of priority populations	Given the need to identify populations based both on prevalence and incidence, the priority populations are identified based on the intervention gaps. *How can this be resolved in advance?*

Potential Conflict Categories	Descriptions
• CPG oversight and management	Lack of consensus, agreement, and understanding of the bylaws, operating policies, procedures, and other issues can continually arise unless there is a system to adopt and approve. *How often do CPG management issues need to be addressed? What timelines are involved?*
• CPG-related elections	Membership can be contentious given the CDC guidance of Parity, Inclusion, and Representation. *Have the CPG operating policies and procedures adequately addressed this?*
• Conflicts of interest	CPG Members who also have a stake in the outcome.
• Health department disputes	Managing the relationships among CPG members and the health department can sometimes be challenging. *What happens if the CPG members disagree or wish to challenge a decision made by the health department?*

Needs Assessment Agreement

The CPG assesses the prevention needs across the geographic area of concern as defined by the CPG-affiliated health department. This includes a detailed review of the epidemiological data including a thorough explanation, preferably by an epidemiologist for the health department who can translate the surveillance information, so that all CPG members able to understand the data. At a minimum, the prevalence (estimated numbers of persons living with infections) and incidence (new infections) data should be provided. The following list includes suggested data elements to support the process to prioritize populations when that step occurs.

CPGs need to consider the following data as they consider prevention priorities:

Prevalence estimates (estimated numbers of persons living with STIs as of a specific date)

- Actual numbers
- Rates per 100,000 (recent census data by county of area covered compared to numbers of persons estimated to be living in that county) as well as by metropolitan statistical areas (cities) included in the reach of the CPG.
- Demographics by county/city, to include race, age, and gender
- Geography, maps to include actual numbers and rates
- Modes of transmission by county/city

Incidence (numbers of persons diagnosed within the previous twelve months) with all STIs including HIV, HIV diagnosed with AIDS upon initial test, Hepatitis, Gonorrhea, Chlamydia, and Syphilis

- Actual numbers
- Rates per 100,000 (recent census data by county of area covered compared to numbers of persons estimated to be living in that county) as well as by metropolitan statistical areas (cities) included in the reach of the CPG
- Demographics by county/city, to include race, age, and gender
- Geography, maps to include actual numbers and rates
- Modes of transmission by county/city

Time to AIDS (the number of months after initial diagnoses cases were diagnosed with AIDS, divided into twelve, twenty-four and thirty-six months)

- Actual numbers
- Rates per 100,000, (recent census data by county of area covered compared to numbers of persons estimated to be living in that county) as well as by metropolitan statistical areas (cities) included in the reach of the CPG
- Demographics by county/city, to include race, age, and gender
- Geography, maps to include actual numbers and rates
- Modes of transmission by county/city

The presentation of this data in as detailed a form as possible, including illustrative visuals, will greatly help all members of the CPG understand

1. Where new disease is occurring
2. Where the estimates of persons living with the disease are located
3. What modes of transmission are of greatest concern
4. What demographics appear to be of the highest concern (including a review of rates and total numbers)
5. Who (defined by demographics and geography) is testing late (AIDS and Time to AIDS indicators)
6. Who are the obvious target groups carrying the greatest burden of existing and new disease

This process can greatly reduce the debate about what priority populations and interventions should be used to achieve the greatest impact on disease prevention.

The Ryan White program requires each state to craft a statewide coordinated statement of need (SCSN) based on epidemiological data, consumer surveys, and provider input, as well as utilizing data from non-HIV specific data sources like the U.S. Census Bureau, housing programs, substance abuse programs, prisons, and other related entities. This document is also to be included as a reference for the needs assessment process in order to consider the best data to complement the epidemiological data. One key element will be the physical locations of STD clinics, HIV clinics, and state-approved testing sites that can also be mapped and compared with the epidemiological data.

Priorities

Conflicts often arise during the process to set annual priorities for the CPG. For example, the epidemiological data may

suggest that in Xyz County, the rate per 100,000 persons for HIV transmission for blacks is 509.32, which ends up being the highest infection rate in the area served by the CPG. That sounds straightforward. However, when the CPG reviews the total infections, they will see that blacks in Xyz County only comprise 2% of all new infections or 82 new infections. Meanwhile, black men who have sex with men in Abc County have a rate of 402.18, but there are 612 new cases. Abc County is more likely to need prevention interventions to have the largest impact upon the overall disease state in the CPG service area.

This process will require time and open space for dialogue, training, and conversation. No matter how many times a person may hear an epidemiological update, new layers of insight and information come to light each time for various CPG members. If participants are not exposed to these reports and information on a regular basis, it can be challenging for them to grasp the exact meaning each time. The full CPG ought to have the benefit of at least one presentation from the health department documenting the extent of the data available.

Oversight and Management of the CPG

Given the basic suggested structure of co-chairs to operate the CPG, one from the health department and one from the community, clear job definitions, nominating processes, and an overall organizational framework may need to be in place in order to prevent conflict among the participants. The series of questions below may help with the overall process.

1. Are there job descriptions spelled out for the community and state co-chairs?
2. Are the timelines for a twelve-month period spelled out?
3. Is there an organizational chart that includes committees and a separate job description section?
4. Is this information included in a Microsoft PowerPoint orientation slide deck that is updated each year?

CPG Elections – Membership management

One of the recurring challenges faced by CPGs is the need to have Parity, Inclusion, and Representation (PIR) among the membership as outlined in the table below. However, this approach can be a main proponent in avoiding conflict related to types of input. This process of PIR requires due diligence on the part of the co-chairs and leadership of the CPG to work to achieve appropriate representation.

PIR	Definitions
Parity	All members of the CPG possess skills and knowledge to contribute have equal opportunity for input, participation, and voting
Inclusion	Ensuring the views and needs of populations affected and infected and at risk of STIs are regularly represented.
Representation	Confirm the CPGs include representation that reflects their community's' or population's values, norms, and/or behaviors. Members need to vote and communicate as representatives for specific populations.

Beyond the PIR approaches, it is important to be sure membership understands their term, how they were selected, whom they represent, and what their role is to be when they join the group. Most CPGs have terms and term-limits to membership. Mentorship is one way to help newcomers adapt to an existing group. For example, a person who has served on the CPG for several years may be assigned a newly elected member to help walk through the background, history, and responsibility. One viewing of a PowerPoint slide deck is more of an introduction, than a full-fledged orientation. It takes time when meetings occur sporadically to capture and keep the role, purpose, and vision together. Mentoring can help with that.

Defining membership by type can also be helpful. Is the member a representative of a group of people? Are they involved because of whom they work for? How do they represent participation?

Tip: Annually conduct a survey of CPG members to inquire about their level of confidence in their role, the purpose of the CPG, and whether or not they have questions related to the CPG that would help avoid conflict.

Conflicts of Interest

Conflict of interest occurs when[15]:

1. An appointed voting member of the CPG has a direct fiduciary interest (which includes ownership; employment; contractual; creditor, or consultative relationship to; or Board or staff membership) in an organization (including any such interest that existed at any time during the twelve months preceding her/his appointment), with which the CPG has a direct, financial and/or recognized relationship; and

2. When a member of the CPG knowingly takes action or makes a statement intended to influence the conduct of the CPG in such a way as to confer any financial benefit on the member, family member(s), or on any organization in which s/he is an employee or has a significant interest."

The above definition came from the AED Center for AIDS & Community Health *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*. The inclusion of a conflict of interest policy includes these definitions and also includes specific steps to follow when a conflict of interest occurs. Most CPGs face conflicts of interest.

It is vital that those who receive funding through the CPG process are also at the table. This poses a challenge when voting occurs related to priority populations because the agencies currently receiving funding will want the populations they serve ranked high in order to continue their programs. Many CPGs address this concern by suggesting that currently funded agencies are not eligible to vote for the annual priority-setting process.

However it is addressed, a policy on conflict of issues including how to address them when they occur will prevent potential conflict.

Health department disputes

The various pressures connected to coordinating with the health department include:

1. A state government bureaucracy that can block the necessary freedom for community leaders to seek interventions that are not acceptable to state funders. Recent instances have pulled state funding from CPG authorized programs because they had condom distribution in gay bars — a priority population and intervention selected by the CPG. There are times when state health departments are unable to provide flexibility related to the CPG-advised needs because of their political environment.

a. If this had happened to the CPG given the situation where you work, what alternative could there have been to avoid this conflict?

b. How can a CPG counter a decision from a health department that has selected the opposite result?

2. Some governmental settings limit the involvement of their personnel with the CPG process; others encourage full involvement. Each case is slightly different depending upon the CPG and the directives the department may receive from state leadership. Questions that may be helpful to address include:

   a. What attributes do you think are important from the state to have a healthy CPG?

   b. Does your CPG leadership know the state health officer?

   c. Do they know the chief epidemiologist?

   d. Is the CPG connected to the state AIDS Director?

3. How often do you meet with the State HIV/AIDS Director, or the public health officer as the seated Community Planning Group?

   a. Never – Request a meeting.

   b. Rarely – maximize the time spent together.

   c. Regularly – Seize this opportunity for broader involvement and systemic change that could lead to reforms enhancing screening, testing, and linking persons to care.

The policies addressed by state health departments include:

State policy, law, regulation, style	Descriptions
Disease reporting	Does the CPG know what laws exist in the state related to reporting HIV, Hepatitis, Syphilis, Gonorrhea, and Chlamydia? What are the laws and how have they been applied?
Testing/screening	Has the CPG been briefed on the state's policies and regulations related to testing? Is it mandatory for a person who tests with one sexually transmitted infection to be tested for others with permission? How does partner notification work? What percentages of people who are identified through partner notification are actually tested? Of those tested, how many tested positive? Is it more or less than previous years?
Role of Disease Intervention Specialist	Sometimes the disease intervention specialists (DIS) – sometimes a different title in different states – do not report to the HIV/AIDS or STD section of the state. Where do they report? Who sets the protocols for these workers? Is it clear that anyone with an STD or STI should also be asked if they would like an HIV test?
Community involvement in state activities	What is the history with other CPGs and the state health department? Has the CPG been active in their communications with the state?
Infection statues on the books	What laws exist about a person knowingly transmitting STIs? Some states have felony laws – how does that impact testing and screening, if at all?
Prisons/corrections	Is the state working with the state correctional system to coordinate outreach into the prisons and discharge programs?
Sexually transmitted disease clinics within local health departments	Are the STD clinics connected with the CPG? How are they performing in the following areas: follow-up testing, partner notification, and finding those who test positive?

As they relate to disease prevention, the CPG needs to consider these broader issues order to be comprehensive in their review of disease reduction and prevention throughout their area.

Social Determinants of Health

Influences that determine health outcomes include where people grow, live, work, socialize and form relationships[16]. The correlations to life experience and likelihood of disease need to be considered in the annual planning and prioritizing of target groups to support disease reduction. Incarceration, addiction, a mental health diagnoses, and/or a history of STIs may represent a target group for prevention different than those existing in basic epidemiology. This broadened view has led to the CDC to expand its focus on STIs, as opposed to HIV/AIDS alone, among the CPGs. As of publication, however, the new guidance has not been released, despite updated information that indicates this direction[1718]. In late 2008, a meeting was conducted to explore the inclusion of social determinants of health within the disease prevention paradigm. It was suggested by the authors (not the CDC at that time) that including social determinants of health would be applicable in reducing new disease.

How are social determinants of health connected to CPGs and conflict management? Science exists indicating where we live, work, mature, and grow in combination with our demographics and other characteristics can predict health outcomes. This widened view helps provide more options to the CPG. Increased options might include

- Prioritizing prioritizing target populations that possess social determinants of health, rather than just disease;
- For example, focus on women who are single-heads of households living below the poverty level for HIV prevention tactics.
- Considering people inside STD clinic settings as "at-risk" and striving to administer HIV tests to 100% of all people testing positive for any STI;
- Returning focus to adolescent and young men of color before they become sexually active if their circumstance includes social determinants that are correlated to disease — unstable housing, inconsistent school attendance, early encounters with law enforcement, and single head of household.

These ideas are premature in terms of science, but including social determinants of health within the CPG is not. The broader the options, the lower the conflict. When we are struggling over limited resources and prioritizing women of color over men of color, persons who have same-gender sex, or persons of a certain age, it can be extremely personal and misinterpreted as devaluation. However, when target populations are examined in the context of life experiences, not just demographics, understanding how disease thrives in those settings becomes clearer and less personal. It also helps to avoid some of the base-level stigma that leads to the discrimination that many CPG members have personally experienced. Currently, including social determinants of health in the annual CPG plan is healthy and can prevent conflict. In the long term, it may required to think about all STIs and social determinants of health in a more official capacity.

"It is hard to change our point of view in a conflict. Most often, it is because we are not nearly as interested in resolving the conflict and possibly creating a new 'pearl' as we are in being right." – Thomas Crum

5

Chapter 5 – Conflict Management and Intervention

Conflict often occurs among a small group of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable.[19]

Conflict can be viewed as a difference in perspectives: what you see, think, feel, and believe may be different from what I see, think, feel, and believe. Conflict is thus a part of all human interaction, and it can have a positive influence.[20]

"Everything has been said before, but since nobody listens we have to keep going back and beginning all over again..." – Mark Twain

There are multiple definitions of conflict management from varying individuals and groups in all kinds of settings[21]. The common features are:

- Emotional ownership of one's view, thus needing to defend a belief with limited listening capacity;
- True differences of opinion based on individual life experiences and knowledge
- A person's need to be heard, and in some cases, to be right;
- Fear that disease will spread to friends, family and loved-ones;
- A history of being stigmatized, ignored, and not heard.

Conflict can immediately move many persons to avoidance[22]. It can also be uncomfortable, controlled by anger and frightening. However, in groups where conflict is anticipated and managed, discussions and content are not hijacked by emotional flare-ups. When conflict is identified, labeled, and consistently handled, the results are typically positive.

All conflict needs a negotiator who is not involved in the debate or conflict. While this may often be the CPG co-chair, at times there may need to be a third party identified to facilitate the discussion to allow for the conflict to be fully heard and kept focused on content, rather than emotions.

When Conflict Happens

Since conflict is inevitable, it is beneficial to have a plan of action already in place to manage it. The model below outlines conflict management at the conceptual level and is followed by detailed guidance.

A current and helpful model to apply to the CPG process is the Interest-Based Relational (IBR) Approach[23]. This strategy respects diversity and differences while helping people avoid becoming too entrenched in a fixed position.

There are six basic rules that are necessary to understand before employing the five steps outlined later in this chapter.

1. Make sure that good relationships are the first priority.
   a. Treat each other calmly, work toward mutual respect.
   b. Be courteous and remain constructive under pressure.

2. Keep people and problems separate.
   a. Recognize, and find a way to believe, that the other person is not just "being difficult." Find the real difference from your own.
   b. Separate your reaction to the content from the person – the issue can be debated without damaging a working relationship.
3. Pay attention to the interests that are being presented.
   a. Listen carefully to understand why the person has the position they have.
   b. Work to not disagree with how or why the person arrived at their position.
4. Listen first, talk second.
   a. Understand the other point of view first.
   b. Present alternative views after you understand; find commonalities where possible.
5. Set out the facts.
   a. Agree together on the objective, observable facts.
   b. Agree that these facts contribute to the decision being made.
6. Explore options together.
   a. Be open to the idea that a third position could bring resolution that is not yours, or the other person's.
   b. Determine if there is common ground in the third position.

These rules or approaches have built-in mechanisms to avoid becoming unyielding, defensive, and stuck. No group wants to have "no way out" of a conflict. Since emotion is likely to be a big part of the conflict, these approaches help retain focus.

Keeping these rules in mind can assist in the actual conflict management process.

There are five steps:

1. Set the scene.
   a. Agree to use the IBR approach or decide internally to use it yourself.
   b. Remind yourself and others participating in the discussion that this conflict has developed and that resolution is the goal now that a conflict has been identified.
   c. Remember, while your point of view may not be the only perspective, it offer be an appropriate solution. Consider sharing.
2. Gather information.
   a. Confirm that you understand the other person's viewpoint. Try to restate their view in your own words to confirm your understanding of the differences.
   b. Model and/or state that you respect the different point of view.
   c. Work to understand the motivations and/or goals of the opposing point of view.
3. Agree about the conflict or problem.
   a. Be sure that the people trying to resolve the problem agree on what the problem is.
   b. Be sure all parties involved agree on the problem to be settled.
4. Brainstorm possible solutions.
   a. Once the problem is defined and the differences between the parties are identified, think together or as a group to determine what other solutions there may be.
   b. Commit to considering other solutions.
5. Negotiate a solution.
   a. If there are real differences, isolate the points that are agreed upon from those which are not, and see if a solution can be negotiated.
   b. Assuming the conflict is resolved, thank the other person for the process.
   c. If the conflict isn't resolved, agree upon who will be involved to help settle the conflict, table the discussion for the time being, and agree on the steps and timeline to finalize the discussion.

The IBR Model outlined above can be easily incorporated into the conflict management resolution policy for the CPG. If everyone understands this approach will be used, it will support strong relationships throughout the CPG, help to make meetings more productive and enjoyable, and the decisions made will be of higher quality because the conflict has been identified, labeled, and addressed through an objective process.

Conflict Resolution Leadership

No matter what the existing policy and/or procedures there are for conflict management within the CPG, it is up to the CPG co-chairs to identify conflict as it occurs. This sounds straightforward; however conflict can erupt in ways that are sudden and not obvious. Conflict can involve groups of people from the same meeting who agree, and groups who disagree, with a point. The role of the facilitator or co-chairs requires the ability to label conflict when it occurs, and immediately implement the conflict management policy.

Satisfactory conflict resolution

In a group dynamic, it is important for the parties involved to agree that the conflict has been resolved. The co-chairs may want to consider having the original conflict and the agreed-upon resolution recorded in the minutes and/or in writing depending upon the setting where the conflict intervention took place.

Location and use of conflict management

Conflict management entails a decision making process about how and when to implement the policy. Conflict can occur in a

1. Full CPG meeting with dozens of attendees;
2. Committee meeting with less than ten attendees;
3. Conflict resolution session between two or more members involved in a meeting, as outlined by the process selected by all members.

If a conflict arises during a full CPG meeting, the best approach may be to attempt to settle the conflict then and there. It is also equally appropriate to

ask for a separate conflict resolution meeting to address the conflict in a less public, more controlled environment. This also allows the involved parties time to decrease their emotional investment. However, most causes of conflict relate to decisions that are time sensitive. Another useful approach is to take a break from the larger meeting and go through an abbreviated process to determine if the conflict can be resolved quickly. The 'stop the meeting' approach requires the time of the other members of the group to be respected. However, it can result in a better decision for the entire group if a resolution can be found immediately.

Conflict policies

The cornerstone of conflict management is the following three sets of conflict policies.

Conflict Policy	Deescription
Conflict of Interest	Informs the entire CPG who has a role with an agency that may stand to gain or lose based on decisions made by the CPG
Conflict Management	Addresses how the CPG will resolve conflicts when they arise, who has the right to call for a conflict resolution process, and pinpoints who will facilitate the conflict resolution
Conflict Resolution	As a part of CPG membership, the inclusion of an agreement to resolve all conflicts by all members helps maintain a cohesive group where all parties are equal

The conflict of interest policy has been used by many CPGs as a successful way to disclose potential conflicts of CPG members. Successful conflict of interest policies include

1. Disclosure by the CPG member of any personal or financial gains that may be achieved through decisions made by the CPG;
2. Disclosure by the CPG member of roles he or she may have on member organizations' Boards of Directors, as a client, former, or potential employee;
3. A statement indicating that the CPG member or any immediate family member has received or intends to receive gratuities, favors, or anything of material value from any CBO through the CPG that might alter their ability to work objectively in the community planning process.

The contents of the conflict management policy may want to address:

1. Who has the right to request the use of the conflict management process – any sitting member of the CPG might be a place to start?
2. Who will determine if and when the conflict management process should be applied and in what setting?
   a. Either co-chair could be identified as the decision maker for whether or not the conflict will require a full process.
   b. Who will determine, and how, if the conflict can be settled during the meeting? Will a break be called or is a specific hearing necessary?
   c. Since the final decision rests with the committee chairs, will they take action when conflict arises during committee meetings?
   d. What happens when one of the co-chairs, or committee chairs, is involved in the conflict? Often an additional party is identified to resolve the conflict and to avoid further complications.
3. How will conflict resolution processes be facilitated?

Identification of the conflict and its resolution should be reported back to the CPG and recorded. This allows for an annual inventory and review of conflicts, which helps avoid recurrence such in the future and builds in a quality assurance measure to overall CPG performance.

6

Chapter 6 – Templates, Guides, and Checklists

A: Conflict Assessment Tool

The Conflict Assessment Tool is designed to (1) inventory existing conflict prevention and management activities for the CPG, (2) identify areas where conflict prevention and/or management procedures may need to be addressed, and (3) assign responsibilities for who will address identified gaps by when. The following is a definition and guide for the worksheet on the following page.

Category	Definition
Policies	
Conflict Management	Does the CPG have a conflict management policy in writing? Was it completed recently? Do CPG members have a chance to reconsider it on an annual basis? If it needs to be addressed, by what committee and when?
Membership Description	Are members clear why and how they are involved with the CPG? Is there an annual questionnaire or assessment to anonymously inquire if they are clear on their role and the role of the CPG?
Value Statement	Does the CPG have a value statement about how it conducts business? Typical values include: treating each other with respect; putting aside personal agendas; committee recommendations to the full CPG need to be fully supported by committee members – disagreements need to be handled within the committee; focus on disease prevention – not funding; and/or committing to work together and through conflict.
Conflict of Interest	CPG members are expected to participate objectively (without bias and based on data). Does the conflict of interest statement, typically signed by all CPG members, address voting privileges, methods of addressing conflicts when they occur, and identify all parties that may have conflicts (such as a consumer board member or staff member of a funded)?
History	
Conflicts – past 2 years	Have there been conflicts over the past two years? If so, was there a pattern? Does a new policy or clarification need to be written to avoid these conflicts?
Policy review annually	Is a committee reviewing the conflicts that occur and the conflict-related policies and procedures annually?

A. Conflict Assessment Tool instructions, continued

Category	Definition
Orientation	
Conduct new member orientation	Is orientation completed at least once per year? Is it completed for all new members after their election and before their first meeting?
Assign mentors	Does the CPG offer mentoring for new members?
Ensure participation	Is the attendance policy at CPG meetings and committee meetings made clear? What happens if these guidelines are not followed?
Review Process	
Conflict review	Do the executive committee or co-chairs review conflicts on an annual basis review? Are conflicts that are reported according to policy addressed within the timeframe provided?
Role Definition	
State co-chair	Is there a job description including what the state is responsible for? Is it reviewed on an annual basis?
Community co-chair	Is there a job description including what the community is responsible for? Is it reviewed on an annual basis?
Officers	Are there officers or is there an executive committee that can serve as the appeal board for conflicts? Is that specified in the existing policies?
Members	Do members have a clear guide for their successful participation in the CPG including attendance, contributing in meetings, and advance preparation?

A: Conflict Assessment Tool

Category	Have in writing?	CPG members have signed statement of receipt?	Needs updating?	Committee charge / update timeline
Policies				
Conflict Management				
Membership Description				
Value Statement				
Conflict of Interest				
History				
Conflicts – past 2 years				
Policy review annually				
Orientation				
Conduct new member orientation				
Assign mentors				
Ensure participation				
Review Process				
Conflict review				
Role Definition				
State co-chair				
Community co-chair				
Officers				
Members				

B: Checklist for Conflict Prevention

The following checklist can help CPGs prevent conflicts. Each element listed is to be checked only if it has been addressed as it relates to conflict prevention. Elements that are not checked, should be assigned to a committee to address.

Conflict Prevention Element	CPG has completed. On hand, current and relevant.	Follow-up is needed to update or address this element. Include which committee or who by what date.
Conflict of Interest statements completed by each CPG member, at least annually, or whenever a member's circumstances change		
Orientation for each new CPG member before their first meeting		
Needs assessment – process for development and process for annual adoption		
Priority setting – process for development and process for annual adoption		
CPG oversight and management – clarity of roles, facilitation guidelines		
CPG elections – formal policy for representation by consumers, organizations, and functions within the state; clear nominations process		
PIR – is it clear to members that the CPG meets the CDC criteria?		
Health Department conflicts – are there mechanisms in place to address conflicts when they arise? Are CPG members aware of all of the sections of the health department and disease control and prevention, such as DIS, Corrections, etc.?		
Social Determinants of Health – has the CPG begun to integrate considerations of social determinants of health in their annual plan including all STIs?		

C: Orientation for the Community Planning Group Checklist

This template is designed to provide a comprehensive list of topics to be covered in the orientation process to new members. It is suggested that a PowerPoint deck be designed to provide the unique answers for your specific group, which can then be used to orient new members. It is further suggested the orientation process be conducted once per year for the entire group. This could occur, for example, thirty minutes prior to the start of a meeting to avoid experienced group members from over-exposure to the content. Community groups who utilize an orientation process have fewer conflicts.

Categories included
Previous year's CPG Plan
Mission statement
Bylaws
Committee or subcommittee structure and staffing
Ground rules
Meeting minutes
Decision-making process and procedures
Job descriptions for co-chairs, committee chairs, etc.
Timeline, work plan, calendar, or planning cycle
Listing of all CPG members with contact information and rules related to email and list serve use
Common abbreviations, acronyms, and glossary of terms
Conflict of interest statement
CPG member sign off that they have been through orientation, received materials, have completed a conflict of interest form, and have signed up for committee work

D: Facilitator's Guide for Conflict Management

The following table includes some suggestions for conflict management procedures and policies. They will hopefully serve as a starting place for the CPG to craft their own specific approach to conflict. This policy is only required when conflict disrupts the flow of the meeting and the co-chair or committee chair is asked to respond. However, if it escalates to this level, these procedures ensure there is a low-damage way to approach high conflict situations.

Topic	Detail
Full CPG Meeting	If conflict arises among multiple members, the facilitator will be responsible for taking action using one of the three following options. Take a cool down period, reunite in a few minutes, re-launch the conversation and remind participants of the ground rules. Gain control of the conversation, articulate the elements of the conflict, resume the discussion and remind participants of the ground rules. Outline the conflict, be sure it is recorded accurately in the minutes, and move the conversation forward.
CPG Committee Meeting	If conflict arises among committee members, the chair of the committee will be responsible for taking action using one of the three following options. Take a cool down period. If all parties agree, the committee may reconvene while the conflicting members attempt to reach an understanding on their own. Gain control of the conversation, articulate the elements of the conflict, resume the discussion and remind participants of the ground rules. Outline how the conflict will be addressed using the more formal approach outlined below.
Ground Rules	Commit to the process and the results. Participate in all decision-making activities. Put aside personal agendas. Separate agency/organization goals and objectives from the needs of the CPG. Manage committee disagreements within the committee. Once a decision is made at the committee level, it should be owned and supported by every member of that committee.

E. Suggested Policy and Procedure Areas for CPGs to Prevent Conflict

The table below provides the content areas and a brief description that may help CPGs avoid conflict. It is helpful to have the procedures and policies spelled out in advance. This will result in fewer opportunities for conflicting interpretations.

Topic	Detail
Membership	Terms of service, how elections are handled, how officers are selected Job descriptions of co-chairs (community / state) and leadership Attendance requirements, member expectations, code of conduct requirements
Committee structure	Committee descriptions, and responsibilities, committee timelines and expectations
Orientation	Who is responsible for providing and what is the policy for CPG attendance related to having been through an orientation
PIR	It is appropriate to have someone responsible for Parity, Inclusion, and Representation to ensure compliance with this important outcome
Conflict ,management	A signed conflict of interest form (usually renewed annually), a procedure for handling conflicts, training or orientation on conflict management as a full CPG, and clarity about who is in charge of handling conflict

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