DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Announcement Number 99004]

Human Immunodeficiency Virus (HIV) Prevention Projects and HIV Prevention Community Planning Guidance

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services.

ACTION: Request for comments.

SUMMARY: CDC is preparing to announce the availability of fiscal year 1999 funds to provide support for HIV prevention projects through State and local health departments. This program announcement will assist the Nation's disease prevention efforts by supporting HIV prevention activities and the community planning process to best target resources and activities. CDC invites comments from organizations and individuals on the draft of this announcement which is included. Based on comments received, the final announcement will be published later this year. Also included for comment is the HIV prevention community planning guidance document. This document will be included in the application kit for applicants for HIV prevention funding.

DATES: Submit written comments in response to this notice to: Jessica Gardom, Division of HIV/AIDS Prevention, National Center for HIV/STD/TB Prevention (NCHSTP), Centers for Disease Control and Prevention (CDC), Mailstop E–58, 1600 Clifton Road, NE., Atlanta, GA 30333.

Comments must be received on or before June 18, 1998.

SUPPLEMENTARY INFORMATION: The following is a complete text of the draft program announcement for HIV Prevention and HIV Prevention Community Planning Guidance.

Human Immunodeficiency Virus (HIV) Prevention Projects

Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 1999 funds for cooperative agreement programs for Human Immunodeficiency Virus (HIV) Prevention. This program addresses the Healthy People 2000 priority area of HIV Infection. The purpose of this program is to assist public health departments (1) to reduce or prevent the transmission of HIV by reducing or preventing behaviors or practices that place persons at risk for HIV infection; and (2) to reduce associated morbidity and mortality of HIV-infected persons by increasing access to early medical intervention.

Eligible Applicants

Eligible applicants are health departments of States and their bona fide agents that currently receive CDC HIV prevention funds under Program Announcement 804. This includes the 50 States, six cities (Chicago, Houston, Los Angeles, New York, Philadelphia, and San Francisco), the District of Columbia, Puerto Rico, American Samoa, the Virgin Islands, the Federated States of Micronesia, Guam, the Northern Mariana Islands, the Republic of the Marshall Islands, and the Republic of Palau.

Availability of Funds

Approximately $250 million is expected to be available in FY 1999 to fund 65 awards. It is expected that the awards will range from approximately $60,000 to approximately $24,000,000. It is expected that the awards will begin on or about January 1, 1999. Awards will be funded for a 12-month budget period within a project period of 5 years.

Continuation awards within an approved project period will be made on the basis of satisfactory progress as evidenced by required reports and the availability of funds. Funding estimates may change. Should funds available for this program either increase or decrease significantly during the project period, funding may be awarded competitively.

A. Direct Assistance

You may request Federal personnel, equipment, or supplies as direct assistance, in lieu of a portion of financial assistance.

B. Use of Funds

Funds may not be used to supplant State or local health department funds available for HIV Prevention. Funds may not be used to provide direct medical care (e.g., ongoing medical management, medications, etc.). With documented opportunity for comment by the HIV Community Planning Groups (CPGs), funds awarded for HIV Prevention activities may be used to support HIV/AIDS Surveillance and HIV Sero epidemiology projects. CDC must approve the use of prevention funds for surveillance and the activities supported must directly improve and support HIV prevention activities or the community planning process. The CPG comments on the use of prevention funds may be addressed in the overall letter of concurrence submitted with the application. A separate letter(s) of concurrence must be submitted if the request to use prevention funds for these activities occurs at a later time.

C. Funding Preferences

In 1999, current levels of funding will be maintained for all project areas. Priority will be given to funding activities and interventions identified through the HIV Prevention Community Planning process.

Program Requirements

A comprehensive HIV prevention program includes the following components:

A. A participatory HIV prevention community planning process, in accordance with the guidelines and requirements in the HIV Prevention Community Planning Guidance;

B. Epidemiologic and behavioral HIV/AIDS surveillance, as well as collection of other health and demographic data relevant to HIV risks, incidence, or prevalence;

C. HIV prevention counseling, testing, referral, and partner notification (CTRPN), with strong linkages to medical care, treatment, and other needed services;

D. Health education and risk reduction (HE/RR) activities, including individual-, group-, and community-level interventions;

E. Increasing access to diagnosis and treatment of other STDs;

F. School-based efforts for youth;

G. Public information programs;

H. Quality assurance and training;

I. Laboratory support for HIV prevention;

J. HIV prevention capacity-building activities, including expansion of the public health infrastructure by contracting with non-governmental organizations, especially community-based organizations;

K. An HIV prevention technical assistance assessment and plan;

L. Evaluation of major program activities, interventions, and services.

All of these components except B, E, and F are funded under this announcement. In conducting activities to achieve the purpose of this program announcement, the recipient will be responsible for the activities under A and CDC will be responsible for conducting the activities under B.

A. Required Recipient Activities

1. HIV Prevention Community Planning

All recipients must:

- Develop a comprehensive HIV Prevention Plan for their jurisdictions

through a participatory process as described in the Guidance on HIV Prevention Community Planning (included in application kit).

- Justify discrepancies between the plan and the proposed program activities.

HIV prevention community planning is an ongoing, iterative planning process that is (1) evidence-based (i.e., based on HIV/AIDS and other epidemiologic data, including STD and behavioral surveillance data; qualitative data; ongoing program experience; program evaluation; and a comprehensive needs assessment process) and (2) incorporates the views and perspectives of the groups at risk for HIV infection, as well as providers of HIV prevention services. In HIV prevention community planning, recipients share responsibilities for developing a comprehensive prioritized HIV prevention plan with other State and local agencies, non-governmental organizations, and representatives of communities and groups at risk for HIV infection.

Persons at risk for HIV infection and persons with HIV infection should play a key role in identifying prevention needs not adequately met by existing programs and in planning culturally competent services. Priority setting accomplished through a participatory process will result in programs that are responsive to high priority, community-validated needs within defined populations. Refer to the Guidance on HIV Prevention Community Planning in the application kit.

2. Counseling, Testing, Referral, and Partner Notification (CTRPN)

a. General

All recipients must:

- Provide CTRPN services consistent with the current CDC HIV Counseling, Testing, and Referral Standards and Guidelines.

The major functions of CTRPN programs are to provide individuals a convenient opportunity to: (1) Learn their current HIV sero status; (2) participate in counseling to help initiate and maintain behavior change to avoid infection or, if already infected, to prevent transmission to others; (3) obtain referral to additional prevention, medical care, and other needed services; and (4) provide prevention services and referral for sex and needle-sharing partners of infected persons.

b. Counseling and Testing

All recipients must:

- Routinely offer, on a voluntary basis with informed consent, confidential client-centered HIV prevention counseling and HIV laboratory testing services.
- Provide, unless prohibited by law or regulation, anonymous opportunities for persons to receive client-centered HIV prevention counseling and HIV laboratory testing.
- Implement and maintain a written policy for contacting clients, especially those who are infected with HIV or at high risk of becoming infected, but have not returned to receive their HIV test results and post-test counseling.
- Develop, implement, and maintain a mechanism for assessing the proportion of tested clients who return to receive HIV test results and post-test counseling in both confidential and anonymous testing programs.
- When low return rates (e.g., less than 90% return for sero positives or less than 75% return for sero negatives) are identified, reasons for the low rate must be documented and steps must be taken to correct factors that are contributing to the low rates.

HIV prevention counseling must be client-centered; i.e., tailored to the behaviors, circumstances, and special needs of the person being served. Client-centered counseling is conducted in an interactive manner, responsive to individual client needs. The focus is on developing realistic prevention goals and strategies rather than simply providing information. HIV prevention counseling should be:

- Culturally competent;
- Sensitive to issues of sexual identity;
- Developmentally appropriate; and
- Linguistically specific.

Recipients are encouraged to give priority to providing services in areas with high rates of HIV sero prevalence or AIDS incidence and sites serving clientele known to have high rates of HIV infection or risk behavior.

The availability of anonymous services may encourage some persons at risk for HIV infection to seek services that they would otherwise be reluctant to access. Counseling for clients who test positive in anonymous testing sites should include information about the benefits of receiving follow-up services under a confidential system, information about how to enter such a system, and strong encouragement to access such services.

Some clients who are HIV infected or at high risk of infection may require prevention case management, which includes multiple counseling sessions. Recipients should provide additional prevention counseling to meet the needs of these clients. Funds awarded through the cooperative agreement can be used to support such ongoing counseling and prevention case management in coordination with patient care systems such as the Ryan White funded early intervention services.

If recipients opt to charge for services, they should do so on a sliding scale. No one should be denied services because of an inability to pay. Funds generated from charging clients should be used to support HIV prevention program activities and services.

For additional guidance on the implementation of these services, refer to the attachments.

c. Referral and Linkages With Other Service Providers

All recipients must:

- Develop, implement, and maintain a system to ensure clients who are HIV positive receive appropriate counseling, and are entered and maintained in an appropriate system of care, which includes prevention services.
- Develop, implement, and maintain a mechanism for assessing the proportion of HIV-seropositive persons referred for specific additional services who complete their referrals (i.e., are seen by and receive services from the persons or organizations to which they are referred).

Clients who are at increased risk for HIV infection and clients who are infected with HIV often need many services such as further HIV prevention counseling, evaluation of immune system function, early medical intervention for HIV infection, STD screening and treatment, substance abuse counseling and treatment, tuberculosis testing and treatment, and family planning. These services should be provided at the testing site, if possible.

All clients who are found to be HIV-infected at any CTRPN service site should receive:

- A CD4+ cell test, an initial viral load staging, or the current recommended test to determine stage of illness; and appropriate medical management;
- An assessment of medical eligibility for treatment;
- Counseling about the benefits of early medical treatment opportunities, either on-site or through referral, to receive appropriate medical therapies including STD diagnosis and treatment and TB skin testing;
- Prevention case management;
- Referral for substance abuse treatment, if indicated;
- Referrals for all indicated services;
- Follow-up to ensure that referrals have been successfully accomplished.

If these services are not available at the HIV testing site, individuals must be referred to another service provider.

Information about services available through referral should be regularly updated so that counselors can refer clients for services currently available in the local area. A system that (1) links counseling and testing sites with other health, medical, and psychosocial service providers and (2) provides feedback to the health department on completion of referrals is an essential component of current HIV prevention program standards of care.

Funds provided through this cooperative agreement cannot be used to provide ongoing clinical and therapeutic care of HIV-infected persons. Support for such services should be obtained from other sources of funding, or the services should be obtained through referral to local providers.

d. Partner Notification

All recipients must:

- Establish standards, implement, and maintain procedures for confidential voluntary notification of sex and needle-sharing partners of HIV-infected persons, consistent with the CDC Partner Notification Guidance, to be published.
- Maintain their good faith effort to notify spouses of infected persons as required by law and as certified to CDC.
- Develop, implement, and maintain a mechanism to determine that notification and appropriate follow up of partners has been completed.
- Develop, implement, and maintain a system to assess the partner notification program and improve its function.

In a comprehensive HIV prevention program, partner notification is essential for ensuring that sex and needle-sharing partners of HIV-infected persons are notified about their risk and offered HIV prevention counseling, testing, and referrals. Partner notification is a primary prevention service with the following objectives:

(1) To confidentially inform partners of their possible exposure to HIV;

(2) To provide partners with client-centered prevention counseling that assists and supports them in their efforts to reduce their risks of acquiring HIV or, if infected, of transmitting HIV infection; and

(3) To minimize or delay disease progression by identifying HIV infected partners as early as possible in the course of their HIV infection and assisting them in obtaining appropriate preventive, medical, and other support services.

Partner notification programs should include the following components, ensuring that they are consistent with State and Federal laws:

(1) Client Referral: In client-referral, the HIV-infected person notifies his or her sex or needle-sharing partners of their exposure to HIV. Program staff will provide the client with counseling and support on techniques to confidentially notify and refer their sex or needle-sharing partners to client-centered HIV prevention counseling.

(2) Provider Referral: In provider referral, a health professional who has been specially trained to provide the service notifies the HIV-infected individual's sex or needle-sharing partners of their exposure to HIV. In situations where the HIV-infected person chooses provider referral, program staff will offer assistance in confidentially notifying those partners and offering them counseling, testing, and referral services.

(3) Spousal Notification: The Ryan White CARE Re-authorization Act of 1996, Pub. L. 104–146, Section 8(a), requires that States take administrative or legislative action to require a good faith effort be made to notify a spouse of a known HIV-infected patient that such a spouse may have been exposed to the human immunodeficiency virus and should seek testing. The statute defines a spouse as any individual who is the marriage partner, as defined by State law, of an HIV-infected person, or who has been the marriage partner of that person at any time within the 10-year period prior to the diagnosis of HIV infection. All HIV Prevention Cooperative Agreement recipients must comply with these requirements. Currently, all States and territories have certified to CDC that they will require a good faith effort as required by law.

The partner notification program should be evaluated periodically to do the following:

- Help identify barriers and gaps in service delivery, as well as define the HIV-infected population, so that services can be better directed towards target populations;
- Plan, refine, and target program intervention strategies;
- Analyze and refine resource allocation;
- Provide population-specific feedback to health departments, community-based organization staff, community planning groups, and other community prevention partners; and
- Identify technical assistance needs including training.

All individual data will be maintained at the State and local jurisdiction to assist in developing and monitoring local services. The jurisdiction must adhere to strict protection and confidentiality of client and partner records.

3. Health Education/Risk Reduction (HE/RR)

All recipients must:

- Implement an array of HE/RR activities, and provide resources to minority and other community-based organizations (CBOs) to implement HE/RR activities, in accordance with the priority target populations and interventions identified in their Comprehensive HIV Prevention Plan.
- Ensure interventions are culturally competent, developmentally appropriate, linguistically specific, and sensitive to sexual identity.
- Briefly report to CDC the rationale (e.g., scientific or programmatic basis) for each of the HE/RR interventions implemented.

HE/RR programs and services are efforts to reach persons at increased risk of becoming HIV-infected or, if already infected, of transmitting the virus to others, with the goal of reducing the risk of these events occurring. These programs should be directed to persons whose behaviors or personal circumstances place them at high risk. Examples of high risk groups include men who have or have had sex with men; persons who exchange sex for drugs, money, housing, or food; persons with a newly diagnosed STD; youth who are engaging or are likely to engage in high-risk behavior; women who are sex partners of persons who engage in high-risk behavior; persons in the correctional and criminal justice systems; or homeless persons in high-risk situations.

High priority interventions (as identified by the community planning group) at the individual, group, and community levels should have priority for support with funds awarded through this cooperative agreement. The following are brief descriptions of these programs:

a. Individual Level Interventions include a range of one-on-one client services. Individual prevention counseling assists clients in assessing their own behavior and planning individual behavior change, supports and sustains behavior change, and facilitates linkages to services that support behaviors and practices that prevent the transmission of HIV. Project areas are encouraged to provide, either onsite or through referral, additional prevention counseling, as appropriate to the needs of these clients.

Prevention case management is an individual level intervention directed at persons who need highly individualized support, including substantial

psychosocial, interpersonal skills training, and other support, to remain sero negative or to reduce the risk of HIV transmission to others. HIV prevention case management services are not intended to be substitutes for medical case management or extended social services.

Prevention case management services should complement ongoing HIV prevention services such as HIV antibody counseling, testing, referral, and partner notification and early medical intervention programs. Coordination with HIV counseling and testing clinics, STD clinics, TB testing sites, substance abuse treatment programs, and other health service agencies is essential to successfully recruiting or referring persons at high risk who are appropriate for this type of intervention. See the HIV Prevention Case Management Guidance, September 1997.

b. Group Level Interventions shift the delivery of service from the individual to groups of varying sizes. Group level interventions are intended for persons at increased risk of becoming infected or, if already infected, of transmitting the virus to others. They provide education and support in group settings to promote and reinforce safer behaviors and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change. The content of the group session should be consistent with the format, i.e., groups can meet one time or on an on-going basis. One-time sessions can provide participants an opportunity to hear and learn from one another's experiences, role play with peers, and offer and receive support. Ongoing sessions may offer stronger social influence with potential for developing emergent norms that can support risk reduction. Multiple sessions may be needed for persons at high risk of HIV infection. A group level intervention can include more tailored individual level interventions with some of the group members.

c. Community Level Interventions are directed at changing community norms to increase community support of behaviors known to reduce the risk for HIV infection and transmission. While individual and group level interventions also may be taking place within the community, interventions that target the community are unique in their purpose and are likely to lead to different strategies than other types of interventions. Community level interventions aim to reduce risky behaviors by changing attitudes, norms, and practices through health communications, social (prevention) marketing, community mobilization and organization, and community-wide events.

The primary goals of these programs are to promote healthy behaviors, to change factors that affect the health of community residents, and ultimately, to improve health status. The community may be defined in terms of a neighborhood, region, or some other geographic area, but only as a mechanism to access the social networks that may be located within those boundaries. These networks may be changing and overlapping, but should represent some degree of shared communications, activities, and interests.

Community level interventions are designed to affect social norms or shared beliefs held by members of the community. Specific activities include, for example:

- Identifying and describing (through needs assessments and ongoing feedback from the community) structural, environmental, behavioral, and psycho social facilitators and barriers to risk reduction in order to develop plans to enhance facilitators and minimize or eliminate barriers;
- Persuading community members who are at risk of acquiring or transmitting HIV infection to accept and use HIV prevention measures; and
- Informing community members—regardless of their personal risk level—of their important role in HIV prevention in their communities.

d. Street and community outreach programs are one type delivery method for the interventions described above. They are defined by their locus of activity and by the content of their offerings. These programs reach persons at high risk, individually or in small groups, on the street or in community settings. The programs provide them with prevention messages, information materials, and other services, and assist them in obtaining other HIV prevention services such as HIV-antibody counseling and testing, HIV risk-reduction counseling, STD and TB treatment, substance abuse prevention and treatment, family planning services, tuberculin testing, and HIV medical intervention. Refer to Guidelines for Health Education and Risk Reduction Activities, U.S. Department of Health and Human Services, Public Health Service, April 1995.

4. Public Information (PI) Programs

The purposes of public information programs and activities funded through this cooperative agreement are to build general support for safe behavior, to dispel myths about HIV/AIDS, to address barriers to effective risk reduction programs, and to support efforts for personal risk reduction. In addition to informing general audiences, public information programs should assist in informing persons at risk of infection of how to obtain specific prevention and treatment services, such as CTRPN and STD screening and treatment. Public information programs and messages should be based on an assessment of needs in each State and local area. Messages to communicate through public information programs may include how HIV is and is not transmitted; how to avoid becoming infected; what the impact of other STDs is on the risk of HIV transmission; what to do if you think you might be infected; the benefits of knowing your sero status, including early diagnosis and treatment for HIV disease; and how to talk to your children, friends, and neighbors about HIV prevention.

Give priority to materials directed to hard-to-reach audiences and populations heavily affected by the HIV epidemic. Submit any newly developed public information resources and materials to the National AIDS Information Clearinghouse so that they can be incorporated into the current database for access by other organizations and agencies.

5. Quality Assurance and Staff Training

All recipients must:

- Develop and implement a mechanism for assessing the performance and training needs of staff providing HIV prevention services, especially those staff providing HIV prevention counseling and partner notification. Staff training should be guided by the assessment.
- Develop comprehensive written quality assurance procedures and staff performance standards and make them available to all program staff. Management should ensure these policies and procedures are followed.
- Develop and implement a quality assurance system for all counseling and testing providers, with special attention to assuring that seropositive clients learn their test results.
- Develop and implement a mechanism for assessing the proportion of HIV-seropositive persons referred for additional services who complete their referrals. Review data and improve process as necessary.
- Develop and implement a mechanism to determine that notification and follow up of partners has been completed. Review data and improve process as necessary.
- Develop and implement a mechanism to assure HE/RR activities

are culturally competent, developmentally appropriate, linguistically specific, and sensitive to sexual identity.

• Develop and maintain a mechanism to ensure the consistency, accuracy, and relevance of information provided to the public through local hotlines including information about referral services.

Quality assurance is essential to make certain that delivery of quality HIV prevention services is consistent and to ensure interventions are delivered in accordance with established standards. Quality assurance programs include measures to maintain high performance expectations of staff and that appropriate, competent, and sensitive methods are used for counseling, referral of clients, and providing other risk reduction messages. These quality assurance procedures and staff training should extend to the organizations providing HIV prevention activities through contracts.

Quality assurance and staff training is an ongoing process. An important component of this process is routine, periodic observation during counseling sessions and subsequent feedback to reinforce specific strengths noted and address any deficiencies detected. Performance standards that define expectations for the context and delivery of the counseling massages should be developed.

Feedback from client satisfaction surveys should be used routinely as a factor in assessing the services provided.

6. HIV Prevention Capacity-Building Activities

Recipients must:

• Develop, implement, and maintain a plan to provide financial assistance to CBOs and other HIV prevention providers that includes provisions for ensuring that funds are awarded on a timely basis.

• Issue Requests for Proposals (RFPs) within 90 days of the receipt of the notice of grant award. Multi-year assistance is allowable, provided the initial award was made competitively.

In order to build capacity, health departments should provide financial and technical assistance to strengthen their own infrastructure and that of non-governmental organizations to deliver effective HIV prevention interventions. Some examples of capacity building activities are implementing systems to ensure quality and integration of services (particularly HIV, STD, TB, and drug treatment), strengthening laboratory capacity, improving community needs assessments, funding community-based organizations to provide services, and providing technical assistance in all aspects of program planning and operations.

7. HIV Prevention Technical Assistance Assessment and Plan

Recipients must:

• Assess their own needs, as well as the needs of community-based organizations in their jurisdiction, for technical assistance in the areas of HIV prevention program planning, implementation, and evaluation.

• Develop, implement, and maintain a plan to provide the technical assistance indicated by the assessment.

Recipients should identify their own current and projected technical assistance needs and the needs of the jurisdiction's community-based providers, for program planning, implementation, and evaluation. Recipients should develop and implement a plan to provide ongoing technical assistance for HIV prevention and early medical intervention services in their communities, as indicated by the assessment. These should include planning, implementing, and evaluating prevention programs, activities, and services. Technical assistance should include the active monitoring of services and programs provided by CBOs.

Program management, strategies for meeting the HIV prevention needs of populations at high risk, and strategies for overcoming barriers to prevention should be priority areas for technical assistance programs.

8. Evaluation of Major Program Activities, Interventions, and Services

Evaluation is essential to monitor progress, measure program success, and strengthen programs and program activities. To this end, recipients need to conduct evaluation activities that will assess their progress in HIV prevention efforts and will contribute to the planning, implementation, and evaluation of effective HIV prevention programs.

The evaluation activities described here are listed as six phases. It is expected that there will be a range in recipient capacity and resources to conduct evaluations and that some recipients will have already conducted some of the phases. Therefore, although the phases are listed in an idealized sequence, recipients should implement the phases in a manner that reflects their current evaluation achievements, capacity, activities, resources, and needs. Each year, in their annual CDC funding applications, recipients should submit progress reports and data pertaining to the phases they implemented during the previous year and establish objectives for the upcoming year. As grantees implement new phases of evaluation, those phases that were previously initiated should be continued.

CDC is creating a *CDC Evaluation Guidance* that will be disseminated to recipients. The guidance is designed to assist recipients in preparing their application and implementing evaluation activities described in this announcement. To this end, the guidance provides an overview of CDC's evaluation model, upon which this announcement is based; describes recipient evaluation activities and data collection for each phase; lists references for technical assistance and training to build recipient capacity to implement these activities; and contains definitions of key terms.

All recipients should include the following evaluation activities in their programs:

a. Phase I: Development of a Comprehensive Evaluation Plan

Recipients should develop a comprehensive plan for evaluation of health department and health department-funded HIV program services and interventions. The plan should describe what will be done each year over the next five years. Phases II through IV describe the five types of evaluation in which grantees should engage. The plan should be clear, specific, and realistic.

b. Phase II: Evaluation of HIV Prevention Community Planning

Recipients should track and keep records on an ongoing basis in the following areas pertaining to the community planning process and development and implementation of the Comprehensive HIV Prevention Plan, using the Evaluation Guidance tools.

(1) Recruitment of community planning group members and representation of affected communities and areas of expertise on the community planning group (Community Planning Core Objectives 1 and 2).

(2) Application of a needs assessment and an epidemiologic profile to determine target groups and HIV prevention strategies (Community Planning Core Objective 3).

(3) Application of scientific knowledge in the selection and formulation of intervention strategies (Community Planning Core Objective 4).

(4) Developing goals and measurable objectives for the planning process and monitoring progress on the objectives.

(5) Assessing the cost of the process.

(6) Assessing the extent to which resources allocated by the health department match the epidemiologic profile.

(7) Assessment of the extent to which the final version of the Comprehensive HIV Prevention Plan is used in the recipient health department's budget decisions and in the health department's planning and development of HIV prevention program activities (Community Planning Core Objective 5).

c. Phase III: Program Design Evaluation

Prior to launching new program activities, recipients should assess the quality of program activity designs to ensure that the proposed interventions are scientifically sound, the implementation system is well organized, and stated goals are clear and feasible. (Factors to be evaluated are discussed in the section on Evaluation Reporting Format.)

d. Phase IV: Process Evaluation of HIV Prevention Programs

Conduct process evaluation through:

- Ongoing data collection and monitoring regarding the implementation of health department and health department-funded program activities.
- Assessment of the congruency between the intended and actual implementation of health department and health department-funded program activities.
- Use evaluation findings in order to improve program activities as indicated by the data.

e. Phase V: Outcome Evaluation

Outcome evaluation for this announcement is defined as the assessment of the effects of an intervention on the individuals who were targeted in the intervention. For example, changes in knowledge, attitudes, or behavior are usually outcome variables.

Recipients whose award is more than $1 million are expected to carry out at least one outcome evaluation during the five-year period. Outcome evaluation may be most easily achieved for the following types of interventions: HIV counseling and testing, referral, individual-level counseling, group-level counseling, and institution-based programs. *CDC Evaluation Guidance* (to be published) will describe recommended outcome evaluation designs and emphasize those designs that are cost-efficient and practically feasible to implement.

f. Phase VI: Impact Evaluation

Impact evaluation is the assessment of the effects beyond the outcome. For example, assessment of the cumulative effect of all HIV prevention activities in the jurisdiction is an impact evaluation.

CDC plans to conduct national impact evaluation studies using HIV/AIDS surveillance and other public health data sets. Recipients are not required to perform their own impact evaluation (but may do so if they wish and resources permit); however, recipients must participate in CDC's HIV prevention effectiveness indicators project.

9. Other Activities

Recipients must:

a. Have the capability to access the Internet and to download documents about HIV from CDC and other sites.

b. Ensure participation of appropriate representatives (governmental and non-governmental) in national or regional planning and implementation meetings.

Recipients should budget funds provided through this cooperative for these efforts. For example, travel funds should be available for community planning co-chairs to travel to the HIV Co-chairs meeting.

B. CDC Activities

1. Provide consultation and technical assistance in all aspects of the comprehensive HIV prevention program, including the community planning process, and planning, conducting, and evaluating HIV prevention and intervention activities.

2. Provide up-to-date information including diffusion of best-practices in all areas of the diagnosis, treatment, surveillance, and prevention of HIV.

3. Provide assistance to improve systems that monitor disease and reporting trends.

4. In consultation with recipients, assess training needs and determine how best to meet those needs. For HIV Prevention, CDC, in concert with State and local health departments, will provide training, either directly or through its network of STD/HIV prevention training centers, for persons who supervise, manage, and perform partner notification and other outreach activities and for staff who provide direct patient care.

5. Facilitate the adoption and adaptation of effective prevention intervention models among project areas through workshops, conferences, written communications.

6. Assist recipients in evaluating their program performance, in meeting their objectives, and in complying with cooperative agreement requirements.

7. Coordinate multi State approaches to HIV prevention and intervention.

8. Support individual project areas by providing technical assistance in the development of new or innovative models for behavioral and clinical interventions and the evaluation of them.

Application Content

A. General

Develop applications in accordance with CDC 0.1246E, information contained in the program announcement, and the instructions and format provided below.

Sequentially number all pages in the application and attachments, include a table of contents reflecting major categories and corresponding page numbers. Submit the original and each copy of the application unstapled and unbound. Provide only those attachments directly relevant to this application. All materials must be single spaced, printed in 12 CPI font, unreduced, on 8½″ by 11″ paper, with at least 1″ margins, and printed on one side only.

B. Cross-Program Activities

Submit a brief statement addressing major HIV, STD, and TB cross-program issues. In this statement summarize progress made in the last 12 months and the current level of shared activities across HIV, STD, and TB programs. Discuss plans to improve coordination across HIV, STD, and TB programs over the next 12 months, including plans to increase collaboration in surveillance and any other efforts to improve program coordination.

C. HIV Prevention Community Planning (Not To Exceed 20 Pages)

1. National Community Planning: Progress Report and 1999 Objectives

Provide a brief summary of progress in accomplishing the following national community planning core objectives. Also, please summarize steps that will be taken over the next 12 months to accomplish the national core objectives.

a. Fostering the openness and participatory nature of the community planning process.

(1) Describe any efforts in the past 12 months in recruiting, training, and supporting community planning group members, and methods used to obtain input from outside group membership. Briefly profile the number of HIV prevention community planning groups convened in the jurisdiction. If the jurisdiction convenes other county or regional groups that provide input to a community planning group, please

describe this structure. Briefly describe any changes in the planning structure of your jurisdiction. Also briefly describe any mechanisms used during the past 12 months for coordination with other planning activities, e.g., Ryan White Title I and II, STD, TB.

(2) Describe any new or additional steps to be taken in each of these areas in the next 12 months to foster the openness and participatory nature of the community planning process.

b. Ensuring that the community planning groups reflect the diversity of the epidemic in your jurisdiction, and that expertise in epidemiology, behavioral science, health planning and evaluation are included in the process.

(1) Summarize the characteristics and expertise represented by members of the community planning groups over the past 12 months. Discuss any gaps in representation and approaches that have been used during the past 12 months to address the gaps. Briefly describe any methods used to obtain input from outside group membership. Do not include any information that might link HIV status to any individual.

(2) Please describe planned activities for the next 12 months including plans for addressing any gaps in representation.

c. Ensuring that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment.

(1) Briefly describe the process that was used or steps that were taken over the past 12 months to develop or modify the epidemiologic profile and the needs assessment. Briefly describe how priority populations were identified from the epidemiologic profile and needs assessment.

(2) Describe plans for updating or modifying the Epi profile and needs assessment over the next 12 months.

d. Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values.

(1) Briefly describe the process that was used to prioritize interventions over the past 12 months.

(2) Describe any changes planned in the prioritization process in the next 12 months.

e. Fostering strong, logical linkages between the community planning process, plans, application for funding and HIV prevention resources.

(1) Briefly describe the linkage between this application for funding and allocation of CDC HIV prevention resources and the HIV Prevention Plan.

(2) Describe any changes planned in the next 12 months.

(3) Describe linkages between planned expenditures (as reported in the budget tables), epidemiological statistics, and plans for addressing any gaps between budget levels and epidemiologic statistics.

2. Community Planning Technical Assistance and Evaluation

a. Technical Assistance

(1) Briefly describe any technical assistance provided to the community planning group in the past 12 months.

(2) Describe areas of needed technical assistance and planned methods for obtaining this assistance in the next 12 months.

b. Evaluation

(1) Briefly describe how the community planning process was evaluated over the past 12 months and the major conclusions of the evaluation.

(2) Describe plans to evaluate the community planning process over the next 12 months.

3. Comprehensive HIV Prevention Community Plan

Please provide as an attachment, the current version of your Comprehensive HIV Prevention Plan. For areas without a jurisdiction-wide planning group, include regional plans and a jurisdiction-wide summary of recommendations and conclusions. If the jurisdiction has developed a separate document that updates and describes refinements or changes to the original Comprehensive HIV Prevention Plan, please attach both the original Plan and the supplementary document that updates the Plan. Include the proposed activities for 1999, letters of concurrence/non-concurrence from each community planning group in the jurisdiction, a line item budget and narrative justification, and relevant attachments. (The Comprehensive Plan or the jurisdiction-wide summary are attachments to the application and are not included in the page limit for this section.)

a. Priority populations and interventions. List the populations identified in the HIV Prevention Community Plan in rank order. For each of these populations list the recommended interventions (e.g., CTRPN, HE/RR) in rank order. For each intervention, list goals recommended in the plan. Please use the following format:

Population #1
Intervention #1
Goals
Intervention #2
Goals
Population #2

D. HIV Prevention Program (Not to Exceed 30 Pages)

1. Progress Report for 1998

Summarize progress during the past year in achieving objectives related to each of the programmatic activities listed below. For each activity, describe progress toward achieving program objectives, related training and quality assurance activities, program evaluation findings, changes or adjustments resulting from evaluation findings, and reasons for not attaining an objective.

a. HIV CTRPN;
b. HE/RR (including individual level interventions, group level interventions, community level interventions, and street and community outreach);
c. Public Information Programs;
d. Evaluation Activities;
e. HIV prevention capacity building activities;
f. Quality assurance and training;
g. Other activities.

2. Budget Tables

Complete the Table of Estimated Expenditures for 1998 HIV Prevention funding, indicating 1998 HIV prevention allocations by intervention, population, and race/ethnicity. This is used to report to Congress and Office of Management and Budget on use of tax dollars, targeted programs, and to justify need for additional support.

3. Program Goals, Objectives, and Activities

a. 5-Year Programmatic Goals

Based on the past 5 years' activities, provide overall programmatic goals for the next five-year period. These are intended to provide a general framework-objectives and activities will be developed annually, when each of the next budget period program applications are written.

b. 1999 Priority Populations and Interventions

List the priority populations identified by the recipient in rank order. For each of these populations, list the interventions the grantee plans to fund in rank order. For each intervention list the goals. For each goal, state realistic, specific, time-phased, and measurable objectives to be achieved during the next 12 months. Outline strategies and activities to be undertaken and services to be provided to achieve objectives. Include, as needed, training, quality assurance, and capacity-building objectives related to each intervention. Please use the following format:

Population #1
Intervention #1
Goals
Objectives
Activities
Intervention #2
Goals
Objectives
Activities
Population #2
Intervention #1

c. Linkages Between Primary and Secondary HIV Prevention Activities

Briefly describe the linkages that will be developed and maintained between primary and secondary prevention services in the jurisdiction. Provide goals and realistic, specific, time phased, and measurable objectives for the next 12 months. Outline strategies and activities to be undertaken to achieve these objectives.

d. Linkages With Other HIV Prevention Related Activities

Briefly describe the program's proposed linkages with other HIV prevention-related activities (e.g., epidemiologic and behavioral surveillance; research; substance abuse, STD, and family planning programs; and program evaluation activities) and the prevention program strategies proposed in this application. Provide goals and realistic, specific, time phased, and measurable objectives for the next 12 months. Outline strategies and activities to be undertaken to achieve these objectives.

e. Coordination of HIV Prevention Services and Programs

Briefly describe the program's plans for coordination among public and non-governmental agencies to provide HIV prevention services and programs. Provide goals and realistic, specific, time phased, and measurable objectives for the next 12 months. Outline strategies and activities to be undertaken to achieve these objectives.

f. Technical Assistance

Briefly describe your need, as well as the needs of the community-based organizations in your jurisdiction, for technical assistance in the areas of HIV prevention program design, implementation, and evaluation. Describe plans for addressing these technical assistance needs. Provide goals and realistic, specific, time phased, and measurable objectives for the next 12 months. Outline strategies and activities to be undertaken to achieve these objectives.

g. Program Evaluation

Each year, in their annual CDC funding applications, recipients should submit progress reports and data pertaining to the phases they implemented during the previous year and establish objectives for the upcoming year. As grantees implement new phases of evaluation, those phases that were previously initiated should be continued.

4. Explain Any Differences Between the Priority Populations, Interventions, and the Proposed Program Activities and Those Recommended in the Comprehensive HIV Prevention Plan (e.g., other funding sources are supporting an activity, other providers are meeting a need, public health interest, legal constraints)

E. Concurrence of HIV Prevention Community Planning Groups

Recipients must submit letters of concurrence or non-concurrence from each HIV prevention community planning group convened within the jurisdiction. The letters should indicate the extent to which the recipient and the HIV prevention community planning groups have successfully collaborated in developing the comprehensive HIV prevention plan and have reviewed and agree upon the program priorities contained in this application. The letter should describe the process used to obtain concurrence, including a description of the process used for review of the application by the community planning group, the time frame allotted for the review, who from the community planning group reviewed it (co-chairs, members, subcommittee chairs), and the quality of the concurrence (e.g., without reservation, with minor concerns, with important concerns). At a minimum, the letters should be signed by the co-chairs on behalf of the groups. There should be letters from each of the community planning groups described above. If a letter of concurrence includes reservations or a statement of concern/issues, address those concerns in the application. Letters of non-concurrence must cite specific reasons for the non-concurrence. In situations where the community planning group does not concur with the program priorities identified in the funding application and the recipient is proposing to implement activities or allocate Federal resources based on other priorities, a justification must be provided by the recipient as to why the priorities identified through the community planning process are not being implemented.

Instances of planning group concerns or non-concurrence will be evaluated on a case-by-case basis. After consultation, CDC will determine what action, if any, may be appropriate.

F. Budget Information

In accordance with Form CDC 0.1246E, provide a line item budget and narrative justification for all requested costs that are consistent with the purpose, objectives, and proposed program activities. Within this budget, please provide the documentation requested for each cost category:

1. Line item breakdown and justification for all personnel, i.e., name, position title, annual salary, percentage of time and effort, and amount requested.

2. Line item breakdown and justification for all contracts, including: (1) Name of contractor, (2) period of performance, (3) method of selection (e.g., competitive or sole source), (4) description of activities, (5) target population and (6) itemized budget.

3. Requests for any new Direct Assistance Federal assignees, include:

a. The number of assignees requested;

b. A description of the position and proposed duties;

c. The ability or inability to hire locally with financial assistance;

d. Justification for request;

e. An organizational chart and the name of the intended supervisor;

f. The availability of career-enhancing training, education, and work experience opportunities for the assignee(s) and;

g. Assignee access to computer equipment for electronic communication with CDC.

4. Complete CDC budget tables. Note: Following receipt of your 1999 award, additional budgetary information may be requested.

Submission and Deadline

(To be provided with final version)

Evaluation Criteria

A. All applications will be reviewed by CDC program consultants for determination of progress toward stated objectives and for compliance with program guidance. In addition, each application will also receive an external review by an independent team of governmental and non-governmental representatives to determine technical acceptability. The purposes of this external review will be to evaluate each application individually against to the following criteria:

1. The need for support as documented in the Epidemiologic Profile and Needs Assessment including

(1) the degree to which trends in reported AIDS cases and HIV sero prevalence show the need for increased HIV prevention activities and services, and (2) the extent of unmet prevention needs as identified through the needs assessment in the Comprehensive HIV Prevention Plan.

2. Determine progress and continued compliance with the Community Planning Guidance and this document.

3. The extent to which the short-term and long-term objectives are realistic, measurable, time-phased, and related to the project's Comprehensive HIV Prevention Plan.

4. The quality of the recipient's plan for conducting program activities, the potential effectiveness of the proposed methods in meeting the stated objectives, and previous success in implementing activities and services. This includes the degree to which the proposed program activities and methods are science-based (i.e., theory-predicted or based on findings of scientific research) and the likelihood that the recipient can effectively implement the proposed activities and services.

5. The quality of the proposed evaluation plan.

6. The extent to which the budget request is clearly explained, is adequately justified, and is consistent with the intended use of Federal funds.

7. The degree to which the applicant has met the CDC Policy requirements regarding the inclusion of women, ethnic, and racial groups in the proposed research. This includes:

a. The proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation.

b. The proposed justification when representation is limited or absent.

c. A statement as to whether the design of the study is adequate to measure differences when warranted.

d. A statement as to whether the plans for recruitment and outreach for study participants include the process of establishing partnerships with communities) and recognition of mutual benefits.

B. In addition, the external review will:

1. Recommend specific actions for CDC to ensure that project areas are developing, implementing, and refining technically acceptable prevention plans.

2. Recommend technical assistance or other support to further a project area's progress in implementing community planning.

3. Identify innovative or promising practices in HIV prevention and community planning and recognize successes.

4. Determine national progress in implementing HIV prevention community planning and potential technical assistance needs in 1999.

Other Requirements

A. Technical Reporting Requirements

A report describing progress in HIV prevention community planning and HIV prevention program activities is required annually with the application for funding.

An original and two copies of a financial status report (FSR) are required no later than 90 days after the end of each budget period and a final report after the project period. Submit the all reports to the Grants Management Branch, CDC.

Statistical reports of HIV-antibody counseling and testing activities (OMB [Office of Management and Budget] Approval No. 0920–0280) are required 45 days after the end of each quarter. Project areas are required to collect and report data for each episode of counseling or testing funded by CDC on all of the following variables: Project area, site type, site number, date of visit, sex, race/ethnicity, age, reason for visit, risk for HIV infection, whether test is anonymous or confidential, whether client accepted testing, results of test, whether post-test counseling occurred, date of post-test counseling and state, county, and zip code of client residence. Data should be collected in a manner consistent with and not in place of client-centered counseling. Project areas may collect other information to meet local data and evaluation needs. Project areas may use CDC scan form for reporting or a local form with data reported electronically. Project areas are encouraged to report data at client record level. Project areas may request technical assistance to achieve this.

For other requirements, see the following attachments.

B. AR98–1 Human Subjects Requirements

C. AR98–2 Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research

D. AR98–4 HIV/AIDS Confidentiality Provisions

E. AR98–5 HIV Program Review Panel Requirements

F. AR98–6 Patient Care

G. AR98–7 Executive Order 12372 Review

H. AR98–8 Public Health System Reporting Requirements

I. AR98–9 Paperwork Reduction Act Requirements

J. AR98–10 Smoke-Free Workplace Requirements

K. AR98–11 Healthy People 2000

L. AR98–12 Lobbying Restrictions

Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under sections 317, 301, and 311 of the Public Health Service Act (42 U.S.C. 241(a) and 247(b)), (42 U.S.C. 241) and (42 U.S.C. 243), as amended. The Catalog of Federal Domestic Assistance (CFDA) number for this project is 93.940.

Where To Obtain Additional Information

Please refer to Program Announcement 99004 when you request information. For a complete program description, information on application procedures, an application package, and business management technical assistance, contact: Kevin Moore, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Announcement Number 99004, Centers for Disease Control and Prevention (CDC), Room 300, Mailstop E–15, 255 East Paces Ferry Road, NE., Atlanta, GA 30305–2209; Telephone (404) 842–6550; Email address KGM1@CDC.GOV; See also the CDC home page on the Internet: http://www.cdc.gov.

For program technical assistance, contact your project officer or Jessica Gardom, Division of HIV/AIDS Prevention, National Center for HIV/STD/TB Prevention (NCHSTP), Centers for Disease Control and Prevention (CDC), Mailstop E–58, 1600 Clifton Road, NE., Atlanta, GA 30333; Telephone (404) 639–5248; Email address JCG3@CDC.GOV.

Dated: May 13, 1998.

Joseph R. Carter,

Acting Associate Director for Management and Operations, Centers for Disease Control and Prevention (CDC).

Guidance: HIV Prevention Community Planning for HIV Prevention Cooperative Agreement Recipients

Essential Components of a Comprehensive HIV Prevention Program

To implement a comprehensive HIV prevention program, State, local, and territorial health departments that receive HIV Prevention Cooperative Agreement funds should assure that efforts in their jurisdictions include all of the following essential components:

1. A community planning process, known as HIV prevention community planning, in accordance with this guidance;
2. Epidemiologic and behavioral surveillance, as well as compilation of other health and demographic data relevant to HIV risks, incidence, or prevalence;
3. HIV counseling, testing, referral, and partner notification (CTRPN) with strong linkages to medical care, treatment, and other needed services;
4. Health education and risk reduction (HE/RR) activities, including individual-, group-, and community-level interventions;
5. Accessible diagnosis and treatment of other sexually transmitted diseases;
6. Accessible diagnosis and treatment of tuberculosis and other opportunistic infections;
7. School-based efforts for youth;
8. Public information programs;
9. Training and quality assurance;
10. Laboratory support;
11. HIV prevention capacity-building activities, including expansion of the public health infrastructure by contracting with non-governmental organizations, especially community-based organizations;
12. An HIV prevention technical assistance assessment and plan; and
13. Evaluation of major program activities, interventions, and services.

This guidance addresses the first of these components, HIV prevention community planning, and outlines the minimum standards that CDC requires of its health departments in the implementation of the community planning process. Definitions and programmatic standards and guidelines referenced in this guidance are further described in the materials included with the 1999 HIV prevention cooperative agreement program announcement number 99004.

Financial Support of HIV Prevention Community Planning

HIV prevention cooperative agreement funds should be used to support all aspects of the community planning process, including:

1. Supporting planning group meetings, public meetings, and other means for obtaining community input;
2. Facilitating involvement of all community planning group members in the planning process, particularly those persons with and at risk for HIV infection;
3. Supporting capacity development for inclusion,* representation** and parity*** of community representatives and other planning groups members to participate effectively in the process;
4. Providing technical assistance to health departments and community planning groups;
5. Supporting infrastructure for the HIV prevention community planning process;
6. Collecting, analyzing, and disseminating relevant data; and
7. Evaluating the community planning process.

Goal of HIV Prevention Community Planning

The goal of HIV prevention community planning is to improve the effectiveness of State, local, and Territorial health departments' HIV prevention programs by strengthening the scientific basis, relevance, and focus of prevention interventions. CDC monitors progress in meeting this goal through the following five core objectives:

Core Objectives:

1. Fostering the openness and participatory nature of the community planning process.
2. Ensuring that the community planning group(s) reflects the diversity of the epidemic in the jurisdiction, and that expertise in epidemiology, behavioral science, health planning, and evaluation are included in the process.
3. Ensuring that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment.
4. Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost and cost effectiveness, theory, and community norms and values.
5. Fostering strong, logical linkages between the community planning process, application for funding, and allocation of CDC HIV prevention resources.

Definition of HIV Prevention Community Planning

HIV prevention community planning is an ongoing, iterative planning process that is (1) evidence-based (i.e., based on HIV/AIDS and other epidemiologic data, including STD and behavioral surveillance data; qualitative data; ongoing program experience; program evaluation; and a comprehensive needs assessment process) and (2) incorporates the views and perspectives of groups at risk for HIV infection for whom the programs are intended, as well as providers of HIV prevention and STD treatment services. Together, representatives of affected populations, epidemiologists, behavioral scientists, HIV/AIDS prevention service providers, STD treatment providers, health department staff, and others analyze the course of the epidemic in their jurisdiction, assess HIV prevention needs, determine their priority prevention needs, identify HIV prevention interventions to meet those needs, and develop comprehensive HIV prevention plans that are directly responsive to the epidemics in their jurisdictions. These comprehensive HIV prevention plans address all the essential components of a comprehensive HIV prevention program described in the section Essential Components of a Comprehensive HIV Prevention Program, or explain why a particular component is missing.

Prioritizing HIV prevention needs is a critical part of program planning. Community planning group members are expected to follow a logical, evidence-based process in order to determine the highest priority prevention needs in their jurisdiction. These prioritized prevention needs are particularly important to the health department in allocating prevention

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* Inclusion, representation, and parity are fundamental tenets of HIV prevention community planning. Inclusion is defined as the assurance that the views, perspectives, and needs of all affected communities are included and involved in a meaningful manner in the community planning process. This is the assurance that the community planning process is inclusive of all the needed perspectives.

** Representation, is the assurance that those who are representing a specific community truly reflect that community's values, norms, and behaviors. This is the assurance that those representatives who are included in the process are truly able to represent their community. At the same time, these representatives should be able to participate as group members in objectively weighing the priority prevention needs of the jurisdiction.

*** Parity, is the condition whereby all members of the HIV prevention community planning group have the skills and knowledge for input and participation, as well as equal voice in voting and other decision-making activities. This is ensuring that those representatives who are included in the process can participate equally in the decision-making process.

dollars. Specific high priority HIV prevention needs (both populations and interventions) identified in the comprehensive HIV prevention plan are then operationalized in the health department's application to CDC for Federal HIV prevention funds. There should be strong, logical linkages between the community planning process, the comprehensive HIV prevention plans, the health department's application for Federal funds, and the allocation of Federal HIV prevention resources by the health department.

To meet this definition, community planning groups must focus primarily on the tasks of planning. Once a comprehensive plan has been developed, the community planning group should periodically review it to determine whether or not it is necessary to:

1. Seek additional information to clarify and focus prevention priorities;
2. Define potential methods for obtaining needed additional information;
3. Give additional attention to strengthening specific recommendations in the plan, such as
a. The linkages between primary prevention activities and secondary prevention, STD treatment, drug treatment, and medical services;
b. Development of an in-depth plan for coordination of health department HIV prevention activities with the prevention activities of other governmental and non-governmental agencies in the jurisdiction;
c. Conducting an assessment of technical assistance needs in the jurisdiction and developing a plan for meeting the needs;
4. Review program implementation information that would inform the planning process and potentially affect the priorities in the plan, e.g., progress reports from contractors, process evaluation data from other program activities;
5. Monitor any shifts in incidence;
6. Conduct new or additional needs assessment, resource inventories, focus groups, etc.;
7. Review new research findings on intervention effectiveness and determine the impact, if any, on the plan; and
8. Consider how new biomedical or prevention technologies might best be utilized.

These reviews may result in additional objectives for the community planning group in the upcoming year and an updated or revised comprehensive plan. Community planning groups may choose to take a long-term approach to their planning process, in one year reviewing the plan and developing action steps to strengthen it; in the next, focusing on implementing the steps and revising the plan; in the next, focusing on a particular population for which more information is needed; in the third, returning to the basic community planning steps. The planning process should be flexible, taking a long-term approach and negotiating meaningful tasks for the planning group that contribute and enhance the comprehensive plan. The important, overall goal of HIV prevention community planning is to have in place a comprehensive HIV prevention plan that is current, evidence based, adaptable as new information becomes available, tailored to the specific needs of each jurisdiction, and widely distributed in an effort to provide a road map for prevention that can be used by all prevention providers in the jurisdiction.

Principles of HIV Prevention Community Planning

The following principles trace their origins to several sources: HIV prevention program assessments conducted by CDC staff; CDC's Planned Approach to Community Health (PATCH) program; CDC's Assessment Protocol for Excellence in Public Health (APEX/PH) project; the ASTHO/NASTAD/CSTE State Health Agency Vision for HIV Prevention; the June 1994 External Review of CDC's HIV Prevention Strategies by the CDC Advisory Committee on the Prevention of HIV Infection; experience and recommendations of health departments and non-governmental organizations; the health promotion, community development, behavioral and social sciences literature; and CDC and its partners' experience in implementing community planning since 1994.

All Grantees Are Required To Adhere to 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.
4. Representation on a community planning group includes:
a. Persons who reflect the characteristics of the current and projected epidemic in that jurisdiction (as documented by the epidemiologic profile) in terms of age, gender, race/ethnicity, socioeconomic status, geographic and metropolitan statistical area (MSA)-size distribution (urban and rural residence), and risk for HIV infection. In addition to reflecting the characteristics outlined above, these representatives should articulate for, and have expertise in understanding and addressing, the specific HIV prevention needs of the populations they represent. At the same time, these representatives should be able to participate as group members in objectively weighing the priority prevention needs of the jurisdiction.
b. State and local health departments, including the HIV prevention and STD treatment programs.
c. State and local education agencies.
d. Other relevant governmental agencies (e.g., substance abuse, mental health, corrections).
e. Experts in epidemiology, behavioral and social sciences, program evaluation, and health planning.
f. Representatives of key non-governmental and governmental organizations providing HIV prevention and related services (e.g., STD, TB, substance abuse prevention and treatment, mental health services, HIV care and social services) to persons with or at risk for HIV infection.
g. Representatives of key non-governmental organizations relevant to, but who may not necessarily provide, HIV prevention services (e.g., representatives of business, labor, and faith communities).
5. The HIV prevention community planning process attempts to accommodate a reasonable number of representatives without becoming so large that it cannot effectively function. To assure needed input without becoming too large to function, HIV prevention community planning group(s) seek additional avenues for

obtaining input on community HIV prevention needs and priorities, such as holding well-publicized public meetings, conducting focus groups, and convening ad hoc panels. This is especially important for obtaining input relevant to marginalized populations that may be difficult to recruit and retain as members of the planning group (e.g., injecting drug users).

6. Nominations for membership are solicited through an open process and candidates are selected, based on criteria that has been established by the health department and the community planning group. The nomination and selection of new community planning group members occurs in a timely manner to avoid vacant slots or disruptions in planning. In addition, the recruitment process for membership in the HIV prevention community planning process is proactive to ensure that socioeconomically marginalized groups, and groups that are under served by existing HIV prevention programs, are represented.

7. All members of the HIV prevention community planning group(s) are offered a thorough orientation, as soon as possible after appointment. The orientation includes:

a. Understanding the roles and responsibilities outlined in this document,

b. Understanding the procedures and ground rules used in all deliberations and decision making,

c. Understanding the specific policies and procedures for decision-making, resolving disputes, and avoiding conflict of interests that are consistent with the principles of this guidance and are developed with input from all parties. These policies and procedures address:

1. Process for making decisions within the planning group (vote, consensus, etc.),

2. Conflict(s) of interest for members of the planning group(s),

3. Disputes within and among planning group(s),

4. Differences between the planning group(s) and the health department in the prioritization and implementation of programs/services, and

5. A process for resolving these disputes in a timely manner when they occur.

d. Understanding HIV prevention interventions and comprehensive prevention programs.

Orienting new members is an ongoing process that may include mentoring new members throughout the year.

8. Health departments assure that HIV prevention community planning group(s) have access to current information related to HIV prevention and analyses of the information, including potential implications for HIV prevention in the jurisdiction. Sources of information include evaluations of program activities, programmatic research, social and behavioral sciences, and other sources, especially as it relates to the at-risk population groups within a given community and the priority needs identified in the comprehensive plan.

9. Identification, interpretation, and prioritization of HIV prevention needs reflect the epidemiologic profile, needs assessment, and culturally relevant and linguistically appropriate information obtained from the communities to be served, particularly persons with or at risk for HIV infection.

10. Priority setting for specific HIV prevention strategies and interventions is based on specific criteria outlined in this document and each criterion should be formally considered by the HIV prevention community planning group(s) during priority-setting deliberations.

11. The HIV prevention community planning process produces a comprehensive HIV prevention plan, jointly developed by the health department and the HIV prevention community planning group(s), which includes specific, high priority HIV prevention strategies and interventions targeted to defined populations. Each health department's application for CDC funds addresses the plan's high priority elements that are most appropriately met by HIV prevention cooperative agreement funds. The comprehensive plan includes the essential elements listed in the section Essential Elements of a Comprehensive HIV Prevention Plan.

12. Because the plan is comprehensive, it should be distributed widely as a resource to guide programmatic activities and resources outside of those supported with CDC Federal HIV prevention funds.

13. The HIV prevention community planning process is evaluated to ensure that it is meeting the core objectives of community planning.

Steps in the HIV Prevention Community Planning Process

The steps of the HIV prevention community planning process follow:

1. Epidemiologic Profile: Assess the extent, distribution, and impact of HIV/AIDS and other STDs in defined populations in the community, as well as relevant risk behaviors. In defining at-risk populations, special attention should be paid to distinguishing behavioral, demographic, and racial/ethnic characteristics. This is the starting point for defining future HIV prevention needs in defined, targeted populations within the health department's jurisdiction. Other methods for segmenting audiences for prevention messages may also be used.

2. Needs Assessment/Resource Inventory: Assess existing community resources for HIV prevention and STD treatment to determine the community's capability to respond to the epidemic. These resources should include fiscal, personnel, and program resources, as well as support from public (Federal, State, county, municipal), private, and volunteer sources. This inventory should attempt to identify HIV prevention and STD treatment programs and activities according to the high-risk populations defined in the epidemiologic profile. The needs assessment/resource inventory should be based on a variety of sources (both qualitative and quantitative), should be collected using different assessment strategies (e.g., surveillance; survey; formative, process, and outcome evaluation of programs and services; outreach and focus group(s); public meetings), and should incorporate information from both providers and consumers of services. Techniques such as over sampling may be needed to collect valid information from certain at-risk populations.

3. Gap Analysis: Identify met and unmet HIV prevention and STD treatment needs within the high-risk populations defined in the epidemiologic profile and needs assessment/resource inventory. Findings from the needs assessment about high-risk populations (e.g., size of population, impact of HIV/AIDS, risk behaviors) and from the resource inventory about existing services should assist in identifying priority prevention needs. For example, if a large number of clients are turned away each day from an STD clinic that has a high HIV sero positivity rate, then there is clearly a gap in HIV prevention services.

4. Intervention Inventory: Identify potential strategies and interventions that can be used to prevent new HIV infections within the high-risk populations defined in the needs assessment;

5. Prioritization: Prioritize (rank order) HIV prevention needs in terms of: (1) High-risk populations; and (2) interventions and strategies for each high-risk population based on the following criteria:

a. Documented HIV prevention needs based on the current and projected impact of HIV/AIDS and other STDs in

defined populations in the health department's jurisdiction;

b. Outcome effectiveness of proposed strategies and interventions (either demonstrated or probable);

c. Available information on the relative costs and effectiveness of proposed strategies and interventions (either demonstrated or probable);

d. Sound scientific theory (e.g., behavior change, social change, and social marketing theories) when outcome effectiveness information is lacking;

e. Values, norms, and consumer preferences of the communities for whom the services are intended;

f. Availability of other governmental and non-governmental resources (including the private sector for HIV prevention); and

g. Other State and local determining factors.

Each criterion should be considered by the HIV prevention community planning group(s) during priority-setting deliberations. At a minimum, the community planning groups must provide a clear, concise, logical statement as to why each population and intervention given high priority was chosen.

6. Plan Development: Develop a comprehensive HIV prevention plan consistent with the high priority needs identified through the community planning process. The plan must contain all of the elements described in the following section, Essential Elements of a Comprehensive HIV Prevention Plan. CDC does not require a new plan each year. Plans may cover more than one year. However, project areas are expected periodically to review, revise, and refine the plans, as indicated by any new or enhanced surveillance data, intervention research, needs assessment, program policy, or technology. (See Definition of HIV Prevention Community Planning)

7. Evaluation: Evaluate the effectiveness of the planning process. Health departments should track and keep records on an ongoing basis in the following areas pertaining to the community planning process and development and implementation of the comprehensive HIV prevention plan:

a. Recruitment of community planning group members and representation of affected communities and areas of expertise on the community planning group (Community Planning Core Objectives 1 and 2).

b. Application of a needs assessment and an epidemiologic profile to determine target groups and HIV prevention strategies (Community Planning Core Objective 3).

c. Application of scientific knowledge in the selection and formulation of intervention strategies (Community Planning Core Objective 4).

d. Developing goals and measurable objectives for the planning process and monitoring progress on the objectives.

e. Assessing the cost of the process.

f. Assessing the extent to which resources allocated by the health department match the epidemiologic profile.

g. Assessment of the extent to which the final version of the Comprehensive HIV prevention plan is used in the health department's budget decisions and in the planning and development of HIV prevention program activities (Community Planning Core Objective 5).

8. Update: Use program evaluation data and updated or revised epidemiologic, needs assessment, intervention research, program policy, and technologic data to improve the next year's planning process and to update, as appropriate, the comprehensive plan. (See Definition of HIV Prevention Community Planning)

Essential Elements of a Comprehensive HIV Prevention Plan

The HIV prevention community planning process should produce a comprehensive HIV prevention plan, jointly developed by the health department and the HIV prevention community planning group(s), which includes specific, high priority HIV prevention strategies and interventions targeted to defined populations.

The necessary elements of a comprehensive HIV prevention plan include the following:

1. Epidemiologic Profile: An HIV/AIDS epidemiologic profile that outlines the epidemic in that jurisdiction. The profile includes data from a variety of sources (demographic and socioeconomic data, reported AIDS cases, reported HIV infections from areas with confidential reporting, HIV sero prevalence and sero incidence surveys/studies (where available], HIV risk behaviors, and surrogate markers for HIV risk behaviors, e.g., sexually transmitted disease (STD) and teen pregnancy rates and information on drug use.) Furthermore, the profile includes a narrative explanation of all data provided.

2. Needs Assessment/Resource Inventory/Gap Analysis: A description of met and unmet HIV prevention needs in target populations to be reached by primary HIV prevention interventions, and barriers in reaching populations. The description of target populations may include age group, gender, race/ethnicity, socioeconomic status, geographic area, sexual orientation, risk for HIV infection, primary language, and significant cultural factors.

3. Prioritization: The populations at high risk for HIV in rank order (i.e., prioritization), and the culturally and linguistically appropriate individual-, group-, and community-level strategies and interventions to reach each. These high-risk populations should include defined target populations whose sero status is unknown, negative, or positive. The strategies and interventions should include the interventions described in the section Essential Components of a Comprehensive HIV Prevention Program, as well as school-based programs, and other HIV prevention activities. Both existing and proposed interventions should be described. A clear, concise, logical statement of the reason each prioritized intervention was selected should be included.

4. Linkages: A description of how activities proposed in the comprehensive plan to prevent transmission or acquisition of HIV (primary prevention activities) are linked to activities to prevent or delay the onset of illness in persons with HIV infection (secondary prevention activities), to STD treatment, drug treatment, and Ryan White Comprehensive AIDS Resources Emergency (CARE) Act planning.

5. Goals: Short and long term goals for HIV prevention in defined populations being reached with defined interventions.

6. Surveillance and Research: A description of ongoing HIV prevention surveillance and research activities (e.g., epidemiologic and behavioral surveillance, research, and program evaluation activities), how these are linked to prevention program strategies in the plan, and any additional surveillance and research that is needed.

7. Coordination: A description of how governmental and non-governmental agencies will coordinate to provide comprehensive HIV prevention services and programs within the area for which the plan is developed.

8. Technical Assistance Needs Assessment and Plan: An HIV prevention technical assistance needs assessment identifying needs of the health department, community planning group(s), and community-based providers in the areas of program planning, implementation, and evaluation, and a plan of activities that addresses the technical assistance needs.

9. Community Planning Evaluation Plan: An evaluation plan for the HIV prevention planning process.

Letters of Concurrence/Nonconcurrence

Each health department, in its application, must include a letter of concurrence or nonconcurrence from every HIV prevention community planning group convened within the health department's jurisdiction. At a minimum, the letter(s) should be signed by the co-chairs on behalf of the group(s).

HIV prevention community planning group members should carefully review the comprehensive HIV prevention plan and the health department's entire application to CDC for Federal funds (including the proposed budget). Because the community planning process requires prioritization of HIV prevention needs and because prioritization directly corresponds to resource allocation, it is critical that the community planning group review the proposed allocation of resources in the health department's application (and, especially, to review expenditure levels in light of the epidemiologic profile). Community planning groups are not asked to review and comment on internal health department issues, such as salaries of individual health department staff, but instead to indicate:

1. The extent to which the health department and the HIV prevention community planning group(s) have successfully collaborated in developing, reviewing, or revising the comprehensive HIV prevention plan;

2. The extent to which the activities, programs, and services, for which the health department is requesting CDC funds, are responsive to the priorities in the comprehensive plan;

3. The process used for obtaining concurrence, including

a. A description of the process used for review of the application by the community planning group,

b. The time frame allotted for the review,

c. Who from the community planning group reviewed it (co-chairs, members, subcommittee chairs), and

d. The quality of the concurrence (e.g., without reservation, with minor concerns, with important concerns).

Letter(s) of concurrence may include reservations or a statement of concern/issues. The health department should address these reservations or concerns in an addendum to the HIV prevention application.

Letter(s) of nonconcurrence indicate that an HIV prevention community planning group disagrees with the program priorities identified in the health department's application. The letter should cite specific reasons for nonconcurrence. In instances of nonconcurrence and when a health department does not concur with the recommendations of the HIV prevention community planning group(s) and believes that public health would be better served by funding HIV prevention activities/services that are substantially different, the health department must submit a letter of justification in its application. CDC will assess and evaluate these justifications on a case-by-case basis and determine what action may be appropriate. A letter of nonconcurrence does not necessarily mean that the jurisdiction will lose any portion of its CDC funding. These actions can range from:

1. Obtaining more input/information regarding the situation;

2. Meeting with the health department and co-chairs;

3. Negotiating with the health department regarding the issues raised;

4. Recommending local mediation;

5. Approving the health department's application as is;

6. Requesting that a detailed plan of corrective action be developed to address the areas of concern and to be executed within a specified time frame;

7. Conducting an on-site comprehensive program assessment to identify and propose action steps to resolve areas of concern;

8. Conducting an on site program assessment focused on a specific area(s);

9. Developing a detailed technical assistance plan for the project area to help systematically address the situation; and

10. Placing conditions or restrictions on the award of funds pending a future submission by the applicant.

Roles and Responsibilities—Health Departments

State, local, and territorial health departments are responsible for the health of the populations in their jurisdictions. States have a broad responsibility in surveillance, prevention, overall planning, coordination, administration, fiscal management, and provision of essential public health services. The role of the health department in the community planning process is to:

1. Establish and maintain at least one HIV prevention community planning group that meets the principles described in the section Principles of HIV Prevention Community Planning. Health departments are required to determine how best to achieve and integrate statewide, regional, and local community planning within their jurisdictions. In those jurisdictions where CDC has direct cooperative agreements with both State and local health departments, health departments are expected to have systems and procedures in place to facilitate coordination and communication between the State and local health departments and their community planning groups.

2. Identify a health department employee, or a designated representative, to serve as co-chair of each HIV prevention community planning group in the project area; if State health departments implement more than one planning group within their jurisdiction, they may wish to designate local health department representatives as co-chairs of these planning groups.

3. Assure collaboration between HIV prevention community planning group(s) and other relevant planning efforts, particularly the process for allocating Titles I, II, and IIIb of the Ryan White Comprehensive AIDS Resources Emergency Act and the STD prevention program. Health departments may consider merging the HIV prevention community planning process with other planning bodies/processes already in place. If such mergers are undertaken, health departments must adhere to the principles of HIV prevention community planning, as contained in this document.

4. Provide an epidemiologic profile of the HIV prevention community planning group's jurisdiction to assist the group in establishing program priorities based on the extent, distribution, and impact of the HIV/AIDS epidemic. The profile should compile, analyze, and synthesize data from a variety of sources (demographic and socioeconomic data, reported AIDS cases, reported HIV infections from areas with confidential reporting, HIV sero prevalence and sero incidence surveys/studies [where available], HIV risk behaviors and surrogate markers for HIV risk behaviors, e.g., sexually transmitted disease (STD) and teen pregnancy rates and information on drug use.) Further, the profile should include a narrative explanation of all data provided and a summary of key findings.

5. Provide expertise and technical assistance, including ongoing training on HIV prevention planning, STD treatment and the interpretation of epidemiologic, behavioral, and evaluation data, to ensure that the planning process is comprehensive and evidence based.

6. Distribute widely the comprehensive HIV prevention plan and utilize existing networks to promote linkages and coordination among local

HIV prevention service providers, public health agencies, STD treatment clinics, community planning groups, and behavioral and social scientists who are either in the local area or who are familiar with local prevention needs, issues, and at-risk populations.

7. Develop an application for HIV prevention cooperative agreement funds, based on the comprehensive HIV prevention plan(s) developed through the HIV prevention community planning process, seek review of the application and letter(s) of concurrence/nonconcurrence from the community planning group(s), and allocate resources based on the plan's priorities.

8. Operationalize and implement HIV prevention services/activities outlined in the comprehensive plan including awarding and administering HIV prevention funds.

9. Administer HIV prevention funds awarded under the cooperative agreement, ensuring that funds are awarded to contractors within 90 days of the time that the health department receives notice of grant award from CDC. Monitor contractor activities and document contractor compliance.

10. Ensure that technical assistance is provided to assist health departments and community-based providers in the areas of program planning, implementation, and evaluation as identified in the comprehensive HIV prevention plan. Health departments should meet these needs by drawing on expertise from a variety of sources (e.g., the CDC-supported TA network, health departments, academia, professional and other national organizations, and non-governmental organizations).

11. Administer and coordinate public funds from a variety of sources, including Federal, State, and local agencies, to prevent HIV transmission and reduce associated morbidity and mortality.

12. Ensure program effectiveness through specific program monitoring and evaluation activities. This may include conducting or contracting for process and outcome evaluation studies, providing technical assistance in evaluation, or ensuring the provision of evaluation technical assistance to funding recipients.

13. Provide periodic feedback to the community planning group on the successes and barriers encountered in implementing HIV prevention interventions.

HIV Prevention Community Planning Groups

The role of the planning group(s) in the HIV prevention community planning process is to:

1. Elect a community co-chair to work with the co-chair designated by the health department.

2. Determine the technical assistance needs of the community planning group to enable them to execute an effective community planning process.

3. Carefully review available epidemiologic, evaluation, behavioral and social science, cost and cost-effectiveness, and needs assessment data and other information required to prioritize HIV prevention needs.

4. Identify unmet HIV prevention needs within defined populations.

5. Prioritize HIV prevention needs by target populations and propose high priority strategies and interventions.

6. Identify the technical assistance needs of community-based providers in the areas of planning, implementing, and evaluating prevention interventions.

7. Assess how well the priorities outlined in the plan are represented in the health department's application to CDC for Federal HIV prevention funds.

8. Community planning groups must focus primarily on the tasks of planning, as described above. Whether or not community planning groups take on additional tasks beyond those described in this document is determined locally by the health department and the community planning group (see Definition of HIV Prevention Community Planning). The planning process should be flexible, taking a long-term approach and negotiating meaningful tasks for the planning group that contribute and enhance the comprehensive plan. The important, overall goal of HIV prevention community planning is to have in place a comprehensive HIV prevention plan that is current, evidence based, adaptable as new information becomes available, tailored to the specific needs of each jurisdiction, and widely distributed in an effort to provide a road map for prevention that can be used by all prevention providers in the jurisdiction.

Shared Responsibilities Between Health Departments and HIV Prevention Community Planning Groups

Together, the health department and the community planning group should:

1. Develop and implement policies and procedures that clearly address and outline systems for regularly re-examining:

a. Planning group composition, selection, appointment, and terms of office to ensure that all planning group(s) reflect, as much as possible, the population characteristics of the epidemic in State and local jurisdictions in terms of age, race/ethnicity, gender, sexual orientation, geographic distribution, and risk for HIV infection;

b. Roles and responsibilities of the community planning group, its members, and its various components (e.g., subcommittees, workgroups, regional groups, etc.);

c. Methods for reaching decisions; attendance at meetings; resolution of disputes identified in planning deliberations; and resolution of conflict(s) of interest for members of the planning group(s).

2. Develop and apply criteria for selecting the individual members of the HIV prevention community planning group(s) within the jurisdiction. Special emphasis should be placed on procedures for identifying representatives of socioeconomically marginalized groups and groups that are under served by existing HIV prevention programs.

3. Determine the most effective mechanisms for input into the HIV prevention community planning process. The process must be structured in such a way that it incorporates and addresses needs and priorities identified at the community level (i.e., the level closest to the problem or need to be addressed).

4. Provide a thorough orientation for all new members, as soon as possible after appointment. New members should understand:

a. The roles, responsibilities, and principles outlined in this document;

b. The procedures and ground rules used in all deliberations and decision making; and

c. The specific policies and procedures for resolving disputes and avoiding conflict of interests that are consistent with the principles of this guidance and are developed with input from all parties.

5. Determine the distribution of planning funds to (a) support planning group meetings, public meetings, and other means for obtaining community input; (b) facilitate involvement of all participants in the planning process, particularly those persons with and at risk for HIV infection; (c) support capacity development for inclusion, representation, and parity of community representatives and for other planning group members to participate effectively in the process; (d) provide technical assistance to health departments and community planning groups by outside experts; (e) support planning infrastructure for the HIV prevention community planning process; (f) collect, analyze, and disseminate relevant data; and (g) evaluate the community planning process.

6. Consider what additional data are needed for decision-making about priority needs, and propose methods for obtaining the data.

7. Develop goals for HIV prevention strategies and interventions in defined target populations.

8. Develop, update annually, and disseminate the comprehensive HIV prevention plan.

9. If there are multiple community planning groups in the jurisdiction, integrate multiple HIV community prevention plans into a project-wide comprehensive HIV prevention plan.

10. Foster integration of the HIV prevention community planning process with other relevant planning efforts. Consider how the following are addressed within the Comprehensive HIV prevention plan:

a. HIV prevention interventions;

b. Early intervention, primary care, and other HIV-related services;

c. STD, TB, and substance abuse prevention and treatment;

d. Women's health services;

e. Mental health services; and

f. Other public health needs.

Centers for Disease Control and Prevention

The role of CDC in the HIV prevention community planning process is to:

1. Provide leadership in the national design, implementation, and evaluation of HIV prevention community planning.

2. Collaborate with health departments, community planning groups, national organizations, Federal agencies, and academic institutions to ensure the provision of technical/program assistance and training for the HIV prevention community planning process. The CDC project officer is key to this collaboration. He/she works with the health department and the community co-chairs to provide technical/program assistance for the community planning process, including discussing roles and responsibilities of community planning participants, disseminating CDC documents, and responding to direct inquiries to ensure consistent interpretation of the guidance.

3. Provide technical/program assistance through a variety of mechanisms to help recipients understand how to (a) ensure parity, inclusion, and representation of all members throughout the community planning process; (b) analyze epidemiologic, behavioral and other relevant data to assess the impact and extent of the HIV/AIDS epidemic in defined populations; (c) conduct needs assessments and prioritize unmet HIV prevention needs; (d) identify and evaluate effective and cost-effective HIV prevention activities for these priority populations; (e) provide access to needed behavioral and social science expertise; (f) identify and manage dispute and conflict of interest issues; and (g) evaluate the community planning process.

4. Require that application content submitted by HIV prevention cooperative agreement recipients for HIV prevention community planning funds is in accordance with the principles and the roles and responsibilities outlined in this guidance.

5. Monitor the HIV prevention community planning process, especially around the five core objectives.

6. Require as a condition for award of cooperative agreement funds that recipients' applications are in accordance with the comprehensive plan developed through the HIV prevention community planning process or include an acceptable letter of justification.

7. Identify the essential components of a comprehensive HIV prevention program.

8. Collaborate with health departments in evaluating HIV prevention programs.

9. Collaborate with other Federal agencies (particularly the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration) in promoting the transfer of new information and emerging prevention technologies or approaches (i.e., epidemiologic, biomedical, operational, behavioral, or evaluative) to health departments and other prevention partners, including non-governmental organizations.

10. Compile annually a report on the projected expenditures of HIV prevention cooperative agreement funds by specific strategies and interventions. Collaborate with other prevention partners in improving and integrating fiscal tracking systems.

Accountability

CDC is committed to the concept of HIV prevention community planning as outlined in this guidance. In summary, CDC expects that:

1. Health departments will support and facilitate the community planning process;

2. Community planning groups will develop plans in which they have prioritized (rank ordered) HIV prevention needs, including populations and interventions;

3. Health departments will reflect these priorities in their applications to CDC and implement effective HIV prevention programs based on the comprehensive HIV prevention plan; and

4. Community planning groups will review the entire application for their jurisdiction, including the budget, prior to writing letters of concurrence and nonconcurrence.

CDC will continue to conduct external reviews of health department HIV prevention cooperative agreement applications and comprehensive HIV prevention plans to monitor the progress health departments and community planning groups are making in meeting these expectations. These reviews will focus on whether or not:

1. A jurisdiction's planning process is in compliance with this guidance and the five core objectives;

2. Priority populations and recommended interventions identified in the comprehensive HIV prevention plan are consistent with the epidemiologic profile, needs assessment, and behavioral/social science data presented in the plan;

3. Proposed prevention program objectives, activities, and budget in the application are consistent with the comprehensive HIV prevention plan; and

4. Any discrepancies noted are adequately justified.

CDC will review the recommendations provided by the External Reviewers and consider them when making decisions concerning issues such as funding restrictions and conditions, as well as detailed plans of technical assistance.

[FR Doc. 98–13307 Filed 5–18–98; 8:45 am]

BILLING CODE 4163–18–P