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001. form	re: Travel Order; [Personally Identifiable Information] [Partial] (1 page)	10/01/1993	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3772

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Meeting with National Skills Buiding Conference 11-2-93

2018-0756-F
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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
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b(1) National security classified information [(b)(1) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

RECEIVED

FEB 22 1994

NATIONAL SKILLS BUILDING CONFERENCE

February 16, 1994

Dear Colleague,

Please find enclosed a copy of the 1994 National Skills Building Conference (NSBC) *Final Report*. I'm sending you this report because you were either involved in the planning of the conference, quoted within or endorsed the conference; or, perhaps your photograph is included within the report.

Thank you for your support of NSBC and we hope to see you in Atlanta this fall for the '94 NSBC.

If you have any questions, please do not hesitate to call me at 202-546-6119. Thank you!

Sincerely,

Danny Linden
Conference Manager

SPONSORED BY:

AIDS NATIONAL INTERFAITH NETWORK
REV. KENNETH T. SOUTH
EXECUTIVE DIRECTOR

NATIONAL ASSOCIATION OF PEOPLE WITH AIDS
WILLIAM J. FREEMAN
EXECUTIVE DIRECTOR

NATIONAL MINORITY AIDS COUNCIL
PAUL AKIO KAWATA
EXECUTIVE DIRECTOR

300 EYE ST., NE
SUITE 400
WASHINGTON
DC 20002-4389
TEL. 202-546-6119
FAX 202-546-6418

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FINAL REPORT

STRENGTH

1993 NATIONAL SKILLS BUILDING CONFERENCE

SPONSORED BY

AIDS National Interfaith Network
110 Maryland Avenue, NE, Suite 504 Washington, DC 20002
202-546-0807 FAX 202-546-5103

National Association of People With AIDS
1413 K Street, NW Washington, DC 20005
202-898-0414 FAX 202-898-0435

National Minority AIDS Council
300 Eye Street, NE, Suite 400 Washington, DC 20002-4389
202-544-1076 FAX 202-544-0378

Action on AIDS –

Thanks & appreciation – individuals / organizations

Woes of the past

"12 years of 'inaction'"

"no frank discussion"

"if middle aged members of Congress were 1st to succumb, you'd have spent more & found answers"

MK Goals/President's goals – drive the research process to ~~cure~~ / knowledge / assure care / present further spread

Some honest appraisal is needed –

passion alone doesn't make an education program happen

enthusiasm doesn't balance the books –

all the money in the world spent on the wrong questions won't yield the right answers.

"Ignore AIDS & it will bury the rest of you" –

Care system – loss of resource

prevention system – lack of infrastructure

communities – fractured over access / education / prevention / inclusion

workplaces

international affairs

Making the practical happen –

Walking society through the end of denial into reality –

"not me / not so"

anger & sorrow

constructive action –

new approach to research

more open discussion

film on sex education

Fed'l employees

- Not just Mother's voices, but Father's voices
- businesses that back
  - community funding
  - open education
- commitment / support for all affected groups -
  - understanding the overlapping fights -
    - racism / sexism / homophobia
    - substance abusers

Withdrawal/Redaction Marker
Clinton Library

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

TRAVEL ORDER

XX Original ☐ Amendment No. _____ ☐ Cancellation
(See HHS Travel Manual, Part 3, for Detailed Instructions)

1. TRAVEL ORDER NO. 0017094043

2. APPROPRIATION NO. 7541101

3. ESTIMATED COST*

	TO DHHS	TO OTHERS
TRAVEL	$	$ 668.00
PER DIEM	323.00	
OTHER	80.00	
TOTAL	$ 403.00	$ 668.00

4. NAME AND POSITION OR RANK
Kristine M. Gebbie

(b)(6)

6. CONSTITUENT/BUREAU/DIVISION/REGION
DHHS/ PHS/ Office of Nat'l AIDS Policy Coordination

8. APPROX. DATE OF DEPARTURE 11/2/93

7. PRESENT OFFICIAL STATION
Washington, D.C.

9. APPROX. DATE OF RETURN 11/5/93

10. ITINERARY AND PURPOSE OF TRAVEL *(Show city, state or country, dates and reasons—use continuation sheet if necessary)*

From Washington, D.C. to New Orleans, LA to Reading, PA to Philadelphia, PA and return to Washington, D.C.

CLINTON LIBRARY PHOTOCOPY

Purpose: New Orleans,-to attend the National Skills Building Confgrence
Reading, PA- to lecture at the Reading Hospital, and to tour ~~XXXX~~ MERCK industries
Philadelphia- to attend symposium at the Franklin Institute and to ~~x~~ meet with faculty at the Univ. of Pennsylvania

[cov]

Prepared by: GWirth: ONAPC: 202-690-5560: 10/29/93

NOTICE: TRAVELERS ARE RESPONSIBLE AND LIABLE FOR UNUSED GTR'S — TICKETS RECEIVED UNTIL THEY HAVE BEEN PROPERLY ACCOUNTED FOR ON A TRAVEL VOUCHER OR RETURNED TO THE AGENCY.

11. SPECIAL AUTHZTN

TRAVEL BY PRIVATELY OWNED AUTO IS AUTHORIZED ON MILEAGE BASIS RATE SPECIFIED BELOW FOR: ☐ EMPLOYEE AND/OR ☐ DEPENDENTS

___¢ PER MILE AS MORE ADVANTAGEOUS TO GOVT ___¢ PER MILE NOT TO EXCEED COMMON CARRIER COSTS ___¢ PER MILE NOT TO EXCEED COSTS BY GOVT-OWNED AUTO

☐ GSA AUTO ☐ AUTO RENTAL UNDER GSA CONTR XX OTHER *(Specify below)*

☐ EXCESS BAGGAGE ☐ REGISTRATION FEE Taxis/Limos

11A. CHANGE OF STATION

TRANSPORTATION OF ☐ DEPENDENTS ☐ H/H GOODS & PERS. EFFECTS

☐ TEMPORARY QTRS ☐ RESIDENCE TRANSACTIONS ☐ TEMPORARY STORAGE

☐ HOUSE HUNTING TRIP ☐ MISC. EXP. ALLOWANCE ☐ OTHER *(Specify)*

HHS 355: ☐ SIGNED ☐ NOT REQUIRED

12. TRAVEL & PER DIEM IS AUTHORIZED IN ACCORDANCE WITH DHHS POLICY AND:

XX FTRs ☐ JTR'S ☐ OTHER *(Specify)*

PER DIEM: ☐ NONE XX IN U.S. ☐ OUTSIDE U.S. ☐ VARYING RATES PER ABOVE REGS.

RATE $ ~~89/34 Phila.~~ 51/26 Reading (M & IE) ☐ LODGINGS PLUS ☐ ACTUAL EXPENSE ☐ FIXED

Funds Available Sally a Jones

13. FOREIGN TRAVEL

TO BE PERFORMED FOR *(DHHS, UN, etc.)*

EXPENSES TO BE PAID BY

SECURITY APPROVAL GRANTED FOR TRAVEL OF ☐ 90 DAYS OR LESS ☐ OVER 90 DAYS DATE _____

RESPONSIBLE FOR SECURITY CLEARANCE OF TRAVELER ASSUMED BY

14. ACCOUNTING DATA *(See HHS Acct'g Manual & Acct'g Code Book)*

1 RECORD TYPE	2-7 EFF. DATE	8-10 TRANSACTION CODE	11 REVERSE CODE	12 MODIFIER	ORIGINAL OBLIGATION 13-15 DOC. REF. CODE	ORIGINAL OBLIGATION 16-25 DOCUMENT NO.	OTHER DOCUMENTS 26-28 DOC. REF. CODE	OTHER DOCUMENTS 29-38 DOCUMENT NO.	39 GEO. CODE	40 FISCAL YEAR	41-47 COMMON ACCOUNTING NO.	48-51 OBJ. CLASS CODE	52-63 AMOUNT DOLLARS & CENTS	64 FED/NON FED	65-79 VENDOR/ CUSTOMER CODE (PRIMARY RECIPIENT)	95-100 PAYMENT COLLECTION DOC.	101-108 PPBS 101-106 CATEGORY	101-108 PPBS 107-108 ACTIVITIES	109 CASE II
2	10/29/93				130	0017094043				4	A730170	21.25	# 403.00	1	(b)(6)				2
2																			
2																			
2																			

15. NAME AND TITLE OF OFFICER RECOMMENDING ABOVE TRAVEL
Arthur J. Lawerence, Ph/.D., Acting Directorm, NAPO

AUTHORITY IS HEREBY GRANTED TO PERFORM TRAVEL AND TO INCUR SUCH EXPENSES AS MAY BE NECESSARY UNDER THE CONDITIONS SET FORTH ABOVE

AUTHORIZED BY Arthur J. Lawerence, PH.D. TITLE Acting Director, NAPO DATE 10/1/93

* To be completed by Office Initiating Travel Order; Other Accounting Data to be Completed by Fiscal/Accounting Office

HHS-1 (REV. 7/89)

TRAVELER

NAPWA

NATIONAL
ASSOCIATION
OF PEOPLE
WITH AIDS

June 29, 1993

Via Courier

Kristine M. Gebbie
Special Assistant to the President
National AIDS Program Office
Hubert H. Humphrey Building
200 Independence Avenue
Room 73-8G
Washington, D.C. 20203

Re: Invitation to Deliver Closing Plenary Address, 1993 National Skills Building Conference November 2, 1993, New Orleans

Dear Ms. Gebbie,

It was a pleasure to welcome you to Washington last week during President Clinton's announcement of your appointment as the government's principal AIDS coordinator. We all wish you the very best and we are committed to your success as you take on the challenges of coordinating the federal response to HIV in the United States.

I am writing to invite you to be Plenary Speaker at the Closing Luncheon of the third annual National Skills Building Conference, at 12:00 p.m. on Tuesday, November 2, 1993 in New Orleans.

The National Skills Building Conference, produced through a unique collaboration between The AIDS National Interfaith Network, The National Minority AIDS Council, and The National Association of People with AIDS, is designed to enhance the effectiveness of front-line, AIDS-service organizations responding to the prevention and service needs of the HIV community. In addition, the Conference seeks to develop and enhance effective collaborations between religious communities, communities of color, and individuals living with HIV disease.

The 1992 National Skills Building Conference, held in Washington, D.C., was an overwhelming success. More than 1,000 participants attended: representatives came from 578 community-based AIDS organizations in 189 cites and 46 states as well as Puerto Rico, Japan, the

1413 K Street, N.W.,
Washington D.C. 20005
Phone: (202) 898-0414
FAX: (202) 898-0435

Dominican Republic, Ireland and Kenya. Participants included board members, executive directors, program managers, pastoral counselors, volunteers, state and local health department officers, corporate/foundation grantmakers, representatives from People with AIDS coalitions and individuals with HIV disease.

Attendees mirrored the "changing face of AIDS" and the communities involved in the efforts against the disease. Sixty percent of the 208 people who completed the final conference evaluation form were people of color: 31 percent were African-American, nine percent were Latino/a, nine percent were Asian/Pacific Islander, four percent were Native American and seven percent indicated "other" -- African, Irish, Caribbean and mixed descents.

An overwhelming majority of the participants in the 1992 National Skills Building Conference praised the content of the program, conference organization and their accommodations. Of the conference attendees who completed the final evaluation form, 75% of the respondents indicated that the overall learning experience gained at the conference was either "very satisfactory" or "excellent." Seventy-nine percent rated the usefulness of the workshop materials as "very satisfactory" or "excellent" and 99% of the participants said that they would recommend the conference to colleagues. Thirty percent of the conference attendees received financial assistance -- $143,000 in scholarship aid was disbursed.

Building upon the success of last year's conference, the 1993 National Skills Building Conference will take place October 31st - November 3rd in New Orleans. We are anticipating 1,500 hundred attendees.

We are requesting that you address the participants at the closing plenary luncheon of the Conference. This unique gathering will provide you with an opportunity to address the largest annual gathering of HIV/AIDS service providers in the country. Your presence would demonstrate the government's support of the very people who are living with or responding to the challenges of HIV in the United States.

I am enclosing materials on last year's conference, including the final report. In addition, you will find advance materials on the 1993 National Skills Building Conference.

We are very hopeful that your schedule will permit you to address the Conference. Please feel free to contact me directly to discuss this invitation.

We wish you every success as you embark on your new responsibilities.

Sincerely yours,

William J. Freeman
Executive Director

Enclosures

THE WHITE HOUSE
WASHINGTON

10/29/93

Kristine

This is subject of meeting on Tuesday in New Orleans after the closing plenary.

Critical issues are:

1) funding: CDC has up to $145 million, although preferred amount would be around $11 million. States want a portion of this to go to program.

2) Maria's issue: who will provide T/A under plan and what will be purpose.

I'll be there too & will field questions. — Carlos

Comm Plan T/A Timeframes Funding

DRAFT

SUPPLEMENTAL GUIDANCE ON HIV PREVENTION COMMUNITY PLANNING FOR NONCOMPETING CONTINUATION OF COOPERATIVE AGREEMENTS FOR HIV PREVENTION PROJECTS

10/28/93

INTRODUCTION

This guidance is offered to assist state and local health department HIV Prevention Cooperative Agreement Grantees (referred to in subsequent portions of this document as "Grantees") in the preparation of plans to undertake HIV Prevention Community Planning in fiscal year (FY) 1994. The Centers for Disease Control and Prevention (CDC) will award up to $_____ for this purpose through the HIV Prevention Cooperative Agreements with state, territorial, and local health departments on January 1, 1994. These funds will be used to establish plans for the use of HIV prevention resources awarded under program announcement #300 (Cooperative Agreement for Human Immunodeficiency Virus {HIV}; Prevention Projects Program Announcement and Availability of Funds for Fiscal Year 1993).

A. ESSENTIAL COMPONENTS OF A COMPREHENSIVE HIV PREVENTION PROGRAM

Participatory community planning is an essential component of effective HIV prevention programs. This type of planning is evidence-based (i.e., based on HIV/AIDS epidemiologic surveillance and other data, ongoing program experience, program evaluation, and a comprehensive, objective needs assessment process) and incorporates the views and perspectives of the groups for whom the

programs are intended, as well as the providers of the services. In addition to community planning, the other essential components of a comprehensive HIV prevention program are (also see program announcement #300):

1. Epidemiologic and behavioral surveillance and research and collection of other health and demographic data to monitor the HIV/AIDS epidemic and behaviors/practices that facilitate HIV transmission, and to project trends in the epidemic;

2. HIV counseling, testing, referral, and partner notification (CTRPN), to provide both anonymous and confidential client-centered opportunities for individuals to learn their serostatus and to receive prevention counseling and referral to other preventive, medical, and social services; follow State law ~ consistent w/ state ~~language~~ law

3. Individual level interventions (~~i.~~ e.g., prevention case management) that provide ongoing health education and risk-reduction counseling, assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior, facilitate linkages to services in both clinic and community settings in support of behaviors and practices which prevent transmission of HIV, and to make plans to obtain these services;

4. Health education and risk-reduction interventions for groups to provide peer education and support, as well as to promote and reinforce safer behaviors, and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change;

5. Community level interventions for populations at risk for HIV that seek to reduce risk behaviors by changing attitudes, norms and practices through health communications, social (prevention) marketing, community mobilization/organization, and community-wide events;

6. Public information programs for the general public that seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward individuals with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention in the community;

7. Evaluation and research activities necessary to conduct formative, process, and outcome evaluations of HIV prevention programs and to assess the cost-effectiveness and cost-benefit studies of strategies and interventions; and

8. HIV prevention capacity building activities, such as

strengthening public health infrastructure at both the clinic and the community levels, implementing systems to assure the quality of services delivered, and improving the ability to assess the need for, and provide technical assistance in all aspects of program planning and operations.

B. DEFINITION OF HIV PREVENTION COMMUNITY PLANNING

HIV Prevention Community Planning refers to an ongoing process whereby grantees share responsibilities for developing a comprehensive HIV prevention plan with other state/local agencies, nongovernmental organizations and representatives of communities and groups at risk for, or infected with, HIV. Priority setting accomplished through a participatory process will result in programs that are responsive to high priority, community-validated needs within defined populations. HIV prevention programs developed without community collaboration may not be successful in preventing the transmission of HIV or in garnering the necessary public support for effective implementation. Persons at risk for HIV infection and persons with HIV should play a key role in identifying prevention needs not adequately being met by existing programs and in planning for needed services. The necessary steps of HIV Prevention Community Planning are:

1. Assessing the present and future extent, distribution, and

impact of HIV/AIDS in defined populations in the community;

2. Assessing existing HIV prevention community resources to determine the community's capability to respond to the epidemic. These resources should include fiscal, personnel, and program resources, as well as levels of support from public (Federal, state, county, municipal) private, and volunteer sources. This assessment should identify all HIV prevention programs and activities by defined high risk populations;

3. Identifying unmet HIV prevention needs within defined populations;

4. Defining the potential impact of specific strategies and interventions to prevent new HIV infections in defined populations;

5. Prioritizing HIV prevention needs by defined high risk populations and by specific strategies and interventions;

6. Developing a comprehensive HIV prevention plan consistent with the high priority HIV prevention needs identified through the HIV Prevention Community Planning process;

7. Developing an application, by the grantee, for CDC FY 1995 (and beyond) funding based on the comprehensive HIV prevention plan; and

8. Evaluating the effectiveness of the planning process.

C. ELEMENTS OF A COMPREHENSIVE HIV PREVENTION PLAN

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

1. An HIV/AIDS epidemiologic profile (e.g., reported AIDS cases, projected AIDS cases, estimated HIV prevalence in defined populations, HIV incidence, HIV risk behaviors and other information such as, STDs, teen pregnancy, and drug use, needed to target and monitor HIV prevention efforts);

move below 4

2. Goals and measurable objectives for HIV prevention in defined populations during the course of the project period; ← that are programmatically significant 5 yrs.

3. A description of target populations to be reached by primary HIV prevention interventions (i.e., by exposure category, gender, age group, race/ethnicity, socioeconomic status, primary language, significant cultural factors, geographic area) and unmet needs and barriers in reaching populations;

4. A description of priority individual, group, and community level strategies and interventions for defined target populations whose serostatus is unknown, negative, or positive. These strategies and interventions include HIV counseling, testing, referral and partner notification; prevention case management and other one-on-one risk reduction prevention programs; peer education programs for high-risk populations; school-based programs; community mobilization; and health communications and social (prevention) marketing approaches. Both existing and proposed interventions should be described;

5. A description of how primary HIV prevention activities are linked to secondary HIV prevention activities, i.e., activities to prevent or delay the onset of illness in persons with HIV infection;

6. A description of other HIV prevention-related activities (i.e., epidemiologic and behavioral surveillance, research, and program evaluation activities), and how these are linked to HIV and other prevention program strategies in the geographic area for which the plan is developed;

7. A description of how public and nongovernmental agencies will coordinate within the area for which the plan is

developed to provide HIV prevention services and programs; and

8. An evaluation plan for the HIV prevention planning process as delineated in Item 1j of Section D.

9. TA Bullet

D. PRINCIPLES OF HIV PREVENTION COMMUNITY PLANNING

State health agencies 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. States recognize, however, that governmental agencies alone are limited in their scope and ability to solve complex health, social, economic, and environmental problems. Thus, in planning for prevention services, other state and local government agencies (substance abuse, mental health, education, and corrections), nongovernmental agencies, community representatives, and academic institutions must play a key role in identifying needs not adequately being met. Representatives of communities at risk for HIV infection can provide invaluable personal and population-specific perspectives on accessibility and appropriateness of specific prevention interventions.

Although different approaches to community planning may be taken in various communities, grantees will be required to address the

in whole or in part

following principles in all HIV Prevention Community Planning efforts supported by HIV Prevention Cooperative Agreement funds from CDC in FY 1995 and beyond:

1. HIV Prevention Community Planning represents an ongoing process involving the steps delineated in Section A.

2. HIV Prevention Community Planning reflects an open, candid, and participatory process, in which differences in background, perspective, and experience are essential and valued.

3. HIV Prevention Community Planning is characterized by shared priority-setting between organizations administering and awarding HIV prevention funds and the communities for whom the prevention services are intended.

4. Each project area requires at least one HIV Prevention Community Planning group which reflects in its composition, the characteristics of the current and projected epidemic in that jurisdiction (as evidenced in reported AIDS cases, HIV data, if available, and/or surrogate markers where relevant);

5. The recruitment process for membership in the HIV Prevention

Community Planning process is proactive to ensure that all relevant groups are represented. Nominations for membership are identified through an open public process and candidates are selected based on criteria delineated in the application request for HIV community planning funds.

6. From the outset, all members of the HIV Prevention Community Planning group(s) understand the roles and responsibilities as outlined in this guidance and agree to the procedures and ground rules used in all deliberations and decision making.

7. The starting point for defining future HIV prevention needs begins with an accurate assessment of the present and future extent, distribution, and impact of HIV/AIDS in defined populations within the grantee's jurisdiction.

8. Identification, interpretation, and prioritization of HIV prevention needs reflect relevant information obtained from the communities to be served, particularly persons at risk for HIV infection and persons with HIV disease.

9. Assessment of HIV prevention needs is based on a variety of sources (both qualitative and quantitative), is collected using different assessment strategies (e.g., surveillance, survey, formative, process, and outcome evaluation of

programs and services, focus group(s), public meetings, etc.), and incorporates information from both providers and consumers of services.

10. Priority setting for specific HIV prevention strategies and interventions is based on the following criteria: (a) documented HIV prevention needs based on the current and projected impact of HIV/AIDS in defined populations in the grantee's jurisdiction; (b) outcome effectiveness of proposed strategies and interventions (either demonstrated or probable); (c) cost effectiveness of proposed strategies and interventions (either demonstrated or probable); (d) sound scientific theory (e.g., behavior change, social change and social marketing theories); (e) values, norms, and preferences of the communities for which the services are intended; (f) availability of other governmental and nongovernmental resources (including the private sector for HIV prevention); and (g) other state and local determining factors. Each criterion should be formally considered by the HIV Prevention Community Planning group(s) during priority-setting deliberations.

How to weigh criteria

11. Resources are provided to support all steps in the community planning process as listed in Section B, including

facilitating the participation of all participants in the planning process, particularly persons at risk for HIV infection and persons with HIV disease.

12. Specific policies and procedures for resolving conflict identified by the grantee or the planning group(s) are developed jointly by all parties. These policies and procedures include conflict(s) of interest, conflict(s) within + among the planning group, and differences between the planning group and the health department in the prioritization/implementation of programs/services. The conflict resolution process includes a provision by which all parties agree to submit issues that cannot be resolved through the normal process to a neutral arbitrator and to abide by the decision of the arbitrator.

13. HIV Prevention Community Planning process includes the following evaluation components throughout the course of the project period: (a) developing goals and measurable objectives for the planning process; (b) monitoring the objectives; (c) evaluating the operation of the process; (d) evaluating the impact of the planning process; and, (e) assessing the cost of the process.

These principles trace their origins to ongoing 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 draft ASTHO/NASTAD/CSTE State Health Agency Vision for HIV Prevention, findings of CDC's 1993 HIV external review process, experience and recommendations of health departments and nongovernmental organizations, and the health promotion and community development literature.

B. LOGISTICS OF HIV PREVENTION COMMUNITY PLANNING

Beginning in FY 1994, application requirements for cooperative agreement funds under program announcement #300 will include adherence to the principles of HIV Prevention Community Planning outlined in this document. Each recipient of cooperative agreement funds under this announcement will be required to base its funding application for FY 1995 on the results of an HIV Prevention Community Planning process that will be undertaken and completed in FY 1994. Grantees are expected to base subsequent applications on an ongoing community planning process.

In FY 1994, a portion of cooperative agreement funds provided through this program announcement will be identified and specifically earmarked to support HIV Prevention Community Planning. These funds should be used to: (a) support the convening of planning groups, public meetings, and other means for obtaining

? 12-13 M

community input; (b) support technical assistance/capacity development for community representatives and other members of planning groups to participate effectively in the process; (c) provide opportunities for technical assistance to health departments and community planning groups from outside experts; and (d) support community health planning infrastructure for the HIV community planning process; and (e) collect and/or analyze relevant data. The distribution of planning funds within these 5 categories should be determined jointly by the HIV Prevention Community Planning Group and the grantee (also see Section H).

All grantees directly receiving funds under cooperative agreement #300 will be required to conduct HIV Prevention Community Planning in FY 1994. Grantees will be required to determine how best to achieve and integrate statewide, regional, and community planning within their jurisdictions. Recipients must collaborate with local government, nongovernmental organizations, and affected communities to determine the most effective mechanisms for input into the HIV Prevention Community Planning process. Identification of these mechanisms should be based on a dialogue between the state and local health agencies and the community. 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 where the problem is identified). Models for obtaining input include but are not limited to: a state-wide planning model;

great

a regional planning model; a Metropolitan Statistical Area planning model; and/or existing planning bodies.

Grantees will be responsible for developing criteria for selecting the individual members of the HIV Prevention Community Planning groups within their jurisdiction. State grantees should involve local health authorities and community leaders in developing such criteria; local grantees should similarly involve state health authorities and community leaders in developing such methods.

ok

The HIV Prevention Community Planning process should include representatives who reflect the population characteristics of the current and projected HIV/AIDS epidemic in that jurisdiction as reflected in reported AIDS cases, HIV data, if available, and/or surrogate markers where relevant in terms of age, gender, race/ethnicity, geographic distribution, sexual orientation, and HIV exposure category. Representation should also include (a) state and local health departments and other relevant governmental agencies (substance abuse, mental health, education, corrections); (b) experts in epidemiology, behavioral and social sciences, evaluation research and health planning; and (c) representatives of a reasonable sample of nongovernmental 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, etc.) to persons at risk for or infected with HIV. The HIV Prevention Community Planning process should attempt to accommodate a reasonable number of representatives without becoming so large that it cannot effectively discharge its functions. HIV Prevention Community Planning group(s) are encouraged to 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.

who?

Planning Councils should be routinely informed about the status of current knowledge related to HIV prevention from the behavioral and social sciences, especially as it relates to the at-risk population groups within a given geographic community. Planning Council members should also be routinely updated about relevant new findings generated from the behavioral and social sciences.

CDC + grantee

put in roles + responsibilities

Every CDC grantee receiving funding under program announcement #300 is responsible for identifying a health department co-chair for each HIV planning group in the project area; the group, once convened, selects the other co-chair.

The HIV Prevention Community Planning Group(s) should be routinely informed of other relevant planning efforts, particularly the process for allocating Titles I, II, and III of the Ryan White

Comprehensive AIDS Resources Emergency Act. Health departments should consider the benefits of merging the HIV Prevention Community Planning process with other planning bodies/processes already in place. If such mergers are proposed, grantees must adhere to the principles of HIV Prevention Community Planning, as specified in Section D.

The HIV Prevention Community Planning process should result in a comprehensive plan, jointly developed by the grantee and the HIV Prevention Community Planning group(s) which includes specific, high-priority HIV prevention strategies and interventions targeted to defined populations to be supported with HIV prevention cooperative agreement funds. Thus, each grantee's application for FY 1995 funds (and beyond) should address the plan's high priority elements in its application for funds under program announcement #300. In those jurisdictions where CDC has direct cooperative agreements with both state and local health departments, grantees are expected to coordinate planning with one another prior to finalizing their own HIV prevention plans.

Each grantee, in its FY 1995 application and beyond must include a letter of concurrence or nonconcurrence from each HIV Prevention Community Planning group convened within the grantee's jurisdiction. Letters of concurrence would indicate the extent to which the health department and the HIV Prevention Community

Planning group(s) have successfully collaborated in developing an integrated HIV community plan and agree upon the program priorities contained in the application. An HIV Community Planning group that disagrees with the program priorities identified in the grantee's application should cite specific reasons for nonconcurrence. In those instances where a grantee does not concur with the findings or recommendations of the HIV Prevention Community Planning group(s) and believes the public health would be better served by funding HIV prevention activities/services that are substantially different, it must submit a letter of justification in its application.

Grantees are responsible for operationalizing and implementing HIV prevention services/activities outlined in the comprehensive plan, including selecting the specific organizations/entities that should provide HIV prevention services/activities, awarding, and administering HIV prevention funds.

F. RESTRICTIONS

Funds for HIV Prevention Community Planning will be awarded through the HIV Prevention Cooperative Agreements with state, territorial, and local health departments on January 1, 1994, but planning funds will be restricted pending receipt and approval by CDC of a description of the grantees proposed HIV Prevention

Community Planning process. Upon receipt of plans describing the HIV Prevention Community Planning process, CDC will review each grantee's plan to ensure compliance with the Principles (Section D) and Logistics (Section E) delineated within this guidance. When approved, restrictions on the expenditure of planning funds will be removed.

Recipients are encouraged to submit a plan as soon as possible, but are required to submit one no later than February 28, 1994.

G. APPLICATION CONTENT

Applications for awards of planning funds under CDC program announcement #300 must include: (1) a description of the proposed HIV Prevention Community Planning process including a timetable for implementation; (2) Criteria for the proposed methods for nominating, recruiting, and selecting members of the HIV Prevention Community Planning group(s); (3) a budget justification for each of the allowable expenses under community planning funds as delineated in Paragraph 2, Section E; and (4) an outline describing proposed policies and procedures for deliberations, decision-making, and resolving conflict arising during the planning process.

H. ROLES AND RESPONSIBILITIES

GRANTEES

The role of grantees in the HIV Prevention Community Planning process is as follows:

1. Administer and coordinate public funds from a variety of sources, including Federal, state, and local, to prevent HIV transmission and reduce associated morbidity and mortality;

2. Administer HIV prevention funds awarded under the cooperative agreement, ensuring that funds are awarded to contractors in a timely manner, monitoring contractor activities, and documenting contractor compliance;

~~3. Provide HIV prevention services;~~ Is not in planning

4. Provide HIV/AIDS surveillance and other relevant data and analyses of statewide, regional, and/or local data to assist the HIV community planning process in establishing program priorities based on the current and future extent, distribution, and impact of the HIV/AIDS epidemic;

5. Collaborate with state, local, and community partners to determine the most effective means for implementing HIV Prevention Community Planning in their jurisdiction (see Section D);

6. Ensure that specific policies are in place articulating the roles and responsibilities of the various components of the HIV Prevention Community Planning process.

7. Establish policies that address planning group composition, selection and appointment, terms of office, in consultation with health authorities and community leaders in that jurisdiction; consistent w/ existing state law.

8. Ensure that all planning group(s) reflect the population characteristics of the current epidemic in state and local jurisdictions in terms of age, race/ethnicity, gender, sexual orientation, geographic distribution, and HIV exposure category;

9. Provide expertise and technical assistance, including ongoing training on HIV prevention planning and the interpretation of epidemiologic and evaluation data, to ensure that the planning process is comprehensive and scientifically valid;

10. Promote linkages between the local community HIV prevention services providers, public health agencies 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.

11. 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;

assurance statement

12. Provide technical assistance to staff and contract agencies for program planning, intervention, and evaluation;

13. Allocate resources based on the comprehensive HIV prevention plan; and

activities included in the plan provide for measurement of

14. Ensure program effectiveness through specific evaluation activities, including conducting or contracting outcome evaluation studies, providing technical assistance in evaluation, or assuring the provision of evaluation technical assistance to funding recipients. in accordance w/ the plan.

HIV PREVENTION COMMUNITY PLANNING GROUP(S)

The role of the planning group(s) in the HIV Prevention Community Planning process is to:

1. Delineate technical assistance/capacity development needs for effective community participation in the planning

process;

2. Review available data and other information required to prioritize HIV prevention needs and collaborate with the health department on how best to obtain additional data and information;

3. Assess existing HIV prevention community resources to determine the community's capability to respond to the epidemic;

4. Identify unmet HIV prevention needs within defined populations;

5. Prioritize HIV prevention needs by target populations and by specific strategies and interventions;

6. Identify the technical assistance needs of community-based providers in the areas of program planning, intervention, and evaluation;

7. Consider how CTRPN, early intervention, primary care, and other HIV-related services, as well as STD, TB, substance abuse prevention and treatment, mental health services, and other public health needs are addressed within the

comprehensive HIV prevention plan; and

8. Evaluate the HIV Prevention Community Planning process and assess the responsiveness and effectiveness of the grantee's application in addressing the priorities identified in the comprehensive HIV prevention plan.

SHARED RESPONSIBILITY BETWEEN GRANTEES AND HIV PREVENTION COMMUNITY PLANNING GROUP(S)

1. Select co-chairs for HIV Prevention Community Planning Group(s): Grantees select an employee of the health department as one co-chair and the community planning group selects the other;

2. Develop procedures that address (a) voting policies and provisions for proxy voting and non-attendance at meetings; (b) resolution of conflict identified in planning deliberations; and (c) grievance procedures, including the use of a neutral arbiter;

3. Determine the distribution of planning funds to (a) convene planning groups, public meetings, and other means for obtaining community input; (b) support technical assistance/capacity development for community representatives, and other members of the planning groups to participate effectively in the process;

(c) provide opportunities for technical assistance to health departments and community planning groups from outside experts; (d) support community health planning infrastructure for the HIV community planning process; and (e) collect and/or analyze relevant data;

4. Assess the present and future extent, distribution and impact of HIV/AIDS in defined populations in the community.

5. Conduct a needs assessment process to identify unmet HIV prevention needs within defined populations;

6. Develop goals and measurable objectives for HIV prevention strategies and interventions in defined target populations;

7. Foster integration of the HIV Prevention Community Planning process with other relevant planning efforts; and

8. Develop a comprehensive HIV prevention plan.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The role of CDC in the HIV Prevention Community Planning process is to:

1. Provide funding to all grantees under Program Announcement #300 for the community planning process and for the implementation of HIV prevention activities;

2. Require that plans submitted by HIV Prevention Cooperative Agreement recipients for HIV Prevention Community Planning are in accordance with the principles in this guidance;

3. Require as a condition for award of cooperative agreement funds, that recipients' FY 1995 applications are in accordance with the comprehensive plan developed as a result of the HIV Prevention Community Planning process or include an acceptable letter of justification as delineated in Section D;

4. Collaborate with health departments, national organizations, federal agencies, and academic institutions in providing technical assistance and training for the HIV Prevention Community Planning process. Technical assistance could address subjects such as analysis and interpretation of data relevant to the needs assessment and prioritization process, planning models, conflict resolution, behavioral/social science and evaluation;

5. Identify the minimal program components of a comprehensive

HIV prevention program;

6. Collaborate with grantees in evaluating HIV prevention programs; and

7. Collaborate with other federal agencies in promoting the transfer of new information and emerging prevention technologies (i.e., epidemiologic, biomedical, operational, behavioral, or evaluative) to health departments and other prevention partners, including nongovernmental organizations.

In addition to supplemental funds awarded for HIV Prevention Community Planning in FY 1994, state and local health departments will receive an increase in new funds awarded for HIV prevention when compared with FY 1993. Grantees are encouraged to delay the long-term commitment of part or all of these additional HIV prevention funds in order to implement unmet program needs, as identified by HIV Prevention Community Planning group(s), during FY 1994.

optional

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10/28/93