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CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION

HIV/AIDS PREVENTION

Briefing for Secretary Donna E. Shalala

April 19, 1994

HIV/AIDS Prevention

Agenda

Briefing
for
Secretary Shalala

April 19, 1994

Introduction and Overview ..... Dr. David Satcher

Overview of External Review of CDC HIV/AIDS
Prevention Programs ..... Dr. James Curran

Overview of CDC HIV Prevention Marketing Initiative ..... Ms. Melissa Shepherd

Overview of HIV Prevention Community
Planning Process ..... Dr. Ronald Valdiserri

Questions and Answers

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External Review of CDC's HIV/AIDS Prevention Programs

External Review of CDC's HIV Prevention Programs

- In February 1993, CDC's Associate Director for HIV/AIDS requested that the CDC Advisory Committee on the Prevention of HIV Infection (CDC ACPHI) oversee an external review of CDC's HIV prevention programs.

- The five program areas to be reviewed were:

  - Monitoring the HIV Epidemic
  - Promoting Knowledge of Serostatus
  - Developing Partnerships for HIV Prevention
  - Preventing Risk Behaviors Among School Students
  - Improving Public Understanding of the HIV Epidemic

- Subcommittees (external review groups) to the ACPHI were formed and were assisted by subject area experts in addressing issues and concerns in the 5 program areas. Each external review group consisted of 2 or 3 ACPHI members and about 10 subject area experts.

- The issues and concerns to be addressed were published in the Federal Register to allow even broader input into the review process by outside interested groups.

- Between April and October 1993 the external review groups held more than 30 public meetings in 18 cities and met with governmental and nongovernmental representatives to discuss HIV program strategies and activities.

- In November 1993, the Subcommittees presented their findings and recommendations to the ACPHI for full advisory committee review.

- The ACPHI has reviewed the subcommittee reports and developed an Executive summary (Appendix A) containing nine general themes and a formal list of priority recommendations to be addressed by CDC.

- CDC has developed a timetable for addressing all of the committee's recommendations.

- Additionally, CDC recently began new prevention activities which address many of the recommendations of the external review groups:

  - HIV Prevention Community Planning
  - The Prevention Marketing Initiative
  - A comprehensive CDC-wide plan for preventing HIV infection among youth

CDC's HIV Prevention Marketing Initiative

PREVENTION MARKETING INITIATIVE

SYNOPSIS OF ACTIVITIES
January - March 1994

The Prevention Marketing Initiative (PMI) is an application of marketing techniques and consumer-oriented health communication technologies based on science and directed, in this first phase, to the prevention of the sexual transmission of HIV and other STDs among young people 18-25 years of age. Secretary of the Department of Health and Human Services Donna Shalala was briefed on all four tiers of the PMI on December 21, 1993, and participated in the national launch activities on January 4, 1994.

Tier One: National Health Communications

Public Service Announcements (PSAs) were released on January 4, 1994, in conjunction with the launch of the PMI.

- The press conference releasing the PSAs and launching the initiative was covered by 88 journalists. The launch activities and the additional press outreach resulted in 4,600 media placements in the 60 days following the launch. 86.9% of the media placements were print, 13.1% were broadcast. Total audience impressions exceeded 1-1/2 billion, which means that every American over 18 years of age was exposed to an average of 6 media placements.
- Print placements included 63.7% news stories, 8.3% position editorials, 11.2% opinion editorials, and 16.7% columns. News stories were 92% positive or neutral, editorials were 70% positive or neutral, and columns were 30% positive or neutral.
- The majority of criticisms were about condoms, with 34% of the criticisms stating the opinion that condoms are ineffective, 24% voicing the opinion that promoting condoms promotes sex, and 14% indicating that abstinence should be the only prevention strategy mentioned.

In addition to the launch activities, CDC planned and executed many reactive responses to the media, such as writing letters to editors and columnists, conducting interviews, and placing matte articles. Also, at the Association for the Advancement of Science conference in San Francisco in February 1994, CDC and FDA conducted a joint press briefing for health and science reporters about the PMI and condom effectiveness. This activity resulted in 36 media placements, with audience impressions exceeding 72 million.

Public response to the media activities is as follows:

- CDC has received over 2,800 letters, with 77% of them expressing support for the PMI and the PSAs.
- A recent public opinion poll sponsored by the CDC and conducted by Chilton

Research indicates that 86% of those polled think HIV prevention information should be aired on television. 73% (and 83% of those polled who are 18-25) think that HIV prevention information about condoms should be on television.

The PSAs have received more than $2 million in donated broadcast time through March 31, 1994. In addition, the PSAs have been broadcast in 65 military bases throughout the country. American Airlines is playing one of the condom radio PSAs in its music programming on all domestic flights. One of the condom PSAs has been placed on video rental copies of a recently released movie, *Reality Bites*.

Tier Two: Prevention Collaborative

The launch of the PMI was attended by more than 200 individuals representing national and community-based organizations. An additional 400 individuals participated via satellite. Prevention Collaborative Organizations directly reached over 2 million additional individuals through newsletters, information kits, and direct mail regarding the PMI.

165 individuals representing Prevention Collaborative Organizations attended a planning meeting in Washington, D.C., on March 3 and 4. During this meeting, workshop participants provided CDC with recommendations on guidelines for community participation in the PMI and on national strategies.

A formal assessment of technical assistance needs of Prevention Collaborative Organizations is currently being conducted. In addition, this assessment will quantify prevention marketing activities planned for the remainder of 1994.

The PMI has developed the following technical assistance documents:

- *Media Relations*, a guide to proactively utilizing the media
- *Crisis Communications*, a guide to handling controversial topics in the media.
- *Building Coalitions*, a guide to effectively building coalitions and partnerships for planning and implementation of HIV prevention programs.
- *State of the Art in Promoting Condoms*, a literature review documenting all that is currently understood about the behavioral determinants to condom use.
- *Promoting Abstinence*, a literature review documenting all that is currently known about abstinence behaviors.

Tier Three: Local Demonstration Sites

CDC, through the PMI, is assisting five communities to take the lead in planning and implementing innovative, data-driven prevention marketing programs to prevent the sexual transmission of HIV and other STDs among young people. The sites include Nashville, Northern Virginia, Phoenix, New Jersey, and Sacramento. Both long-term and short-term process and outcome effectiveness evaluation measures are being applied. These evaluation

measures will be continuously reviewed and programmatic activities will be shifted as necessary. In addition, lessons applicable to participatory planning and social marketing will be documented and distributed on a routine basis. For example, lessons learned from the first quarter are currently being documented in the following manner:

- *What is Prevention Marketing* is a technical assistance document that will list tips on how to explain prevention marketing to diverse audiences.
- *Participatory Social Marketing: A Community Perspective* is a document that is being written by the sites to be shared with other communities about values clarification in participatory planning for the PMI.

Three of the five sites have accomplished, through intense emphasis on community participation, the initial planning processes. These three, Phoenix, New Jersey, and Sacramento, are beginning to apply newly acquired skills in collecting and analyzing data to develop a blueprint of HIV risk among young people in their respective communities. The other two sites, Nashville and Northern Virginia, are still involved in the early stages of community participation. By September 1994, all demonstration sites will have participated in two quarterly meetings, which focus on skills building for participatory planning. In addition, the site coordinators have been trained in public speaking and media relations.

Tier Four: Integration with Community Planning

Integration with the HIV Prevention Community Planning process at the end of 1994, with the publication and distribution of community participation guidelines and the provision of technical assistance to assist community planning groups in the implementation of PMI at the local level. As local community planning groups identify young people as a priority audience, they will be informed of the additional technical support specific to this target audience and behaviors that will be available through the PMI.

Integration with community planning at the national level has occurred through coordinated activities within CDC's Centers, Institutes, and Offices. The PMI is currently being coordinated by a CDC-wide steering committee chaired through the Office of the Associate Director for HIV/AIDS, Dr. James Curran.

Centers for Disease Control and Prevention
Prevention Marketing Initiative (PMI) *
Major Milestones 1994

JAN
- PMI Launch

FEB
- CDC (NCPS) meetings with NMOs/CBOs
- National Episcopal AIDS Coalition Annual Meeting
- Meeting with gay community

MAR
- Prevention Collaborative Meeting
- Localization and distribution of PSAs to affiliates & independents
- Cable PSD Meeting
- KCET (Hispanic/Latino Marketing) Meeting

APRIL
- Meeting with Public Service Directors from top 10 seroprevalence areas
- Demo sites quarterly skills-building conference
- Meet with Hispanic reseachers at NIH-sponsored meeting
- NASTAD Meeting

MAY
- Health Promotion Meeting
- NIDA Meeting
- Prevention Collaborative assessment
- Distribute Washington meeting report
- PMI posters available for distribution
- Media relations TA document available for distribution
- Crisis communications TA document available
- Building coalitions TA document available

JUNE
- CDC Education Grantees Meeting
- Religious Community PMI strategy paper
- Consumer Magazine Editors Meeting
- State of the Art in Promoting Condoms TA document available
- Promoting Abstinence document available

JULY
- *In a New Light* TV special
- Workgroup discussions of draft guidelines
- TA documents available: Talking About Social Marketing
  Participatory Social Marketing
- New edits of PSAs available

AUG
- Youth Svcs. Organizations' PMI strategy paper
- CDC HIV Prevention Grantee (NCPS/DSTD) Annual Meeting
- Demo sites quarterly skills-building conference
- Entertainment outreach

SEPT
- Integration with prevention programs/comm. planning
- Guidelines/strategies available for distribution
- PHS National Minority AIDS Congress
- Television information special

OCT
- Publication of PMI guidelines/strategies

NOV
- Technical assistance available to HIV Prevention Community Planning programs

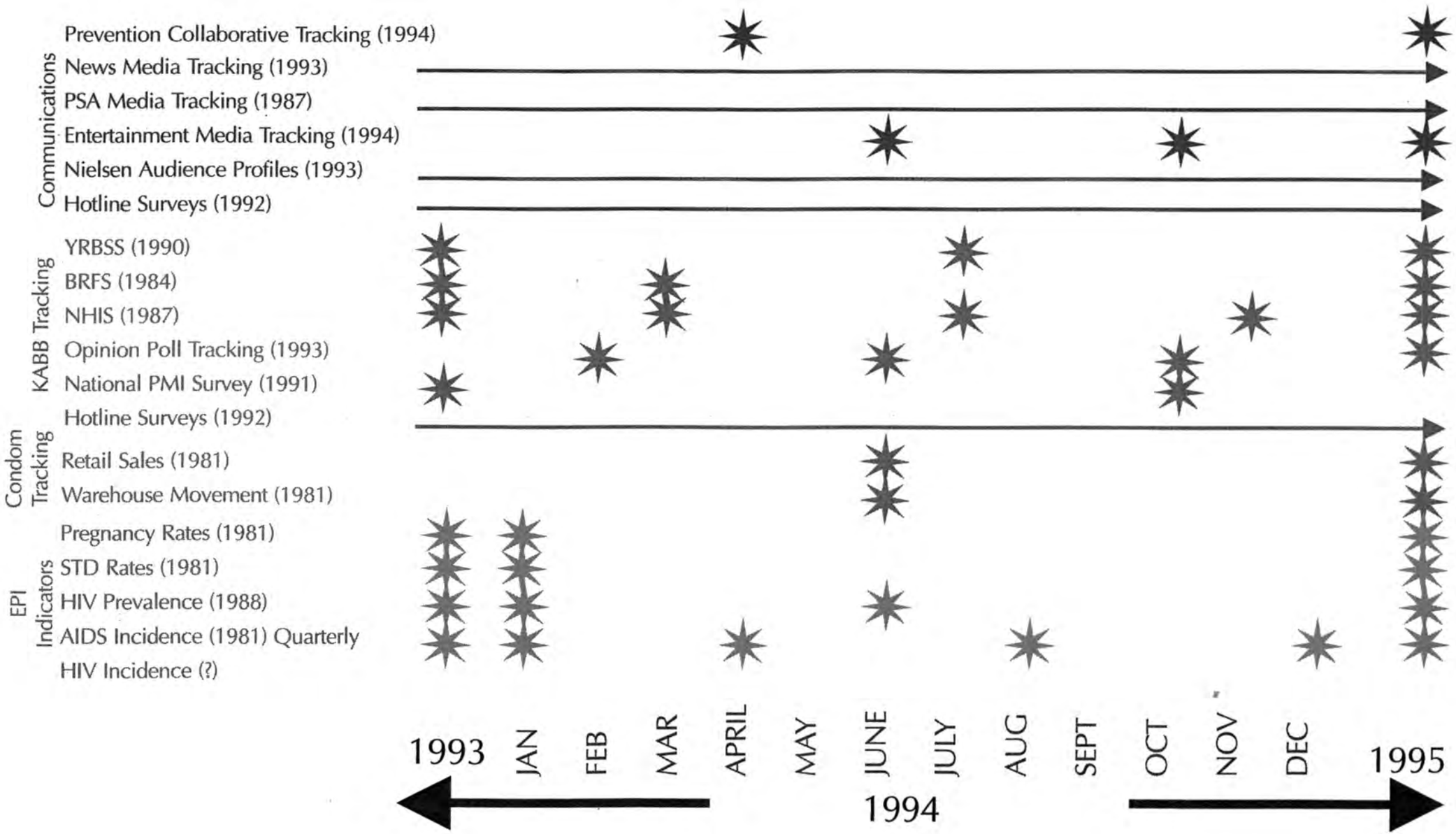
DEC
- World AIDS Day
- Demo sites quarterly skills-building conference

Health Communications
Research & Evaluation
Local Demo Projects

Tier 1
Tier 2
Tier 3
Tier 4

* First phase: Young people 18-25 years of age

Prevention Marketing Initiative Evaluation System



The HIV Prevention Community Planning Process

HIV Prevention Community Planning

- In December 1993, CDC issued its HIV Prevention Community Planning Guidance (Appendix C-1) to all State, territorial and local health departments that receive HIV prevention funds from CDC. The guidance requires health departments to undertake an HIV Prevention Community Planning process in FY 1994 to qualify for HIV prevention funding for FY 1995 and beyond.

- The guidance outlines a process whereby the identification of high-priority prevention needs is shared between the health department administering the funds and the representatives of the communities for whom the services are intended.

- Throughout the development of the guidance document, CDC held meetings in which governmental and nongovernmental organizations provided input. Additionally, a meeting was held to obtain input from the general public.

- On January 1, CDC awarded $12 million in supplemental HIV Prevention Planning Funds to health departments to help them establish plans for the use of future HIV prevention resources. These funds were restricted, pending the submission to CDC by February 28, of grantees plans for conducting the process in their jurisdictions. Sixty-four of 65 grantees have submitted their plans in compliance with this request.

- In addition to including representatives of affected populations within planning groups, the HIV Prevention Community Planning process embraces the notion that the behavioral and social sciences must play a critical role in the development, implementation, and evaluation of HIV prevention programs within a given community.

- CDC is providing technical assistance and training to health departments and community groups within the following disciplines:

    - Parity, Inclusion, and Representation
    - Surveillance and Uses of Epidemiologic Data
    - Community Planning Processes/Models
    - Evaluation of Effective and Cost-Effective HIV Prevention Efforts
    - Access to Behavioral and Social Science Expertise
    - Conflict of Interest and Dispute Resolution

    This technical assistance is being delivered through a network of governmental, nongovernmental, and private providers (Appendices C-2 and C-3).

- Included in the guidance is specific information on the essential components of a comprehensive HIV program; the necessary elements of a comprehensive HIV

prevention plan; principles that all HIV community planning efforts must address; the logistical requirements that State, territorial, and local health departments must comply with in their applications for funding; and the roles and responsibilities of the grantees, the community planning groups, and CDC.

- H.R. 1538, The Comprehensive HIV Prevention Act of 1993 (Rep. Pelosi), has a number of similarities to, as well as some significant differences from, CDC's guidance.

Appendices

Appendix A

Appendix A

DRAFT - NOT FOR DISTRIBUTION

EXTERNAL REVIEW

OF HIV PREVENTION STRATEGIES

FINAL REPORT

Draft 4.0

13 April 1994

Thirteen years after its recognition, the epidemic of human immunodeficiency virus (HIV) infection continues to pose an enormous threat to American health. Approximately 40,000 to 80,000 new HIV infections still occur yearly among men, women, and children in the United States. Each costs the American people dearly in direct medical costs and far more in lost earnings, social upheaval, and personal suffering. The resulting HIV-related deaths from a year's new U.S. infections are equivalent to the total mortality of the Vietnam War. The stakes in devising and implementing more effective ways to prevent new HIV infections are therefore immense.

The prevention task has also reached immense proportions. Approximately three-quarters of a million Americans are estimated to be HIV infected, with many unaware of their infection status. Their sex or drug-use partners are at very high risk of acquisition of HIV infection and need to be reached with interventions to prevent continued transmission. Millions of others have a short-term risk that is currently lower, but nonetheless real, especially over time. To address this great need, the national HIV prevention program must reach tens of millions. This is a massive effort, requiring insightful and committed leadership, science-based policies and strategies, careful planning, ample resources, strong public and private sector alliances, and a comprehensive system of health services. While much has been accomplished, constraints in each of these areas have hampered prevention efforts since the early years of the epidemic, and much remains to be done.

CDC'S HIV PREVENTION PROGRAM

The lead responsibility for implementing the federal HIV prevention program lies with the Centers for Disease Control and Prevention (CDC). The program has evolved since the mid 1980s to include support for state and local health department programs, a national public information network, and education programs in the nation's schools--as well as epidemiologic, behavioral, health services, and laboratory studies, and disease monitoring. These activities are dispersed among ten centers, institutes, and offices within CDC, administered separately, and coordinated by the Office of the Associate Director for HIV/AIDS. (See Appendix A.)

CDC's strategic planning for HIV prevention began in 1989. Phase I established *four general goals*:

1) Assess risks
2) Develop prevention technologies
3) Build prevention capacities
4) Implement prevention programs

Building on this broad strategy, Phase II focused on four groups at increased risk for HIV infection: women and infants, injecting drug users, youth in high-risk situations, and men who have sex with men. In Phase III, CDC outlined *five program strategies* expected to have the

greatest HIV prevention impact. These strategies, and their corresponding programmatic focus within CDC, are as follows:

1. **Strengthen current systems and develop new systems to monitor the HIV/AIDS epidemic, as a basis for directing and assessing HIV prevention programs**

   CDC's HIV/AIDS monitoring activities are concentrated in the National Center for Infectious Diseases (NCID). This Center maintains AIDS case surveillance; monitors the prevalence of HIV infection; supports studies of HIV-associated morbidity and mortality; provides technical assistance to standardize HIV infection reporting and evaluate other monitoring efforts; conducts epidemiologic studies to describe the natural history of and risk factors for HIV infection; assesses the nature/frequency of blood exposures, infection risks, and efficacy of preventive measures in health-care settings; and conducts laboratory studies to identify factors involved in HIV virulence, transmission, and disease. The National Center for Health Statistics (NCHS) and National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) also conduct important surveillance activities, especially related to attitudes and risk behaviors.

2. **Increase public understanding of, involvement in, and support for HIV prevention**

   These activities are centered in the National AIDS Information and Education Program (NAIEP), located in the Office of the Associate Director for HIV/AIDS. As CDC's national health communications program on HIV/AIDS, NAIEP helps ensure access to information about HIV/AIDS and improve community support for behavior change. Since 1987, NAIEP has operated the mass media communication effort "America Responds to AIDS", the CDC National AIDS Hotline, the CDC National AIDS Clearinghouse, initiatives to create partnerships with the private sector, and evaluation research. In addition, the National Center for Prevention Services (NCPS) provides funding to the public information components of the cooperative agreements with State and local health departments

3. **Implement comprehensive school health education programs to prevent the initiation of risk behaviors that lead to HIV infection and other health problems in youth**

   School health activities are administered by CDC's NCCDPHP. Since 1987, NCCDPHP has undertaken initiatives to help schools develop, implement, and evaluate HIV/AIDS education programs. The Center supports the training of teachers, administrators, policymakers, and representatives from youth-serving organizations on effective HIV prevention education methods. A limited number of activities are also directed to youth who are not in school. In addition, the NCPS funds community-based organizations to provide outreach, counseling, testing, and referral programs for out-of-school youth. The NAIEP also targets youth through its public information campaign.

4. Collaborate with prevention partners to prevent or reduce HIV-related risk behaviors

NCPS administers CDC's prevention partnerships with federal agencies, health departments, non-governmental organizations, and community groups involved in HIV-related behavior-change activities. NCPS provides support to these organizations by either direct funding or indirect funding via cooperative agreements with health departments and/or the U.S. Conference of Mayors. Collaboration has evolved to include technical assistance, training, education, behavioral research, and outreach. Target audiences, which have expanded over the years in response to the changing demographics of the epidemic, include persons with hemophilia, men who have sex with men, substance users, out-of-school youth, commercial sex workers, the homeless, persons in correctional facilities, and women in high-risk situations.

5. Increase knowledge of HIV serostatus and improve referral systems to appropriate prevention and treatment services

The main focus of CDC's HIV prevention effort has been the counseling, testing, referral, and partner notification (CTRPN) program, also administered by NCPS. State-based CTRPN activities currently constitute the largest proportion of funding for HIV prevention services by health departments and other organizations. Their stated purpose is to provide persons at risk for HIV infection an opportunity to 1) learn their serostatus, 2) receive prevention counseling, 3) obtain referrals for additional services, and 4) if infected, help their sex and needle-sharing partners receive prevention services and referrals.

EXTERNAL REVIEW OF CDC'S FIVE HIV PREVENTION STRATEGIES

In early 1993, CDC initiated an external review of these five program strategies. Acknowledging that the prevention program was built rapidly in response to recognition of the epidemic in the 1980s. CDC staff believed it appropriate to step back, assess their approach to prevention, and obtain recommendations to enhance future success.

Each of the five program strategies therefore became the subject of an investigation by one of five external review groups. Over an 8-month period, each group reviewed CDC's current activities related to one of the five strategies, consolidated their findings, and developed recommendations. Functioning as subcommittees of the CDC Advisory Committee on the Prevention of HIV Infection (ACPHI), the groups were each composed of approximately ten members, including three representatives from the CDC ACPHI, one of whom served as Chair. The other participants, all subject experts from outside CDC, served as consultants, with a lead consultant acting as Co-Chair. (See Appendix B.)

Each review group developed its own process and produced a comprehensive summary report. The complete reports are included in this document. They provide essential descriptions of each group's review process in addition to detailed findings and recommendations. Representatives of the five groups formally presented these reports to the CDC ACPHI on November 17-18, 1993.

GENERAL FINDINGS

The full Advisory Committee's review and discussion of the subcommittees' reports yielded nine common themes that the members viewed as important to highlight:

1. Prevention is necessary and urgent.

HIV infection is an urgent, and unique, prevention challenge because of the virus' virulence, long incubation period, length of infectiousness, grave prognosis, and potential for exponential spread. The epidemic is fostered by a complex interaction of biological, behavioral, and social forces. It is a growing problem in disenfranchised communities that are faced with a multitude of other compelling problems. And it emanates from the most personal and private of individual behaviors--sex and drug use. With neither a cure nor a vaccine on the immediate horizon--and with a huge national reservoir of infection--the only promising barrier against the virus is widespread adoption and maintenance of personal behaviors that eliminate or minimize the chances of exposure and infection.

Preventing new HIV infections requires a commitment from all levels of government to the diverse neighborhoods of America. The lack of such a commitment, along with restrictive federal policies, has weakened the prevention effort since the onset of the epidemic--constraining funding, limiting flexibility, discouraging innovation, and thwarting prevention specialists in their efforts to use resources where they would be most effective. Added to this set of problems is the relegation of prevention to a status secondary to that of treatment. Although progress in treatment of those already HIV infected must and will continue, it is not a substitute for prevention. With the prospect of ever-more-complex and expensive treatment regimens, prevention will continue to get short shrift unless the nation's leadership maintains a clear financial and moral commitment to prevention as the fundamental weapon against continued of the epidemic.

2. Behavior can be changed.

Both formal research and the practical experience of communities demonstrate that intensive interventions *can* reduce risk behaviors. Relatively little is known, however, about the comparative effectiveness of different approaches to induce desired changes. Despite advances in knowledge in recent years, we are only beginning to understand how to help people make the leap from possessing information about health to changing their behavior on the basis of that

information. Nonetheless, given the enormous social and economic costs of the HIV epidemic if permitted to run its present course, even modest behavior changes must be viewed as successful. The essential question--still unanswered--is what *set* of interventions can change *most* people's behavior *most* of the time--*over a lifetime*.

3. Prevention should be guided by science.

Since behavior change is the main prevention intervention for HIV infection, behavioral research must be the foundation upon which the national program is based. Unfortunately, the nation has invested inadequately in prevention research, especially as it concerns human sexuality and drug-use behaviors. Thus, much essential knowledge still eludes us. The key role for CDC is to develop, synthesize, and promulgate scientific guidance for the HIV prevention activities carried out by community organizations and state and local health authorities. This means clarifying goals, definitions, and measures of effectiveness; identifying successful and unsuccessful strategies; and developing and applying quality standards. The task will require considerable strengthening of the science base as well as substantial increases in funding for prevention research.

4. Prevention requires sustained, long-term efforts.

Despite hopes to the contrary, the HIV/AIDS epidemic is not a transitory crisis with a "quick fix." Pressures to come up with fast, easy solutions have left us with a prevention model that is inadequate to address the *lifetime risk* of HIV infection: We must both initiate *and sustain* changes in risk behaviors; we need *generational changes in social norms*. The urgency of the escalating epidemic calls for an acceleration of both the scale and the scope of the national prevention agenda. CDC must move away from the short-term infectious disease control model and instead mount a long-term effort similar to those instituted for smoking cessation and prevention of heart disease. This does not mean that the sense of urgency should be lost; on the contrary, short-term "emergency" efforts are still needed, with scientific lessons summarized and applied as soon as possible. But, just as some research involving treatment of breast cancer or diabetes takes many years to yield valid results, so, too, must HIV prevention efforts have long-term support.

5. Partnerships and collaboration are key.

Problems with programmatic cohesion both within the federal government and with others involved in HIV prevention at the national, state, and local levels has severely hampered the prevention effort. Several federal agencies in addition to CDC, as well as health departments, non-governmental organizations, corporations, religious organizations, and academic institutions all have parts to play in funding, planning, and implementing prevention activities. Although CDC has the lead in these efforts, opportunities have clearly been missed for establishing and

promulgating a unified agenda for prevention services and research. CDC, or some other federal entity, must take responsibility for developing functional alliances, promoting participatory planning, encouraging communication, and ensuring coordination.

CDC's recent initiation of a community planning process for the awarding of HIV prevention grants is a welcome response to some of these problems. But the process will need to be monitored closely to ensure that communities have sufficient time and technical assistance to meet their new responsibilities. There is also the danger that "bottom-up" community planning will lead to abdication of CDC's responsibility to provide needed oversight and scientific guidance. A local organization's deep commitment to HIV prevention and strong community ties does not guarantee it the requisite knowledge and skills to design and successfully carry out a broad, long-term prevention program. The line between support and responsible supervision on the one hand, and arbitrary interference on the other, presents a major challenge for the CDC.

6. Prevention interventions must strike a balance between targeted efforts and efforts to change general community norms.

HIV prevention is complicated by a problematic epidemiologic reality: nearly all Americans are at some risk of HIV infection, but their *degree* of risk varies dramatically. Those charged with carrying out prevention must choose strategies and allocate resources with this uneven risk in mind. There can be no standard formula; we must constantly question whether the right balance is being achieved. Insufficient attention to the highest-risk populations will squander resources and fail to halt the epidemic's spread. Limitation of outreach to *only* those at highest risk will promote a false sense of security, miss some opportunities to prevent HIV infection, and limit public support for national prevention efforts.

7. More funding for prevention is needed.

Excessively limited resources and inappropriate restrictions on their use have hampered HIV prevention efforts. Although CDC's total HIV prevention budget has grown from $200,000 in fiscal year 1981 to $498.2 million in fiscal year 1993, funding for the prevention program was essentially flat over the last 3 years (with an actual decrease in fiscal year 1992). Despite an increase to $543 million in 1994, the level of federal financial commitment to HIV prevention is inadequate to address the overwhelming need for *long-term, sustained, individual-level behavior change interventions for millions* of at-risk and HIV-infected persons. Restrictive policies and Congressional earmarks attached to these funds have further curbed flexibility and prevented the implementation of innovative and important prevention approaches. **The Committee recognizes that although HIV prevention is expensive, the alternative--unchecked spread of infection continuing indefinitely--is many times more costly.**

8. Stigmatization and discrimination continue to adversely affect prevention efforts.

Despite progress in the development of a caring and compassionate national attitude toward persons with HIV infection and AIDS, ignorance, bigotry, and discrimination still pose obstacles to prevention. A continuing effort to dispel misconceptions about HIV transmission and to protect the confidentiality and human rights of those with or at risk for HIV infection must be an integral part of the national prevention agenda.

9. CDC's organizational structure may be hindering prevention efforts.

CDC's HIV prevention programs are dispersed among ten centers that compete internally for resources; the effort lacks a clear line of authority for policy, programming, and budget from HIV leadership to staff. CDC's main HIV prevention activities are subsumed within the Division of STD/HIV Prevention in NCPS. Some view this as lessening the perceived priority of HIV prevention, isolating sexual transmission from other modes of spread, and inappropriately imposing the operational model of STD control on HIV prevention. Another key question is how to strengthen the capability to do *good science* in the prevention program. Key activities that *should* be tied to prevention--disease monitoring, epidemiologic studies, laboratory investigation are situated in the NCID, which shares neither staff nor programmatic emphasis with NCPS. Broader ramifications at the non-federal level center on fragmented funding streams, barriers to integration, and a piecemeal approach to the work of prevention.

Although CDC's structure has been reviewed more than once over the past several years, the Committee members generally agree that another look is merited. Indeed, testimony from those working at the community level suggests that the current structure is sufficiently dysfunctional as to warrant immediate action. The CDC Director should seek the participation of affected constituencies--including state and local health departments and community grantees--in considering whether the current structure is optimal for meeting AIDS prevention needs.

SPECIFIC FINDINGS AND RECOMMENDATIONS

While acknowledging CDC's strong efforts to date, each of the five external review groups recommended some fundamental changes in the agency's approach to HIV prevention to understand and better respond to the national challenge of the HIV/AIDS epidemic. The following is a summary of their findings and recommendations.

Monitoring the Epidemic

The subcommittee found the AIDS case reporting system to be the main thrust of CDC's monitoring efforts, providing the only population-based data that are useful for evaluating disease prevalence by gender, race/ethnicity, age, and mode of exposure. Despite its continuing value as an information source, the system has limitations, most centering on the lengthy interval between HIV infection and AIDS. The subcommittee therefore recommended a *shift in emphasis toward the "front end" of the epidemic*--advocating a wider view of monitoring that includes precursors to AIDS, including sexual and drug-use behaviors.

Details of the subcommittee's review of CDC's efforts to monitor HIV-associated behaviors, occupational and nosocomial exposures and infections, the virus, HIV/AIDS incidence and prevalence, and HIV-associated morbidity and mortality can be found in Appendix C. Key recommendations are that CDC should:

1. Coordinate a strategic plan to define the determinants of risk behavior and seek support at the highest level of government for its implementation, including reinstituting the National HIV Behavioral Risk Factor Surveillance Survey.

2. Conduct an ongoing, long-term, population-based national study of sexual and drug-use behaviors associated with HIV transmission.

3. Consolidate monitoring activities for occupational exposure to HIV with core hospital infection surveillance programs, and other monitoring systems.

4. Enhance efforts to identify incident HIV infections in affected communities and link incidence studies to behavioral data on HIV transmission risks through coordinated surveillance.

5. By use of more innovative cooperative agreements, improve the capability of local health departments and community organizations to determine the incidence and prevalence of HIV infection.

6. Define and enforce a strict confidentiality standard for reporting of HIV infection and AIDS.

7. Expand intramural and extramural laboratory and clinical research efforts to determine the relationship of different HIV strains to transmission and virulence.

8. Modify the "spectrum of disease" studies to detect differences in new populations at risk by weighted sampling. Integrate HIV infection surveillance with surveillance of opportunistic infections.

9. Speed the development and dissemination of prevention guidelines for opportunistic infections.

The group emphasized that enhanced and redirected monitoring activities at the community level must be accompanied by guaranteed access to appropriate care and treatment services for persons with HIV infection. Although this is not CDC's primary responsibility, improved access to care is another important step to enhance prevention opportunities. CDC should therefore assume an advocacy role for care and treatment to support its prevention efforts.

Improving Public Understanding of the Epidemic

The subcommittee reviewing NAIEP activities concluded that the goal of the early years of CDC's mass communication effort--to increase general awareness of AIDS--has been achieved. They therefore recommended a *shift away from the emphasis on the general public and toward specific populations at increased risk* of HIV infection. The urgent prevention needs of the second decade of the epidemic require provision of explicit, factual information targeted to persons at risk.

Recommendations related to NAIEP in general were as follows:

1. CDC should develop a strategic communications plan to set priorities for use of limited funds and ensure that programs are rooted in communication science and public health theory and practice.

2. Given that a hostile political environment has impeded an appropriate communications response, a) Congress must legislatively and fiscally empower CDC to carry out the strategic plan, b) CDC must be a more aggressive advocate for its own interests and for the public health science it represents, and c) the Secretary of Health and Human Services must become a more aggressive advocate for CDC's interests.

3. Criteria for developing risk-reduction messages should be developed and promulgated based on efficacious public health interventions, methods, and communications science.

4. Decision processes should reflect the magnitude and urgency of the HIV/AIDS crisis and the need for rapid responses.

5. CDC should involve affected populations in the development and implementation of the strategic plan.

The subcommittee also reviewed each of the eight NAIEP components. Although none was seen as unnecessary, the group determined that demands on many of the components had exceeded

resources and that CDC needs to make difficult decisions about priority audiences and services. The recommendations for each component are included in the subcommittee's full report. Some key findings and recommendations are highlighted below.

1. National AIDS Clearinghouse services were determined to be underutilized because of lack of targeted promotion. CDC should refocus services to meet the needs of priority audiences, especially front-line community organizations.

2. National AIDS Hotline staff demonstrated impressive expertise and commitment. A concern was the difficulty in quickly assessing fast-breaking new items and generating responses to resulting peaks in usage. The main recommendation was to develop a long-term strategic plan to manage such peaks.

3. The America Responds to AIDS campaign, although acknowledged as contributing to public awareness, was seen as subject to political considerations that conflict with public health goals, not adequately targeted to people at highest risk, and only selectively based on prevention science. CDC was urged to broaden its media strategies beyond public service announcements. Media programs should be oriented toward risk education, with messages based on *specific methods* of demonstrated efficacy.

4. The public information components of the cooperative agreements with health departments could be improved by forming partnerships to integrate health communications, improve planning, minimize duplication, and make funding decisions.

5. National partnership agreements with CDC showed many strengths. Recommendations were to develop one strategic plan to direct these partnerships and to examine the role of funding.

6. Health communications efforts for minorities were seen as a weakness of the program. CDC should seek the assistance of minority advisory groups to enhance communications with diverse groups.

Preventing Risk Behaviors among School-Aged Youth

This subcommittee called for better coordination of CDC's youth-related programs and *expansion of the strategic plan for school-based programs to address the prevention needs of all young people*, in or out of school. A subtext was the ongoing problem of targeting. Both general prevention approaches and strategies for youth at high risk are needed in schools and elsewhere. Given insufficient funding for both, challenges remain in achieving the appropriate balance between general prevention and targeted approaches for youth.

In addition to a series of specific recommendations, the subcommittee had four core recommendations:

1. CDC's program for preventing HIV infection in youth is based on an existing strategic plan for school-based HIV education programs. CDC must now develop a national strategic plan to prevent HIV and related health risks among *all* youth by working not only with schools, but also with other youth-serving organizations, the media, and the business community. CDC should review its various youth-serving programs, with the intent of consolidating, or where consolidation is not practical, better coordinating youth initiatives.

2. CDC should continue to work through the schools to address HIV prevention directly, while also ensuring an integrated, comprehensive approach to preventing other HIV-related health problems in youth.

3. CDC should take immediate action to more substantially address the needs of youth at particularly high risk of HIV infection, whether they are in *or out* of school, including strategies for working with youth-serving agencies and organizations other than schools. This expanded focus should not detract from general school-based prevention strategies. Additional funding will be needed to adequately address both general school-based strategies and those targeted to youth in high-risk situations.

4. CDC should solicit broader, earlier, and more extensive input into program planning, implementation, and evaluation from direct-care providers, peer counselors, school health personnel, community groups, advocacy groups, young persons, and families.

Developing Partnerships for HIV Prevention

This subcommittee concluded that HIV prevention partnerships are not working as well as they should. Characterized by ill-defined goals, poor communications, lack of trust, and conflicting roles, they are further threatened by dwindling resources and competition for funding. Anger related to lack of technical assistance and confusion about CDC's role create additional barriers. Health departments, nongovernmental organizations, community-based organizations, and affected populations are all looking to CDC to *become a strong national advocate for HIV prevention and to provide the leadership, funds, skills, and training needed to forge effective, participatory partnerships*. The group's priority recommendations cover five areas of concern:

Leadership. Recommendations centered on the urgent need for CDC to take the lead in coordinating and integrating prevention services among federal agencies. CDC should articulate national HIV prevention goals "to restore itself to the high standards of science and to the legacy of commitment to the public health on which its reputation was built."

Communications. Four recommendations to improve communications among CDC, health departments, community organizations, and targeted populations focused on dispelling confusion about education versus prevention, articulating national prevention goals, clarifying roles and responsibilities, and ensuring cultural and linguistic appropriateness of prevention messages.

Equity. The group made a strong case for participatory planning. They stressed the need for mutual respect and meaningful communications to facilitate trust in partnerships, and emphasized that effective partnerships require time, direct contact, and a minimum level of core resources.

Funding. Among the recommendations in this area were that CDC should 1) tie equity in funding allocations to interventions that are effective for each targeted group, 2) guarantee increased funds to integrated prevention programs, and 3) provide funds for cross-training.

Coordination. CDC was urged to enhance coordination of HIV prevention activities by providing technical assistance, convening a multi-disciplinary task force to foster partnerships, and broadening the scope of prevention alliances.

The group identified barriers to and strategic needs for 1) enhancing partnerships, 2) forging effective alliances, 3) providing technical assistance, and 4) integrating services. "Turf" issues were found to impede collaboration at the community level; these need to be overcome at the federal level before they can be effectively addressed by state and local agencies. The subcommittee also identified new prevention partnership opportunities, with recommendations related to 1) rural areas, 2) border health issues, 3) correctional facilities, and 4) youth in high-risk settings.

Promoting Knowledge of Serostatus

The group disputed the view that the CTRPN program should be the cornerstone of the national effort to prevent HIV infection and raised questions about its emphasis, management, and effectiveness. They concluded that CTRPN programs generally do *not* comply with guidance issued by CDC. Moreover, even if CDC guidance were followed, with current resource levels and program structure, CTRPN programs would not be sufficient to change high-risk behaviors.

In their lengthy discussion of findings and recommendations, the subcommittee noted that HIV antibody testing has too often been erroneously equated with HIV prevention. While acknowledging the benefits of the HIV antibody test as a diagnostic tool to help infected persons obtain medical treatment, the group found its benefits as a prevention tool to be much less clear. Indeed, a negative HIV antibody test result may contribute to the continuation of high-risk

behaviors by some persons. The key recommendation was therefore to *shift the emphasis away from testing as the main prevention intervention.* The two needed alternatives are 1) ongoing, individual-level behavior-change interventions for those at highest risk of HIV infection and those already infected, and 2) large-scale community-level interventions aimed at changing community norms.

The group recommended that CDC require that decisions about the relative role of CTRPN in the prevention mix be determined through a representative local process. Health departments, working with their communities, should have flexibility in determining the relative allocation of resources among the various components of the "continuum of prevention services." At the same time, the availability of anonymous testing services must be ensured.

Practical problems with the current CTRPN program were also noted. Suggested improvements included 1) ensuring professionalism in partner notification, 2) improving the current CDC structure for prevention, 3) improving quality assurance, and 4) ensuring access to care, including to prevention services.

CONCLUSION

The year-long external review documented by the following subcommittee reports represents an enormous effort by Advisory Committee members, consultants, and scores of volunteers who testified at site visits, attended meetings, and related their experiences with HIV prevention work in general and CDC programs in particular. Countless hours were also contributed by CDC staff, who were unfailingly cooperative and candid. The Committee thanks all who were involved.

CDC is to be commended for initiating and supporting this unprecedented effort. It is evident that the subcommittees' findings and recommendations have been taken seriously, and many have already been acted upon. The Committee looks forward to the agency's response to this report and intends to work to improve CDC's role as a leader in and advocate for HIV prevention.

The past 13 years are seen by many as being marked a national failure to recognize the impact of the HIV/AIDS epidemic, to mobilize prevention partnerships and resources effectively, and to act decisively to halt the spread of HIV infection. Against the backdrop of an expanding and still uncontrolled epidemic, tight resources, and a legacy of restrictive policies, CDC's prevention program continues to evolve. This external review is the first step in what the Committee hopes will be a continuing process of assessment and "course correction." Unfortunately, the structure of the review precluded an analysis of CDC's *overall* approach to HIV prevention: the plan, the objectives, the acceptable outcomes, the components of the prevention mix that are (and are not) achieving success. Such an analysis is a logical--and necessary--next step. Although much has been done to understand the dynamics of the epidemic and to intervene to control its spread, the struggle is far from over. And the most difficult part surely lies ahead.

Appendix B

Appendix B

Prevention Marketing Initiative Evaluation System

Communications Tracking

The **Prevention Collaborative** tracking is a yearly assessment of activities planned to document the technical assistance needs of Prevention Collaborative Organizations.

The **News Media** tracking is a broadcast and print service that provides clips and transcripts about PMI-related media placements. Data are collected on numbers and types of placements as well as content.

The **Public Service Advertising** tracking provides information on when (date and time) and where (market and station) the PSAs are aired and gives the estimated value of the donated time.

The **Entertainment Media** tracking is a quarterly assessment of PMI messages included in entertainment programming.

Nielsen Television Rating data are purchased monthly to gauge the audience impressions generated by PSAs and other television programming.

Data from a random sampling of **Hotline Callers** routinely provide a profile of callers to the CDC National AIDS Hotline. In addition, specific questions are asked to gauge the impact of special media events on the types of questions asked.

Knowledge, Attitudes, Beliefs, and Behavior Tracking

The **Youth Behavior Risk Surveillance System (YBRSS)** is a bi-annual school-based survey which collects HIV and AIDS knowledge, attitude, belief, and risk behavior information.

The **Behavioral Risk Factor Surveillance System (BRFSS)** is an annual state health department-based probability survey which collects information on HIV and AIDS knowledge, attitudes, and beliefs.

The **National Health Interview Survey (NHIS)** is an annual national probability in-home survey conducted by CDC's National Center for Health Statistics. This survey has an AIDS supplement, providing data on knowledge, attitudes, and beliefs.

National Public Opinion Polls are conducted quarterly to gauge public opinion on a variety of issues related to the Prevention Marketing Initiative.

Condom Tracking

Retail sales data are reported annually to track trends in retail condom sales.

Sales-Area Marketing Incorporated (SAMI) data are reported annually to track warehouse movement of condoms. These data provide a more accurate figure of quantity of condoms being distributed.

Epidemiologic Indicators

Pregnancy data, STD data, HIV prevalence data, and AIDS incidence data are examined annually to gauge trends within populations of special interest to the PMI and as a long-term evaluation measure.

HIV incidence data would be especially helpful to the PMI tracking system, but are not currently being tracked.

STD data are examined annually to gauge increases or decreases.

Appendix C

Appendix C-1

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

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 and subsequent fiscal years. The Centers for Disease Control and Prevention (CDC) will award approximately $12,000,000 in new funds for the FY 1994 planning process through the HIV Prevention Cooperative Agreements with state, territorial, and local health departments on or about January 15, 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 at risk for HIV infection/transmission for whom the programs are intended, as well as the providers of HIV prevention 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, consistent with state laws, 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;

3. Individual level interventions (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 (e.g., substance abuse treatment settings) in support of behaviors and practices which prevent transmission of HIV, and to help clients 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 provide interpersonal skills training in negotiating and sustaining appropriate behavior change;

5. Community level interventions for populations at risk for HIV infection 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-benefits of strategies and interventions; and

8. HIV prevention capacity-building activities, such as strengthening governmental and nongovernmental public health infrastructure in support of HIV prevention, implementing systems to ensure the quality of services delivered, and improving the ability to assess community needs 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 HIV infection or already infected. 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 are unlikely to

be successful in preventing the transmission of HIV infection or in garnering the necessary public support for effective implementation. Persons at risk for HIV infection and persons with HIV infection should play a key role in identifying prevention needs not adequately being met by existing programs and in planning for needed services that are culturally appropriate. 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 community resources for HIV prevention 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 assessment should identify all HIV prevention programs and activities according to 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; and

7. Evaluating the effectiveness of the planning process.

The grantee will develop an application for CDC FY 1995 (and beyond) funding based on the Comprehensive HIV Prevention Plan.

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 that reflects the current and future epidemic in that jurisdiction (e.g., reported AIDS cases, projected AIDS cases, estimated HIV prevalence in defined populations, HIV incidence, HIV risk behaviors, and other information, such as sexually transmitted diseases

(STDs), teen pregnancy, and drug use, needed to target and monitor HIV prevention efforts).

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

3. A description of priority individual-, group-, and community-level strategies and interventions that are culturally and linguistically appropriate 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.

4. 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.

5. Goals and measurable objectives that are programmatically meaningful for HIV prevention in defined populations. These goals and objectives should be developed for both the short- term (budget period) and the long-term (project period).

6. A description of other HIV prevention-related activities (e.g., 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.

8. An HIV prevention technical assistance plan identifying needs of grantees and community-based providers in the areas of program planning, implementation, and evaluation.

9. An evaluation plan for the HIV prevention planning process as delineated in Item 13 of Section D.

D. PRINCIPLES OF HIV PREVENTION COMMUNITY PLANNING

State 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. 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 unmet needs. Representatives of communities at risk for HIV infection can provide invaluable personal and population-specific perspectives on accessibility and cultural appropriateness of specific prevention interventions.

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

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 grantee is required to identify at least one HIV Prevention Community Planning group (consideration should be given to the use of planning bodies/processes already in place) 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 relevant surrogate markers). Other members of the planning group(s) should include scientific experts, service providers, and organizational representatives as delineated in Section E.

5. Nominations for membership are identified through an open process and candidates are selected based on criteria delineated in the application request for HIV community planning funds. 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 underserved by existing HIV prevention programs, are represented.

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 epidemiologic profile of the present and future extent, distribution, and impact of HIV/AIDS in defined, targeted populations within the grantee's jurisdiction. In defining at-risk populations, special attention should be paid to distinguishing the behavioral, demographic, and racial/ethnic characteristics.

8. Identification, interpretation, and prioritization of HIV prevention needs reflect culturally relevant and linguistically appropriate 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; outreach and focus group(s); public meetings), and incorporates information from both providers and consumers of services. Techniques such as oversampling may be needed to collect valid information from certain at-risk populations.

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 consumer preferences of the communities for whom 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.

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

participants in the planning process, particularly those persons at risk for HIV infection and persons with HIV disease.

12. Specific policies and procedures for resolving disputes and avoiding conflict of interest identified by the grantee or the planning group(s) are consistent with the principles of this guidance, and are developed with input from all parties. These policies and procedures address conflict(s) of interest for members of the planning group(s) as well as disputes within and among planning group(s), differences between the planning group(s) and the grantee in the prioritization and implementation of programs/services, and a process for resolving these disputes in a timely manner when they occur.

13. The 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 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, community development, and behavioral/social sciences literature.

E. LOGISTICS OF HIV PREVENTION COMMUNITY PLANNING

Beginning in FY 1994, applicants for cooperative agreement funds under program announcement #300 will be required to adhere 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 implemented in FY 1994. Grantees are expected to base subsequent applications on this ongoing community planning process.

In FY 1994, supplemental funds are being provided through this program announcement to specifically support HIV Prevention Community Planning. These funds should be used to (a) support planning group meetings, public meetings, and other means for obtaining community input; (b) support capacity development for parity, inclusion, and representation of community representatives and for other members of planning groups to participate effectively in the process; (c) provide technical assistance to health departments and community planning groups by outside

experts; (d) support planning infrastructure for the HIV community planning process; and (e) collect and/or analyze and disseminate relevant data. The distribution of planning funds within these five 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. Grantees must collaborate with governmental and 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 public 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, 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 group(s) within their jurisdiction. State grantees should involve local public health authorities and leaders of affected communities in developing such criteria; local grantees should similarly involve state health authorities and leaders of affected communities in developing such methods. Special emphasis should be placed on procedures for identifying representatives of socioeconomically marginalized groups and groups that are underserved by existing HIV prevention programs.

The HIV Prevention Community Planning process must include representatives who reflect the population characteristics of the current and projected HIV/AIDS epidemic in that jurisdiction as indicated by reported AIDS cases, HIV data, if available; and other relevant surrogate markers, in terms of age, gender, race/ethnicity, socioeconomic status, geographic distribution (e.g., special needs of small MSA or rural populations), sexual orientation, and HIV exposure category. In addition to reflecting the population characteristics outlined above, it is important that these representatives articulate for and have expertise in understanding and addressing the specific HIV prevention needs of the populations they represent. Representation should also include (a) state and local health departments, state and local education agencies and other relevant governmental agencies (substance abuse, mental health, corrections); (b) experts in epidemiology, behavioral and social sciences, evaluation research, and health planning; and (c) representatives of a 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 HIV infection

or already infected. The HIV Prevention Community Planning process should attempt to accommodate a reasonable number of representatives without becoming so large that it cannot effectively function. 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.

HIV Prevention Community Planning group(s) should have access to current information related to HIV prevention from evaluation of programs and the behavioral and social sciences, especially as it relates to the at-risk population groups within a given community. Planning group members should also be routinely updated about relevant new findings of behavioral and social scientists.

Every CDC grantee receiving funding under program announcement #300 is responsible for identifying a health department employee, or a designated representative, to co-chair each HIV planning group in the project area; if state grantees 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. The group, once convened, selects the other co-chair.

The HIV Prevention Community Planning Group(s) should be routinely informed by the grantee of other relevant planning efforts, particularly the process for allocating Titles I, II, and IIIb of the Ryan White Comprehensive AIDS Resources Emergency Act. Grantees should consider merging the HIV Prevention Community Planning process with other planning bodies/processes already in place. *If such mergers are undertaken, 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 HIV Prevention 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 applications.

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 grantee and the HIV Prevention Community Planning group(s) have successfully collaborated in developing a comprehensive HIV prevention

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. CDC will evaluate and assess these justifications on a case-by-case basis to make final determinations for award of funds.

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, and awarding and administering HIV prevention funds.

Some grantees may be unable to complete all aspects of the HIV Prevention Community Planning process in FY 1994. At a minimum, all grantees will be expected to (a) identify and convene an HIV Prevention Community Planning group(s); (b) determine the present and future extent, distribution, and impact of HIV/AIDS in defined populations within the grantee's jurisdiction; (c) conduct an HIV prevention needs assessment; and (d) begin the prioritization process. If the grantee and the community planning group(s) are unable to finalize the comprehensive HIV prevention plan before the grantee is required to complete and submit the application for FY 1995 funding, the grantee, *with the written concurrence of the community planning group(s) in that jurisdiction*, may request an extension of time to complete the planning process. CDC will evaluate and assess these requests on a case-by-case basis to make a final determination.

If CDC determines that additional time is necessary to complete the planning process, the extension will be granted contingent on the understanding that the grantee will still be required to submit an initial FY 1995 application to the HIV Prevention Community Planning group(s) in that jurisdiction for review and written comment on the program priorities identified in the grantee's application. This review and comment should be based on the objective information obtained from the HIV prevention needs assessment and the analysis of the extent, distribution, and impact of HIV/AIDS in defined populations within the grantee's jurisdiction. Upon completion of the comprehensive HIV prevention plan, the grantee will submit a revised FY 1995 application to CDC.

F. RESTRICTIONS

Funds for the HIV Prevention Community Planning process will be awarded through the HIV Prevention Cooperative Agreements with state, territorial, and local

health departments on or about January 15, 1994. However, planning funds will be restricted in the following manner: (a) up to one-half of the planning funds will be released upon receipt of a written assurance that the grantee will comply with the Principles (Section D) and Logistics (Section E) delineated in this guidance, and (b) the remaining funds will be released upon approval of the application described in Section G.

Upon receipt of the planning application, CDC will review each grantee's planning application for compliance with the principles and logistics outlined in this guidance. When approved, restrictions on the expenditure of remaining planning funds will be removed.

G. PLANNING APPLICATION CONTENT

Applications for awards of planning funds under CDC program announcement #300 must include (a) a detailed and itemized description of the proposed structure and timetable for the HIV Prevention Community Planning process throughout that jurisdiction (e.g., number, location, jurisdiction, and size of the planning group(s); proposed merger with existing planning bodies; designated health department co-chairs, and (b) criteria and procedures for nominating, recruiting, and selecting members of the HIV Prevention Community Planning group(s), including a description of specific collaboration with governmental and nongovernmental organizations and affected communities on this issue.

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

H. ROLES AND RESPONSIBILITIES

GRANTEES

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

1. 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.

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/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.

4. 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).

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

6. Establish policies that address planning group composition, selection, appointment, and terms of office, in consultation with health authorities and community leaders in that jurisdiction.

7. 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.

8. 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.

9. Promote linkages among 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.

10. 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.

11. Ensure that technical assistance is provided to meet the needs of grantees and community-based providers in the areas of program planning, intervention, and evaluation as identified in the HIV prevention plan. Grantees should meet these needs by drawing on expertise from a variety of sources (e.g., health departments, academia, professional and other national organizations, and nongovernmental organizations).

12. Allocate resources based on the Comprehensive HIV Prevention Plan.

13. Ensure program effectiveness through specific evaluation activities, including conducting or contracting for outcome evaluation studies, providing technical assistance in evaluation, or ensuring the provision of evaluation technical assistance to funding recipients.

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 epidemiologic, evaluation, behavioral and social science, cost-effectiveness, and needs assessment 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 community resources to determine the community's capability to respond to the HIV epidemic.

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 program planning, intervention, and evaluation.

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

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 a health department employee, or a designated representative as one co-chair, and the community planning group selects the other.

2. Develop procedures that address (a) policies and provisions for reaching decisions and policies on attendance at meetings; (b) resolution of disputes identified in planning deliberations; and (c) resolution of conflict(s) of interest for members of the planning group(s).

3. Determine the distribution of planning funds to (a) support planning group meetings, and the participation of group members, public meetings, and other means for obtaining community input; (b) support capacity development for parity, inclusion, and representation of community representatives, and for other members of the planning groups to participate effectively in the process; (c) provide technical assistance by outside experts to health departments and community planning groups; (d) support community health planning infrastructure for the HIV community planning process; and (e) collect and/or analyze and disseminate relevant data.

4. Assess the present and future extent, distribution, and impact of HIV/AIDS in defined populations in the jurisdiction in which the planning is taking place.

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

6. Identify specific high priority strategies and interventions for defined target populations.

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

8. Integrate multiple HIV community prevention plans into a project-wide Comprehensive HIV Prevention Plan and foster integration of the HIV Prevention Community Planning process with other relevant planning efforts.

9. Develop and periodically update a comprehensive HIV prevention plan including the provision of technical assistance to meet the needs of grantees and community-based providers in the areas of program planning, implementation, and evaluation.

CENTERS FOR DISEASE CONTROL AND PREVENTION

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

1. Collaborate with health departments, national organizations, federal agencies, and academic institutions to ensure the provision of technical/program assistance and training for the HIV Prevention Community Planning process. Technical/program assistance will help recipients to

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; and (f) identify and manage dispute and conflict of interest issues.

2. Require that application content submitted by HIV Prevention Cooperative Agreement recipients for HIV Prevention Community Planning funds is in accordance with the principles in this guidance.

3. Monitor the HIV Prevention Community Planning process.

4. 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.

5. Identify the minimal program components of a comprehensive HIV prevention program.

6. Collaborate with grantees in evaluating HIV prevention programs.

7. 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 nongovernmental organizations.

8. 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.

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 over those awarded in FY 1993. Grantees are encouraged to delay the long-term commitment of part or all of these additional HIV

prevention funds to implement unmet program needs, as identified by HIV Prevention Community Planning group(s), during FY 1994.

APPLICATION SUBMISSION AND DEADLINE

The original and two copies of the application (PHS Form 5161-1) must be submitted to Elizabeth M. Taylor, Grants Management Officer, Procurement and Grants Office, Centers for Disease Control and Prevention, 255 East Paces Ferry Road, N.E., Mailstop E16, Atlanta, GA 30305 on or before *February 28, 1994.*

WHERE TO OBTAIN ADDITIONAL INFORMATION

Business management technical assistance including information on application procedures and copies of application forms may be obtained from Marsha Driggans, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention, 255 East Paces Ferry Road, N.E., Mailstop E16, Atlanta, GA 30305, (404) 842-6523.

HIV Prevention, Community Planning Supplement must be referenced in all requests for information pertaining to this project.

Programmatic technical assistance may be obtained from your CDC project officer Division of Sexually Transmitted Diseases/HIV Prevention, Center for Prevention Services, Centers for Disease Control and Prevention, Mailstop E44, Atlanta, GA 30333, (404) 639-8315.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
[Program Announcement Number 305A]

Fiscal Year 1994 Preventive Health Services
Addendum to Program Announcement 305
Cooperative Agreements for National/Regional Minority Organization HIV/STD Prevention, Immunization, and TB Projects

Introduction

The Centers for Disease Control and Prevention (CDC) announces the availability of one-time, fiscal year (FY) 1994 supplemental funds for current awardees of the National/Regional Minority Organizations (NRMO) program to provide technical assistance and training to community planning groups and the state and local health departments working with them to facilitate representation, inclusiveness, and parity in the implementation of HIV-prevention community planning. The community planning process is described in the attachment to this document, titled "Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects." This announcement is an addendum to Program Announcement Number 305, in which current recipients are collaborating with health agencies and community organizations to coordinate technical assistance and training programs that serve racial and ethnic minority populations. This announcement describes technical assistance and training that is to be provided by NRMOs to assist state and local health departments and their community planning groups in assuring that (1) the community planing process developed in their areas is an open, collaborative process; (2) persons at risk for HIV infection and persons with HIV infection play a key role in identifying prevention needs

not adequately being met by existing programs and in planning for needed services that are culturally and linguistically appropriate, (3) representatives of communities at risk for HIV infection provide personal and population-specific perspectives on accessibility and cultural appropriateness of specific prevention interventions, and (4) the community planning process is proactive in reaching a diverse strata of community groups including socioeconomically marginalized groups and groups that are underserved by existing HIV prevention programs. There is a compelling urgency to provide the programmatic technical assistance and training in parity, inclusion, and representation to facilitate the community planning process for HIV prevention. This rapid implementation is essential in order to complete the HIV prevention community planning process during calendar year 1994. The programmatic technical assistance and training to be supported under this competitive supplement is consistent with the scope of activities currently funded under announcement 305. Thus, these recipients have the existing capacity to carry out the increased programmatic technical assistance and training immediately. These recipients have existing collaborative relationships with the communities, organizations, state and local health departments, and CDC that will enable them to eliminate initial start-up and learning periods that would involve employee training, development of collaborative relationships, and training of collaborative partners.

The Public Health Service (PHS) is committed to achieving the health promotion and disease prevention objectives of "Healthy People 2000," a PHS-led national activity to reduce morbidity and mortality and improve the quality of life. This announcement is related to the priority areas of Educational and Community-Based Programs, HIV Infection, Sexually Transmitted Diseases (STDs), and Immunization and Infectious Diseases. (To order a copy of **Healthy People 2000**, see the section entitled **Where to Obtain Additional Information**).

Authority

This program is authorized under the Public Health Service Act: Sections 301(a) and 317 of the Public Health Service Act, [42 U.S.C. 241(a) and 247b], as amended.

Eligibility

Eligible applicants for this competitive supplement are the current cooperative agreement recipients under announcement 305, "National/Regional Minority Organizations HIV/STD Prevention, Immunization, and TB Projects." Eligibility is limited to these organizations since this is a competitive supplement to a pre-existing program announcement.

Availability of Funds

Approximately $750,000 is expected to be available for a one-time award in FY 1994 to supplement up to 5 cooperative agreements. The awards are not expected to exceed $150,000 each and are not expected to be refunded beyond the current budget period.

Use of Cooperative Agreement Funds

Cooperative agreement funds may be used for costs associated with providing technical assistance and training to community planning groups and the health departments working with them to assure representation, inclusiveness, and parity in the HIV-prevention community planning process as described in the "Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects." Federal funds are intended to assist NRMOs in an effort to assist state and local areas in the development of

community planning processes that are inclusive and representative of the affected and infected populations of that area as described in the Program Requirements and Guidance section of this program announcement. Each recipient of supplemental funding will be expected to make onsite visits.

Background

HIV prevention community planning is an ongoing process whereby state and local HIV-prevention organizations share responsibilities for developing a comprehensive HIV prevention plan with other state/local agencies, non-governmental organizations, and representatives of communities and groups at risk for HIV infection or already infected. HIV prevention programs developed without community collaboration are unlikely to be successful in preventing the transmission of HIV infection or in garnering the necessary public support for effective implementation. Persons at risk for HIV infection and persons with HIV infection should play a key role in identifying prevention needs not adequately being met by existing programs and in planning for needed services that are culturally and linguistically appropriate. Representatives of communities at risk for HIV infection can provide invaluable personal and population-specific perspectives on accessibility and cultural appropriateness of specific prevention interventions. It is essential that the recruitment process for membership in the HIV prevention community planning process is an open process based on the criteria outlined in the community planning guidance document, and is proactive to assure that a diverse strata of community groups, including socioeconomically marginalized groups and groups that are underserved by existing HIV prevention programs, are represented. Therefore, the need exists for state/local planning groups to enhance their community planning processes to ensure total community involvement.

Purpose

The purpose of this addendum to Program Announcement 305 is to provide community organizations and state and local health departments with the necessary technical assistance and training to : (1) assure that inclusion, representation, and parity occur in the community planning process; and (2) enhance their selection processes, as well as, the selection process of their grantees, for equitable representation on, and ongoing participation in, HIV prevention planning groups; thereby, enhancing the capacity of affected communities and non-governmental organizations to participate effectively and equally in the planning process.

Program Requirements and Guidance

All applicants must develop realistic, time-phased objectives for proposed technical assistance and training activities and services in the areas of representation, inclusiveness, and parity in the HIV prevention community planning process. Objectives should include action steps to implement the priority activities described below:

Priority Activities

1. Provide health departments and their community planning groups with consultation on the development of an open, inclusive nomination process and criteria for ensuring inclusiveness, representation, and parity to all participants in all aspects of the HIV prevention community planning process.

2. Provide health departments and their community planning groups with training, technical assistance, and other educational processes on subjects relevant to communities' participation in HIV prevention community planning (e.g., cultural diversity, values clarification, and dynamics of dealing with and ensuring participation of disenfranchised populations who have also been stigmatized).

3. Provide health departments and their community planning groups with approaches and methods to translate epidemiologic and other technical information to assist planning groups in making informed community decisions.

4. Assist health departments and their community planning groups to identify sources of training and technical assistance on issues of inclusion, representation, and parity that are available locally or could be made available locally.

5. Provide consultation to health departments and their community planning groups on means and mechanisms for identifying and recruiting socioeconomically marginalized groups and groups that are underserved by existing HIV prevention programs in the community planning process.

6. Provide health departments and their community planning groups with information on the most appropriate and effective methods for widely publicizing planning efforts to affected communities.

7. Coordinate all requests for and delivery of technical assistance and training through appropriate CDC staff.

General Requirements

Conduct an on-going process evaluation of supplemental activities funded through this cooperative agreement. Process evaluation is a quantitative and qualitative description of the program activities, the services, and the recipients of services. Each applicant must develop and implement an on-going evaluation plan, using process evaluation. The evaluation plan should be detailed and clearly articulated. It should present an evaluation design appropriate to the project objectives and activities.

The required evaluation plan should be capable of responding to the following statements and questions related to priority activities numbers 1 - 8 and the responses should be included in quarterly reports:

1. A detailed description of each program activity and progress in achieving each activity.
2. Detailed answers to the following questions:
   A. To which groups were the services provided and how many persons participated?
   B. What was the service and who provided it?
   C. When, how often, how long was the service provided?
   D. Where was it provided?

E. How were the services provided?

F. Was the service useful to the recipient group as assessed by them?

G. Was the service delivered in a timely manner?

H. What was the impact of providing the service on the area's community planning process (e.g., how has inclusiveness, representation, and parity improved)?

To answer questions F,G,and H, organizations may need to conduct follow-up data collection efforts of recipients of technical assistance and training.

3. Describe program successes, barriers, and other external problems encountered in planning, implementing, or providing services. This may include difficulty in initiating or maintaining effective collaborative relationships or in coordinating services with other organizations and agencies.

Because of the additional cost and need for scientific support beyond the scope of these cooperative agreements, NMOs and RMOs are not expected to conduct individual behavioral or health outcome evaluations with these funds (i.e., long-term effects of the program in terms of changes in behavior or health status, such as changes in HIV seroincidence after intervention).

Reporting Requirements

The reporting requirements for this supplement are the same as those outlined in Program Announcement 305, including quarterly narrative progress reports 30 days after the end of each quarter and an annual financial status report 90 days after the end of each budget period. An original and two copies of all reports must be submitted to the Grants Management Officer, Grants Management Branch, CDC.

Centers for Disease Control and Prevention Activities

The CDC shall be responsible for conducting the following:

1. Coordinate all requests for technical assistance and training between the NMO/RMO and the community organizations (via State and Local health departments) requiring the technical assistance.
2. Provide consultation and technical assistance in planning, operating, and evaluating program activities under this announcement.
3. Assist in developing plans for evaluation of all program activities and services and interpreting evaluation findings.
4. Assist successful applicants in collaborating with state and local health departments and other PHS grantees.
5. Facilitate the transfer of successful prevention interventions and program models to other areas.
6. Monitor the successful applicant's program activities, protection of client confidentiality, and compliance with other requirements.
7. Facilitate the exchange of program information and technical assistance among community organizations, health departments, and NMOs and RMOs.

Application Content

All applicants must prepare their applications in accordance with PHS form 5161-1, information contained in the program announcement, and the general instructions outlined below. When writing the application, careful consideration should be given to the **Review and Evaluation Criteria** section below. The applicant should provide a detailed description of the objectives, activities, intended collaboration, and evaluation activities.

All applicants must attach a listing of the offices, affiliates, and organizations participating in the proposed delivery of technical assistance and training. NMOs or RMOs administering programs through participating affiliates, chapters, or other minority organizations ***must identify the racial and ethnic composition of the membership of the governing bodies only if they are different from those reported in the original approved application.*** The governing bodies must consist of more than 50% racial or ethnic minorities.

Application Narrative Format

Applicants must use the following format for the narrative portion of their applications, refer to the relevant program requirements and guidance, **address requirements and issues in 1-7 as follows, and consider the review and evaluation criteria when developing the application**. All pages should be typed and double-spaced.

1. **Abstract (not to exceed 1 page)**: Summarize the technical assistance and training activities for which funds are requested. The applicant's organizational structure must also be summarized as well as proposed collaboration and coordination with other agencies.
2. **Experience in Providing Technical Assistance and Training (Not to exceed 2 pages):** Describe the applicant's experience in providing technical assistance and training on health planning and/or community development.
3. **Experience in Providing Multicultural and Multiethnic Relevant Technical Assistance and Training (Not to exceed 2 pages)** Describe the applicants experience in providing relevant multicultural and multiethnic technical assistance and training (e.g., cross-cultural training, cultural appropriateness, cultural diversity, languages other than English, etc.).
4. **Program Objectives (Not to exceed 1 page):** Specify the program objectives and show how they relate to the priority activities.

5. **Methods for Providing HIV Prevention Community Planning Technical Assistance and Training (Not to exceed 5 pages):**

   A. Describe the applicant's approaches to conducting technical assistance and training on issues of inclusiveness, representation, and parity in HIV prevention community planning for state and local health departments and their community planning groups.

   B. Summarize the applicant's capacities to develop, implement, and evaluate the proposed methods and approaches. Include descriptions of the types, magnitude, and priority of barriers to community input in HIV prevention community planning and how these barriers might be overcome.

   C. Explain how each of the technical assistance and training activities listed under the Priority Activities will be conducted. Describe how the technical assistance and training will be tailored to meet local needs; what sources of information will be used; and what procedures will be used to facilitate inclusion, representation, and parity in state and local health departments' community planning process.

   D. Show how the applicant will meet the identified needs and objectives and increase the capacities of state and local health departments, their grantees, and their community planning groups that receive technical assistance and training.

6. **Collaboration/Coordination (Not to exceed 2 pages):**
   A. Describe the roles of potential collaborating organizations (affiliates, chapters, other minority organizations, etc.) including the specific activities each of the organizations will undertake in the proposed program plan.
   B. Describe past experience, if any, in collaborating and coordinating programs and activities with these organizations.
   C. Include in the attachments evidence of current and relevant past collaboration and coordination such as jointly developed work plans or memoranda of understanding.
7. **Evaluation Plan (Not to exceed 2 pages):** Describe the plan for evaluating program activities and services. Indicate how progress made in achieving objectives will be measured and how the quality of services provided will be ensured. Specify the process through which program objectives and plans will be modified to meet emerging and changing needs of recipient groups.

Review and Evaluation Criteria

Applications submitted under this announcement will be evaluated through a competitive review process which will include review of an application describing and justifying the proposed activities.

The CDC-convened committee will evaluate each application on an individual basis according to the following criteria:

1. The extent to which the applicant documents experience in providing technical assistance and training on health planning and/or community development. **(25 points)**

1. The extent to which the applicant documents experience in providing technical assistance and training on health planning and/or community development. **(25 points)**
2. The extent to which the applicant documents other relevant experience in providing technical assistance and training on multicultural and multiethnic issues. **(15 points)**
3. The extent to which the applicant demonstrates an understanding of and documents the types, magnitude, and priority of barriers to community input in HIV prevention community planning. **(15 points)**
4. The extent to which the proposed objectives are specific, measurable, time-phased, consistent with the program purpose and the proposed activities, and consistent with the applicant organization's overall mission. **(20 points)**
5. The quality of the applicant's approaches and methods for providing technical assistance and training in inclusion, representation, and parity in the community planning process and the likelihood that the proposed methods will be successful in achieving proposed objectives. **(15 points)**
6. The extent to which the evaluation plan measures the achievement of program objectives and monitors the implementation of proposed activities. **(10 points)**

Funding Preferences

In making awards, consideration will be given to supporting organizations that a) have the proven organizational capacity to deliver multicultural/multiethnic training and technical assistance; and b) represent each of the following population groups: African American, Hispanic, American Indian/Alaskan Native; and Asian/Pacific Islanders.

E.O. 12372 Review

Applications are subject to Intergovernmental Review of Federal Programs as governed by Executive Order 12372. E.O. 12372 sets up a system for state and local government review of proposed federal assistance applications. Applicants should contact their state single point of contact (SPOCs) as early as possible to alert them to the prospective applications and to receive instructions on the state process. For proposed projects that serve more than one state, the applicant should contact the SPOC for each state served. If SPOCs have any state process recommendations on applications submitted to CDC, they should forward them, no later than *60 days after submission,* to Clara M. Jenkins, Grants Management Officer, Grants Management Branch, Procurement and Grants Office. Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, N.E., Room 320, Mail Stop E-15, Atlanta, GA 30305. The CDC does not guarantee to accommodate or explain state process recommendations it receives after *60 days after submission.*

Public Health System Reporting Requirements

This program is not subject to the Public Health System Reporting Requirements.

Catalog of Federal Domestic Assistance Number

The Catalog of Federal Domestic Assistance Number is 93.939, HIV Prevention Activities - Non-Governmental Organization Based.

Other Requirements

HIV Program Review Panel Requirements

Recipients must comply with the terms and conditions included in the document titled, "**Content of HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs (June 1992)**", a copy of which is included in the application kit. In complying with the program review panel requirements contained in this document, recipients are encouraged to use a current program review panel such as the one created by the state health department's HIV/AIDS Prevention Program. If the recipient forms its own program review panel, at least one member must also be a designated representative of a state or local health department.

Application Submission and Deadline

On or before January 31, 1994, submit the original and two copies of the application (PHS Form 5161-1) to Clara M. Jenkins, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE, Room 320, Mail Stop E-15, Atlanta, GA 30305. Faxed copies will **NOT** be accepted.

Deadline: Applications will meet the deadline if they are either received on or before the deadline of 4:30 p.m. (EST), January 31, 1994, or sent on or before the deadline date and received in time for submission to the independent review group. (Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or U.S. Postal Service. Private metered postmarks will not be acceptable proof of timely mailing.)

Applications that do not meet these criteria will be considered late and will not be considered. Late applications will be returned to the applicant.

Where to Obtain Additional Information

If you have questions after reviewing the contents of the documents, business management technical assistance may be obtained from Sharron Orum or Van Malone, Grants Management Specialists, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 255 East Paces Ferry Road, NE., Room 320, Mail Stop E-15, Atlanta, GA 30305, (404) 842-6575.

Program Announcement Number 305A, supplement to Program Announcement 305, "Cooperative Agreements for National/Regional Minority Organization HIV/STD Prevention, Immunization, and TB Projects" must be referenced in all requests for information pertaining to these projects.

Programmatic technical assistance may be obtained by calling Gary West, or NMO Project Officers, Division of STD/HIV Prevention, National Center for Prevention Services, Centers for Disease Control and Prevention (CDC), Mail Stop E-07, Atlanta, GA 30333, (404) 639-8317. (Technical assistance may also be obtained from your respective state/local health departments.)

Potential applicants may obtain a copy of "**Healthy People 2000**" (Full Report, Stock No. 017-001-00474-0) or "**Healthy People 2000**" (Summary Report, Stock No. 017-001-00473-1) referenced in the "Introduction" through the Superintendent of Documents, Government Printing Office, Washington, DC 20402-9325, telephone (202) 783-3238.

HIV PREVENTION COMMUNITY PLANNING
Directory of Technical Assistance Providers

ACADEMY FOR EDUCATIONAL DEVELOPMENT	
Carol Schechter Project Director Academy for Educational Development 1255 23rd St, NW Washington DC 20037 office: (202) 884-8700 fax : (202) 884-8713	Coralee Hoffman Senior Program Officer Academy for Educational Development 1255 23rd St, NW Washington DC 20037 office: (202) 884-8700 fax : (202) 884-8713
Susan Middlestadt, Ph.D. VP & Director of Behavioral Research Academy for Educational Development 1255 23rd St, NW Washington DC 20037 office: (202) 884-8700 fax : (202) 884-8713	Sharon Novey Program Consultant Academy for Educational Development 1255 23rd St, NW Washington DC 20037 office: (202) 884-8700 fax : (202) 884-8713
NATIONAL ASSOCIATION OF PEOPLE WITH AIDS	
William J. Freeman Executive Director National Association of People with AIDS 1413 K Street, NW Washington DC 20005 office: (202) 898-0414 fax : (202) 898-0435	Cornelius Baker Director of Public Policy National Association of People with AIDS 1413 K Street, NW Washington DC 20005 office: (202) 898-0414 fax : (202) 898-0435
NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS	
Julie Scofield Executive Director National Alliance of State and Territorial AIDS Directors 444 N. Capitol St, NW, Suite 617 Washington DC 20001 office: (202) 434-8090 fax : (202) 434-8092	Joe Kelly Research Director National Alliance of State and Territorial AIDS Directors 444 N. Capitol St, NW, Suite 617 Washington DC 20001 office: (202) 434-8090 fax : (202) 434-8092
NATIONAL COUNCIL OF LA RAZA	
M. Cristina López Acting VP for Institutional Development National Council of La Raza 810 First Street, NE Suite 300 Washington DC 20002 office: (202) 289-1380 fax : (202) 289-8173	Frank Beadle de Palomo Director, Center for Health Promotion National Council of La Raza 810 First Street, NE Suite 300 Washington DC 20002 office: (202) 289-1380 fax : (202) 289-8173

NATIONAL MINORITY AIDS COUNCIL	
Paul Akio Kawata Executive Director National Minority AIDS Council 300 Eye St, NE Suite 400 Washington DC 20002 office: (202) 544-1076 fax : (202) 544-0378	Helen Fox Director of Public Policy Education National Minority AIDS Council 300 Eye St, NE Suite 400 Washington DC 20002 office: (202) 544-1076 fax : (202) 544-0378
Manuel Magaz Project Director National Minority AIDS Council 300 Eye St, NE Suite 400 Washington DC 20002 office: (202) 544-1076 fax : (202) 544-0378	
THE NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER	
Ron Rowell Executive Director The National Native American AIDS Prevention Center 3515 Grand Ave, Suite 100 Oakland CA 94610 office: (510) 444-2051 fax : (510) 444-1593	Vince Sanabria Technical Assistance Liaison The National Native American AIDS Prevention Center 3515 Grand Ave, Suite 100 Oakland CA 94610 office: (510) 444-2051 fax : (510) 444-1593
NATIONAL ORGANIZATION OF BLACK COUNTY OFFICIALS, INC.	
Crandall O. Jones Executive Director National Organization of Black County Officials, Inc. 440 First Street, NW Suite 500 Washington DC 20001 office: (202) 347-6953 fax : (202) 393-6596	Natalie Jones HIV/AIDS Project Director National Organization of Black County Officials, Inc. 440 First Street, NW Suite 500 Washington DC 20001 office: (202) 347-6953 fax : (202) 393-6596

UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION	
Rebeca Ramos Project Director United States-Mexico Border Health Association 6006 N. Mesa, Suite 600 El Paso TX 79912 office: (915) 581-6645 fax : (915) 833-4768	Gerardo De Cosio Public Sector Specialist United States-Mexico Border Health Association 6006 N. Mesa, Suite 600 El Paso TX 79912 office: (915) 581-6645 fax : (915) 833-4768
Mary Sánchez-Bane Community Liaison United States-Mexico Border Health Association 6006 N. Mesa, Suite 600 El Paso TX 79912 office: (915) 581-6645 fax : (915) 833-4768	