FOIA Number: 2018-0758-F

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Issues - CDC [Centers for Disease Control] Initiative - 3/99

Stack:	Row:	Section:	Shelf:	Position:
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DATE & TIME: Thursday, February 25, 1999 at 10:00 a.m.

PLACE: 999 E Street, N.W. Washington, D.C. (Ninth Floor)

STATUS: The Hearing Will be Open to the Public.

ITEMS TO BE DISCUSSES:

Correction and Approval of Minutes.

Advisory Opinion 1999-01: Mark Greene.

Revising

Revising the National Voting System Standards.

Report of the Audit Division on Clinton/Gore '96 Primary Committee, Inc.

Report of the Audit Division on Clinton/Gore '96 General Committee, Inc. and Clinton/Gore '96 General Election Legal and Accounting Compliance Fund.

Report of the Audit Division on the Dole for President Committee, Inc. (Primary).

Report of the Audit Division on the Dole/Kemp '96 and Dole/Kemp Compliance Committee, Inc. (General).

Legislative Recommendations, 1999.

Notice of Proposed Rulemaking on the Electronic Freedom of Information Act Amendments ("EFOIA").

Administrative Matters.

PERSON TO CONTACT FOR INFORMATION: Mr. Ron Harris, Press Officer, Telephone: (202) 694-1220.

Majorie W. Emmons,

Secretary of the Commission.

[FR Doc. 99-4203 Filed 2-16-99; 3:10 pm]

BILLING CODE 6715-01-M

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act. Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than March 12, 1999.

A. Federal Reserve Bank of New York (Betsy Buttrill White, Senior Vice President) 33 Liberty Street, New York, New York 10045-0001:

1. Lakeland Bancorp, Oak Ridge, New Jersey; to merge with High Point Financial Corp., Branchville, New Jersey, and thereby indirectly acquire The National Bank of Sussex County, Branchville, New Jersey.

Board of Governors of the Federal Reserve System, February 11, 1999.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 99-3885 Filed 2-17-99; 8:45 am]

BILLING CODE 6210-01-F

FEDERAL RESERVE SYSTEM

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: Board of Governors of the Federal Reserve System.

TIME AND DATE: 11:00 a.m., Monday, February 22, 1999.

PLACE: Marriner S. Eccles Federal Reserve Board Building, 20th and C Streets, N.W., Washington, D.C. 20551

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

2. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Lynn S. Fox, Assistant to the Board; 202-452-3204.

SUPPLEMENTARY INFORMATION: You may call 202-452-3206 beginning at approximately 5 p.m. two business days before the meeting for a recorded announcement of bank and bank holding company applications scheduled for the meeting; or you may contact the Board's Web site at http://www.federalreserve.gov for an electronic announcement that not only lists applications, but also indicates procedural and other information about the meeting.

Dated: February 12, 1999.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 99-4048 Filed 2-12-99; 5:08 pm]

BILLING CODE 6210-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Human Immunodeficiency Virus (HIV) Prevention Activities for African American Populations

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

ACTION: Notice and request for comments.

SUMMARY: The Fiscal Year 1999 appropriation for CDC includes an increase in funds to support Human Immunodeficiency Virus (HIV) prevention activities predominantly for African American populations. CDC is proposing to award approximately $15.5 million to fund three cooperative programs to address the needs of these populations: community-based organizations (CBO) program, minority organization technical assistance (MOTA) program, and community coalitions demonstration program to develop linkages among HIV, STD (sexually transmitted diseases), TB (tuberculosis), and substance abuse services. On the basis of demonstrated need and available funds, other disproportionately affected racial and ethnic minority populations may be considered for funding.

Under separate announcements, an additional $500,000 will be awarded to CBOs in the Virgin Islands to provide HIV prevention services, and $300,000 to Divinity Schools affiliated with Historically Black Colleges and Universities to develop HIV prevention training and curricula.

The purpose of this notice is to request comments on these proposed programs. After consideration of comments submitted, CDC will publish program announcements to solicit applications. A more complete description of the goals of these programs, the target applicants, availability of funds, program requirements, and evaluation criteria follows.

DATES: The public is invited to submit comments by March 4, 1999.

ADDRESS: Submit comments to: Technical Information and Communication Branch National Center for HIV, STD and TB Prevention Centers for Disease Control and Prevention (CDC) 1600 Clifton Road, NE., Mailstop E-49 Atlanta, GA 30333.

FOR FURTHER INFORMATION CONTACT: Technical Information and Communications Branch National Center for HIV, STD, and TB Prevention Centers for Disease Control and Prevention, 1600 Clifton Road, NE., Mail Stop E-49, Atlanta, GA 30333, Fax (404) 639-2007, E-mail address: *hivmail@cdc.gov*, Telephone (404) 639-2072.

SUPPLEMENTARY INFORMATION:

CBO Program

The purpose of this program is to support the development and implementation of effective community-based HIV prevention programs, including programs provided by faith-based CBOs, that serve African American communities.

1. Goals (CBO)

A. Provide financial and technical assistance to indigenous CBOs to provide HIV prevention services to primarily African American populations for which gaps in services are demonstrated. For this program, indigenous organizations are defined as organizations that evolved from and are located within the communities they serve.

B. Support HIV prevention programs that reflect national program goals and are consistent with the HIV prevention priorities outlined in the jurisdiction's comprehensive HIV prevention plan.

C. Promote the collaboration and coordination of HIV prevention efforts among CBOs and other local, State, and federally funded programs.

2. Eligible Applicants (CBO)

Eligible applicants are minority CBOs, including faith-based organizations, that meet the following criteria:

A. An IRS-determined 501(c) tax-exempt status

B. A governing board composed of more than 50 percent of the racial or ethnic population to be served. This body must also include, or demonstrate the ability to obtain meaningful input and representation from, members of the target populations, for example, men who have sex with men, youth, women at risk, transgender populations, substance abusers.

C. Located and providing services in any of the following:

(1) The 20 metropolitan statistical areas (MSAs) with more than 1000 AIDS cases in African American populations in 1997. These MSAs are: Atlanta, GA; Baltimore, MD; Boston, MA; Chicago, IL; Dallas, TX; Detroit, MI; Ft. Lauderdale, FL; Houston, TX; Jacksonville, FL; Los Angeles-Long Beach, CA; Miami, FL; Newark, NJ; New Haven, CT; New Orleans, LA; New York, NY; Oakland, CA; Philadelphia, PA; San Francisco, CA; West Palm Beach, FL; and Washington, D.C.; or

(2) The counties and independent city with the most syphilis cases in 1997 but not included in the list of MSAs above. The counties are: Cumberland, NC; Cuyahoga, OH; Davidson, TN; Forsyth, NC; Franklin, OH; Fresno, CA; Guilford, NC; Hinds, MS; Jefferson, AL; Jefferson, KY; Maricopa, AZ; Marion, IN; Milwaukee, WI; Oklahoma, OK; Prince Georges, MD; Shelby, TN; and Tuscaloosa, AL. The independent city is St. Louis, MO.

D. Minority CBOs currently funded under program announcement 704 that are located and provide services in the areas specified in B and C are eligible to apply for funding under this program announcement. However, awards to currently funded minority CBOs will not exceed $100,000.

E. Faith-Based Organizations: For the purpose of this program announcement, a faith-based community organization is a non-profit organization which

(1) Has a religious, faith, spiritual focus or constituency, and

(2) Has access to local religious, faith, and spiritual leaders.

Eligible organizations include:

(1) Individual church, mosque, or temple or network of same, or

(2) A community-based organization whose primary constituency is faith, spiritual, or religious communities, organizations, or leaders thereof.

3. Availability of Funds (CBO)

Approximately $9,600,000 is available for funding approximately 45 minority CBOs, including faith-based community organizations. Approximately $600,000 of this total will be awarded to faith-based organizations;

A. Approximately $7,000,000 will be awarded to CBOs in the 20 MSAs with more than 1000 AIDS cases in African American populations in 1997. Awards for new organizations will range from $150,000 to $300,000 and the average award will be approximately $200,000. Applications for more than $300,000 will be deemed ineligible.

B. Approximately $1,600,000 will be awarded to CBOs located and providing services in the counties and independent city with the most syphilis cases in 1997 not included in the top 20 MSAs. These awards will average $200,000 and will range from $150,000 to $250,000. Applications for more than $250,000 will be deemed ineligible.

C. Approximately $1,000,000 may be awarded to minority CBOs currently funded under Program Announcement 704 that are located and provide services in the MSAs, counties, and independent city listed above. Supplemental awards for currently funded minority CBOs will not exceed $100,000. Applications for more than $100,000 will be deemed ineligible. Funds awarded to currently funded CBOs must be used to enhance or expand existing activities.

D. Funding Priorities: In making funding decisions, efforts will be made to ensure a national geographic distribution of funded CBOs, based on AIDS morbidity, and to ensure a national distribution of funded CBOs in terms of targeted risk behaviors, based on AIDS morbidity.

4. Program Requirements (CBO)

A. Conduct HIV counseling, testing, and referral services and health education and risk reduction (HE/RR) interventions for persons at high risk of becoming infected or transmitting HIV to others. Counseling, testing, and referral services as well as the following four HERR interventions will be funded: Individual Level, Group Level, Community Level, and Street and Community Outreach. Each recipient must conduct at least one of these priority interventions. Applicants are encouraged not to apply for more interventions than they can conduct effectively.

B. Assist high-risk clients in gaining access to HIV antibody counseling, testing, and referral for other needed services.

C. Assist HIV positive persons in gaining access to appropriate HIV treatment and other medical care, substance abuse prevention services, STD treatment, partner counseling and referral services, and health education and risk reduction services.

D. Coordinate and collaborate with health departments, community planning groups, and other organizations and agencies involved in HIV prevention activities, especially those serving the same target population.

E. Evaluate all major program activities and services.

5. Evaluation Criteria (CBO)

A. Assessment of Need and Justification for the Proposed Activities (15 points)

B. Long-term Goals (5 points)

C. Organizational History and Capacity. (20 points)
D. Program Plan (30 total points)
E. Evaluation Plan (20 points)
F. Communications/Dissemination Plan (5 points)
G. Plan for Acquiring Additional or Matching Resources (5 points)
I. Budget/Staffing Breakdown and Justification (not scored)
J. Training and Technical Assistance Plan (not scored)
K. Before final award decisions are made, CDC may make site visits to CBOs whose applications are highly ranked or may review the following items with the local or State health department and applicant's board of directors:
1. The organizational and financial capability of the applicant to implement the proposed program;
2. The application and program plans for priority interventions, compliance with the jurisdiction's HIV prevention priorities as outlined in the comprehensive plan or, if the proposed program varies from the jurisdiction's comprehensive plan, evaluate the rationale for the variance; and
3. The special programmatic conditions and technical assistance requirements of the applicant.
A fiscal Recipient Capability Assessment may be required of applicants prior to the award of funds.

MOTA Program

1. Goal (MOTA)

Improve the capacity of CBOs, including faith-based organizations, to deliver effective HIV prevention services to African Americans and increase the effectiveness and responsiveness of the HIV prevention community planning process and health department HIV prevention programs to meet the needs of African American communities heavily affected by HIV and other STDs.

2. Eligible Applicants (MOTA)

A. National, regional, or local minority organizations.
B. National, regional, or local minority religious, spiritual, or faith-based organization, which may include churches, mosques, or temples.

3. Availability of Funds (MOTA)

A. Approximately $2.4 million will be available. Approximately $600,000 of the $2.4 million will be available for faith-based projects.
B. Funding priorities will ensure
(1) A national geographic distribution of available technical assistance and training services, consistent with AIDS morbidity;
(2) Availability of technical assistance and training services to organizations predominantly serving African Americans and highly affected subgroups consistent with AIDS morbidity of these subgroups; and
(3) An appropriate balance in the types of technical assistance and training services available.

4. Program Requirements (MOTA)

Delivery of technical assistance must be specified according to (1) racial or ethnic population and (2) targeted high-risk group (e.g., men who have sex with men [MSMs], injecting drug users [IDUs] and non-injecting substance users, women at risk, transgender, high-risk heterosexuals, youth).
Organizations may apply to provide technical assistance in one or more of the following areas. However, applicants need not apply to provide service in all areas and should not attempt to provide technical assistance in areas in which they do not currently have expertise and capacity.
A. Technical Assistance for HIV Prevention Service Delivery;
B. Technical Assistance for Management and Administrative Capacity;
C. Technical Assistance to ensure the needs of racial and ethnic minority populations are addressed in Community Planning; or
D. Technical Assistance to develop community capacity for leadership in HIV prevention programs and policy making.

5. Evaluation Criteria (MOTA)

Criteria A through G will be scored, but weights have not been assigned. Public comment is encouraged.
A. Assessment of Need and Justification for Proposed Activities.
B. Long-term Goals.
C. Organizational History and Capacity.
D. Program Proposal.
(1) Involvement of Target Population.
(2) Appropriateness of Interventions.
(3) Objectives.
(4) Plan of Operations.
(5) Scientific, Theoretical, Conceptual, or Program Experience Foundation.
(6) Coordination and Collaboration.
(7) Time Line.
E. Evaluation Plan.
F. Communication and Dissemination Plan.
G. Plan for Acquiring Additional or Matching Resources.
H. Budget/Staffing Breakdown and Justification (not scored).
I. Training and Technical Assistance Plan (not scored).

Community Coalition Demonstration Program

The purpose of this program is to improve the health status of African American community members by increasing access to linked networks of health services including HIV, STD, TB, and substance abuse prevention, treatment, and care.

1. Goals (Community Coalition)

A. Plan and develop a linked network of HIV, STD, TB, and substance abuse prevention, treatment, and care services for African American and Latino community members.
B. Strengthen existing linkages among local prevention, treatment, and care providers to better serve African American and Latino communities heavily affected by HIV, STD, TB, and substance abuse.

2. Eligible Applicants (Community Coalition)

A. Local non-profit health, social service, or voluntary service organizations, or CBOs with IRS-determined 501(c) tax-exempt status and a governing or advisory body composed of more than 50 percent of the racial or ethnic minority population to be served.
B. Applications under this announcement will be categorized into one of two mutually exclusive groups:
(1) Organizations serving communities located in high HIV prevalence MSAs, or
(2) Organizations serving communities located in lower HIV prevalence geographic areas.

3. Availability of Funds (Community Coalition)

A. Phase 1 (Year 1)

Approximately 20 organizations will be funded in 1999 to plan and design a linked network of services in African American or Latino communities highly affected by HIV, STD, TB, and substance abuse. Approximately $2,750,000 will be available to fund approximately 15 projects in the high prevalence MSAs listed under CBOs. It is estimated that the average award will be $180,000, ranging from $75,000 to $300,000. Approximately $750,000 will be available in FY 1999 to fund approximately 5 projects in lower HIV prevalence geographic areas listed under CBOs. It is estimated that the average award will be $150,000, ranging from $50,000 to $200,000.

B. Phase 2 (Year 2–5)

Three to five of the Phase 1 grantees will receive continuation awards for

Phase 2. Selection of Phase 2 grantees will be based on the extent and quality of progress in the planning and designing phase. The number of Phase 2 awards will be based on availability of funds. Phase 2 awards will be made for a 12-month budget period within a project period of up to four years.

Applications for more than $300,000 in high prevalence areas and $200,000 in low prevalence areas will be deemed ineligible.

C. Funding Priorities

In making awards for Phase 1, priority will be given to assuring geographic distribution nationally consistent with HIV/AIDS morbidity.

4. Program Requirements (Community Coalition)

A. Phase 1

The recipient will be responsible for coordinating efforts among collaborating organizations and agencies and will:

(1) Identify a full-time position with the responsibility, authority, professional training, and experience needed to lead and coordinate program activities of the coalition;

(2) Convene a work group consisting of representatives from local service providers and affected community members to develop a plan for a linked network of services;

(3) Identify key community leaders and engage them as part of the coalition;

(4) Establish linkages with local HIV prevention community planning groups;

(5) Conduct a community needs assessment, as appropriate;

(6) Develop an inventory of existing community resources, as appropriate;

(7) Use information developed by the community planning groups pertinent to the targeted community;

(8) Establish linkages with existing local and community-based organizations funded by the federal government to prevent and treat HIV/AIDS, other STDs, TB, and substance abuse including local health departments, neighborhood health clinics, WIC programs and family planning clinics;

(9) Participate in at least one CDC sponsored meeting of funded agencies; and

(10) Begin to implement the plan for a linked network of services.

B. Phase 2

The recipient will:

(1) Fully implement the plan;

(2) Serve as liaison among members of the coalition to provide management oversight, facilitate program implementation and operations, and maintain effective working relationships; and

(3) Conduct an evaluation of the system and of client outcomes.

5. Evaluation Criteria (Community Coalition)

A. Assessment of Need and Justification for Proposed Activities (Total 20 Points).

B. Long-term Goals (Total 5 points).

C. Existing Collaborative Activities and Organizational History and Capacity (25 points).

D. Program Plan (25 points).

E. Program Management and Staffing Plan (10 points).

F. Communication and Dissemination Plan (5 points).

G. Evidence of Support from the Target Community (10 points).

H. Plan for Acquiring Additional or Matching Resources (not scored).

I. Budget Breakdown and Justification (not scored).

J. Training and Technical Assistance Plan (not scored).

Dated: February 11, 1999.

Joseph R. Carter,

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

[FR Doc. 99-3939 Filed 2-17-99; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration (SAMHSA)

Notice of Technical Assistance Workshops

AGENCY: Center for Mental Health Services; Center for Substance Abuse Prevention; Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, HHS.

Notice is hereby given of the following workshops for the provision of technical assistance to potential applicants for SAMHSA grants.

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT), are offering a series of three one-day regional Technical Assistance Workshops for prospective applicants. These workshops will be conducted jointly by the three SAMHSA Centers to provide support to prospective applicants in preparing their applications to published grant announcements.

It is anticipated that several SAMHSA grant announcements will be featured at the workshop:

Center for Mental Health Services

Comprehensive Community Mental Health Services for Children and Their Families
Community Action Grants for Service Systems Change—Phase I
School Violence

Center for Substance abuse Prevention

Community—Initiated Prevention Interventions
Family Strengthening
Substance Abuse Prevention and HIV Disease Prevention

Center for Substance Abuse Treatment

Targeted Capacity Expansion
Targeted Capacity Expansion Program for Treating Substance Abuse and HIV/AIDS
Adolescent Treatment Models
Comprehensive Community Treatment Program for the Development of New and Useful Knowledge
Community Action Grants
HIV/AIDS Outreach

These GFAs can be found at the SAMHSA Web Site at www.SAMHSA.gov. following publication in the **Federal Register**. Potential participants are strongly encouraged to check these resources and be familiar with the GFAs in which they are interested prior to attending the workshop.

The Technical Assistance Workshops will be held at the following locations: Workshop I—Washington, DC, Thursday, March 11, Washington Hilton and Towers, 1919 Connecticut Avenue, NW., Washington, DC 20009, (202) 483-3000; Workshop II—Chicago, IL , Wednesday, March 17, Sheraton Chicago Hotel & Towers, 301 East North Water Street, Chicago, IL 60611, (312) 464-1000; and Workshop III—Los Angeles, CA, Friday, March 19, LA Airport Hilton and Towers, 5711 West Century Blvd, Los Angeles, CA 90045, (310) 410-4000.

Registration and check-in at each site will be at 8:00 a.m.; workshop hours are 8:30 a.m.-5:00 p.m.

Preliminary Agenda Highlights for the TA Workshops include: (1) Review of SAMHSA programs and priorities; (2) Provision of related resource materials; (3) Technical/practical aspects of the grant application process including application requirements, improving applications, instruction in completing required forms, submission, review, award procedures, and program evaluation; (4) Separate breakout sessions for discussion of specific grant

MAJOR MINORITY FOCUSED ORGANIZATIONS

BOLDED organizations are those with which OMH has an umbrella cooperative agreement. This allows us OMH to identify a project, and based on funding, make an award through a streamlined process which does not require competitive bidding or grant review.

* those with an "*"" have an HIV/AIDS related component either funded by OMH or other source.

Sponsor	Location	Target Audience
Congress of National Black Churches		Black religious
NAACP	Baltimore	
National Black Nurses Association	WDC	
National Council of Negro Women	WDC	
National Medical Association	WDC	Black physicians
National Urgan League	NYC	Black civil rights
***National Association for Equal Opportunity in Higher Education (NAFEO)**	Silver Spring, MD	Black education group with HIV focus
***Asian Pacific Islander American Health Forum**	Sdan Francisco	API health care issues
Association of Asian/Pacific Community Health Organizations	Oakland, CA	Coalition of Sec. 330 community health centers
Organization of Chinese Americans	WWDC	
***NCLR -- National Council of La Raza**	WDX	Hispanic civil rights, education, immigration, health
***COSSMHO - Coalition of Hispanic Health and Human Service Organizations**	WDC	Hispanic health and human services organizations
League of United Latin American Citizens (LULAC)	WDC office	Hispanic civil right, education organization
Interamerican College of Physicians and Surgeons	**WDC**	Hispanic medical society – more Central and S. American focused

ASPIRA Association	WDC	Hispanic youth
National Association of Hispanic Nurses	WDC	
National Association of Latino Elected and Appointed Officials	WDC office	
National Hispanic Medical Association	WDC	Hispanic medical society
*LLEGO – National Latino/a Lesbian and Gay Organization	WDC	
National Puerto Rican Coalition	WDC	P.R. focused civil right organization
Pan American Health Organization	WDC	U.S. - Mexico border focused
***Association of American Indian Physicians**	Oklahoma City	Indian phsicians
American Indian Health Care Association	Broomfield, CO	
*National Native American AIDS Prevention Center	Oakland, CA	
National Congress of American Indians	WDC	
***National Minority AIDS Council**	WDC	

OTHER ORGANIZATIONS WITH WHICH THE OFFICE OF MINORITY HEALTH HAS COOPERATIVE AGREEMENTS WHICH DO NOT YET HAVE AN HIV/AIDS FOCUS

Note: cooperative agreements allow OMH to fund projects without going through the usual, extended contract process. Once a project and funding are identified, it is a simple process to make an award to an organization.

American Indian Higher Education Consortium
Hispanic Association of Colleges and Universities
Hispanic Serving Health Professions Schools
Inter-University Program for Latino Research
Minority Faculty Development Program/Harvard Medical School
Minority Health Professions Foundation
National Asian Pacific American Families Against Substance Abuse
National Hispanic Religious Leaders Partnership
National Latino Children's Institute
Public Health Foundation
Quality Education for Minorities
Summit Health Institute for Research and Education

UPCOMING NATIONAL AND REGIONAL HIV/AIDS CONFERENCES

Title	Sponsor	City	Date
US Conference on AIDS	NMAC, et al	Denver	November
1999 Women and AIDS Conference	City of LA, DHHS	Los Angeles	10/9 - 12/99
Forward in Faith	National Episcopal AIDS Coalition	San Francisco	3/24 - 25/2000
7the Encuentro	LLEGO	Los Angeles	10/9 - 12/99
11th Annual Maryland AIDS Conf.	Univ. MD; AETC	Baltimore	10/7 - 8/99
National HIV Prevention Conference	CDC	Atlanta	8/29 - 9/1/99
Connection 99: 3rd Annual Conference for Hotlines, Helplines, Referral Services	American Social Health Association	Atlanta	8/26/- 28/99
HIV Innovations Along the Border	CODAC Behavioral Services	Tuscon, AZ	8/12 - 13/99
1999 Minority Executives Directors Leadership Forum	NMAC	St. Thomas, VI	8/12 - 15/99
97th Annual Scientific Assembly	National Medical Association	Las Vegas	8/8 - 13/99
14th Annual – Working with America's Youth	National Resource Center, Youth Services, Un. Of OK	Minneapolis	7/25 - 28/99
Unidos Para Nuestra Comunidad	National Association of Hispanic Nurses	San Juan	7/21 - 23/99
Improving HIV Care and Prevention – for Multiply Diagnosed	Veterans Affairs, NIH, HUD	WDC	6/28 - 29/99

H:\HIVorgsconferences.wpd

Capacity-Building Assistance for CDC-funded Community-Based Organizations (CBOs) Providing HIV Prevention Services to African American Populations at High Risk for HIV

The Centers for Disease Control and Prevention (CDC) announces the availability of limited funds to develop and implement regionally structured and focused capacity-building assistance for CDC-funded community-based organizations (CBOs) providing HIV prevention services to African American populations at high risk for HIV. This program will serve four regional groups as follows:

Northeast Region: CT, MA, ME, NH, NJ, NY, PA, RI, VT,.PR, U.S. Virgin Islands

Midwest Region: IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI

South Region: AL, AR, D.C., DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV

West Region: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

Capacity-Building assistance will be provided in two categories (A and B),

Category A includes:

(1) Organizational Infrastructure Development and Assessment, and

(2) Intervention Design, Development, Implementation, and Evaluation

Category B includes:

(1) Community Capacity-Building for HIV Prevention, and

(2) HIV Prevention Community Planning Effectiveness and Participation

Eligible Applicants for Category A are:

1. A National Minority Organization serving four regions either independently or as a lead agency within a coalition; or
2. A lead regional minority organization within a coalition of regional minority organizations representing and serving all four regions.

Eligible applicants for Category B are:

1. A National Minority Organization serving up to four regions either independently or as a lead agency within a coalition; or
2. A regional minority organization serving one region either independently or as the lead agency within a coalition; or
3. A local minority organization as the lead agency within a coalition serving one region.

All eligible applicants must meet the following criteria:

1. Have a copy of a currently valid IRS Tax Determination letter stating that the organization is a 501(c)3.
2. If applying for **Category A**, have a documented and established 3-year record of service to community-based organizations serving African American populations. If applying for **Category B**, applicants must meet the criteria for Category A and **must also** have a documented and established 3-year record of service to African American communities or an African American sub-population heavily affected by HIV.
3. Have a governing body composed of greater than 50 percent African American members.
4. Fifty percent of key positions, including management, supervisory, administrative, and service positions filled by African American persons.

Please note: For a full list of eligibility requirements, please see the published program announcement.

CDC Technical Assistance (TA)

CDC will provide pre-application technical assistance during an audio conference scheduled for the following date:

June 17 (2:30 - 4:00 p.m. EDT)

How to Participate in the Audio Conference
No registration is required. Because there are a limited number of telephone lines available, we ask that you assemble interested participants from your organization at a speaker phone if possible.

- Please dial-in 5 -10 minutes before the conference.
- Non-federal participants: Call toll-free 800-311-3437.
- Federal participants: Call 404-639-3277.
- Please have the conference code (**990238**) and name of the audio conference ("Capacity Building") ready.
- Place speaker phones and background music on mute.
- Join the audio conference "silently" without speaking.
- Do not use cellular phones.

For further information about participating, please visit the web site at **http://www.cdc.gov/hiv** or, after May 28, call toll-free to 888-CDC-FAXX (when prompted, enter Document Number 260320 and a return fax number).

Internet Services

CDC will post application packages that include tool kits and a copy of the program announcement on the Division of HIV/AIDS Prevention (DHAP) Web site at: **http://www.cdc.gov/hiv/funding**

Other Assistance

The CDC National Prevention Information Network (NPIN) will provide updated information on these and other TA services by phone, fax, e-mail, and the Internet. CDC NPIN also will process requests for application packets and related materials for Program Announcement No. 99095. To contact the CDC NPIN:

Phone 1-800-458-5231

TTY Services 1-800-243-7012

Fax 1-888-282-7681

E-mail ..... application-cba@cdcnpin.org

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Draft Questions and Answers
Crisis Response Teams

Q. What are Crisis Response Teams?

A. Crisis Response Teams are multidisciplinary technical assistance teams composed of experts in HIV research, prevention and treatment, and in substance abuse. These teams will be made available to provide technical assistance to localities most highly impacted by HIV/AIDS within racial and ethnic minority populations. The teams will work as partners with local officials, public health personnel and minority community-based organizations to help them address their minority HIV/AIDS situation, and they will develop new strategies to increase the effectiveness of their prevention and treatment efforts to reduce HIV/AIDS morbidity and mortality in those areas

Q. How will Crisis Response Teams do this?

A. Crisis Response Teams will work in partnership with leaders and individuals from the local community, and provide training in a new assessment tool we call Rapid Assessment and Response. Experts on the Crisis Response Teams will review information gathered using this tool with the community advisory group, so that new intervention strategies to reduce the impact of the HIV epidemic may be considered. The teams will work in partnership with the local community to produce a final report with an assessment of the local epidemic among minorities, including endemic local challenges and targeted strategic advice for effective interventions.

Q. What is this Rapid Assessment and Response tool?

A. Rapid assessment incorporates both quantitative and qualitative data to better understand the overall context in which health care and prevention services are viewed and used. This approach was initially developed by the World Health Organization to allow a quick assessment of a given public health problem and to develop highly targeted local interventions to address it. That strategy has been adapted for use in this country. Individuals from the local community play a key role in gathering data as part of the assessment process and using it to define interventions that respond to defined needs.

Q. How will the crisis response teams work with cities so that they can use this rapid assessment approach to combat their HIV epidemics?

A. First, the Crisis Response Teams will only go to eligible cities that have requested this new form of technical assistance. In those cases, the chief elected official, with support from the head of the health department, already sent a letter to HHS requesting this expertise to address the ongoing HIV epidemic among the local minority populations. Local leaders will put together a Community Advisory Committee and identify a group of local outreach workers who can gather assessment data within their communities. The crisis team members will train the local workers in what data is to be collected and how to get it. The field workers will collect assessment information over a two-month period, under the guidance of a local researcher skilled in ethnographic methods.

During this time, the HHS team, while not on-site, will remain accessible for questions and technical assistance to the field team When all the data has been gathered, the Crisis Response Team will go to the city and work with the team of outreach workers and local researchers to interpret the data and identify new interventions that could help to curtail the epidemic in the city.

Q. What is the role of the Community Advisory Committee and who is on it?

A. The Community Advisory Committee should include representatives from existing policy and planning bodies in the cities (such as the Ryan White Planning Council and Community Planning Groups for HIV prevention); leaders of organizations that work with the indigenous affected populations; faith community representatives; and persons living with HIV and those affected by HIV and substance abuse. The advisory committee members should be representative of the local demographics of the HIV epidemic in minority communities. This committee will be invited to receive an orientation on the purpose and nature of rapid assessment and they will be encouraged to participate in the process as key informants.

The advisory committee plays a key role in preparing a final report with an action plan to address HIV within minority populations based on this information that will be presented to the chief elected official.

Q. How will the results of this crisis response team initiative help local communities?

A. There are both direct and indirect benefits to the community. The most direct benefit is that through this intensive, yet comprehensive assessment, the community is able to develop a targeted strategy to curb the spread of HIV/AIDS in the local minority populations. Likewise overlapping public health issues such as STD prevention and substance abuse may simultaneously be addressed because of their relationships to HIV/AIDS prevention and treatment.

Indirectly, this initiative provides local public health officials with training in new assessment methods that the communities can apply to other health or social conditions such as teen pregnancy, delinquent child support payments and spousal abuse

Q. How long will the entire process take in each city?

A. We estimate that in most instances, the process can be completed -- from initial consultation with local elected leadership to submission of an action plan and final report -- within 10 weeks.

Q. What is the cost to the local community and to the federal government?

A. Communities will incur no cost for the Crisis Response Team's assistance; however, a city's participation in this technical assistance initiative also will not result in any additional federal funding for their local HIV/AIDS-related programs. HHS will provide training and expert professional technical assistance with existing personnel and will cover the cost of field data collection operations, estimated at $24,000 per community. The HHS agencies with key roles in HIV/AIDS programs or services will share this expense.

Q. So communities won't be entitled to any additional federal funding through the crisis response team effort?

A. This program's funding only provides for free training and technical assistance to help local communities devise effective and targeted strategies to reduce the enormous toll that the HIV epidemic continues to take in minority populations. It does not supply local communities with additional monies for specific programs. Instead it focuses on working with communities to review and maximize the use of existing resources to reach populations at highest risks with effective interventions.

Q. Why aren't the Crisis Response Teams providing more assistance, in particular financial resources, to the cities to address this problem?

A. There are limits to what the Crisis Response Teams can do The key here is technical assistance -- making available additional technical expertise to help cities better target their existing efforts with current financial resources. This is not to be confused with the awarding of grant funds or the start of any new initiative.

Q. What is the eligibility criteria for a city to receive a crisis response team?

A. The jurisdiction must have a population greater than 500,000, the number of persons living with HIV/AIDS must be greater than 1,500 among African-American and Hispanics combined; these minority groups must account for at least 50 percent of the total community living HIV/AIDS cases; and the chief elected official must request the technical assistance.

Q. What cities are eligible to request a crisis response team?

A. A total of 16 cities are eligible to receive Crisis Response Team technical assistance. Those cities are Atlanta; Baltimore; Chicago; Detroit; Ft. Lauderdale; Houston; Jersey City, N.J.; Los Angeles; Miami; Newark, N.J.; New Haven/Bridgeport/ Danbury/Waterbury/Conn.; New York City; Philadelphia; San Juan, P.R.; Washington, D.C., and West Palm Beach/Boca Raton, Fla.

Q. Which cities have requested a crisis response team?

A. A total of 11 of the eligible chief elected officials requested assistance thus far: Atlanta; Baltimore; Chicago; Detroit; Los Angeles; Miami; New Haven/ Bridgeport/Danbury/ Waterbury, Conn., Newark, N.J.; Philadelphia; Washington, D.C.; and West Palm Beach/Boca Raton, Fla.

Q. What factors were used in the process to determine an order in which cities would be scheduled?

A. Several factors were considered in selecting the first three cities for the crisis team intervention. These included: AIDS case number and case rates among African American and Hispanic populations in each city; measures reflective of the substance abuse epidemic in each city, including emergency room admissions for cocaine and for heroin use, and treatment statistics for cocaine and heroin addiction; indicators for high-risk sexual behavior including the

rate and number of gonorrhea cases in each city; and the availability of an on-site ethnographic research capability to assist the crisis teams collect critical background data. The first cities selected had high rankings for these indicators and have a solid research capability to support the assessment process.

Q. Why these 11 cities and what about the ones left out that did not meet the criteria?

A. Certainly the HIV/AIDS problem impacts many communities large and small. We set criteria that we thought would help us identify the most serious problems in some of the largest areas first. It's possible that at a later date we could extend similar types of assistance to other communities. It's important to first get a handle on this initial wave of cities -- the initial three and the other nine we've identified -- before going further. We can learn something from our work with these first ones that can be applied in assisting other communities down the road. Sixteen cities were eligible, but Houston, Ft. Lauderdale, Jersey City, N.J., New York City and San Juan have not yet requested this intervention.

Q. Why is HHS doing this when these areas already have HIV Prevention Community Planning Groups and Ryan White Planning Councils? Does that mean these two planning bodies are not working?

A. No. The Crisis Response Teams are intended to build on and bring in new information that will be helpful to both the Title I HIV Planning Councils and the HIV Prevention Community Planning groups. The Crisis Response Teams represent an intensive, targeted effort within minority populations to gain additional qualitative and quantitative data through new rapid assessment methods that will enhance current community approaches to addressing this issue. This information goes beyond traditional needs assessments which must rely heavily on available statistical data on reported AIDS cases (that typically lags behind important information for more recently infected or undiagnosed individuals), and what services are actually used by persons seeking care.

Q. How will the Community Advisory Committee interact with the Ryan White Planning Councils and HIV Prevention Community Planning Groups?

A. We are recommending that the chief elected official include representatives from both the Title I HIV Planning Councils and HIV Prevention Community Planning Groups on the Community Advisory Committee, as it is vital to include the expertise of these groups when thinking through prevention and care issues in their jurisdiction. Furthermore, a report of the work of the Community Advisory Committee will be submitted to the offices of the chief elected official and health department, and would be available through those channels.

Q. Why are you responding to AIDS in minority communities?

A. This Administration has been committed from its earliest days to a strong, effective response to the HIV/AIDS epidemic. Our efforts have realized reductions in the number of AIDS deaths and newly reported AIDS cases across all racial and ethnic groups in recent years, but minority populations remain disproportionately affected by HIV/AIDS, and morbidity and mortality rates are not dropping as rapidly for these individuals. This requires a new, intensified focus to identify and implement targeted strategies to ensure that our racial and ethnic minority populations benefit from the prevention and excellent treatment options now available.

Q. Why are some metropolitan areas, such as the Connecticut cities or the Boca Raton/West Palm Beach cluster, combined? It seems like a lot of geographical distance between the various components of those two clusters.

A. HHS uses the standard Metropolitan Statistical Area (MSA) definitions and New England County Metropolitan Areas (NECMA) designations, which also have been used to guide HRSA Title I grants. OMB most recently updated its MSAs on June 30, 1998, using the 1990 census data.

[CITY NAME] ONE OF THREE SITES SELECTED FOR SPECIAL CRISIS RESPONSE TEAMS TO BATTLE HIV/AIDS IN URBAN MINORITY POPULATIONS

[CITY NAME] is one of three initial cities named today by the U.S. Department of Health and Human Services to receive special HIV/AIDS technical assistance to help combat the spread of AIDS among its racial and ethnic minority populations.

Beginning later this month, a special team of experts in HIV/AIDS research, prevention and treatment, and substance abuse will be sent to [CITY NAME] for eight to 10 weeks to provide the assistance. The team will meet with local government officials and community-based organizations that work with racial and ethnic minority persons living with HIV/AIDS, including [NAMES OF LOCAL GROUPS], to help them develop targeted strategies to curb the rapid spread of HIV/AIDS among minority populations in the [CITY NAME] community.

This effort is part of an HHS joint venture with the Congressional Black Caucus (CBC) and other members of Congress to combat the disproportionate impact of HIV/AIDS in African-American and other racial and ethnic minority communities. In October 1998, the Clinton Administration committed $156 in additional resources to combat HIV/AIDS in racial and ethnic minority communities hardest hit by this disease. Crisis Response Teams are an integral part of that effort.

[MAYOR/CHIEF EXECUTIVE QUOTE]

In being selected for a special Crisis Response Team, [CITY NAME] met criteria developed by HHS to target this special assistance to cities with minority populations most impacted by HIV/AIDS. These criteria include having a population of more than

500,000 persons, having at least 1,500 African-American or Hispanic persons living with HIV/AIDS, and at least 50 percent of HIV/AIDS cases must involve African-American and Hispanics combined.

[THOUGH{CITY NAME}MET THE CRITERIA, MAYOR/CHIEF EXECUTIVE DOE HAD TO REQUEST FORMALLY FOR A CRISIS RESPONSE TEAM'S ASSISTANCE, AND THAT REQUEST WAS MADE.]

[CITY NAME] is one of 11 communities to receive Crisis Response Team assistance. Those other communities include: Atlanta; Baltimore; Chicago; Los Angeles; New Haven/Bridgeport/Danbury/Waterbury, Conn.; Newark, N.J.; Washington, D.C.; and West Palm Beach/Boca Raton, Fla., [OTHER TWO INAUGURAL CITIES].

In [CITY NAME], [INSERT LOCAL MINORITY HIV/AIDS DATA]

The team's overall goal is to reduce HIV/AIDS morbidity and mortality among minorities here in the [Detroit] metropolitan area. The HHS Crisis Response Team will meet with [ADD NAMES IF WANT] during the consultation period. Following its intensive work with [CITY NAME] [LIST LOCAL HIV/AIDS EXPERTS], the teams will work in partnership with the local community to produce a final report with an assessment of the local epidemic among minorities, including endemic local challenges and targeted strategic advice in the form of an action plan.

Crisis Response Teams will be comprised of experts from HHS' Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, the National Institutes of Health, and the HHS Office of HIV/AIDS Policy.

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Sample Letter to the Editor

Dear Editors:

This time last year, the Congressional Black Caucus opened a dialogue with the U.S. Department of Health and Human Services (HHS) to discuss the growing impact of HIV/AIDS among African Americans and other minority populations. The result was that the President and Congress obtained $156 million in additional resources to combat HIV/AIDS in those racial and ethnic minority communities hardest hit by this disease. We hope to continue those enhancements in the upcoming budget year.

In [CITY NAME] and other communities throughout the country, HIV/AIDS is rapidly becoming a disease of color. Among African Americans, AIDS is the leading killer of 25- to 44-year-old men and the second leading killer of women in the same age group.

Our city has been selected to receive the services of a special HHS technical assistance Crisis Response Team from Washington, D.C. This team of experts in HIV/AIDS research, prevention and treatment, and in substance abuse programs will be joining forces over the next few weeks with our own public health officials and community-based organizations to analyze the growing HIV/AIDS problem among minorities here in [CITY NAME]. This should allow us to hammer out new solutions and targeted strategies that make the best use of available resources. The end result of this will be a thorough written report that can be used as a guidepost to respond aggressively to the AIDS epidemic locally and to reduce the extra burden this disease is placing on our minority citizens.

We are fortunate to benefit from this free expertise. Many communities would welcome this intensive, yet comprehensive technical assistance when it comes to addressing critical health crises like this one.

As a member of the Congressional Black Caucus and as a representative of the citizens of this community, I am especially proud to have been a part of making this happen for [CITY NAME]. But getting this kind of help is one thing, and making it work is a different challenge entirely. To make the visit of the Crisis Response Team a successful endeavor for our community -- and especially for those African-American and other minority families whose lives are being touched by HIV/AIDS -- all of us must pull together to advance this effort.

I encourage every official group or individual who is asked to participate to cooperate with and contribute to the Crisis Response Team as best they can, not for our own individual portfolios, but for the health and well-being of our entire community.

Sincerely,

CBC Member Signature

FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

DATE: 6/15/99

TO: Deborah
c/o Todd @ White House

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HHS Press Release

HHS ANNOUNCES THREE SITES FOR SPECIAL CRISIS RESPONSE TEAMS TO BATTLE HIV/AIDS IN MINORITY COMMUNITIES

HHS Secretary Donna E. Shalala today announced that Detroit, Philadelphia and Miami will be the first of 11 U.S. metropolitan areas to receive special technical assistance from federal teams of experts to help combat the spread of HIV/AIDS among racial and ethnic minority populations.

Beginning this month, HHS will send special teams of experts known as Crisis Response Teams into the three cities for eight to 10 weeks. The Crisis Response Teams will meet with local officials, public health personnel and community-based organizations that work with racial and ethnic minority persons living with HIV/AIDS and help them develop targeted strategies to curb the rapid spread of HIV/AIDS among minority populations in their communities.

"We're going into these communities as partners to offer our assistance and expertise," said Secretary Shalala. "Our interest is in helping people who are already getting good results in tough situations do even better. Further targeting our interventions could save lives."

This effort is part of an HHS joint venture with the Congressional Black Caucus (CBC) and other members of Congress to combat the disproportionate impact of HIV/AIDS in African-American and other racial and ethnic minority communities. In October 1998, the Clinton Administration committed $156 million in additional resources to combat HIV/AIDS in racial and ethnic minority communities hardest hit by this disease. Crisis Response Teams are an integral part of that effort.

"Each community is different. But the vast experience among Crisis Response Team members in dealing with HIV/AIDS at the local level should help the various communities tap into their own unique challenges and resources," said Surgeon General David Satcher. "Together, we can target the best approach for reaching their respective minority groups who have HIV/AIDS."

HHS targeted cities with the largest minority populations affected by HIV/AIDS. To be eligible for this assistance, cities had to have populations of at least 500,000 persons and at least 1,500 African-American or Hispanic persons living with HIV/AIDS. Also, these minority groups had to account for at least 50 percent of the community's HIV/AIDS cases. Once a city qualified under these criteria, the chief elected official in that community had to request that HHS dispatch a Crisis Response Team.

Other communities currently scheduled to receive help from Crisis Response Teams include Atlanta; Baltimore; Chicago; Los Angeles; New Haven/Bridgeport/Danbury/Waterbury, Conn.; Newark, N.J.; Washington, D.C.; and West Palm Beach/Boca Raton, Fla.

The teams' overall goal is to reduce HIV/AIDS morbidity and mortality among minorities. Following their intensive work with each locality, the teams will work in partnership with the local community to produce a final report with an assessment of the local epidemic among minorities, including endemic local challenges and targeted strategic advice in the form of an action plan.

Crisis Response Teams will be comprised of experts from HHS' Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, the National Institutes of Health, and the HHS Office of HIV/AIDS Policy.

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Fact Sheet

June 16 1999

Contacts: HHS Press Office (202) 690-6343

HHS: Addressing HIV/AIDS
Among Urban Minority Communities

Overview: On October 28, 1998, President Clinton, Health and Human Services (HHS) Secretary Donna E. Shalala and Surgeon General David Satcher unveiled a strategy to enhance federal efforts to fight HIV/AIDS in America's urban minority communities in response to the worsening, disproportionate impact of the disease in these populations. The strategy unveiled at the White House with the Congressional Black Caucus and other members of Congress focused on a special $156 million package woven into the existing FY 1999 budget for these efforts.

An integral part of the strategy includes HHS employing a form of technical assistance called Crisis Response Teams. These multidisciplinary teams will go into individual communities where racial and ethnic minority populations are hardest hit by HIV/AIDS. The teams will work as partners with local officials, public health personnel and minority community-based organizations to help them address their minority HIV/AIDS situation and develop new strategies to increase the effectiveness of their prevention and treatment efforts to reduce HIV/AIDS.

Experts helping experts

In many cases, local communities have found ways to address the HIV/AIDS problem at large, but targeting issues specific to minority populations can be particularly challenging. Crisis Response Teams are being formed with experts from HHS' Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the HHS Office of HIV/AIDS Policy. They will offer external perspective and expertise.

Each community is required to form a Community Advisory Committee to work in tandem with the Crisis Response Team. The advisory committee will be comprised of representatives from local policy and planning bodies, leaders of community-based organizations that work with indigenous minority populations, community representatives, and local persons living with HIV/AIDS who are representative of the disease's demographics in minority communities.

HHS estimates that in most instances, the process can be completed -- from initial consultation with local elected leadership to submission of an action plan and final report -- within 10 weeks. Communities will incur no cost for the Crisis Response Team's assistance; however, a city's participation in this technical assistance initiative will not result in any additional federal funding for their local HIV/AIDS-related programs.

HHS will provide training and expert professional technical assistance with existing personnel and will cover the cost of field data collection operations, estimated at $24,000 per community. The HHS agencies with key roles in HIV/AIDS programs or services will share this expense.

Targeting Communities Hardest Hit

HHS determined 16 communities that had large minority populations affected by HIV/AIDS were eligible for this assistance. The three inaugural sites for Crisis Response Teams are Detroit, Miami and Philadelphia.

The teams will visit the remaining eligible communities by early 2000. They include: Atlanta; Baltimore; Chicago; Los Angeles; Newark, N.J.; New Haven/Bridgeport/Danbury/Waterbury, Conn.; Washington, D.C.; and West Palm Beach/Boca Raton, Fla.

Additionally, Ft. Lauderdale, Houston, New York City, Jersey City, N.J. and San Juan, P.R., were deemed eligible but have not yet requested HHS assistance. It is possible that similar types of assistance may be extended to other communities at a later date.

Evaluating the Severity of the Situations

The eligibility criteria used to determine which cities qualified for rapid assessment and response technical assistance included:

- Populations of at least 500,000 persons;
- At least 1,500 African-American or Latino persons (combined) living with HIV/AIDS;
- and African-American and Hispanics accounting for at least 50 percent of the total community HIV/AIDS cases.

Once qualified, the chief elected official in that community had to request that HHS dispatch a Crisis Response Team.

Local Press Release example

DETROIT ONE OF THREE SITES SELECTED FOR SPECIAL CRISIS RESPONSE TEAMS TO BATTLE HIV/AIDS IN URBAN MINORITY POPULATIONS

[Detroit] is one of three initial cities named today by the U.S. Department of Health and Human Services to receive special HIV/AIDS technical assistance to help combat the spread of AIDS among its racial and ethnic minority populations.

Beginning later this month, a special team of experts in HIV/AIDS research, prevention and treatment, and substance abuse will be sent to [Detroit] for eight to 10 weeks to provide the assistance. The team will meet with local government officials and community-based organizations that work with racial and ethnic minority persons living with HIV/AIDS, including [names of local groups _], to help them develop targeted strategies to curb the rapid spread of HIV/AIDS among minority populations in the [Detroit] community.

This effort is part of an HHS joint venture with the Congressional Black Caucus (CBC) and other members of Congress to combat the disproportionate impact of HIV/AIDS in African-American and other racial and ethnic minority communities. In October 1998, the Clinton Administration committed $156 in additional resources to combat HIV/AIDS in racial and ethnic minority communities hardest hit by this disease. Crisis Response Teams are an integral part of that effort.

[Mayor/Chief Executive quote goes here_]

In being selected for a special Crisis Response Team, [Detroit] met criteria developed by HHS to target this special assistance to cities with minority populations most impacted by HIV/AIDS. These criteria include having a population of more than

500,000 persons, having at least 1,500 African-American or Hispanic persons living with HIV/AIDS, and at least 50 percent of HIV/AIDS cases must involve African-American and Hispanics combined.

[Though Detroit met the criteria, Mayor/Chief Executive Doe had to request formally for a Crisis Response Team's assistance, and that request was made _.]

[Detroit] is one of 11 communities to receive Crisis Response Team assistance. Those other communities include: Atlanta; Baltimore; Chicago; Los Angeles; New Haven/Bridgeport/Danbury/Waterbury, Conn.; Newark, N.J.; Washington, D.C.; and West Palm Beach/Boca Raton, Fla.

[In Detroit, add local minority HIV/AIDS data].

The team's overall goal is to reduce HIV/AIDS morbidity and mortality among minorities here in the [Detroit] metropolitan area. The HHS Crisis Response Team will meet with [add names if want] during the consultation period. Following its intensive work with [Detroit HIV/AIDS experts], the teams will work in partnership with the local community to produce a final report with an assessment of the local epidemic among minorities, including endemic local challenges and targeted strategic advice in the form of an action plan.

Crisis Response Teams will be comprised of experts from HHS' Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, the National Institutes of Health, and the HHS Office of HIV/AIDS Policy.

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Draft Questions and Answers
Crisis Response Teams

Q. What are Crisis Response Teams?

A. Crisis Response Teams are multidisciplinary technical assistance teams composed of experts in HIV research, prevention and treatment, and in substance abuse. These teams will be made available to provide technical assistance to localities most highly impacted by HIV/AIDS within racial and ethnic minority populations. The teams will work as partners with local officials, public health personnel and minority community-based organizations to help them address their minority HIV/AIDS situation, and they will develop new strategies to increase the effectiveness of their prevention and treatment efforts to reduce HIV/AIDS morbidity and mortality in those areas.

Q. How will Crisis Response Teams do this?

A. Crisis Response Teams will work in partnership with leaders and individuals from the local community, and provide training in a new assessment tool we call "rapid assessment and response." Experts on the Crisis Response Teams will review information gathered using this tool with the community advisory group, so that new intervention strategies to reduce the impact of the HIV epidemic may be considered. The teams will work in partnership with the local community to produce a final report with an assessment of the local epidemic among minorities, including endemic local challenges and targeted strategic advice for effective interventions.

Q. What is this rapid assessment and response tool?

A. Rapid assessment incorporates both quantitative and qualitative data to better understand the overall context in which health care and prevention services are viewed and used. This approach was initially developed by the World Health Organization to allow a quick assessment of a given public health problem and to develop highly targeted local interventions to address it. That strategy has been adapted for use in this country. Individuals from the local community play a key role in gathering data as part of the assessment process and using it to define interventions that respond to defined needs.

Q. How will the crisis response teams work with cities so that they can use this rapid assessment approach to combat their HIV epidemics?

A. First, the Crisis Response Teams will only go to eligible cities that have requested this new form of technical assistance. In those cases, the chief elected official, with support from the head of the health department, already sent a letter to HHS requesting this expertise to address the ongoing HIV epidemic among the local minority populations. Local leaders will put together a Community Advisory Committee and identify a group of local outreach workers who can gather assessment data within their communities. The

crisis team members will train the local workers in what data is to be collected and how to get it. The field workers will collect assessment information over a two-month period, under the guidance of a local researcher skilled in ethnographic methods.

During this time, the HHS team, while not on-site, will remain accessible for questions and technical assistance to the field team. When all the data has been gathered, the Crisis Response Team will go to the city and work with the team of outreach workers and local researchers to interpret the data and identify new interventions that could help to curtail the epidemic in the city.

Q. What is the role of the Community Advisory Committee and who is on it?

A. The Community Advisory Committee should include representatives from existing policy and planning bodies in the cities (such as the Ryan White Planning Council and Community Planning Groups for HIV prevention); leaders of organizations that work with the indigenous affected populations; faith community representatives; and persons living with HIV and those affected by HIV and substance abuse. The advisory committee members should be representative of the local demographics of the HIV epidemic in minority communities. This committee will be invited to receive an orientation on the purpose and nature of rapid assessment and they will be encouraged to participate in the process as key informants.

The advisory committee plays a key role in preparing a final report with an action plan to address HIV within minority populations based on this information that will be presented to the chief elected official.

Q. How will the results of this crisis response team initiative help local communities?

A. There are both direct and indirect benefits to the community. The most direct benefit is that through this intensive, yet comprehensive assessment, the community is able to develop a targeted strategy to curb the spread of HIV/AIDS in the local minority populations. Likewise overlapping public health issues such as STD prevention and substance abuse may simultaneously be addressed because of their relationships to HIV/AIDS prevention and treatment.

Indirectly, this initiative provides local public health officials with training in new assessment methods that the communities can apply to other health or social conditions such as teen pregnancy, delinquent child support payments and spousal abuse.

Q. How long will the entire process take in each city?

A. We estimate that in most instances, the process can be completed -- from initial consultation with local elected leadership to submission of an action plan and final report -- within 10 weeks.

Q. What is the cost to the local community and to the federal government?

A. Communities will incur no cost for the Crisis Response Team's assistance; however, a city's participation in this technical assistance initiative also will not result in any additional federal funding for their local HIV/AIDS-related programs. HHS will provide training and expert professional technical assistance with existing personnel and will cover the cost of field data collection operations, estimated at $24,000 per community. The HHS agencies with key roles in HIV/AIDS programs or services will share this expense.

Q. So communities won't be entitled to any additional federal funding through the crisis response team effort?

A. This program's funding only provides for free training and technical assistance to help local communities devise effective and targeted strategies to reduce the enormous toll that the HIV epidemic continues to take in minority populations. It does not supply local communities with additional monies for specific programs. Instead it focuses on working with communities to review and maximize the use of existing resources to reach populations at highest risks with effective interventions.

Q. Why aren't the Crisis Response Teams providing more assistance, in particular financial resources, to the cities to address this problem?

A. There are limits to what the Crisis Response Teams can do. The key here is technical assistance -- making available additional technical expertise to help cities better target their existing efforts with current financial resources. This is not to be confused with the awarding of grant funds or the start of any new initiative.

Q. What is the eligibility criteria for a city to receive a crisis response team?

A. The jurisdiction must have a population greater than 500,000; the number of persons living with AIDS must be greater than 1,500 among African-American and Hispanics combined; these minority groups must account for at least 50 percent of the total community living HIV/AIDS cases; and the chief elected official must request the technical assistance.

Q. What cities were eligible to request a crisis response team?

A. A total of 16 cities are eligible to receive Crisis Response Team technical assistance. Those cities are Atlanta; Baltimore; Chicago; Detroit; Ft. Lauderdale; Houston; Jersey City, N.J.; Los Angeles; Miami; Newark, N.J.; New Haven/Bridgeport/ Danbury/Waterbury/Conn.; New York City; Philadelphia; San Juan, P.R.; Washington, D.C.; and West Palm Beach/Boca Raton, Fla.

Q. Which cities have requested a crisis response team?

A. A total of 11 of the eligible chief elected officials requested assistance: Atlanta; Baltimore; Chicago; Detroit; Los Angeles; Miami; New Haven/Bridgeport/Danbury/ Waterbury, Conn.; Newark, N.J.; Philadelphia; Washington, D.C.; and West Palm Beach/Boca Raton, Fla..

Q. What factors were used in the process to determine an order in which cities would be scheduled?

A. Several factors were considered in selecting the first three cities for the crisis team intervention. These included: AIDS case number and case rates among African American and Hispanic populations in each city; measures reflective of the substance abuse epidemic in each city, including emergency room admissions for cocaine and for heroin use, and treatment statistics for cocaine and heroin addiction; indicators for high-risk sexual behavior including the rate and number of gonorrhea cases in each city; and the availability of an on-site ethnographic research capability to assist the crisis teams collect critical background data. The first cities selected had high rankings for these indicators and have a solid research capability to support the assessment process.

Q. Why these 11 cities and what about the ones left out that did not meet the criteria?

A. Certainly the HIV/AIDS problem impacts many communities large and small. We set criteria that we thought would help us identify the most serious problems in some of the largest areas first. It's possible that at a later date we could extend similar types of assistance to other communities. It's important to first get a handle on this initial wave of cities -- the initial three and the other nine we've identified -- before going further. We can learn something from our work with these first ones that can be applied in assisting other communities down the road. Sixteen cities were eligible, but Houston, Ft. Lauderdale, Jersey City, N.J., New York City and San Juan have not yet requested this intervention.

Q. Why is HHS doing this when these areas already have HIV Prevention Community Planning Groups and Ryan White Planning Councils? Does that mean these two planning bodies are not working?

A. No. The Crisis Response Teams are intended to build on and bring in new information that will be helpful to both the Title I HIV Planning Councils and the HIV Prevention Community Planning groups. The Crisis Response Teams represent an intensive, targeted effort within minority populations to gain additional qualitative and quantitative data through new rapid assessment methods that will enhance current community approaches to addressing this issue. This information goes beyond traditional needs assessments which must rely heavily on available statistical data on reported AIDS cases (that typically lags behind important information for more recently infected or undiagnosed individuals), and what services are actually used by persons seeking care.

Q. How will the Community Advisory Committee interact with the Ryan White Planning Councils and HIV Prevention Community Planning Groups?

A. We are recommending that the chief elected official include representatives from both the Title I HIV Planning Councils and HIV Prevention Community Planning Groups on the Community Advisory Committee, as it is vital to include the expertise of these groups when thinking through prevention and care issues in their jurisdiction. Furthermore, a report of the work of the Community Advisory Committee will be submitted to the offices of the chief elected official and health department, and would be available through those channels.

Q. Why are you responding to AIDS in minority communities?

A. This Administration has been committed from its earliest days to a strong, effective response to the HIV/AIDS epidemic. Our efforts have realized reductions in the number of AIDS deaths and newly reported AIDS cases across all racial and ethnic groups in recent years, but minority populations remain disproportionately affected by HIV/AIDS and morbidity and mortality rates are not dropping as rapidly for these individuals. This requires a new, intensified focus to identify and implement targeted strategies to ensure that our racial and ethnic minority populations benefit from the prevention and excellent treatment options now available.

Q. Why are some metropolitan areas, such as the Connecticut cities or the Boca Raton/West Palm Beach cluster, combined? It seems like a lot of geographical distance between the various components of those two clusters.

A. HHS uses the standard Metropolitan Statistical Area (MSA) definitions and New England County Metropolitan Areas (NECMA) designations, which also have been used to guide HRSA Title I grants. OMB most recently updated its MSAs on June 30, 1998, using the 1990 census data.

Draft - for CBC Members media kit

Sample Letter to the Editor

Dear Editors:

This time last year, the Congressional Black Caucus opened a dialogue with the U.S. Department of Health and Human Services (HHS) to discuss the growing impact of HIV/AIDS among African Americans and other minority populations. The result was that the President and Congress obtained $156 million in additional resources to combat HIV/AIDS in those racial and ethnic minority communities hardest hit by this disease. We hope to continue those enhancements in the upcoming budget year.

In [name city] and other communities throughout the country, HIV/AIDS is rapidly becoming a disease of color. Among African Americans, AIDS is the leading killer of 25- to 44-year-old men and the second leading killer of women in the same age group.

Our city has been selected to receive the services of a special HHS technical assistance Crisis Response Team from Washington, D.C. This team of experts in HIV/AIDS research, prevention and treatment, and in substance abuse programs will be joining forces over the next few weeks with our own public health officials and community-based organizations to analyze the growing HIV/AIDS problem among minorities here in [city name]. This should allow us to hammer out new solutions and targeted strategies that make the best use of available resources. The end result of this will be a thorough written report that can be used as a guidepost to respond aggressively to the AIDS epidemic locally and to reduce the extra burden this disease is placing on our minority citizens.

We are fortunate to benefit from this free expertise. Many communities would welcome this intensive, yet comprehensive technical assistance when it comes to addressing critical health crises like this one.

As a member of the Congressional Black Caucus and as a representative of the citizens of this community, I am especially proud to have been a part of making this happen for [city name]. But getting this kind of help is one thing, and making it work is a different challenge entirely. To make the visit of the Crisis Response Team a successful endeavor for our community -- and especially for those African-American and other minority families whose lives are being touched by HIV/AIDS -- all of us must pull together to advance this effort.

I encourage every official group or individual who is asked to participate to cooperate with and contribute to the Crisis Response Team as best they can, not for our own individual portfolios, but for the health and well-being of our entire community.

Sincerely,

CBC Member Signature

Program	Type of Funding: Continued	Competitive	Other	Entities Funded: Federal to Organ.	State to CBO+	Other
Centers for Disease Control and Prevention						
HIV Prevention Among Gay Men of Color		$ 7.0 mil		CBOs/NRLMOs		
Directly Funded Minority CBOs		$ 10.0 mil		CBOs		
TA to Directly Funded CBOs		$ 2.5 mil		CBOs/Nationals		
Minority CBOs Providing Prevention	**$ 4.0 mil***				to CBOs	
Faith Based Initiatives		$ 1.5 mil		HBCU/Div. schools		
Community Dev't Grants for HIV/STD/TB/SA		$ 8.0 mil		CBOs		
Prison Pilot Programs			$ 7.5 mil			selected states
HIV Prevention Community Planning	**$ 15.0 mil***				CBO/health d.	
Prevention Education/Early Identification		$ 5.0 mil		CBOs/health d.'s		
Reducing Transmission Among Minorities	$ 400,000			national org.		
Prevention Among HIV+ Persons	**$ 3.9 mil***				primary care org.	
Prevention of HIV Through STD Tx.	$ 1.7 mil				CBOs/health d.	
Prevention Among Gay Men	$ 800,000			Univ. research		
Research/Intervention Models HIV+ Minorities	$ 1.0 mil				health d.'s	
Office of Minority Health						
Minority Community Coalition Grants (cont.)	$ 748,225			CBOs		
Minority Community Coalition Grants (new)		$ 500,000		CBOs		
Bilingual/Bicultural Services Demonstrations	$ 500,000			CBOs		
Addressing HIV/AIDS in Minorities	$ 100,000			NMAC		
OMH Resource Center	$ 341,000			Contract		
Substance Abuse and Mental Health Services Administration						
Capacity Expansion S.A.Tx and HIV Services		$ 16.0 mil		CBOs, health d.		
Community-based S.A./HIV Outreach Grants		$ 7.5 mil		CBOs, health d.		
Expand SA Treatment Capacity		$ 2.5 mil			State/local/tribes	
Capacity Expansion S.A./HIV Prevention		$ 13.25 mil		CBOs/h.d.'s/univ.		
National Institutes of Health						
Prevention Sciences Initiatives			$ 4.0 mil	Research instit.		
Peer/Provider Education			$ 1.5 mil	CBOs/academic		
Outreach Activities to Nat'l Minority Org.			$ 3.0 mil	Nat'l organ.		
Project ACCESS			$ 1.2 mil	Primary care clinics		

Program	Type of Funding			Entities Funded		
	Continued	Competitive	Other	Federal to Organ.	State to CBO	Other
Health Resources and Services Administration						
Ryan White Title I Formula Grants			**$ 5.0 mil***			to cities/EMAs
Ryan White Title III Planning Grants		$ 3.0 mil		CBOs/CHCs		
Ryan White Title IV Grants		$12.2 mil				Current grantees
AIDS Education & Training Centers		$ 2.0 mil		Contract w/ HBCUs		
Targeted Provider Education		$ 2.8 mil		CBO/nat'l org.		
Peer Education Training Institute			$ 2.0 mil	University		
Training Program to Help CBOs			$ 1.1 mil	NMAC		
Innovative Services Through Health Centers		$ 1.0 mil				Current grantees
Healthy Start		$ 950,000				Current grantees
Special Projects (SPNS)	$ 135,000			University		
TOTALS	**$28,624,225**	**$95,700,000**	**$25,300,000**	**$94,874,225**	**$28,100,000**	**$26,650,000**

This table does not yet include the TA/Capacity Building Grants ($5 million) and the Community Leadership Development Initiative ($2.5 million).

+ State Health Departments or Directly Funded Local Health Departments

* These funds were released by DHHS to grantees

CDC — Minority CBOs providing prevention – Continuation of FY 98 funding
HIV Prevention Community Planning – State cooperative agreements for HIV prevention released every January, of which $15 mil is expected to be redirected at the State level over FY 99
Prevention Among HIV+ Persons – Continuation of FY 98 funding

HRSA — Ryan White Title I – Formula-driven supplemental awards (January 1999)

Community Coalition Development Projects for African American Communities

The Centers for Disease Control and Prevention (CDC) announces the availability of limited funds to support African American community[1] coalitions to plan and develop linked networks of HIV, STD, TB, and substance abuse services within their communities. The purpose of this program is to improve the health status of African American community members by increasing access to health care through linked networks of health services.

Eligible Applicants are non-profit organizations that lead the development of community coalitions to design plans for linked networks of HIV, STD, TB, and substance abuse prevention services in specifically defined African American communities. The applicant lead organization that must meet the following criteria:

1. Have an Internal Revenue Service-determined 501(c)(3) tax-exempt status.
2. Have or develop a board, governing body, or advisory group composed of greater than 50% African Americans.
3. 50% of key staff positions, including management, supervisory, administrative, and service positions, filled by African American persons.
4. Have an established record of providing services to the targeted African American community.

[1]For the purposes of this announcement, the term "community" refers to a specific area within which the lead organization and the coalition's partners will focus their efforts. This area must be defined as one or more contiguous neighborhoods, school districts, zip codes, or census tracts.

5 a. Are located **and** provide services for African Americans in any of the following 20 high AIDS prevalence metropolitan statistical areas with more than 1000 African Americans estimated to be living with AIDS at the end of 1997:

Atlanta, GA; Baltimore, MD; Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH; Chicago, IL; Dallas, TX; Detroit, MI; Fort Lauderdale, FL; Houston, TX; Jacksonville, FL; Los Angeles-Long Beach, CA; Miami, FL; Newark, NJ; New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT; New Orleans, LA; New York City, NY; Oakland, CA; Philadelphia, PA-NJ; San Francisco, CA; Washington, DC-MD-VA-WV; and West Palm Beach-Boca Raton, FL.

or

5 b. Are located **or** provide services in any of the following counties or independent city that had the most syphilis cases in 1997.

The counties are: Cumberland, NC; Cuyahoga, OH; Davidson, TN; Forsyth, NC; Franklin, OH; Fresno, CA; Guilford, NC; Hinds, MS; Jefferson, AL; Jefferson, KY; Maricopa, AZ; Marion, IN; Milwaukee, WI; Oklahoma, OK; Shelby, TN; and Tuscaloosa, AL.
The independent city is St. Louis, MO.

Please note: For a full list of eligibility requirements, please see the published program announcement.

CDC Technical Assistance (TA)

CDC will provide pre-application technical assistance during two audio-conferences scheduled for the following dates:

May 27 (1:00 - 2:30 p.m. EDT)
June 1 (1:00 - 2:30 p.m. EDT)

How to Participate in the Audio Conferences

No registration is required. Because a limited number of telephone lines are available, we ask that you assemble interested listeners from your organization at a speaker phone if possible.

- Please dial-in 5–10 minutes before your conference.
- Non-federal participants: Call toll-free **800-713-1971.**
- Federal participants: Call 404-639-4100.
- Please have conference code (**407763**) and name of the audio-conference ("Coalition Development") ready.
- Place speaker phones and background music on mute.
- Join the audio-conference "silently" without speaking.

For further information about participating, please visit the web site at **http://www.cdc.gov/hiv** or, after May 17, call toll-free to 888-CDC-FAXX (when prompted, enter Document Number 260100 and a return fax number).

Internet Services

CDC will post application packages that include tool kits and a copy of the program announcement on the Division of HIV/AIDS Prevention (DHAP) Web site at: **http://www.cdc.gov/hiv/funding**

Other Assistance

The CDC National Prevention Information Network (NPIN) will provide updated information on these and other TA services by phone, fax, e-mail, and the Internet. CDC NPIN also will process requests for application packets and related materials for Program Announcement No. 99094. To contact the CDC NPIN:

Phone 1-800-458-5231

TTY Services 1-800-243-7012

Fax 1-888-282-7681

E-mail ..... application-ccd@cdcnpin.org

Internet ..... http://www.cdcnpin.org/program

DEPARTMENT OF
HEALTH & HUMAN SERVICES
Center for Disease Control and Prevention (CDC)
MS E-49
Atlanta GA 30333

Official Business
Penalty for Private Use $300

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CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

NCHSTP
National Center for
HIV, STD & TB
PREVENTION

Announces Additional Funds for Community Coalition Development Projects for African American Communities

Community-Based HIV Prevention Projects for African Americans

The goal of this program is to provide financial and technical assistance to Community-Based Organizations (CBOs) so they can provide HIV prevention services to African American populations for which gaps in services are demonstrated.

Eligible Applicants are CBOs, including faith-based community organizations, that meet the following criteria:

1. Have an Internal Revenue Service-determined 501(c)(3) tax-exempt status.

2. Have a board or governing body composed of greater than 50 percent African Americans.

3 a. Are located **and** provide services for African Americans in any of the following 20 high AIDS prevalence metropolitan statistical areas (MSAs) with more than 1000 African Americans estimated to be living with AIDS at the end of 1997:

Atlanta, GA; Baltimore, MD; Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH; Chicago, IL; Dallas, TX; Detroit, MI; Fort Lauderdale, FL; Houston, TX; Jacksonville, FL; Los Angeles-Long Beach, CA; Miami, FL; Newark, NJ; New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT; New Orleans, LA; New York City, NY; Oakland, CA; Philadelphia, PA-NJ; San Francisco, CA; Washington, DC-MD-VA-WV; and West Palm Beach-Boca Raton, FL.

OR

(see next panel)

3 b. Are located **or** provide services for African Americans in any of the following additional counties or independent city, that had the most reported syphilis cases in 1997.

The counties of Cumberland, NC; Cuyahoga, OH; Davidson, TN; Forsyth, NC; Franklin, OH; Fresno, CA; Guilford, NC; Hinds, MS; Jefferson, AL; Jefferson, KY; Maricopa, AZ; Marion, IN; Milwaukee, WI; Oklahoma,OK; Shelby, TN; and Tuscaloosa, AL. The independent city is St. Louis, MO.

For a full list of eligibility requirements, please see the published program announcement.

CDC Technical Assistance (TA)

Audio Conference Calls

CDC will provide pre-application technical assistance via regional audio-conference calls. For full instructions on how to participate, dial the CDC Fax system at 1-888-CDC-FAXX after April 26th (when prompted, enter Document Number 260001 and a return fax number).

May 5	1:00 -2:30 p.m. EST	NW Region
May 11	1:00 -2:30 p.m. EST	SW Region
May 17	1:00 -2:30 p.m. EST	SE Region
May 18	1:00 -2:30 p.m. EST	NE Region

Internet Services

CDC will post application packages that include tool kits on the Division of HIV/AIDS Prevention (DHAP) Web site at:
http://www.cdc.gov/hiv/funding

CDC will maintain a Listserv (HIV-PREV) related to this program announcement. By subscribing to the HIV-PREV Listserv, members can submit questions and will receive information via e-mail with the latest news regarding the program announcement. The Listserv is moderated, and answers to questions sent to the Listserv will be posted for all members to see. Frequently Asked Questions (FAQs) will be posted on the Web site.

You can subscribe to the Listserv at the Web site or via e-mail by sending a message to **listserv@listserv.cdc.gov** and writing the following in the body of the message:
subscribe hiv-prev first name last name

Other Assistance

The CDC National Prevention Information Network (NPIN) will provide updated information on these and other TA services by phone, fax, e-mail, and the Internet. CDC NPIN also will process requests for application packets and related materials. To contact the CDC NPIN:

Phone 1-800-458-5231

TTY Services 1-800-243-7012

Fax 1-888-282-7681

E-mail ..... application-cbo@cdcnpin.org

Internet ..... http://www.cdcnpin.org/program

Pre-Application Technical Assistance Workshops

A coalition of National and Regional Minority Organizations (NRMOs) will deliver pre-application technical assistance conferences for CBO applicants for Program Announcement No. 99092.

The conferences will be conducted on the following dates and in the locations listed below. For additional information, please contact the CDC NPIN at 1-800-458-5231.

April 29	Atlanta, GA
May 3	New Orleans, LA
May 4	Dallas, TX
May 5	Newark, NJ
May 5	Houston, TX
May 5	Oakland, CA
May 7	Raleigh/Durham, NC
May 7	Los Angeles , CA
May 12	Jacksonville, FL
May 14	Baltimore, MD
May 14	Ft. Lauderdale, FL
May 17	Philadelphia, PA
May 17	Phoenix, AZ
May 19	Boston, MA
May 19	Jackson, MS
May 19	St. Louis, MO
May 20	Chicago, IL
May 21	Detroit, MI
May 24	Louisville, KY
TBA	New York, NY

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Announces Additional Funds for African American Community-Based Organizations