

HIV Planning Guidance

**Division of HIV/AIDS Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention**



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I. EXECUTIVE SUMMARY

The Centers for Disease Control and Prevention (CDC) estimates more than 1.1 million adults and adolescents are living with the human immunodeficiency virus (HIV) in the United States and 18% of persons living with HIV are not aware of their status.¹ The epidemic continues to have a disproportionate impact on racial and ethnic minority populations – particularly African Americans and Hispanics – and on men who have sex with men (MSM) and injection drug users (IDUs), regardless of race or ethnicity.

On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the nation’s first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets. It is also a new attempt to set clear priorities and provide leadership for all public and private stakeholders to align their efforts toward a common purpose. The goals of NHAS are to:

- Reduce new HIV infections;
- Increase access to care and improve health outcomes for people living with HIV; and
- Reduce HIV-related health disparities.

To address the challenges of the epidemic and maximize the effectiveness of current HIV prevention methods, CDC’s Division of HIV/AIDS Prevention (DHAP) pursues a High-Impact Prevention (HIP) approach. This approach uses combinations of scientifically proven, cost-effective, and scalable interventions targeted to populations in geographic areas most affected by the epidemic, and promises to greatly increase the impact of HIV prevention efforts. CDC also acknowledges that strengthening our work in HIV testing, linkage, and care will be essential to achieving the goals of the National HIV/AIDS Strategy.

HIV planning is a critical process by which health departments (HDs) work in partnership with the community and key stakeholders to enhance access to HIV prevention, care, and treatment services for the highest-risk populations. CDC expects HIV planning to improve HIV prevention programs by strengthening the 1) scientific basis, 2) community relevance, 3) key stakeholder involvement, 4) population or risk-based focus of HIV prevention interventions in each jurisdiction, and 5) communication and coordination of services across the continuum of HIV prevention, care, and treatment, including social determinants of health associated with but not limited to HIV/AIDS and sexually transmitted diseases, infectious diseases, substance abuse, and mental health.

¹ Centers for Disease Control and Prevention. Monitoring Selected National HIV Prevention and Care Objectives by using HIV Surveillance Data – United States and 6 Dependent Areas – 2012. *HIV Surveillance Supplement Report* 2012;17 (No.3, part A). <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>. Published June 2012. Accessed June 22, 2012.

This guidance for HIV planning defines CDC’s expectations of health departments and HIV planning groups (HPGs) in implementing HIV prevention planning. The HPG is the official HIV planning body that follows the *HIV Planning Guidance* to inform the development or update of the health department’s Jurisdictional HIV Prevention Plan, which depicts how HIV infection will be reduced in the jurisdiction. HIV planning is a required and essential component of a comprehensive HIV prevention program, as outlined in Funding Opportunity Announcement (FOA) PS12-1201, *Comprehensive HIV Prevention Programs for Health Departments (2012–2016)*. CDC is committed to supporting HIV planning, including significant community involvement, scientific basis of program decisions, and targeting resources to have the greatest effect on HIV acquisition and transmission.

Throughout the engagement process and implementation of the Jurisdictional HIV Prevention Plan, HIV planning groups work together to ensure the alignment of activities with the goals of the NHAS² and the execution of HIP programs and activities in their communities. By continually monitoring and updating the engagement process and jurisdictional plan, HIV planning groups and HDs remain effective in their planning approach and in addressing their local ongoing challenges, while adhering to the NHAS.

The HIV Planning Process

In order to achieve the goals of the NHAS, the HIV planning process remains essential. The process involves the identification of the appropriate stakeholders to engage in a process that is results-oriented, in order to ensure that the goals of the NHAS are achieved and that a Jurisdictional HIV Prevention Plan is developed, implemented, and monitored.

The first step in the HIV planning process is centered on **stakeholder identification**. The objective aims to identify community members, key stakeholders, and other HIV service providers involved in HIV prevention, care, and treatment services to participate in a comprehensive engagement process.

After stakeholders are identified, HPGs can move on to the second step, which is centered on a **results-oriented engagement process**. The objective aims to promote collaborative, coordinated, and seamless access to HIV prevention, care, and treatment services, including mental health and substance abuse, to achieve the greatest impact on reducing incidence and HIV-related health disparities.

After completing the engagement process, HPGs can move on to the third step, which is centered on the **Jurisdictional HIV Plan development, implementation, and monitoring**. The objective aims to inform and monitor the development and implementation of the

² Mermin J. The Science and Practice of HIV Prevention in the United States. 18th Conference on Retroviruses and Opportunistic Infections. Boston, February 27-March 2, 2011. Paper #19.

Jurisdictional HIV Prevention Plan, ensure that the engagement process supports the jurisdictional plan, and ensure that the plan is progressing toward reducing HIV incidence and HIV-related health disparities in the jurisdiction. (See diagram on page 7.) A complete description of the HIV planning steps and objectives, including activities and principles, can be found on pages 15-19.

It is critical that both the HD and HPG understand their roles and responsibilities in the operation of the HPGs. The roles and responsibilities of HDs and HPGs should be defined in the bylaws/written protocols (see Section V). They should also be discussed in developing and implementing the engagement process and the Jurisdictional HIV Prevention Plan.

HIV Planning Process

Step 1: Stakeholder Identification

Objective 1:

By the end of each project year, the HD and HPG will identify and implement various strategies to recruit and retain HPG members, targeting participants in the HIV planning process that represent the diversity of HIV-infected populations, other key stakeholders in HIV prevention and care and related services, and organizations that can best inform and support the development and implementation of a Jurisdictional HIV Prevention Plan.

Activity:

Identify community members, key stakeholders, and other HIV service providers involved in HIV prevention, care, and treatment services to participate in a comprehensive engagement process.

Principles:

- Planning processes should align with, and support, the NHAS and HIP.
- The HIV planning group should reflect the local epidemic by involving representatives of populations with high prevalence of HIV infection and should include HIV service providers.
- HPGs and HDs will assess representation and participation of HPG members, HIV service providers, and key stakeholders involved in the planning process to ensure appropriate and optimal participation, as well as improve coordination/collaborations. HPGs are encouraged to include representatives from TB, viral hepatitis, and STD programs.

Step 2: Results-oriented Engagement Process

Objective 2:

By the end of the project year, the HPG will develop an engagement process and the HD will implement a collaborative engagement process that results in identifying specific strategies to ensure a coordinated and seamless approach to accessing HIV prevention, care, and treatment services for the highest-risk populations—particularly those disproportionately affected by HIV across states, jurisdictions, and tribal areas.

Activity:

Develop a collaborative and coordinated engagement process that results in greater access to HIV prevention, care, and treatment services for the most disproportionately affected populations and moves the jurisdiction towards a greater reduction in HIV incidence and HIV-related health disparities.

Principles:

- HDs and HPGs must work collaboratively to develop strategies that will increase access to HIV prevention, care, and treatment services.
- HPGs should identify, encourage, and facilitate the participation of key stakeholders and HIV service providers, particularly those not represented on the HPG, who can best inform and support the goals of the HIV planning process.
- HDs and HPGs must actively engage other planning groups and federally funded grantees in the HIV planning process.

Step 3: Jurisdictional Plan Development, Implementation and Monitoring

Objective 3:

By the end of the project year, HPGs and HDs will identify and employ various methods to elicit input on the development (or update) and implementation of the Jurisdictional HIV Prevention Plan from HPG members, other stakeholders, and providers.

Activity:

Inform and monitor the development (or update) and implementation of the Jurisdictional HIV Prevention Plan to ensure that the engagement process supports the Jurisdictional HIV Prevention Plan and to ensure that the plan is progressing towards reducing HIV incidence and HIV-related health disparities in the jurisdiction.

Principles:

- HDs and HPG members must engage other key stakeholders and providers (non-members of the HPG) who can best inform the development and implementation of the jurisdictional plan.
- HDs and HPGs should make every effort to engage all key stakeholders and providers since their participation in the planning and implementation processes is vital to reducing HIV incidence in the jurisdiction. Although it may not be possible for all key stakeholders and providers to be included in the HPG membership, documentation of the methods used to elicit input from these stakeholders or providers is required.
- HPG members should promote and support, as appropriate and feasible, the implementation of the Jurisdictional HIV Prevention Plan in conjunction with the HD.

II. BACKGROUND

More than over thirty years into the HIV epidemic, HIV infection remains a major public health issue in the United States. More than 50,000 new HIV infections occur annually in the country. More than 1.1 million adults and adolescents are living with HIV and 18% of persons living with HIV are not aware of their status.³ The epidemic continues to have a disproportionate impact on racial and ethnic minority populations – particularly African Americans and Hispanics – and on men who have sex with men (MSM) and injection drug users (IDUs), regardless of race or ethnicity. In 2010, an estimated 46% of all HIV diagnoses occurred among African Americans and 20% in Hispanics. The rates of HIV infection per 100,000 in 2010 were 62.0 among African Americans and 20.4 among Hispanics, compared to 7.3 among whites. The estimated rate of HIV infection per 100,000 among African American females (41.7) was 20 times the rate among white females (2.1); the rate among Hispanic females (9.2) was 4.4 times the rate among white females. Males accounted for 79% of all diagnoses of HIV infection among adults and adolescents. Sixty-one (61%) percent of diagnosed HIV infections among adults and adolescents was attributed to male to male sexual contact. Among adult/adolescent males in whom HIV transmission was by heterosexual contact, African Americans constituted 67% and Hispanic/Latinos 17%. Among adult/adolescent females in whom HIV transmission was by heterosexual contact, African Americans constituted 65% and Hispanic/Latinos 16%.⁴

The History of the HIV Prevention Community Planning Process

The first guidance for HIV prevention community planning was issued in December 1993, when CDC required health departments receiving federal HIV prevention resources to share the responsibility for developing a comprehensive HIV prevention plan with representatives of affected communities and technical experts. This *HIV Planning Guidance* (hereafter referred to as the *Guidance*) has been updated three times. This current *Guidance* replaces the most recent *HIV Prevention Community Planning Guidance and Orientation Guide (2004–2011)* and previous versions of the *Community Planning Guidance* and the *Pacific Island HIV/AIDS Community Action Network Guidance*.

For *Guidance* changes, please refer to Appendix B.

³ Centers for Disease Control and Prevention. Monitoring Selected National HIV Prevention and Care Objectives by using HIV Surveillance Data – United States and 6 Dependent Areas – 2012. *HIV Surveillance Supplement Report* 2012;17 (No.3, part A). <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>. Published June 2012. Accessed June 22, 2012.

⁴ Centers for Disease Control and Prevention. HIV Surveillance Report, 2010; vol 22. <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>.

Rationale for HIV Planning

Prior to December, 1993, communities were conducting HIV prevention activities, but most were not involved in planning comprehensive state and local prevention activities. Decisions on HIV prevention were usually made at a national level—either by Congress or directed by CDC through funding agreements with state, local, or territorial health departments. Beginning in January, 1994, CDC changed the manner in which federally funded state and local level HIV prevention programs were planned and implemented. State, local, and territorial health departments were asked to share the responsibility for developing a comprehensive HIV prevention plan with representatives of affected communities and other technical experts.

A successful HIV planning process should contribute to the reduction of new infections and HIV related health disparities in a jurisdiction. HIV planning is a required component of the Jurisdictional HIV Prevention Plan as outlined in FOA PS12-1201.

CDC is committed to supporting HIV planning, including significant community involvement, scientific basis of program decision, and targeting of resources to have the greatest effect on HIV acquisition and transmission.

High-Impact Prevention

To address the challenges of the epidemic in the United States, advance the prevention goals of the NHAS, and maximize the effectiveness of current HIV prevention methods, CDC's Division of HIV/AIDS Prevention pursues a High-Impact Prevention approach. This approach uses combinations of scientifically proven, cost-effective, and scalable interventions targeted to populations and geographic areas most affected by the epidemic, and promises to greatly increase the impact of HIV prevention efforts. HIP is also designed to maximize the impact of prevention efforts for all Americans at risk for HIV infection, including gay and bisexual men, communities of color, women, injection drug users, transgender women and men, and youth.

Relevance of HIV Planning

The nation's HIV prevention efforts are guided by a single, ambitious strategy for combating the HIV epidemic: the National HIV/AIDS Strategy. With an estimated 18 percent of people living with HIV in the United States unaware of their status, strengthening HIV planning will be a critical component in implementing the NHAS in local jurisdictions. The collaborative process by which HDs work in partnership with the community and key stakeholders should result in the development and implementation of the engagement process and the

Jurisdictional HIV Prevention Plan, the execution of HIP programs and activities, and the achievement of the goals of NHAS.⁵

Purpose of this *Guidance*

The purpose of this *Guidance* is to provide CDC grantees a blueprint for HIV planning and flexible direction to design and implement a participatory HIV planning process. It is structured to:

- 1) Support the implementation of High-Impact Prevention programs;
- 2) Ensure that HIV planning is efficient and focused on results-oriented processes;
- 3) Encourage collaboration and coordination across HIV prevention, care, and treatment services;
- 4) Reduce reporting documentation for HPGs (e.g., the Community Services Assessment is now listed as an activity for the health department in FOA, PS12-1201, and CDC no longer requires HPGs to prioritize populations and report on the 52 attributes);
- 5) Engage a broader group of stakeholders; and
- 6) Focus on streamlining communication and coordination among HDs, HPGs, and community stakeholders, to ensure the implementation of needed services (e.g., mental health, substance abuse, and coinfections of viral hepatitis, STDs, and TB) across the continuum of HIV prevention, care, and treatment services.

The new *Guidance* (2012–2016) describes the importance of collaboration between HDs, HPGs, CDC, community members, and other key HIV stakeholders. Some stakeholders may not be a part of the official HPG membership, but they are needed to develop and implement the Jurisdictional HIV Prevention Plan, the execution of HIP programs and activities, and the achievement of the goals of NHAS.

Intended Audience

This *Guidance* is intended to be used as a resource by HDs, HPGs, key stakeholders, and other partners currently engaged or planning to engage in the HIV planning process.

⁵ Mermin J. The Science and Practice of HIV Prevention in the United States. 18th Conference on Retroviruses and Opportunistic Infections. Boston, February 27-March 2, 2011. Paper #19.

III. INTRODUCTION TO HIV PLANNING

What is HIV Planning?

HIV planning is a process through which people from different walks of life, interests, responsibilities, and involvement in HIV come together as a group to inform and support the development and implementation of a Jurisdictional HIV Prevention Plan. The group's charge is to develop specific strategies to enhance coordinated, collaborative, and seamless access to HIV prevention, care, and treatment services (including mental health, substance abuse, and coinfections of viral hepatitis, STDs, and TB) for the highest-risk populations.

HIV planning is based on the belief that **local planning** is the best way to respond to local HIV prevention needs and priorities. HIV planning should improve HIV prevention programs by strengthening the 1) scientific basis, 2) community relevance, 3) key stakeholder involvement, 4) population or risk-based focus of HIV prevention interventions in each project area, and 5) communication and coordination of services across the continuum of HIV prevention, care, and treatment. Planning should include social determinants of health associated with HIV/AIDS and sexually transmitted diseases, infectious diseases, substance abuse, and mental health.

Fundamentals of HIV Planning

A basic tenet of HIV planning is parity, inclusion, and representation (PIR). Parity is the ability of HIV planning group members to equally participate and carry out planning tasks or duties in the planning process. To achieve parity, representatives should be provided with opportunities for orientation and skills-building to participate in the planning process and have an equal voice in voting and other decision-making activities. Inclusion is the meaningful involvement of members in the process with an active role in making decisions. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included. The planning process must ensure both the parity and inclusion of planning members.

Members should also be representative of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics such as varying educational backgrounds, professions, and expertise.

Other fundamental ideals of HIV planning are that 1) HIV planning is a participatory and collaborative process to ensure that key stakeholders, communities, and tribal, governmental, or non-governmental agencies engage in active and ongoing dialogue with the HD in the development and implementation of the Jurisdictional HIV Prevention Plan to reach the goals of NHAS; 2) the planning process must actively encourage and seek out key stakeholders and community participation; 3) nomination for membership should be solicited through an open

process, and candidate selection should be based on criteria established by the health department and the planning group; 4) comprehensive participation is critical to the success of the jurisdictional plan and HIV planning process; and 5) HPGs must adopt an HIP approach to HIV prevention activities in their communities, as well as utilize the most current epidemiologic surveillance and evidence-based data to guide the planning process.

Key Concepts in HIV Planning

HIV planning efforts should be guided by the five components of HIP:

- Effectiveness and cost;
- Feasibility of full-scale implementation;
- Coverage in the target population;
- Interaction and targeting of interventions; and
- Emphasis on interventions that will have the greatest overall potential to reduce HIV infections.

The planning process should ensure that other interagency services are considered and linked to HIV planning, as appropriate. Issues related to program collaboration and service integration (PCSI), health equity and social determinants of health, and sexual health should also be considered, as appropriate, during the planning process.

Additionally, it is critical that HPGs recognize the important role that antiretroviral treatment now plays in the nation's prevention efforts. HIV treatment providers must be included in the planning process. Groups should strive to engage a range of providers, including nontraditional providers, who cover the syndemics (STD, viral hepatitis, TB, substance abuse, mental health, homelessness, etc.) that co-occur with HIV and ensure that all HPG activities aim to reach the goals of the jurisdictional plan and NHAS. HPGs should proactively engage other planning bodies and other federal grantees during the planning process. The HD and HPG are expected to document and share successful or improved agency collaboration in support of NHAS. They should also identify and document barriers to engaging critical key stakeholders, communities, care agencies, and governmental or non-governmental partners.

All HPGs should consider health inequities that drive the epidemic and must ensure diversity of representation of the most affected communities in this process. They should also ensure that those partners who are engaged in addressing social and structural determinants of HIV are informing the Jurisdictional HIV Prevention Plan, participating in the engagement process, and assisting with expanding other opportunities to extend the effectiveness of local planning. The HD should share with the HPG information about identified gaps in services.

Some jurisdictions may already have an existing HIV Plan. If HDs decide to use their existing plan, such as one from Enhanced Comprehensive HIV Prevention Planning (ECHPP), the plan has to have been developed within 2 years and must address the goals and objectives of PS12-1201. HDs may use or update the existing plan in collaboration with the HPG. It is the responsibility of the HD and HPG to determine whether engagement activities have already occurred in accordance with the plan and how the HPG will participate in the ongoing engagement process.

HIV Planning Guidance

The *Guidance* provides a blueprint for planning and provides flexible direction to CDC grantees receiving federal HIV prevention funds to design and implement a participatory planning process.

The *Guidance* provides:

- A brief overview of the HIV planning process;
- A description of the HIV planning objectives, activities, principles, and monitoring questions that constitute new accountability requirements; and
- A description of the roles and responsibilities of HDs, HPGs, and CDC.

How is the new *Guidance* different from the previous *Guidance*?

First, the *Guidance* supports CDC's HIP approach in guiding HIV prevention programs, interventions, and research, which is embodied in FOA PS12-1201. This FOA focuses on supporting HIP programs and strategies to achieve the greatest impact with every federal HIV prevention dollar. The *Guidance* also establishes an engagement process with community members, key stakeholders, and service providers who can best inform and support the HIV prevention priorities of their jurisdictions.

Second, the *Guidance* defines CDC's expectations for HDs and HPGs in implementing HIV planning. For example, flexibility is offered regarding potential operational modes of planning, such as the number of HPG members, frequency of meetings, meeting participation, and various strategies for expanded stakeholder and community engagement.

How will the planning process be monitored?

Through these required activities:

- *Participation in the development/update of the jurisdictional plan;*
- *Responses to the monitoring questions (Section IV);*
- *Documentation of the engagement process listed in Section IV (this should include how the information gathered through this process informed the development/update of the jurisdictional plan);*
- *Analysis of the Membership and Stakeholder Profile (Appendix E); and*
- *Submission of the letter of concurrence, concurrence with reservations, or non-concurrence (Appendix C).*

Third, the *Guidance* provides new requirements for monitoring the planning process. This is a shared responsibility among CDC, HDs, and HPGs. The planning process will be monitored through 1) participation in the development or update of the Jurisdictional HIV Prevention Plan; 2) responses to the guidance monitoring questions; 3) documentation of the engagement process; 4) analysis of the HPG Membership and Stakeholder Profile; and 5) submission of the letter of concurrence, concurrence with reservation, or non-concurrence. The previous requirements of the Community Services Assessment (CSA) and the prioritization of populations were labor-intensive; therefore, some of the key components of the CSA are now included as an activity in the HD FOA. CDC no longer requires HPGs to prioritize populations and/or interventions and report on the 52 attributes. The *Guidance* now requires HPGs to ensure that the Jurisdictional HIV Prevention Plan identifies those populations with the greatest burden of disease and those at the greatest risk of HIV transmission and acquisition. Additionally, HPGs should ensure that prevention resources are allocated and disseminated to these populations and areas (please refer to the Jurisdictional HIV Prevention Plan section on p. 23).

Fourth, the *Guidance* includes new objectives for the HIV planning process that accurately reflect the specific processes and activities now required. The new objectives are written in a specific, measurable, achievable, realistic, and time-phased ([SMART](#)) format to assist HPGs in monitoring their progress towards the NHAS goals.

Fifth, the *Guidance* streamlines the HIV planning process to support expanded partnerships and a coordinated local response to the HIV/AIDS epidemic aiming to achieve the goals of NHAS. It includes an enhanced focus on improving communication, coordination, and implementation of services across the continuum of HIV prevention, care, and treatment services.

Sixth, the *Guidance* requires the proactive engagement with other relevant federal planning processes, especially from the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Housing Opportunities for Persons with AIDS (HOPWA) program under the U.S Department of Housing and Urban Development (HUD).

IV. IMPLEMENTING HIV PLANNING

The HIV planning process consists of three steps that contain specific objectives, activities, monitoring questions, and principles.

Objectives, Activities, Monitoring Questions, and Principles

As previously noted, the objectives have been revised to accurately reflect the specific processes and activities now required in the *Guidance*. The new objectives are written in a **SMART** format to assist HPGs in monitoring their progress toward the NHAS goals. These objectives are designed to guide HPGs in achieving the goals of reducing HIV incidence and HIV health-related disparities in the jurisdiction. The activities are a means to achieving the objectives. The monitoring questions are intended to assess the extent to which each HIV planning step is being met. The principles are basic guides to ensure that a results-oriented process is being followed.

Step 1: Stakeholder Identification

Objective 1

By the end of the project year, the HD and HPG will identify and implement various strategies to recruit and retain HPG members, targeting participants in the HIV planning process that represent the diversity of HIV-infected populations, other key stakeholders in HIV prevention and care and related services, and organizations that can best inform and support the development and implementation of a Jurisdictional HIV Prevention Plan.

Activity

Identify community members, key stakeholders, and other HIV service providers involved in HIV prevention, care, and treatment services to participate in a comprehensive engagement process.

Monitoring Question

To what extent did HIV service providers and other stakeholders who can best inform the coordination and collaboration of HIV prevention, care, and treatment services participate in the planning process?

Principles

- Planning processes should align with, and support, the NHAS and HIP.
- The HIV planning group should reflect the local epidemic by involving representatives of populations with high prevalence of HIV infection and should include HIV service providers (e.g., community-based organizations (CBOs), care providers from the public and private sectors, community health centers, mental health and substance abuse services, other governmental and non-governmental entities, nontraditional providers, medical education training centers, and community foundations and philanthropic entities).
- HPGs and HDs will assess representation and participation of HPG members, HIV service providers, and key stakeholders involved in the planning process to ensure appropriate and optimal participation, as well as improve coordination/collaborations. HIV planning stakeholders may include representatives from TB, viral hepatitis, and STD programs.

Step 2: Results-oriented Engagement Process

Objective 2

By the end of the project year, the HPG will develop an engagement process and the HD will implement a collaborative engagement process that results in identifying specific strategies to ensure a coordinated and seamless approach to accessing HIV prevention, care, and treatment services for the highest-risk populations—particularly those disproportionately affected by HIV across states, jurisdictions, and tribal areas.

Activity

Develop a collaborative and coordinated engagement process that results in greater access to HIV prevention, care, and treatment services for the most disproportionately affected populations and moves the jurisdiction towards a greater reduction in HIV incidence and HIV-related health disparities.

Monitoring Question

To what extent did the engagement process achieve a more coordinated, collaborative, and seamless approach to accessing HIV services for the highest-risk populations?

Principles

- HDs and HPGs must work collaboratively to develop strategies that will increase access to HIV prevention, care, and treatment services.
 - Strategies should include collaborations with community/primary health care centers, other medical communities, educational institutions, people living with HIV/AIDS (PLWHA), care planning groups, housing/residential services, businesses, faith communities, and other key stakeholders within the HPG’s planning area.
- HPGs should identify, encourage, and facilitate the participation of key stakeholders and HIV service providers, particularly those not represented on the HPG (due to limitations of group size, meeting schedules, etc.), who can best inform and support the goals of the HIV planning process.
 - It is important that HDs and HPGs activity seek out a range of providers that cover syndemics that co-occur with HIV and can facilitate acquisition and transmission of HIV (please see the Program Collaboration and Service Integration section in Appendix F).

- HDs and HPGs must actively engage other planning groups and federally funded grantees in the HIV planning process, such as those funded by HRSA, SAMHSA, and HUD.
- During the engagement process, there should be discussion of the 1) development of services where they do not currently exist but need is evident; 2) enhancement of services in content, format, or delivery so that consumers are more willing to use them; and 3) removal or mitigation of various structural barriers that currently impede access to existing services.

Step 3: Jurisdictional HIV Prevention Plan Development, Implementation, and Monitoring

Objective 3

By the end of the project year, HPGs and HDs will identify and employ various methods to elicit input on the development (or update) and implementation of the Jurisdictional HIV Prevention Plan from HPG members, other stakeholders, and providers.

Activity

Inform and monitor the development (or update) and implementation of the Jurisdictional HIV Prevention Plan to ensure that the engagement process supports the Jurisdictional HIV Prevention Plan and to ensure that the plan is progressing towards reducing HIV incidence and HIV-related health disparities in the jurisdiction.

Monitoring Questions

- To what extent was input from HPG members, other stakeholders, and providers used to inform and monitor the development (or update) and implementation of the Jurisdictional HIV Prevention Plan?
- To what extent were surveillance and service data/indicators utilized to inform and monitor the development (or update) and implementation of the Jurisdictional HIV Prevention Plan?

Principles

- HDs and HPG members must engage other key stakeholders and providers (non-members of the HPG) who can best inform the development and implementation of the jurisdictional plan.
- HDs and HPGs should make every effort to engage all key stakeholders and providers since their participation in the planning and implementation processes is vital to reducing HIV incidence in the jurisdiction. Although it may not be possible for all key stakeholders and providers to be included in the HPG membership, documentation of the methods used to elicit input from these non-voting stakeholders or providers is required (e.g., open comment period during HPG meetings and the engagement process).
- HPG members should promote and support, as appropriate and feasible, the implementation of the Jurisdictional HIV Prevention Plan in conjunction with the HD.

How to Conduct the Engagement Process

The engagement process involves the collaboration of key stakeholders and broad-based communities who collaboratively identify strategies for increased coordination of HIV programs throughout the state, local health jurisdictions, or tribal areas. The collaboration should result in a collective vision that assists the jurisdiction in achieving the goals of NHAS. The strategies should be flexible to ensure that the voices of the community and key stakeholders **who are not members** of the HPG be heard. It is important that these voices are considered in the engagement process and reflected in the Jurisdictional HIV Prevention Plan.

While there is no one correct way to conduct an engagement process, an effective and comprehensive engagement process should include the following elements:

- 1) Initiate open dialogue to understand and provide solutions to jurisdictional challenges. The solutions should result in implementing HIP programs that will affect the reduction of HIV incidence;
- 2) Identify engagement/collaboration barriers and opportunities;
- 3) Include representation from various entities, such as housing, prevention/service providers, and Ryan White Planning Councils, to ensure support and coordination of funding streams for various activities and programs;
- 4) Include other community and key stakeholders who are not participating in the HPG through forums, town hall meetings, webinars, etc.;
- 5) Consider health inequities as a priority to ensure that HIV prevention activities and resources are targeted to populations and communities most disproportionately affected by the HIV epidemic and other syndemic infectious diseases (viral hepatitis, STDs, and TB); and
- 6) Use national, state, and local surveillance and other types of data to inform the engagement process, and guide the delivery of culturally and linguistically appropriate prevention services.

Below are some steps to consider in assisting HPGs to develop a comprehensive engagement process. (Note: Engagement is specific to the jurisdiction. The suggestions below may not be applicable to low prevalence areas.)

- 1) Identify
 - Broad group of key stakeholders and other HIV service providers to include community members.
- 2) Develop and Document

- The engagement process and strategies to recruit and retain new or current partnering organizations.
- The strategies used to convene the HPG along with a broader scope of community and key stakeholders (e.g., face-to-face, webinar, conference calls, and open comment time at HPG meetings).
- The engagement process (to include a written process of collecting and reporting feedback to HPGs).
- Realistic expectations by considering policies, technical assistance (TA), human resources, and budget limitations of the jurisdiction.

3) Convene

- Meetings of the HPG members. This responsibility should be included in the bylaws/written protocols. Virtual meetings, when necessary, may include use of advanced technology (such as webinars, conference calls, or video conferencing) for community members or stakeholders unable to attend regularly scheduled in-person meetings. Advanced technology meetings may also be considered when engaging key stakeholders, HIV service providers, and community members that are non-voting HPG members. The convening of virtual meetings should be in compliance with state/local laws or ordinances and used when financially feasible for the jurisdiction.
- HPG orientations and training meetings. Orientations and trainings should be conducted with HPGs on a regular basis.

4) Gather Information

- To include the epidemiological profile, Jurisdictional HIV Prevention Plan, and additional information or HIV plans to strengthen HPG discussions and decisions.

5) Discuss Opportunities and Challenges

- Discussion items may include location, distance, and types of services offered in the highest-impact areas; access to testing, care and treatment, and partner services; the number of people who are newly diagnosed with HIV and linked to care; or policy issues.⁶

6) Monitor

- By monitoring the engagement process, HDs and HPGs ensure that the identified strategies promote a coordinated, collaborative, and seamless approach to increased access/linkage to prevention, care, and treatment

⁶ This is an example of areas that the HPG may want to consider for its engagement process.

services; improve health outcomes for PLWHA; and move the jurisdiction towards a decrease in new HIV infections.

7) Review and Update

- The strategies from the engagement process to increase coordination of HIV programs and services.
- The appropriate diversity of stakeholders and communities in developing and implementing the Jurisdictional HIV Prevention Plan. HPGs and HDs may also want to include annual benchmarks to improve collaboration among HIV stakeholders and services.
- The frequency of updates delivered to the HPG by the HD demonstrating the progress of the jurisdictional plan.

During the engagement process, HDs are responsible for pursuing engagement strategies with the support of the HPGs.

- The HD should document collaborations among partnering organizations through Memoranda of Agreement or Understanding (MOAs/MOUs) to ensure the roles and responsibilities of each organization are fully understood and implemented.
- The HD should discuss with the HPG and other partnering organizations the desired coordination and collaboration in the engagement process and the development of the Jurisdictional HIV Prevention Plan.
- The HD and HPG should monitor and document challenges and successes in engaging partnering organizations, such as key stakeholders and other HIV service providers, community members, and PLWHA.
- The HD should discuss with the HPG what data (e.g., CD4, viral load, and other surveillance data for HIV prevention) were utilized to determine the areas with the highest burden of disease within the jurisdiction.

Note: In year one of PS12-1201, the engagement process may come after the Jurisdictional HIV Prevention Plan is developed. This may be due to HDs being able to utilize plans developed within the previous 2 years that address the goals and objectives of PS12-1201 (e.g., the ECHPP or NHAS state plan). Health departments may use and/or update these existing plans. In this case, the HD and HPG will conduct an engagement process to provide any additional input into the Jurisdictional HIV Prevention Plan, as needed for year one submission to CDC. In subsequent years, the engagement process should take place before the HD updates the Jurisdictional HIV Prevention Plan.

Jurisdictional HIV Prevention Plan

The Jurisdictional HIV Prevention Plan is a product of the HD. The HPG should inform the development of the plan, ensuring collaboration and coordination of HIV prevention, care, and treatment services. The plan should align with the NHAS goals and include the appropriate HIV prevention services and resources directed and disseminated to the areas with the greatest HIV burden.

The development of the jurisdictional plan should be based on the epidemiological profile of the jurisdiction and other available data sources to identify populations and communities with the greatest burden of disease and populations at greatest risk for HIV acquisition or transmission. For jurisdictions with directly funded state and city health departments, the city jurisdictional plan should complement the state Jurisdictional HIV Prevention Plan.

The Jurisdictional HIV Prevention Plan should include the following:⁷

- 1) A description of existing resources for HIV prevention services, care, and treatment, including key features of the prevention services, interventions, and/or strategies being used or delivered in the jurisdiction;
- 2) Needs assessment (e.g., resources, infrastructure, and service delivery);
- 3) Gaps to be addressed and rationale for selection;
- 4) Prevention activities and strategies to be implemented within the jurisdiction;
- 5) Scalability of activities to achieve high-impact HIV prevention results and responsible agency/group to carry out the activities (e.g., Prevention Unit, Ryan White funded agencies, and Housing Opportunities for People With AIDS); and
- 6) Relevant timelines.

If a plan has already been developed within the previous 2 years that addresses the goals and objectives of this FOA (e.g., ECHPP or NHAS state plan), health departments may use and/or update the existing plan. The plan should include the actions listed above.

Note: The HPG will inform the development and/or update the health department's Jurisdictional HIV Prevention Plan. In addition, the HPG and HD will build an engagement process from the activities set forth in the Jurisdictional HIV Prevention Plan.

⁷ The information listed is an excerpt from FOA PS12-1201.

Submission of the Letter

The Jurisdictional HIV Prevention Plan is submitted by the HD to CDC. The plan should show that programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease.

HPGs are expected to inform and review the Jurisdictional HIV Prevention Plan and submit a letter to CDC signed by the HPG co-chairs on behalf of the HPG membership. The letter can be one of concurrence, concurrence with reservations, or non-concurrence and should be submitted with the Jurisdictional HIV Prevention Plan. The HPG should submit letters annually, as necessary, based on updates or changes to the Jurisdictional HIV Prevention Plan.

The following *must* be included in the respective HPG letters:

- Documentation that the HPG informed or did not inform the development of the Jurisdictional HIV Prevention Plan;
- Description of the process used to review the Jurisdictional HIV Prevention Plan;
- Whether the HPG concurs with the Jurisdictional HIV Prevention Plan;
- If an HPG concurs with reservations, the letter must provide in detail the reason(s) why the group is submitting a concurrence with reservations;
- If an HPG does not concur, the letter must provide in detail the reason(s) why the group is submitting a non-concurrence; and
- Signatures of the HPG co-chairs.
 - Other signatures may be added at the discretion of the HPG depending on the structure of the planning group (e.g., merged planning and care groups).

The HPG should concur, concur with reservations, or non-concur that the plan shows programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease.

The respective letter *should not*:

- Relate to internal health department issues, such as salaries of individual health department staff; or
- Advocate for one group, agency, or issue.

When CDC does not receive an HPG letter of concurrence, the project officer may initiate the following:

- Obtain more input or information from the HPG and HD regarding the situation;
- Meet with the HPG co-chairs and HD staff;
- Negotiate with the HD concerning any issues raised by the HPG;
- Recommend local mediation between the HPG and HD;
- Request that the HD provide a detailed corrective action plan to address areas of concerns expressed by the HPG and specify a timeframe for completion;
- Conduct an onsite, comprehensive program assessment to identify and propose action steps to the HD to resolve areas of concern;
- Conduct an onsite HPG assessment focused on specific area(s) of concerns;
- Develop a detailed technical assistance plan for the jurisdiction to systematically address the concerns and request technical assistance from CDC's Division of HIV/AIDS Prevention capacity building assistance (CBA) program;
- Place conditions or restrictions on the HD funding awards; and/or
- Overrule any HPG objection(s) if the HD can provide fact-based evidence, specifically the collaborative input, development, and review of the jurisdictional plan by the HPG.

Note: A sample of the letter of concurrence can be found in Appendix C.

Ongoing Implementation, Monitoring, and Updating of Plan

Ongoing implementation, monitoring, and updating of the plan is based on the three objectives and monitoring questions for the HIV planning process. HPGs can assist HDs with implementation of the engagement strategies and, when needed, the Jurisdictional HIV Prevention Plan; however, HDs are ultimately responsible for implementation.

There are multiple levels of monitoring (HPG process, engagement process, and the Jurisdictional HIV Prevention Plan with regard to engagement strategies) that will affect ongoing implementation and updating of the plan. Monitoring is a shared responsibility among CDC, the HD, and the HPG. Monitoring activities for the HPG include the following:

- 1) Working with the HD on monitoring the results from the engagement activities and strategies to ensure that they are in alignment with the Jurisdictional HIV Prevention Plan and the goals set forth in NHAS;
- 2) Reviewing the engagement process and strategies to ensure that they meet the needs of the Jurisdictional HIV Prevention Plan;
- 3) Continually assessing key stakeholder involvement and ensuring that the Jurisdictional HIV Prevention Plan is updated when needed; and
- 4) In collaboration with the HD, reviewing and submitting all monitoring documentation required by this *Guidance* annually.

V. ROLES AND RESPONSIBILITIES OF HD, HPG AND CDC

It is critical that both the HD and HPG understand their roles and responsibilities in the operation of the HPG. The history of the HIV planning process has shown that the most serious conflicts arise when there is lack of clarity regarding the roles of the HPG and HD. It is necessary that extensive orientation should be provided by both the HPG and HD when new members are added to the HPG. Each entity plays a role in meeting the challenges of HIV planning—ensuring that key stakeholders’ and the community’s voices are heard and their input is considered and valued.

Health Departments

State, local, and territorial HDs play a critical role in directing HIV prevention efforts towards more high-impact outcomes leading to reduced HIV incidence. They are also critical in helping to ensure the success of HIV planning and being responsible for supporting the HIV planning process through logistical and technical support, staffing, provision of consultants or contractors, and leadership development. Specific duties of the HD include supporting 1) meeting logistics; 2) HPG member involvement with reasonable incentives (transportation, expense reimbursement, etc.) especially for persons with, or at risk for, HIV infection; and 3) infrastructure for the HIV planning process.

CDC encourages HDs and HPGs to utilize various forms of technology (e.g., conference calls, webinars, and video conferencing) to reduce the cost of face-to-face meetings and to ensure broad-based community and key stakeholder representation in the HPG process.

HD Roles and Responsibilities

- Create and maintain one HPG per jurisdiction that meets the objectives, activities, and principles of the *HIV Planning Guidance*. If there is more than one HPG in the jurisdiction, the HD is responsible for deciding the best way to integrate state, regional, and local HIV planning group activities. In states where local jurisdictions are directly funded, the directly funded jurisdictions are responsible for submitting a Jurisdictional HIV Prevention Plan. For states with regional planning groups, planning efforts should be combined, and only one Jurisdictional HIV Prevention Plan and letter of concurrence, concurrence with reservations, or non- concurrence should be submitted to CDC each year.
 - If there are multiple funded jurisdictions within a state (e.g., Los Angeles and San Francisco in California), the state and locally funded jurisdiction HPGs are expected to have access to each other’s jurisdictional plan and engagement process. This agreement will need to be reflected within the Letter of Agreement (LOA) that is included in the FOA application.

- Appoint the HD co-chair.
- Implement the engagement process and the Jurisdictional HIV Prevention Plan with some assistance from the HPG.
- Develop the Jurisdictional HIV Prevention Plan with input from the HPG and the engagement process.
- Keep the HPG informed of other planning processes in the jurisdiction related to HIV care, treatment, and mental health and substance abuse services (such as Ryan White Planning Councils and SAMHSA planning activities) to ensure collaboration between the HPG and the other entities.
- Provide the HPG with information on federal, state, and local public health services (STD, TB, hepatitis, mental health, etc.) for high-risk populations identified in the Jurisdiction's HIV Prevention Plan.
- Ensure that HPGs have access to current HIV prevention information and analyses of data which may have potential implications for HIV prevention in the jurisdiction.
 - Sources of information include program activities, surveillance data, local program experience, programmatic research, the best available science (including cost-effectiveness data), and other relevant information, especially as it relates to at-risk populations.
- Provide the HPG with information on the application and its relationship to accomplishing the goals set forth by the Division of HIV/AIDS Prevention and NHAS.
- Allocate, administer, and coordinate other HIV public funds (federal, state, and local) to maximize the impact of interventions to prevent HIV transmission and reduce HIV-associated morbidity and mortality.
- Provide regular updates to the HPG on successes and barriers encountered in implementing the engagement process and HIV prevention services described in the Jurisdictional HIV Prevention Plan.
- Determine the amount of planning funds necessary to support HIV planning, including meetings and other means for obtaining key stakeholder or community input, facilitation of member involvement, capacity development, technical assistance from outside experts, and representation of the HPG at necessary jurisdictional or national planning meetings. HDs should discuss planning funds with their CDC project officer.
- Develop an application to CDC for federal HIV prevention cooperative agreement funds.
- Document the engagement with other relevant federal planning processes, especially HRSA, SAMHSA and HUD.

HPGs

HPGs are responsible for developing an engagement process for the jurisdiction. HPGs also inform the development or update the HD's Jurisdictional HIV Prevention Plan. The HD is ultimately responsible for implementing the Jurisdictional HIV Prevention Plan.

Note: HPGs do not allocate fiscal resources. That is the role of the HD. The HD and HPG may collaboratively determine whether the HPG will assume additional responsibilities not related to the *Guidance*.

The Primary Goal and Task of the HIV Planning Group

Goal: To inform the development or update of the HD's Jurisdictional HIV Prevention Plan that will contribute to the reduction of new HIV infections in the jurisdiction.

Task: To partner with the health department to address how the jurisdiction can collaborate to accomplish the activities set forth in the health department FOA PS12-1201.

HPG Roles and Responsibilities

- Elect the community co-chair who will work with the designated HD co-chair.
- Ensure membership structure achieves community and key stakeholder representation (parity and inclusion).
- Ensure information is presented in a clear and comprehensive manner.
- Inform the development or update the Jurisdictional HIV Prevention Plan(s).
- Submit a letter of concurrence, concurrence with reservations, or non-concurrence.

HPG and HD Shared Responsibilities

In the spirit of working collaboratively in HIV planning, some responsibilities are shared between HPGs and HDs.

HPG and HD Shared Roles and Responsibilities

- Develop procedures and policies that address membership, roles, and decision making, specifically HPG composition, roles and responsibilities, conflict of interest, and conflict resolution.
 - The group processes (bylaws or written protocols) may already be established, but it is strongly recommended that each group revisit and update them yearly.

- Develop and apply criteria for selecting HPG members, placing special emphasis on identifying representatives of at-risk, affected, HIV-positive, and socioeconomically marginalized populations. PIR remains a critically important tenet of HIV planning.
- Provide a thorough orientation for all new HPG members.
- Determine the most effective strategies for input into the Jurisdictional HIV Prevention Plan and engagement process.
- Monitor or assess the HIV planning group process to ensure that it meets the objectives of the *Guidance*. (HPGs may want to consider documenting how they will collect feedback from members and the process for responding to the feedback.)
- Ensure that HIV prevention efforts are guided by High-Impact Prevention activities.
- Review and update the HPG’s progress yearly—addressing challenges and conclusions from the engagement process and describing any recommended changes to the process. HPGs can submit an addendum (e.g., a few pages) to the interim progress report (IPR) that addresses the topics listed below, as well as any other relevant topics:
 - Brief description of the process used to develop, implement, or assess the progress of the engagement process;
 - Changes in the epidemic (e.g., emergence of new risk populations or geographic distribution);
 - Changes in the jurisdictional plan;
 - Membership, organizational, and community updates;
 - Policy and environmental changes (e.g., budget limitations or new program priorities); and
 - Any changes to the HPG’s bylaws and written protocols.

HPG Members

HPG members have a responsibility to ensure that HIV planning is truly a participatory process. HPG members are expected to participate in scheduled meetings and devote additional time, if needed, to HPG-related activities (e.g., other planning body meetings, CDC webinars/conference calls, and trainings). The tenure of an HPG member should be determined by the HPG and noted in its bylaws/written protocols.

HPG Member Roles and Responsibilities

- Make a commitment to the HIV planning process and its results.
- Understand and follow the bylaws and written protocols.
- Participate in all decision-making and problem-solving activities.
- Serve on committees or work groups, when appropriate, and complete assigned tasks.
- Co-chair the process and lead committees or work groups, when appropriate.
- Have a working knowledge of the HPG guidance, FOA PS12-1201, and the NHAS.
- Make a commitment to work with the HD to ensure that the HPG's engagement process and the jurisdictional plan align with the NHAS goals.
- Utilize the data/information presented to the HPG in the epidemiological profile and the jurisdiction's plan.
- Request additional information if the data presented does not clearly reflect the impact of the epidemic in the jurisdiction.
- Use information provided by the HD to collaboratively develop an engagement process.
- Participate as a partner with the HD to improve the impact of HIV prevention efforts within the local jurisdiction, while abstaining from serving as an advocate for an agency or any specific population.

HPG Co-chairs

HPG co-chairs provide leadership for the participatory process by leading the meetings, conducting HPG activities between meetings, and calling HPG special meetings as necessary. Generally, there is one community co-chair, elected by the HPG membership in accordance with the bylaws/written protocols, and one HD co-chair, appointed by the leadership of the HD. The term of the community co-chair is established in the bylaws/written protocols. The HD co-chair's term is open-ended.

HPG Co-chair Roles and Responsibilities

- Provide leadership to HPG members.
- Facilitate meetings, lead discussions, and ensure that a participatory process is followed.
- Develop meeting agendas with input from the HPG.
- Work closely with the HD staff to ensure that necessary data are provided on a timely basis to the HPG.
- Work with the HD staff to ensure that all HPG members understand the NHAS and assist the HD in achieving the NHAS goals.
- Lead the development of the engagement process and inform the development/update of the Jurisdictional HIV Prevention Plan.
- Promote implementation of the engagement process.
- Work with the HD to ensure that the HPG has adequate time to review the Jurisdictional HIV Prevention Plan before it is submitted to CDC.
- Draft the letter of concurrence, concurrence with reservations, or non-concurrence.
- Participate in discussions with CDC when the HPG does not provide a letter of concurrence or when the engagement process is not aligned with NHAS goals.

Prevention Planning Coordinator

If the HPG has a Prevention Planning Coordinator (PPC) who is not the HPG co-chair, the role of the coordinator is to assist the HD and HPG in implementing the planning process and ensuring that the jurisdictional plan contributes to the reduction of HIV infection in the jurisdiction. The PPC is not a voting member of the HPG. The PPC can be a HD employee or contractor.

Note: Not all HPGs will have a PPC, and it is not a requirement.

PPC Roles and Responsibilities

- Assist HD co-chairs in developing meeting agendas and overall work plans.
- Ensure that technical assistance is provided through various mechanisms to support recipients with the planning process (e.g., analyzing data, achieving PIR, managing conflict, and evaluating the planning process).
- Assist in coordinating efforts between HDs and HPGs.
- Assist with developing the HPG's timeline to ensure that the HPG completes its HIV planning activities and reviews the HD's jurisdictional plan in a timely manner.

- Assist in monitoring the HIV planning process.
- Assist with responses to HD or HPG inquiries to ensure consistent interpretation of the *Guidance*.
- Operate as the administrative assistant for the HPG, if appropriate (e.g., scheduling meetings, taking notes, developing presentations, printing materials, and assisting with travel logistics).

CDC

Just as the HD and the HPG have roles and responsibilities in the HIV planning process, CDC also has specific roles and responsibilities related to supporting and monitoring HIV planning.

CDC Roles and Responsibilities

- Provide leadership in the national design, implementation, and evaluation of HIV planning.
- Ensure that technical and program assistance is provided through various mechanisms to assist recipients with the process and activities of HIV planning.
- Provide leadership to ensure coordination among HDs, HPGs, and directly funded CBOs.
- Monitor the HIV planning process to assist HPGs in achieving their goals and objectives.
- Collaborate with HDs in evaluating HIV prevention programs.
- Keep HDs and HPGs informed about syndemics and emerging trends or changes in the HIV epidemic.
- Provide available jurisdictional and national data on HIV behavioral and case surveillance, prevention program trends, and guidelines to help inform the HIV planning process.
- Ensure that letters of concurrence are received annually.
- Address corrective actions when a jurisdiction is non-compliant with its HPG responsibilities.

Merged Planning Bodies

If HPGs and HDs decide to merge the HIV planning process with other planning bodies (e.g., care planning groups), grantees must adhere to the steps, objectives, activities, and principles of HIV planning as described in this *Guidance*. If HPGs and HDs determine that merging planning bodies is a desired direction, the HDs should contact their project officer prior to the

merger to assist with the timeline, funding questions, and peer-to-peer technical assistance (if necessary).

Group Process

All HPGs are expected to establish bylaws or protocols to avoid confusion or conflict. HPGs should develop or update how they will conduct their business, make decisions, handle conflict, and complete activities. These documents should be reviewed yearly and submitted to the project officer for review when developed or updated.

Note: Bylaws should contain reasonable term limits for HPG membership and appointment of co-chairs (and committees if needed).

VI. SUMMARY

CDC is committed to supporting HIV planning, including significant community involvement, scientific basis of program decisions, and targeting of resources to have the greatest effect on reducing HIV acquisition and transmission.

This *Guidance* recognizes the importance of HDs and HPGs collaboratively working together to align HIV programs and investments to undertake a more coordinated response to the epidemic, as dictated by the NHAS. The epidemic demands a renewed commitment and increased leadership in reaching the goals of the NHAS. Although the *Guidance* aims to streamline the planning process, it does not reduce the responsibility or accountability that is necessary to achieve the objectives of the Jurisdictional HIV Prevention Plan. HPGs **are expected** to undertake a **more** coordinated response among prevention, care, and treatment services. By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, HDs and HPGs have the ability to increase the impact of HIV prevention efforts in their jurisdictions and contribute to the overall reduction of new HIV infections in the United States.

VII. APPENDICES

- Appendix A The Prevention Planning Process “Snapshot”**
- Appendix B Summary of the Guidances: Then (2004–2011) and Now (2012–2017)**
- Appendix C Sample Letter of Concurrence**
- Appendix D Capacity Building**
- Appendix E Membership and Stakeholder Profile**
- Appendix F Additional Resources**
- Appendix G Glossary of Terms**
- Appendix H Acknowledgements**

APPENDIX A: The Prevention Planning Process “Snapshot”

- **Step 1 - Stakeholder Identification:** Identify community members, key stakeholders (e.g., mental health, substance abuse, TB, viral hepatitis, and STD programs), and other HIV service providers involved in HIV prevention, care, and treatment services to participate in the process.
 - a. **Bylaws or Written Protocol Review:** Ensure that infrastructure is in place—governance, membership, term limits, and conflict of interest.
- **Step 2 - Engagement Process:** Identify strategies for increasing coordination of **all** HIV programs (regardless of the funding stream) from the state, local jurisdictions, and tribal governments for the purpose of reducing the rates of new HIV infection. HPGs in collaboration with the health department are expected to engage key stakeholders and the community in the results-oriented engagement process. Steps for engagement should include 1) determining the steps or objectives of the HIV jurisdictional plan; 2) identifying key stakeholders and community members who can best inform or support the development (or updates and revisions) and implementation of the jurisdictional plan; 3) developing results-oriented engagement strategies for current and new partnering agencies; 4) monitoring and revising the engagement process to ensure that engagement activities are in alignment with the Jurisdictional HIV Prevention Plan; and 5) determining how to document the engagement process to include results-oriented activities.
 - a. **Epidemiological Profile and Other Data Sources Review:** Include health impact and social determinants, state and Jurisdictional HIV Prevention Plans, and any additional documents the health department may find important in developing an engagement process.
 - b. **Documentation of the Process:** Utilize conclusions from the engagement strategies for increased coordination of HIV programs throughout the jurisdiction, ensuring that the appropriate mix of stakeholders has been engaged, that resources have been directed by the epidemiological data, and that scalability for high-impact prevention efforts has been addressed.
- **Step 3 - Jurisdictional HIV Prevention Plan:** The HD, with input from the HPG, will develop or update the Jurisdictional HIV Prevention Plan and will provide an overview of the jurisdictional plan to the HPG. The Jurisdictional HIV Prevention Plan should include the collaboration and coordination of HIV prevention, care, and treatment.
 - a. **Ongoing Engagement and Implementation:** Assist the HD in implementation of the engagement strategies and, when needed, the Jurisdictional HIV Prevention Plan.

- b. **Letter of Concurrence, Concurrence with Reservations, or Non-concurrence (Monitoring tool):** Submit a letter, signed by representatives of the HPG, stating that the Jurisdictional HIV Prevention Plan sent forward by the health department demonstrates a collaborative and coordinated approach for HIV prevention, care, and treatment and ensures that prevention services and resources are directed to the areas with the greatest HIV disease burden.

- **Ongoing - Monitoring and Updating the Jurisdictional HIV Prevention Plan:** There are multiple levels of monitoring (HPG process, engagement process, and the Jurisdictional HIV Prevention Plan with regard to engagement strategies). Monitoring is a shared responsibility with the HD and the HPG. Monitoring activities include 1) working with the HD on monitoring the results from the engagement activities and strategies to ensure that they are in alignment with the Jurisdictional HIV Prevention Plan and the goals set forth in the NHAS; 2) reviewing the engagement process and strategies; 3) updating the engagement process and informing the HD on updates that may need to be incorporated into the Jurisdictional HIV Prevention Plan; and 4) in collaboration with the HD, reviewing and submitting all monitoring documentation required by the *Guidance* annually.

APPENDIX B: Summary of the Guidances: Then (2004-2011) and Now (2012-2017)

Issue	Then	Now
Primary or Key Influencing/Driving Factor	2003 Advancing HIV/AIDS Prevention (AHP)	2010 National HIV/AIDS Strategy
Additional Influencing Factors	<ul style="list-style-type: none"> • Evidence-Based Interventions (EBIs) • New Testing Technologies • Program Collaboration and Service Integration (PCSI) • Advancing HIV Prevention Initiative 	<ul style="list-style-type: none"> • High-Impact Prevention • Enhanced Comprehensive HIV Prevention Planning • Health Departments and CPGs’ Request for More Flexibility/Streamlined Approach to Community Planning • Increased Accountability • Enhanced Linkage to Care and Treatment • Integration of STD, Hepatitis, and TB • New Technologies/Use of Internet and Conference Calls for HPG Meetings
Title of the Guidance	<i>HIV Prevention Community Planning Guide</i>	<i>HIV Planning Guidance</i>
Goal of the Planning Group	To develop a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities and interventions for each target population.	To inform the development or update of the health department’s Jurisdictional HIV Prevention Plan that will contribute to the reduction of HIV infection in the jurisdiction.
Primary Task	To work with territorial, state, or local health departments to develop a comprehensive HIV prevention plan that is based on scientific evidence and community need.	To partner with the health department to address how the jurisdiction can collaborate to accomplish the results set forth in the health department FOA PS12-1201 and to reduce HIV incidence in the jurisdiction.
Planning Products	<p>The comprehensive prevention plan included:</p> <ul style="list-style-type: none"> • Epidemiological Profile • Community Services Assessment (CSA) <ul style="list-style-type: none"> ○ Needs assessment, resource inventory, and gap analysis • Prioritizing a set of target populations • Defining a set of prevention activities and interventions necessary to reduce HIV transmission in target populations. • Writing a letter of concurrence, of concurrence with reservations, or non-concurrence 	<p>HIV planning group products include:</p> <p>Note that the Community Services Assessment (which includes the needs assessment, resource inventory, and gap analysis) is listed under the Jurisdictional HIV Planning products in the Health Department FOA.</p> <ul style="list-style-type: none"> • Documentation of the engagement process • Documentation of how the HPG provided input in to the development/update of the Jurisdictional HIV Prevention Plan • Letter of concurrence, concurrence with reservations, or non-concurrence • Responses to the monitoring questions • Membership and Stakeholder Profile

<p>Steps, Goals and Objectives</p>	<p>The guidance had three goals and six objectives</p> <p>Goal 1: Community planning supports broad-based community participation in HIV prevention planning.</p> <p><i>Objective A: Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.</i></p> <p><i>Objective B: Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.</i></p> <p><i>Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.</i></p> <p>Goal 2: Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.</p> <p><i>Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.</i></p> <p><i>Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.</i></p> <p><i>Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.</i></p> <p>Goal 3: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.</p> <p><i>Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.</i></p>	<p>The current <i>Guidance</i> has three steps and three SMART objectives</p> <p>Step 1: Stakeholder identification</p> <p><i>Objective: By the end of the project year, the HD and HPG will identify and implement various strategies to recruit and retain HPG members, targeting participants in the HIV planning process that represent the diversity of HIV-infected populations, other key stakeholders in HIV prevention, care, and related services, and organizations that can best inform and support the development and implementation of a Jurisdictional HIV Prevention Plan.</i></p> <p>Step 2: Results-oriented engagement process</p> <p><i>Objective: By the end of the project year, the HPG will develop an engagement process and the HD will implement a collaborative engagement process that results in identifying specific strategies to ensure a coordinated and seamless approach to accessing HIV prevention, care, and treatment services for the highest-risk populations—particularly those disproportionately affected by HIV across states, jurisdictions, and tribal areas.</i></p> <p>Step 3: Jurisdictional HIV Prevention Plan development, implementation and monitoring.</p> <p><i>Objective: By the end of the project year, HPGs and HDs will identify and employ various methods to elicit input on the development (or update) and implementation of the Jurisdictional HIV Prevention Plan from HPG members, other stakeholders, and providers.</i></p>
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	Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.	
Attributes	The guidance listed 52 attributes that were linked to eight objectives. The attributes assisted CPGs in assessing their progress in meeting the goals. It is important to note that jurisdictions were not required to report individually on each attribute.	No attributes are listed in the current <i>Guidance</i> . In the current <i>Guidance</i> , the three objectives and four corresponding monitoring questions are designed to address accountability, along with other monitoring tools listed below. These objectives are designed to guide HPGs in achieving the goals of reducing HIV incidence and HIV health-related disparities in the jurisdiction. The monitoring questions are intended to assess the extent to which each HIV planning step is being met.
Monitoring & Evaluation and Indicators	<p>Monitoring tools:</p> <ol style="list-style-type: none"> 1. Membership Survey 2. Three goals, eight objectives, and 52 attributes 3. Describing priority populations 4. Describing a set of prevention interventions and activities 5. Assessing the linkages between the comprehensive HIV prevention plan and CDC funding application, as well as linkages between the plan and funded interventions. 6. Concurrence, concurrence with reservations, or non-concurrence letter 	<p>Monitoring tools:</p> <ol style="list-style-type: none"> 1. Stakeholder and Membership Profile. 2. Four monitoring questions: <ol style="list-style-type: none"> a. To what extent did HIV service providers and other stakeholders who can best inform the coordination and collaboration of HIV prevention, care, and treatment services participate in the planning process? b. To what extent did the engagement process achieve a more coordinated, collaborative, and seamless approach to accessing HIV services for the highest-risk populations? c. To what extent was input from HPG members, other stakeholders, and providers used to inform and monitor the development and implementation (or update) of the Jurisdictional HIV Prevention Plan? d. To what extent were surveillance and service data/indicators utilized to inform and monitor the development and implementation (or update) of the jurisdictional plan? 3. Documentation of the process 4. Letter of concurrence, concurrence with reservations, or non-concurrence 5. Documentation of ongoing engagement and implementation 6. Documentation of monitoring and updating the Jurisdictional HIV Prevention Plan

APPENDIX C: Sample Letter of Concurrence, Concurrence with Reservations, or Non-concurrence

Between HIV Planning Group and State or Local Health Department

CDC
Grants Management Officer
Grants Management Branch, Procurement and Grants Office
Funding Opportunity Announcement PS12-1201
Centers for Disease Control and Prevention, MS E-15
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146

Dear Mr(s) (Name):

The ABC State/Local HIV Planning Group (HPG) **concur**, **concur with reservations**, or **does not concur** with the following submission by the ABC State/Local Health Department in response to Funding Opportunity Announcement PS12-1201:

The HPG has reviewed the Jurisdictional HIV Prevention Plan that is to be submitted to the Centers for Disease Control and Prevention (CDC) and **concur**, **concur with reservations**, or **does not concur** that the Jurisdictional HIV Prevention Plan describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. [Insert here whether the HPG provided or did not provide input into the development of the Jurisdictional HIV Prevention Plan. Insert the process used by the HPG to provide input or review the jurisdiction's plan.]

[If applicable, insert how jurisdictions with directly funded states and cities plan to coordinate their HIV Planning process. City Jurisdictional HIV Prevention Plans should complement the state Jurisdictional HIV Prevention Plan to effectively depict and address the HIV epidemic within the jurisdiction.]

[The letter of concurrence, concurrence with reservations, or non-concurrence should be signed and submitted to CDC.]

Signature:
Health Department Co-Chair

Date:

Signature:
Community Co-Chair

Date:

APPENDIX D: Capacity Building

Capacity Building Assistance (CBA) resources are available to HDs and HIV planning groups in a broad range of areas to assist with improving the performance of the prevention planning process (or engagement planning process). CBA services include training; technical assistance; technology transfer; information dissemination; and peer-to-peer mentoring for health departments, HPGs, and other community stakeholders to increase their knowledge, skills, and involvement with HIV planning in their jurisdictions. The CBA delivery mechanisms include face-to-face, online, or webinar events.

CBA topics in organizational and programmatic areas for HPGs include but are not limited to:

- Understanding the National HIV/AIDS Strategy and the Division of HIV/AIDS Prevention's Strategic Plan.
- Understanding the *HIV Planning Guidance* and the engagement process.
- Understanding planning processes that incorporate program collaboration and service integration (PCSI).
- Understanding the importance of coordination, collaboration, and communication as they relate to HIV prevention, treatment, and linkage to care.
- Supporting strategic planning efforts to change existing structures, policies, and regulations that are barriers for optimal HIV prevention, care, and treatment.
- Analyzing epidemiological, behavioral, and other relevant data such as HIV-related syndemics and social determinants of health to support HIV prevention program implementation.
- Implementing parliamentary procedures, meeting processes, and group and meeting facilitation.
- Ensuring parity, inclusion, and representation (PIR) for high-risk, racial, and ethnic minority populations.
- Understanding public health delivery systems.
- Developing leadership regarding co-chair roles and responsibilities.
- Facilitating a formal process to broker peer-to-peer mentorship for, and in support of, health departments and HPGs to share lessons learned and best practices in HIV planning.

CBA resources are also available to support health departments in their implementation of required programmatic activities as described in the HD FOA PS12-1201.

APPENDIX E: Membership and Stakeholder Profile

This profile is to be completed annually by the HPG co-chairs (or appropriate designees). It is designed to assist CDC and health departments in assessing the implementation of HIV planning and will serve also as a useful tool for HPGs in improving prevention planning processes at the local level.

Membership Profile	
Name of the HPG/Jurisdiction:	_____
Type of HPG:	<input type="checkbox"/> Statewide <input type="checkbox"/> Directly funded city/local jurisdiction
Structure:	<input type="checkbox"/> HPG only <input type="checkbox"/> HPG & Ryan White planning group
	<input type="checkbox"/> HPG & other planning bodies (please describe) _____

Total # of Voting Members:	_____
Total # of Stakeholders that Are Non-voting Members:	_____

Epidemic in the Jurisdiction

Please provide a brief description of your jurisdiction's epidemic:

Agency Member Description

Please provide a list of all agencies that participate as members of the HPG:

Examples: Care/Ryan White planning groups, community-based organizations, care providers from the public and private sectors, community health centers, mental health and substance abuse services, and other appropriate governmental and non-governmental entities. Some agencies maybe listed here as well as under the Key Stakeholder section.

Agency Non-voting Member Description

Please provide a list of all agencies that participated in the engagement process that are not voting members of the HPG:

Are the community and key stakeholders in alignment with the highest burden of disease areas in the jurisdiction?

Please describe:

Key Stakeholders – Voting Members

Key Stakeholders	Social Services	PLWHA	Behavioral or Social Scientist	Epidemiologist	HIV Clinical Care Provider	Faith Community	Business/Labor	Community Health Care Centers
Total #								
Key Stakeholders	Substance Abuse	Health Department (HIV, STD, TB, & Hepatitis)	Intervention Specialist	Local Education Agencies/Academic Institutions	Mental Health	Homeless Services	Corrections	HOPWA
Total #								

*In comments section below, please provide a list of any other key stakeholders that are represented. For example: specific community representative, non-profit agency, injection drug user, health department HIV/AIDS, health department STD, pharmacist, HIV case manager, and research center.

Comments:

Key Stakeholders – Non-voting Members

Key Stakeholders	Social Services	PLWHA	Behavioral or Social Scientist	Epidemiologist	HIV Clinical Care Provider	Faith Community	Business/Labor	Community Health Care Centers
Total #								
Key Stakeholders	Substance Abuse	Health Department (HIV, STD, TB, & Hepatitis)	Intervention Specialist	Local Education Agencies/Academic Institutions	Mental Health	Homeless Services	Corrections	HOPWA
Total #								

*In comments section below, please provide a list of any other key stakeholders that are represented. For example: specific community representative, non-profit agency, injection drug user, health department HIV/AIDS, health department STD, pharmacist, HIV case manager, and research center.

Comments:

Geographic Distribution of HPG Members

Geographic Area	Urban	Metropolitan	Rural	Total # of HPG Members
Total #				

* The HD and HPG will have to decide on which definition they will use to describe their areas listed above; the geographic distribution of members should reflect the jurisdiction's epidemic.

Comments:

HIV Risk by Category of HPG Members

Category	MSM	MSM/IDU	IDU/Needle Sharing	Heterosexual	Non-specific or Unknown	Total # of HPG Members
Total #						

Comments:

HPG Membership Category by Race and Ethnicity

Category	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian/Other Pacific Islander	White	More than One Race	Unknown	Total # of HPG Members
Total #								

Comments:

HPG Membership Ethnicity

Category	Hispanic or Latino	Not Hispanic or Latino	Unknown	Total # of HPG Members
Total #				

Comments:

Age of HPG Members

Category	<13	14–19	20–29	30–39	40–49	50–59	60+	Total # of HPG Members
Total #								

Comments:

Gender of HPG Membership

Category	Male	Female	Transgender FTM	Transgender MTF	Unknown	Total # of HPG Members
Total #						

Comments:

Note: This form should be used to assess representation of community members, HIV service providers, and key stakeholders involved in the HIV prevention planning process to ensure appropriate participation; membership is also expected to reflect local epidemiology and needs of the jurisdiction.

APPENDIX F: Additional Resources

National HIV/AIDS Strategy and Fact Sheet

To learn more about the National HIV/AIDS Strategy, go to:

<http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf> (English)

<http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas-fact-sheet.pdf>

<http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas-es.pdf> (Español)

<http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas-fact-sheet-es.pdf>

Program Collaboration and Service Integration

Program Collaboration and Service Integration (PCSI) promotes improved, integrated HIV, Viral Hepatitis, STD, and TB prevention and treatment services at the client level through enhanced collaboration at the health department and jurisdictional levels, as well as at the organizational program level. PCSI offers opportunities to: (1) increase efficiency, reduce redundancy, and eliminate missed opportunities; (2) increase flexibility and ability to adapt to overlapping epidemics and risk behaviors; and (3) improve operations through the use of shared data and enable service providers to adapt to, and keep pace with, changes in disease epidemiology and new technologies.

Populations disproportionately affected by HIV are also affected by other infections, including TB, hepatitis C virus (HCV), hepatitis B virus (HBV), and STDs. Several factors have accelerated the momentum toward collaboration and integration of prevention services related to these diseases in the United States. One factor is a greater understanding of the extent to which these diseases are synergistically interacting epidemics or syndemics. The risk of acquiring any of these diseases is associated with similar behaviors and environmental conditions, and they have reciprocal or interdependent effects. For example:

- HIV, viral hepatitis, and STDs share common risks and modes of transmission;
- STDs increase the risk for HIV infection;
- HIV is the greatest risk factor for progression to TB disease;
- HIV accelerates liver disease associated with viral hepatitis, making hepatitis the leading cause of death among persons living with HIV/AIDS;
- TB is an AIDS-defining opportunistic condition; and
- Clinical course and outcomes are influenced by concurrent disease (HIV/TB can be deadly, and TB accelerates HIV disease progression).

Details of this strategy and approach are outlined in the NCHHSTP PCSI White Paper (http://www.cdc.gov/nchhstp/programintegration/docs/207181-C_NCHHSTP_PCSI%20WhitePaper-508c.pdf).

Division of HIV/AIDS Prevention Strategic Plan (2011–2015)

<http://www.cdc.gov/hiv/strategy/dhap/index.htm>

<http://www.cdc.gov/hiv/strategy/dhap/pdf/DHAP-strategic-plan.pdf>

High-Impact Prevention

http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf

Additional Resources

<http://www.cdc.gov/hiv/topics/basic/index.htm>

APPENDIX G: Glossary of Terms

Application: A health department's formal request to CDC for HIV prevention funding.

Behavioral data: Information collected from studies that examine human behavior relevant to disease risk. For instance, relevant behavioral data for HIV risk may include sexual activity, substance use, condom use, etc.

Capacity building: Process to increase the skills, infrastructure, and resources of individuals, organizations, and communities. Capacity building is a key strategy for the promotion, delivery, and sustainability of HIV prevention programs. As a result of capacity building on HIV prevention programs, the programs will (1) operate optimally and (2) increase their capacity to effectively deliver evidence-based interventions and core public health strategies for HIV prevention.

Capacity building assistance or CBA: Provision is made available through a variety of methods including training, technical assistance (TA), and technology transfer to individuals, organizations, and communities. CBA is provided directly to communities, prevention planning groups, community-based organizations, and health departments.

Centers for Disease Control and Prevention (CDC): The lead federal agency for protecting the health and safety of people, for providing credible information to enhance health decisions, and for promoting health through strong partnerships. Based in

Atlanta, Georgia, this agency of the U.S. Department of Health and Human Services serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

Collaboration: Working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other's capacity—often to achieve a common goal or purpose.

Community members: 1) consumers/ members of the priority population that are receiving services, or 2) people who are not affiliated with organizations but are infected or affected by HIV and have a passion to address HIV.

Comprehensive program, monitoring and evaluation (M&E), and quality assurance (QA) plan, referred to as the Comprehensive Program Plan: A document that details goals and SMART objectives for the proposed HIV program components and activities, the strategies to monitor and evaluate implementation and outcomes, and the set of activities carried out to define, design, assess, monitor, and improve the quality of HIV prevention services and activities.

Concurrence: Refers to the HPG's agreement that the HPG has reviewed the Jurisdictional HIV Prevention Plan that is to be submitted to CDC by the health department and *concur*s that the

Jurisdictional HIV Prevention Plan includes existing prevention programmatic resources to be allocated locally to the areas with the greatest HIV disease burden.

Conflict of interest: Conflict between the private interests and public obligations of a person in an official position.

Cooperative agreement: A financial assistance mechanism that may be used instead of a grant when the awarding office anticipates substantial federal programmatic involvement with the recipient.

Coordination: Aligning processes, services, or systems to achieve increased efficiencies, benefits, or improved outcomes. Examples of coordination may include sharing information—such as progress reports—with state and local health departments, or structuring prevention delivery systems to reduce duplication of effort.

Cost-effectiveness: The relative costs and effectiveness of proposed strategies and interventions, either demonstrated or probable.

Culturally appropriate: Conforming to a culture's acceptable expressions and standards of behavior and thoughts. Interventions and educational materials are more likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot testing them.

Diversity: Individual differences along the dimensions of race, ethnicity, gender, sexual

orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, health or disease status, or other ideologies. The concept of diversity encompasses acceptance, respect, and understanding that each individual is unique.

Engagement process: A process used to identify strategies for increasing coordination between HIV programs of the state, jurisdiction, and tribal communities for the purpose of applying a collective vision for the benefit of the overall jurisdiction. Steps for engagement should include determining the activities of the Jurisdictional HIV Prevention Plan and whom to engage, developing engagement and retention strategies for previous partners, developing engagement strategies for new partnering agencies, prioritizing engagement activities, creating an implementation plan, monitoring progress, and maintaining the partner relationships.

Epidemic: The rapid spread, growth, or occurrence of cases of an illness, health-related behavior, or other health-related events in a community or region in excess of normal expectation.

Epidemiological profile: A document that describes the HIV/AIDS epidemic within various populations and identifies characteristics of both HIV-infected and HIV-negative persons in defined geographic areas. It is composed of information gathered to describe the effect of HIV/AIDS on an area in terms of sociodemographic, geographic, behavioral, and clinical characteristics. The epidemiological profile

serves as the scientific basis of the identification and prioritization of HIV prevention and care needs in any given jurisdiction.

Epidemiology: The study of the causes, spread, control, and prevention of disease in human beings.

Funding opportunity announcement (FOA): A CDC announcement in the Federal Register describing the amount of funding available for a particular public health goal and soliciting applications for funding. The funding opportunity announcement describes required activities and asks the applicants to describe how they will carry out the required activities.

Health equity (U.S. Department of Health and Human Services [DHHS] definition): The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

High-Impact Prevention: By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to populations in geographic areas most affected by the epidemic, this approach promises to increase the impact of HIV prevention efforts—an essential step in achieving the goals of the National HIV/AIDS Strategy (NHAS). This approach is designed to maximize the impact of prevention efforts for the country and

specific jurisdictions by decreasing incidence and increasing health equity.

HIV planning group (HPG): The official HIV planning body that follows the HIV Planning Guidance to inform the development or update of the health department's jurisdictional HIV Prevention Plan that will contribute to the reduction of HIV infection in the jurisdiction.

Incidence: The number of new cases in a defined population within a certain time period, often a year, which can be used to measure disease frequency. It is important to understand the difference between HIV incidence, which refers to new cases, and new HIV diagnosis, which does not reflect when a person was infected.

Incidence rate: The incidence rate provides a measure of the effects of illness relative to the size of the population. The incidence rate is calculated by dividing incidence into the specified period by the population in which cases occurred. A multiplier is used to convert the resulting fraction to a number over a common denominator, often 100,000.

Inclusion: Meaningful involvement of members in the process with an active role in making decisions. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included.

Injection drug user (IDU): Someone who uses a needle to inject drugs into his or her body.

Intervention: A specific activity, or set of related activities, intended to change the knowledge, attitudes, beliefs, behaviors, or practices of individuals and populations to reduce their health risks. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation.

Jurisdiction: An area or region that is the responsibility of a particular governmental agency. This term usually refers to an area where a state or local health department monitors HIV prevention activities (e.g., Jonestown is within the jurisdiction of the Jones County Health Department).

Jurisdictional HIV Prevention Plan: The health department, in collaboration with the HPG, will develop a Jurisdictional HIV Prevention Plan to include the collaboration and coordination of HIV prevention, care, and treatment. The plan should include: a description of existing resources, HIV prevention services and care and treatment; needs (e.g. resources, infrastructure, and service delivery); gaps to be addressed and rationale for selection; prevention activities or strategies being implemented within the jurisdiction; scalability of activities; responsible agency or group to carry out the activity (e.g., Prevention Unit, Ryan White-funded agencies and HOPWA); and relevant timelines.

Met/Unmet need: A **met** need is a need within a specific target population for HIV prevention services that is currently being addressed through existing HIV prevention resources. These resources are available to,

appropriate for, and accessible to that population. For example, a project area with an organization for African American gay, bisexual, lesbian, and transgender individuals may meet the HIV/AIDS education needs of African American men who have sex with men through its outreach, public information, and group counseling efforts. An **unmet** need is a requirement for HIV prevention services within a specific target population that is not being addressed through existing HIV prevention services and activities—either because no services are available or because available services are either inappropriate for, or inaccessible to, the target population. For example, a project area lacking Spanish-language HIV counseling and testing services will not meet the needs of Latinos with limited English proficiency.

Non-concurrence: The HPG disagrees that the Jurisdictional HIV Prevention Plan includes existing prevention programmatic resources to be allocated locally to the areas with the greatest HIV disease burden.

Outcome evaluation: Evaluation employing rigorous methods to determine whether the prevention program has an effect on the predetermined set of goals. These measurements assess the effects of interventions on client outcomes such as knowledge, attitudes, beliefs, and behavior.

Outcome monitoring: Efforts to track the progress of clients or a program based upon outcome measures set forth in program goals. These measurements assess the effects of interventions on client outcomes

such as knowledge, attitudes, beliefs, and behavior. Monitoring allows the identification of changes that occurred, but the intervention may not have been responsible for the change. This would take a more rigorous approach (see Outcome evaluation).

Parity: The ability of HIV planning group members to equally participate and carry out planning tasks or duties in the planning process. To achieve parity, representatives should be provided with opportunities for orientation and skills-building to participate in the planning process and have an equal voice in voting and other decision-making activities.

PLWHA: A person or persons living with HIV or AIDS.

Prevalence: The total number of cases of a disease in a given population at a particular point in time. For HIV/AIDS surveillance, prevalence refers to living persons with HIV disease, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time.

Prevention activity: Activity that focuses on behavioral interventions, structural interventions, capacity building, or information gathering.

Prevalence rate: The number of people living with a disease or condition in a

defined population on a specified date, divided by that population. It is often expressed per 100,000 persons.

Prevention program: An organized effort to design and implement one or more interventions to achieve a set of predetermined goals; for example, to increase condom use with non-steady partners.

Prevention services: Interventions, strategies, programs, and structures designed to change behavior that may lead to HIV infection or other diseases. Examples of HIV prevention services include street outreach, educational sessions, condom distribution, and mentoring and counseling programs.

Qualitative data: Non-numeric data, including information from sources such as narrative behavior studies, focus group interviews, open-ended interviews, direct observations, ethnographic studies, and documents. Findings from these sources are usually described in terms of underlying meanings, common themes, and patterns of relationships. Qualitative data often complement and help explain quantitative data.

Quantitative data: Numeric information—such as numbers, rates, and percentages—representing counts or measurements suitable for statistical analysis.

Representation: The act of serving as an official member reflecting the perspective of

a specific community. A representative should reflect that community's values, norms, and behaviors and should have expertise in understanding and addressing the specific HIV prevention needs of the population. Representatives also must be able to participate in the group and objectively weigh the overall priority prevention needs of the jurisdiction.

Representative: A sample having the same distribution of characteristics as the population from which it is drawn. Therefore, the sample can be used to draw conclusions about the population.

Results-oriented: Developing strategies/activities that will move the group towards accomplishing the objectives set forth in guidance or FOA. A feedback loop or a review process of the strategies/activities should be completed to ensure the desired results were accomplished.

Risk factor or risk behavior: Behavior or other factor that places a person at risk for disease. For example, drug use is a factor that increases risk of acquiring HIV infection, and factors such as sharing injection drug use equipment, unprotected anal or vaginal sexual contact, and commercial unprotected sex increase the risk of acquiring and transmitting HIV.

Ryan White Treatment Modernization Act: The name given to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act when it was reauthorized in 2006. This is the primary

federal legislation that addresses the needs of persons in the United States living with HIV/AIDS and the needs of their families. The original CARE Act was enacted in 1990.

Scalable: Interventions or combinations of interventions that can reach a significant portion of those in need, in a cost-efficient manner, and demonstrate population-level impact.

Seroprevalence: The number of people in a population who test HIV-positive based on serology (blood serum) specimen. Seroprevalence is often presented as a percentage of the total number of specimens tested or as a rate per 1,000 persons tested.

Socioeconomic status (SES): A description of a person's societal status using factors or measurements such as income levels, relationship to the national poverty line, educational achievement, neighborhood of residence, or home ownership.

Stakeholder: A person or representative who has personal or professional experience, skills, resources, or expertise in HIV.

Surveillance: The ongoing and systematic collection, analysis, and interpretation of data about occurrences of a disease or health condition.

Syndemics: Two or more afflictions, interacting synergistically, contributing to excess burden of disease in a population (e.g. STD, viral hepatitis, and substance use). Related concepts include linked

epidemics, interacting epidemics, connected epidemics, co-occurring epidemics, co-morbidities, and clusters of health-related crises.

Target populations: Populations that are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior. Groups are often identified by using a combination of behavioral risk factors and demographic characteristics.

Technical assistance (TA): The delivery of expert programmatic, scientific, and technical support to organizations and communities in the design, implementation, and evaluation of HIV prevention interventions and programs. CDC funds a National Technical Assistance Providers' Network to assist HIV prevention planning groups in all phases of the planning process.

APPENDIX H: Acknowledgements

The Division of HIV/AIDS Prevention sincerely thanks the many individuals and organizations who contributed to the development of the *Guidance*.

Health Department and Community Planning Group input was provided through numerous meetings, conferences, and calls (2007–2011):

- U.S. Conference on AIDS
- HIV Prevention Planning Leadership Summit (workshop and listening sessions)
- PA 04012 Low Prevalence States Consultation – August 2008
- CPG External Work Group Feedback – February 2009
- Webinar 2009
- CPG External Work Group Feedback – November 2009
- Partner Engagement 2011-12