PS12-1201 Jurisdictional HIV Prevention Plan
Planning Period: 2012 – 2016

The jurisdictional HIV prevention plan should cover multiple years within the FOA project period (2012-2016). At a minimum, plans should cover a three-year period. Plans will also need to be updated annually or on an as-needed basis to reflect local needs.

I. Summary:

The Jurisdictional HIV Prevention Plan is a written statement of need developed through a local collaborative process with other HIV/AIDS prevention, care, and treatment providers and programs. The Jurisdictional HIV Prevention Plan must reflect a discussion of existing resources, needs, and gaps for HIV prevention services, to include key features on how prevention services, interventions, and/or strategies are currently being used or delivered in the jurisdiction. Important elements in assessing need include a determination of the populations at greatest risk for HIV, individuals who are unaware of their HIV positive status, a comprehensive understanding of prevention services in the jurisdiction, and a consideration of all available resources. The plan should include a brief overview of epidemiological data, existing quantitative and qualitative information, and emerging trends/issues affecting HIV prevention services in the jurisdiction.

There is no required, standard template for the jurisdictional plans. Each grantee's jurisdictional HIV prevention plan should be specific for that jurisdiction. At a minimum, it should clearly depict the local HIV epidemic, existing resources, services, interventions, and/or strategies for HIV prevention, needs, and gaps in HIV prevention services. Information related to HIV prevention, care, and treatment (HIV continuum of care) should be included within the jurisdictional plan.

II. Process for Developing the Jurisdictional HIV Prevention Plan:

All funded jurisdictions to include the fifty states, eight cities (Atlanta, Baltimore, Chicago, Houston, Los Angeles, New York, Philadelphia, and San Francisco), the District of Columbia, Puerto Rico, the Virgin Islands, and the United States Affiliated Pacific Island jurisdictions are required to have in place a planning process that includes the development of a Jurisdictional HIV Prevention Plan and the establishment of an HIV Planning Group (formerly HIV Community Planning Group). Community planning has evolved into HIV planning, which aims to contribute to HIV prevention through developing both targeted and broad-based collaboration among stakeholders. HIV planning will entail broadening the group of partners and stakeholders engaged in prevention planning, improving the

scientific basis of program decisions, and targeting resources to those communities at highest risk for HIV transmission and acquisition. *Please refer to the most recent HIV Planning Guidance (HPG) for more details about the HIV planning group process.*

Jurisdictions are required to develop a jurisdictional HIV prevention plan to include the collaboration and coordination of HIV prevention, care, and treatment. The jurisdictional HIV prevention plan should align with the goals of the National HIV/AIDS Strategy (NHAS). For jurisdictions with directly-funded state and city health departments, the city jurisdictional plan should complement the state jurisdictional plan and effectively depict and address the HIV epidemic within the jurisdiction. The state and directly-funded city will each need to submit a separate plan to CDC.

When developing the jurisdictional HIV prevention plan, grantees should:

- Include a brief overview of epidemiological data, existing quantitative and qualitative information, and emerging trends/issues affecting HIV prevention services in the jurisdiction.
- Utilize the epidemiologic profile, HIV surveillance, and other available data sources to identify those populations with the greatest burden of the epidemic and those populations at greatest risk for HIV transmission and acquisition.
- Ensure that existing prevention resources are allocated and disseminated locally to the areas with the greatest HIV burden, to include populations identified at greatest risk for HIV transmission and acquisition.

The jurisdictional HIV prevention plan should include:

1) A description of existing resources for HIV prevention services, care, and treatment and key features on how the prevention services, interventions, and/or strategies are currently being used or delivered in the jurisdiction. Please include information on the overall epidemic within the jurisdiction, to include any trends, emerging populations, priority areas, information and resources on HIV testing and linkage to care, treatment, and prevention services.
2) Need (e.g., resources, infrastructure, and service delivery).
3) Gaps to be addressed and rationale for selection. *Prioritize and address gaps that need to be met to increase impact on the HIV epidemic.*
4) Prevention activities and strategies to be implemented within the jurisdiction.
5) Scalability of activities *(see Attachment I in FOA for definition of scalable; please also refer to overview of high-impact prevention).*
6) Responsible agency/group to carry out the activity (i.e., Prevention Unit, Ryan White-funded agencies, and Housing Opportunities for People Living with AIDS (HOPWA)).
7) Relevant timelines.

If a plan that addresses the goals and objectives of this FOA (e.g., Enhanced Comprehensive HIV Prevention Plan (ECHPP), NHAS state plan) has already been developed within the previous two years,

grantees may use and/or update the existing plan. The plan should include the actions listed above. For examples of ECHPP plans developed by the ECHPP jurisdictions, please see website at http://www.cdc.gov/hiv/strategy/echpp/index.htm.

The jurisdictional HIV prevention plan should cover multiple years within the FOA project period (2012-2016). At a minimum, plans should cover a three-year period. Plans may need to be updated annually or on an as-needed basis to reflect local needs.

III. CDC Expectations:

In developing the Jurisdictional HIV Prevention Plan, jurisdictions are expected to:

1) Facilitate a collaborative HIV prevention planning process that contributes to the reduction of HIV infection in the jurisdiction. Through this collaborative process jurisdictions must:
   - Identify and obtain key stakeholder input to ensure broad-based community participation in the planning process. Foster a planning process that encourages parity, inclusion, and representation (alternatively referred to as PIR) among planning members. The health department and prevention planning group should work collaboratively to develop strategies that will increase coordination of HIV programs across state, local, and tribal governments; businesses; faith communities; community/primary health care centers; other medical providers; educational institutions; people living with HIV/AIDS (PLWHA); care planning groups; and other key stakeholders within the jurisdiction. *Please note that these examples are not meant to be an exhaustive list of partners.*

2) Ensure that the HIV Planning Group (HPG) participates in the development of the following activities:
   - **Engagement Process** - Strategies for increasing coordination across HIV programs (i.e., prevention, care, and treatment) across the state, jurisdiction, and tribal and local governments to reduce rates of new HIV infection. Steps for engagement should include: determining the goals of the plan and who 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.

   - **Letter of concurrence, concurrence with reservations, or non-concurrence** – Letter signed by representatives of the HIV Planning Group concurring that the jurisdictional HIV prevention plan sent forward by the health department allocates resources to the areas and populations with the greatest HIV disease burden. The letter should also include the process used by the HIV Planning Group to review the jurisdictional HIV prevention plan. The letter of concurrence,

concurrence with reservations, or non-concurrence should initially be submitted after funding with the jurisdictional HIV prevention plan and annually for the following (subsequent) years.

Please refer to the most recent HIV Planning Guidance (HPG) for more details about the HIV planning group process, engagement process, and letters of concurrence, concurrence with reservations, or non-concurrence.

IV. Special Considerations:

For those health departments that have already developed an ECHPP plan, State NHAS plan, HRSA plan, or any other HIV plan that encompasses the HIV prevention information required for the jurisdiction, they can choose to submit one of those plans to fulfill the requirement of the jurisdictional plan. However, please review and update those plans accordingly (to ensure all elements are included and the time period is relevant) prior to submitting to CDC.

For those states directly funded under ECHPP for their respective city (i.e., Georgia/Atlanta, Maryland/Baltimore, Puerto Rico/San Juan, Texas/Dallas), because the ECHPP plan is for that city, the state may expand upon and use the templates and process from ECHPP to develop a jurisdictional plan for the entire state.

Because each jurisdiction is unique, please identify priority populations and prevention activities and/or resources allocated to these populations within your plans.

V. Submission Procedures:

Jurisdictional plans are due to CDC **by September 28, 2012**. Please submit to PS12-1201@cdc.gov and your assigned project officer. Please ensure that the following items are included with the submission of the jurisdictional plan:

- Needs Assessment, if conducted separately
- Epidemiologic Profile, if not previously submitted with the application
- Letter of concurrence, concurrence with reservations, or non-concurrence from the HIV Planning Group (HPG)
- Documentation of the HPG engagement process. This can be included in the letter of concurrence or as a separate document.

There is no required, standard template for the jurisdictional plans. In addition to written narrative, jurisdictional plans can include graphs, charts, pictures, etc. to assist with providing a pictorial overview of HIV prevention within the jurisdiction. However, please ensure that the submitted plans include all the required elements outlined above.

VI. References and Resources:

HIV Planning Guidance (HPG)

PS12-1201: Comprehensive HIV Prevention Programs for Health Departments
http://www.cdc.gov/hiv/topics/funding/PS12-1201/

High-Impact HIV Prevention
http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf

National HIV/AIDS Strategy (NHAS)
http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas.pdf

Enhanced Comprehensive HIV Prevention Plan (ECHPP)
http://www.cdc.gov/hiv/strategy/echpp/index.htm

CDC Division of HIV/AIDS Prevention - HIV Surveillance Reports
http://www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm

PS12-1201 Comprehensive Program Plan
Reporting Period: January 1, 2012 – December 31, 2016

Description:
The Comprehensive Program Plan is a detailed *"program plan"* which includes program planning (goals, objectives, and activities), monitoring and evaluation (M&E), quality assurance (QA), and capacity building activities specific for PS12-1201. This plan also captures the jurisdiction's annual objectives and targets for the required and recommended components. This program plan is the "work-plan" for the FOA and includes all applicable categories.

Instructions:
1. Provide the amount of funding and resources allocated to the areas with the greatest burden of the HIV epidemic within the jurisdiction, to ensure that resources are reaching the areas of greatest need.

2. Document goals, SMART objectives, capacity building, and monitoring and evaluation activities for the PS12-1201 Comprehensive Program Plan for Categories A, B (if applicable) and C (if applicable). At a minimum, the Comprehensive Program Plan should reflect activities for year 1 (the current budget period) and year 2. However, estimated targets for each program component should be provided for the five year project period. These items can be revised annually as part of the Interim Progress Report.

3. Describe goals for each program component in the plan. Goals should be reflective of the five-year project period.
    a. Goals: Broad aims that define the intended results of each component of core prevention program activity included in the Plan. Collectively, these goals should optimize the provision of HIV prevention, care and treatment in your jurisdiction.

4. Provide annual targets for each program component for each year of the five-year project period for PS12-1201 Category A and Category B. Targets may be updated annually, as appropriate, as part of the Interim Progress Report.

5. List "SMART" outcome and process objectives (Specific, Measureable, Achievable, Realistic, and Time-based) that support each specific activity included in a given goal.
    a. SMART Objectives: Specific and quantifiable targets that measure the overall accomplishment of a goal over a specified period of time. They should describe actions that are distinct, able to be documented or quantified, feasible to execute, realistic to accomplish in the specified time frame and be linked to time-based milestones.

i. Outcome objective: The overall intended effects of the intervention, specifying its purpose and mission. These might include increasing knowledge about HIV, changing risk-related behaviors, promoting community norms for safer sex, or reducing HIV transmission.
ii. Process objective: Process objectives describe the specific intervention activities (activities that will be conducted to meet the goal/objectives), the projected level of effort needed to carry them out, the people responsible for carrying them out, and when they will be completed.
iii. Responsible for implementation: The Program/Division/Office/Agency in charge of implementing the detailed objectives.

6. Describe capacity building plans for each core prevention program component, inclusive of monitoring and evaluation (M&E) capacity building needs.

7. Describe evaluation questions that will be used to monitor program implementation and performance.

    a. **M&E question:** Monitoring and evaluation questions communicate exactly what you want to learn about your program from your evaluation and clearly identify what aspects of your program your evaluation will measure. Monitoring and evaluation questions will be based on program's goals and objectives, resources, and the timeframe during which data are collected.
    b. **Indicator/measure:** A quantitative or qualitative measure of program performance that is used to demonstrate change and which details the extent to which program results and or progress are being or have been achieved. In order for indicators to be useful for monitoring and evaluating program results, it is important to identify indicators that are directly related to your project or program objective.
    c. **Data Source:** Sources of evidence in an evaluation that provide information for the inquiry, analysis, and/or assessment of program goals and objectives. If a data source does not currently exist, provide a brief description of how a specific objective will be measured.
    d. **Timeline**: Date or period by when the data is to be collected locally (data collection) and date or period for when the objectives are expected to be completed (data submission).

Program Monitoring is the systematic, ongoing collection and review of information related to important components of program performance, including implementation and functioning, to determine if programs are operating according to plan and if program objectives are being achieved. *Program Evaluation* is the systematic assessment of program goals, processes, and outcomes in an effort to improve program performance.

Please refer to the National HIV Monitoring and Evaluation (NHM&E) questions and associated required variables for PS12-1201, required and recommended components, as well as the PS12-1201 performance measures for HIV testing and linkage to care activities when completing this program plan.

Note:
For those grantees funded under ECHPP, the comprehensive program plan template is similar in format to the ECHPP workbook 2. Please use information included in the ECHPP workbook for the completion of the program plan, where appropriate.

Program Plan Due Date:
Your program plan is due to CDC no later than **September 28, 2012**. Please submit the program plan to the **PS12-1201@cdc.gov** mailbox with subject line "*PS12-1201 Program Plan – Health Department Name - Date.*" Please send a copy of your plan to your PPB project officer.