HIV PLANNING GUIDANCE

Centers for Disease Control and Prevention
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Purpose of Guidance

1. Support the implementation of high-impact 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 duplication (e.g., Community Services Assessment is listed as an activity for the health department. **HPG no longer prioritizes populations**)
5. Engage a broader group of stakeholders
6. Focus on streamlining communication, coordination and implementation of needed services including mental health and substance abuse across the continuum of HIV prevention, care and treatment services.
High Impact = Populations at Greatest Risk

Hard-hit populations:

- Gay and bisexual men of all races and ethnicities remain the group most severely and disproportionately affected by the epidemic. Men who have sex with men (MSM) represent approximately 2% of the U.S. population, but accounted for 61% of all new HIV infections in 2009.

- By race, age and risk group, young, black gay and bisexual men (ages 13-29) are the only population in the United States in which new HIV infections increased between 2006 and 2009.
Hard-hit populations:

- African Americans are by far the most affected racial/ethnic group in the United States. African Americans represent 14% of the U.S. population, but accounted for 44% of new HIV infections in 2009. The HIV infection rate among African Americans was almost eight times as high as that of Whites in 2009. Among African American women it was 15 times higher than among White women.
High Impact to Populations at Greatest Risk

Hard-hit populations:

• Hispanics/Latinos are also disproportionately affected by HIV, representing approximately 16% of the total U.S. population, but accounting for 20% of all new HIV infections. In 2009, the HIV infection rate among Hispanics/Latinos was three times as high as that of Whites.

• Injection Drug Users (IDUs) represented 9% of new HIV infections in 2009. African Americans accounted for 48% of new infections among IDUs, and Hispanics/Latinos accounted for 21%.

• Transgender individuals are heavily affected by HIV. A 2008 review of studies of HIV among Male-to-Female (MtF) transgender women found that, on average, 28% tested positive for HIV.
Proven HIV Prevention Interventions

- HIV testing and linkage to care
- Antiretroviral therapy
- Access to condoms
- Prevention programs for people living with HIV and their partners
Proven HIV Prevention Interventions

- Prevention programs for people at high risk of HIV infection.
  - Individual, small-group and community interventions for people who are at high risk of HIV infection can reduce risk behaviors
- Substance abuse treatment
- Screening and treatment for other sexually transmitted infections
National HIV/AIDS Strategy (NHAS)

Priorities for HIV Prevention:

• NHAS lays out clear priorities for increasing the impact of HIV prevention efforts in reducing new infections:
  • Intensify HIV prevention in the communities where HIV is most heavily concentrated
  • Expand targeted use of effective combinations of evidence-based HIV prevention approaches
  • Educate all Americans about the threat of HIV and how to prevent it
Why HIV Planning?

• 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
  1. Scientific basis
  2. Community relevance
  3. Key stakeholder involvement
  4. Population or at-risk-based focus of HIV prevention in each project area and
  5. Communication and coordination of services across the continuum of HIV prevention, care and treatment services including determinants associated with but not limited to HIV/AIDS and STDs, infectious diseases, substance abuse and mental health
Fundamentals Not Lost

- Parity, Inclusion and Representation (PIR) must be evident with representation of varying races, ethnicities, genders, sexual orientations, ages and other characteristics such as education, professionals and expertise
Health Department Responsibilities

- Create and maintain one HPG
- Appoint the HD co-chair
- Implement the engagement process and plan with assistance from HPG
- Keep the HPG informed of other planning processes related to HIV care, treatment and other mental health and substance abuse services
- Provide HPG with information on federal, state and local public health services for high-risk populations
- Provide access to current data analysis
- Provide HPG information on its application and its relationship to DHSTS and the NHAS
- Provide update on successes and barriers
- Determine the amount of planning funds necessary to support HIV planning, capacity building and technical assistance
- Develop an application to the CDC for federal HIV prevention cooperative agreement funds
Member Responsibilities

• Make a commitment to the process and its results
• Understand and follow the by-laws and written protocols
• Participate in all decision-making and problem-solving activities
• Co-chair the process and lead committees or workgroups
• Have a working knowledge of FOA PS12-1201 and NHAS
• Commit to work with the HD to ensure that the HPG’s engagement process and plan align with the NHAS goals
• Request additional data if needed to clearly reflect the epidemic
• Use HD information to collaboratively develop an engagement process
• Participate as a partner with the HD while abstaining from serving as an advocate for an agency or specific population
CDC Responsibilities

- Provide leadership in the national design, implementation and evaluation of HIV planning
- Ensure that technical and program assistance are provided through various mechanisms to assist recipients with the process and activities of HIV planning
- Provide leadership to ensure coordination among HD, 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 emerging trends or changes in the HIV epidemic
- Provide available state 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 submitted annually
- Address corrective actions when a jurisdiction is non-compliant with its HPG responsibilities
Fundamentals

1. HPG is a participatory and collaborative process
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 HD and HPG
4. Comprehensive participation is critical to the success of the Plan and the planning process
5. HPGs must adopt High-Impact Prevention approaches to HIV prevention activities in their communities, as well as utilize the most current Epi surveillance and evidence-based data to guide the planning process.
Key Concepts

- Effectiveness and cost
- Feasibility of full-scale implementation
- Coverage of target population(s)
- Interaction and targeting of interventions
- Implementing interventions that will have the greatest overall potential to reduce HIV infections

Issues related to Program Collaboration and Service Integration (PCSI), health equity, social determinants of health and sexual health should also be considered as appropriate during the planning process.
Test and Treat

- HPGs must recognize the important role of antiretroviral treatment in the nation’s prevention efforts, not limited to HIV but syndemics (two or more diseases in a population, i.e., Hepatitis C) which co-occur with HIV.

- HD must develop an enhanced Comprehensive HIV Prevention Plan
How Will the Process Be Monitored

• CDC’s approach is to support HIV programs and strategies to achieve the greatest impact as they apply to stakeholders and providers that can best deliver the services

• Meeting expectations are flexible and left to the HD and HPG

• Monitoring is a shared responsibility among the CDC, HDs and HPGs.
  • Plan update
  • Responses to specific monitoring questions
  • Documentation of engagement
  • Analysis of membership profile
  • Submission of concurrence, non-concurrence or concurrence with reservation with the HDs Prevention Plan
Concur, Concur with Reservation, Non-Concurrence

• That the plan demonstrates a collaborative, coordinated and results-oriented approach to increase access to HIV prevention and care and treatment services directed to populations and geographic areas with the greatest burden of HIV disease to achieve reduction in HIV incidence.

• The letter will not:
  • Address internal HD issues such as salaries of HD staff
  • Address specific proposed activities or
  • Advocate for one group, agency or issue
Objective 1

By the end of the program cycle, the HD and HPG will identify and implement strategies to recruit and retain HPG members and to target populations in the HIV planning process that represent the diversity of the HIV infected populations, other key stakeholders in prevention and care and related services and organizations that can best inform and support the development and implementation of the HIV plan.

Completed

- Membership criteria
- By-laws
- Policy & Procedures
**Objective 2**

Results-oriented engagement process - by the end of the project year, the HPG will develop an engagement process with specific strategies to ensure a coordinated, collaborative and seamless approach to accessing HIV prevention, care and treatment services for high risk populations, particularly those disproportionately affected by HIV across the state.

- Prevention and Care Collaborative Workgroup, initiated in 2010, will continue to outline specific strategies.
- Six pilot projects will implement PCSI model with intention to expand.
- All non-clinically-based C&T sites will be linked to a treatment provider (Rapid, Rapid) for the second rapid on a preliminary + test with immediate (with 8 working hrs.) linkage to care following the client’s timeline.
Objective 3

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

Objective 3

- Ongoing project for HIV/AIDS Issues Committee
- Focus groups of key stakeholders in different regions of the state
- Other