

**Community Planning Group  
Planning Priorities Committee  
Meeting Minutes**

**Monday, March 22<sup>nd</sup>, 2010**

**1:00 – 3:00 p.m.**

**The Office of HIV Planning, 340 N. 12<sup>th</sup> Street, Suite 203, Philadelphia, PA 19107**

**Present:** Dawn M. Acero, David Acosta, Marné Castillo (Co-Chair), Tony Daniel (Co-Chair), Rick Feely, Denette Lienau

**Staff:** Aneeza Agha, Joseph Ellis, Michael Milsop

**Guests:** Eugenio Garcia, José Benitez

**Excused:** Andrew de los Reyes, David Powell

**Call to Order:**

D. Acosta called the meeting to order at 1:10 pm. Afterwards, each member of the group took a moment to introduce his or herself.

**Approval of Agenda**

After reviewing the agenda, the group approved the document by general consensus.

**Approval of Minutes** (*February 22<sup>nd</sup>, 2010*)

The group took a moment to review a draft of the minutes from their last meeting. D. Lienau noted that her last name was misspelled in the document. **Motion: With the correction noted, D. Lienau moved and D. Acero seconded to approve the draft of the minutes that was included in the handouts. Motion Passed: All in favor.**

**Report of Staff**

None

**Report of Co-Chair**

None

**Discussion Items:**

• **Outstanding Questions about Factors**

M. Milsop informed the committee that there were still a few data issues with some of their selected factors for prioritization. Concerning substance use (injection drugs) as a key indicator of risk behaviors, he said that Ricardo Tull, the Program Coordinator for OAS, had told him that there were no data available on the total number of people who had received treatment for injection drug abuse. He said that the data were unavailable because the city did not track the number of substance abuse patients and there was no way to obtain the information from insurance companies or hospitals. Since all the other factors had concrete ranges, he explained, the committee would have to decide whether to keep substance abuse (injection drugs) as a key indicator of risk behaviors and, if so, how

to measure the factor. In response to a question by D. Acosta, A. Agha clarified that the committee could decide to work with estimations as data. However, she said that they would want to give a lesser weight to any factors that were based on estimations. D. Lienau proposed keeping the factor and explaining to the CPG that it should receive a lesser weight because it was based on estimates and not hard data.

J. Benitez informed the group that research-based estimates on the number of substance users in treatment in Philadelphia were available from David Metzger, an Associate Professor with the Penn Center for AIDS Research. A. Agha asked whether the estimates could be broken down by age and gender since the factors would be decided separately for each of the target populations. D. Acosta replied that the research-based estimates should be available by age and gender and J. Benitez said that he could get the estimates from D. Metzger within a week or two.

J. Benitez suggested that the committee make a recommendation for the city to begin tracking the number of individuals receiving treatment for substance use. He said that the data would only become more important moving forward and that, by not pushing the city to collect the data, they would struggle with the same lack of data during the development of the next prevention plan. D. Acosta agreed, noting that the lifting of the federal ban on needle exchange programs would also make the data more important.

M. Castillo said that there could be another potential source of data on substance using populations in the city. She told the group that, a few years ago, an award had been released specifically for agencies dealing with substance abuse. She believed the award may have come from OAS and that the project was called Reach but, as she was unsure, she offered to investigate further. She then reiterated that, concerning substance abuse as a key indicator of risk behaviors, the committee would attempt to gather as much information as possible and then explain to the CPG that the factor should receive a lesser weight if the available data were inconclusive. The rest of the group agreed.

Concerning syphilis, the other key indicator of risk chosen by the committee, M. Milsop said that he had just received some more information on the factor from A. de los Reyes just before the meeting started. He reported that, although the disease was only tracked by gender, A. de los Reyes might be able to find out risk categories as well. Additionally, he said that the committee should investigate all types of syphilis: primary, secondary, and tertiary. M. Castillo asked whether the data on syphilis separated new infections from reinfections. She noted that, at the CHOP clinic, there was a high number of syphilis cases but, misleadingly, they were all attributed to the same few people who were often reinfected. D. Acosta believed that the data would be separated because syphilis was a reportable disease. M. Milsop said that he would investigate the matter.

D. Acosta asked whether the group had considered Hepatitis as a key indicator of risk for IDU populations. He felt that there would be a great deal of data on the disease available because he believed the jurisdiction was placing a priority on it. Additionally, he noted that attempts to include Hepatitis in HIV planning would do well for PCSI (Program Collaboration and Service Integration) efforts in the city. M. Milsop said that focusing

on individuals co-infected with Hepatitis and HIV could be a special instruction for the grantee.

M. Milsop informed the group that, according to Kathleen Brady, there was no information on the factor ‘multiple high risk behaviors’ because the Health Department did not currently collect it. As a result, he said that, if the group wanted to maintain the factor, they would have to develop a definition and a source of data for it. He then reminded the committee that, after the weighting process, they would be attaching the social drivers they had previously selected to each of the populations, which could be viewed as an alternative to multiple risk behaviors.

D. Lienau asked whether the data used to support the social drivers could also be used for multiple high risk behaviors. However, M. Milsop pointed out that the social drivers were too different from multiple risk behaviors for their supportive data to be interchangeable. As an example, he noted that lack of education, a social driver, could not be viewed as a risk behavior.

A. Agha told the committee that, if they decided to remove ‘multiple high risk behaviors’ from the list of factors due to the lack of supportive data, they could include a write up in the plan on the effects of multiple risk behaviors in order to keep it in consideration during the creation of the next prevention system. M. Castillo and D. Acosta both supported the idea, saying that it was probably the best option available due to the lack of supportive data. M. Castillo clarified that the factor ‘multiple high risk behaviors’ should be removed from the list and the rest of the group agreed.

M. Milsop directed the group’s attention to the two handouts entitled *Large Scale Rating Model for Target Populations*. He explained that, after the CPG had weighted the factors, they would then rate each of them as they pertained to each of the target populations based on available information. He noted that, as the sheets were currently written, the target populations would be outlined by risk category and by gender. However, he said that the group could also decide to define the populations by just risk category or gender, noting that there were advantages and disadvantages for each system. As an example, he said that, if they decided to use only risk categories, there would be less worksheets to complete but the process would not be as clear and Trans populations would likely be rated lower since data on the population were limited. A. Agha said that, if the group decided to categorize the populations by gender alone, they might want to select a score for Trans populations since there would not be any data available for them. She then informed the group that, during the development of the last prevention plan, the target populations had been defined by age (youth and adult) and risk category. M. Castillo felt that, for the second worksheets, the populations should be categorized by both risk behavior and gender for the sake of clarity. The rest of the group agreed.

Returning to the Worksheet entitled *Weighting Factors for Target Populations*, A. Agha reminded the committee that they would have to stress to the CPG that the more subjective factors should receive a lower weight because they lacked substantiated data for support. R. Feely said that there was some information available on the difficulty of meeting the needs of Trans populations. D. Acosta also reported that AACO had just

completed a needs assessment for MSM populations in the city, which he said would be presented to the CPG in the near future. M. Milsop noted that, despite what had been done for Trans and MSM, there still were no needs assessments for the other targeted populations. A. Agha pointed out that, even though the office could construct some level of needs assessment for the remaining populations using the CSA and information on available programs, the resulting data would still not be as substantiated as what were available for HIV/AIDS prevalence and incidence. As a result, she continued, information on ‘difficulty of meeting population needs’ and ‘barriers to reaching the population’ would still be relatively subjective.

D. Acero noted that a lack of data could be considered a barrier to reaching a population. A. Agha supported the statement and noted that, as J. Benitez had suggested earlier, the committee could make a recommendation about the need to collect specific data so that it would be included in the next prevention plan.

- **Allocation Percentages**

M. Milsop informed the group that, after the populations had been prioritized, the committee would have to focus on allocating percentages of funding to each of the targeted populations. He reminded the committee that, during the development of the last prevention plan, the group had opted to allow the Health Department to make the allocations decisions because data on HIV prevalence and incidence were not available. However, he suggested that the committee make the decision on their own this time and noted that the data-driven prioritization of the populations would make the process much easier. R. Feely asked whether the populations for the percentages would be categorized by risk or gender. M. Milsop replied that the categorization used would be up to the committee. R. Feely asked if the allocations percentages would be driven by the prioritization of the populations. M. Milsop responded that, again, the decision was the committee’s to make.

D. Lienau stated that she was concerned about LEP (Limited English Proficiency) individuals being underrepresented in community planning. As a result, she said that she wanted to address the matter at a CPG meeting. M. Milsop clarified that the concern over LEP populations could be included in the prevention plan as a recommendation. A. Agha agreed but suggested that D. Lienau gather some supportive data before initiating the conversation at a CPG meeting.

A. Agha informed the group that the care system had recently used the same weighting process that the committee had just agreed upon for the factors. She reported that, after the activity, some individuals had complained about the process, feeling that limiting the number of times the top weights could be used was equal to a forced decision. As a result, she asked the group whether they wanted to make any changes to their process. D. Lienau felt that no changes were necessary, noting that three uses of the highest weight was a third of the total factors. The rest of the group agreed.

R. Feely asked if he or other members of the CPG had to be present at the meeting in order to participate in the weighting process. A. Agha replied that she was unsure

whether the Bylaws made any specific dictates about the weighting process. As a result, she said that she would check and report back before the CPG meeting.

As the conversation was drawing to a close, M. Milsop offered to develop a Powerpoint presentation for the weighting in order to walk the members of the CPG through each stage of the process. The rest of the committee agreed that a presentation would be helpful for the process.

### **Old Business**

None

### **New Business**

A. Agha told the group that if anyone was interested in more information on the prioritization process, the OHP could provide them with such a document.

### **Announcements**

R. Feely announced that TIP would become an independent organization that was fully run by Trans individuals in the spring.

### **Adjournment**

The meeting was adjourned by general consensus at 2:07 pm.

Respectfully Submitted,

Joseph Ellis, Staff

### **Handouts Distributed at the Meeting:**

- Meeting Agenda
- Meeting Minutes (*February 22<sup>nd</sup>, 2010*)
- Weighting Worksheet 2010
- Weighting Model for Heterosexual Male Populations 2010
- Weighting Model for Heterosexual Female Populations 2010
- OHP Meeting Calendar

COMMUNITY PLANNING GROUP (CPG)

**Planning Priorities Committee**

**Meeting Agenda**

**Monday, March 22<sup>nd</sup>, 2010**

**1:00 p.m. – 3:00 p.m.**

The Office of HIV Planning, 340 N. 12<sup>th</sup> Street, Suite 203, Philadelphia

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**Call to Order/Introductions**

**Approval of Agenda**

**Approval of Minutes**

**Report of Staff**

**Report of Co-Chairs**

**Discussion Items:**

- **Outstanding Questions about Factors**
- **Allocation Percentages**
- **Next Steps**

**Old Business**

**New Business**

**Announcements**

**Adjournment**

*The next meeting of the Planning Priorities Committee is scheduled for  
**Monday, April 26<sup>th</sup>, 2010 from 1:00 - 3:00 pm**  
At the Office of HIV Planning, 340 N. 12<sup>th</sup> Street, Suite 203, Philadelphia*

*Please refer to the Office of HIV Planning's attached Calendar of Events or its website, [www.hivphilly.org](http://www.hivphilly.org),  
for updated committee meeting information.*

**Please contact the office at least 5 days in advance if you require special assistance**

**Community Planning Group  
Planning Priorities Committee  
Meeting Minutes**

**Monday, February 22<sup>nd</sup>, 2010**

**1:00 – 3:00 p.m.**

**The Office of HIV Planning, 340 N. 12<sup>th</sup> Street, Suite 203, Philadelphia, PA 19107**

**Present:** Dawn Acero, Tony Daniel (Co-Chair), Andrew de los Reyes, Rick Feely, Denette Lineau

**Staff:** Aneeza Agha, Joseph Ellis, Michael Milsop

**Excused:** David Acosta, Marné Castillo (Co-Chair), David Powell

**Call to Order:**

A. De los Reyes called the meeting to order at 1:15 pm.

**Approval of Agenda**

After taking a moment to review the agenda, the group approved the document by general consensus.

**Approval of Minutes** (*January 25<sup>th</sup>, 2010*)

The group took a moment to review a draft of the minutes from their last meeting.

**Motion:** Afterwards, D. Lineau moved and D. Acero seconded to approve the draft of the minutes that was included in the handouts. **Motion Passed:** All in favor.

**Report of Staff**

None

**Report of Co-Chair**

None

**Discussion Items:**

• **Finish Planning Process for Weighting Factors**

M. Milsop directed the group's attention to Worksheet 1 in the handouts, noting that OHP staff had developed the document following the committee's determinations on factors for target populations, which had been discussed at their last meeting. He proceeded to read through the handout, noting that there were only a few points of clarification required from the committee on some of the factors.

A. de los Reyes asked why the CDC was not included as a data source for HIV/ AIDS prevalence and incidence. M. Milsop replied that the CDC culled its local information from the same sources listed in the worksheet.

M. Milsop informed the group that, in developing the last Prevention Plan, the group had decided to use only gonorrhea instead of all STDs as a key indicator of risk behaviors.

He explained that certain STDs, such as gonorrhea, were better indicators of HIV risk because their symptoms were more likely to cause those at high risk for HIV to go see a doctor. As a result, he asked the committee members whether they wanted to use all STDs as a key indicator of risk behaviors or concentrate on any specific STDs. D. Lineau felt that the group should use all STDs as key indicators because they all indicated risky behavior. However, A. de los Reyes supported using only specific STDs, noting that other STDs, such as chlamydia, would skew the data with large concentrations of populations at a lesser risk of HIV infection. He then specifically stated that, in his opinion, only syphilis should be used as a key indicator because the rate of the disease was increasing and it tended to affect populations that were also at risk for HIV. In response to a question by D. Acero, A. de los Reyes said that he did not feel gonorrhea should be included as a key indicator because currently the disease was mostly affecting populations that were traditionally not at high risk for HIV infection. As a result, the rest of the committee members agreed to use syphilis alone instead of STDs in general.

M. Milsop asked A. de los Reyes whether he would be able to provide data on syphilis rates to the committee for the purposes of their planning. A. de los Reyes replied that he could provide the information; however, he noted that it had also been posted to HIP (Health Information Project).

Moving on to the next factor, M. Milsop noted that using substance use as a factor could be problematic because the size of the population was uncertain. He explained that, since not all substance users sought medical treatment, the available data on the population was incomplete. A. de los Reyes asked whether any members of the CPG were representatives of substance abusers and, thereby, could provide some insights into working with data on them. M. Milsop said that he could contact OAS (Office of Addiction Services) but noted that last time he had asked them for data, he was only able to get information on individuals who had been in treatment. A. de los Reyes suggested speaking with Ricardo Tull, the Program Coordinator for OAS, on the matter because he could give a general overview on the population instead of just numbers on those who had been in treatment. M. Milsop said that he would contact R. Tull but reminded the group that they had wanted to base their decisions on concrete data.

A. Agha pointed out that Worksheet 1 still reflected the decision made during the development of the last prevention plan to use crack/cocaine use specifically as a factor instead of substance use in general. A. de los Reyes asked what the link was between crack/cocaine use and HIV risk. R. Feely replied that individuals under the influence of crack/cocaine were more likely to engage in unprotected sex. A. de los Reyes questioned the connection between crack/cocaine and HIV risk, saying that crack users tended to be disinterested in sex beyond what was required to obtain the drug. Additionally, he said that, if users were prostituting themselves in order to get money for crack, they could be wearing condoms or only engaging in oral sex, which was significantly less risky. He then stated that he did not believe that substance abuse was a necessary factor for prioritizing populations. He explained that the two possible risks that could be attributed to substance use – unprotected sex and the sharing of injection paraphernalia – were

already accounted for under other factors. As a result, he suggested dropping the factor and the rest of the group agreed.

For the next factor, which used injection drug use as a key indicator of risk behavior, M. Milsop noted that prevalence data on the issue should be easily obtained through Dr. Brady and Prevention Point. The rest of the group agreed and decided to keep the factor as it was.

R. Feely asked what the scale was for the riskiness of population behaviors. A. Agha replied that, following a scale provided by the AED Guidelines, sharing contaminated injection equipment was the riskiest behavior, followed in descending order by anal sex w/infected partner; vaginal sex w/infected partner; oral sex w/infected partner; and none, unknown, or low-risk behaviors. The group decided to maintain the factor as it was written.

A. Agha reminded the committee that they had developed the next factor on the list, multiple high risk behaviors, because some groups were at-risk for HIV infection through more than one behavior. However, she said that the factor was more subjective than some of the others on the list and, as a result, should not be weighted as highly as those that were more data-driven. She also noted that the committee would have to develop a scale for the factor and that the results of the weighting would rely on how much CPG members knew about the populations. R. Feely stated that data on multiple-risk behaviors of Trans populations were available through community needs assessments. He asked whether similar assessments had been performed for the rest of the at-risk populations. A. Agha replied that OHP staff would work to acquire all the data on at-risk populations that could be obtained, including literature reviews. M. Milsop agreed; however, he noted that the Health Department did not collect information on multiple-risk behaviors and that literature reviews might not reflect local population trends. Additionally, he said that, regardless of available data, some CPG members were likely to draw on personal experience when completing the worksheet. The group then decided to delay a decision on the factor until they could ascertain what data was available.

M. Milsop stated that the last two factors on Worksheet 1 were also susceptible to a level of subjectivity. D. Lineau agreed, noting that stigma, a barrier to reaching populations, was difficult to measure. R. Feely felt that, again, he could locate data on the last two factors as it related to Trans populations. M. Milsop reiterated that, although literature reviews could provide some insights into barriers to reaching populations, they often did little to represent local issues specifically, which would still leave room for subjectivity.

A. de los Reyes suggested advising the members of the CPG to research the at-risk populations so that they could make informed decisions during the weighting process. He pointed out that, even if the committee and OHP staff compiled all of the data ahead of time, it would be too much information for the group to absorb before they started the process.

A. de los Reyes doubted that the group would be able to find significant local data on the last three factors in Worksheet 1. As a result, he suggested giving the factors a lower weight than the rest of those in the handout. R. Feely informed the group that the last three factors in Worksheet 1 represented the only significant data available for Trans populations. As a result, he questioned whether the factors should be given a lower weight. A. Agha explained that, in order to counter that fact, those factors would get a higher rating for Trans populations in Worksheet 2.

M. Milsop told the group that, concerning the last three factors in Worksheet 1, they had to decide whether or not they were comfortable presenting the CPG with factors that could not be supported by hard data. He clarified that the committee would have to explain to the CPG that the factors would be more subjective than the rest. A. de los Reyes supported the idea, saying that the committee could also explain to the CPG that, because sufficient data was not being collected for some populations, the planning body would have to use professional judgment in making its decisions. The rest of the group agreed.

M. Milsop said that the CPG would use Worksheet 2 to assign final weights to the selected factors for each of the targeted populations. He explained that each member would assign a weight to each factor, all of which would then be added up and divided by the total number of responses to produce a final weight. He then told the committee that they would have to select a scale from which the CPG would make its selections, giving 1-5 and 1, 3, 5, & 8 as examples. A. de los Reyes asked what the benefits were to each of the two scales. M. Milsop replied that 1-5 was an easier concept to grasp and that it had been used by both the prevention and care systems in previous prioritization exercises. However, he said that the scale could occasionally result in very small levels of differentiation, which made prioritization more difficult. As a result, he continued, the care system had just opted to switch to the 1, 3, 5, & 8 system, but had not yet tested it with a prioritization exercise. A. de los Reyes gave his support to the 1, 3, 5, & 8 system because he felt that it would result in clearer priorities. The rest of the group agreed.

M. Milsop noted that, regardless of which scale the committee decided upon, they would have to make it clear to the CPG that not every factor could receive the highest weight. He explained that, by doing so, the priorities would become meaningless. A. de los Reyes asked whether the worksheet could stipulate that each level of the scale could only be used once. A. Agha responded positively but noted that there were a number of ways of dealing with the problem. She said that the committee could also limit the number of times that the highest level of the scale was used. A. de los Reyes supported the idea and suggested limiting the amount of factors receiving a weight of '8' to three. The rest of the group supported the decision. T. Daniel asked what would happen if members ignored the limit and used '8' more than three times. M. Milsop replied that those responses would not be included in the calculation of the final prioritization.

M. Milsop asked the group how they wanted to handle responses that were off of the scale, such as a '6.' A. de los Reyes suggested listing all of the numbers in the scale – 1,

3, 5, & 8 – and having the CPG members circle their selections to avoid responses that were off of the scale. The rest of the group agreed.

A. de los Reyes asked whether OHP staff would develop instructions for the worksheet based on the decisions that the committee had just made. M. Milsop agreed to develop the worksheet with the necessary instructions. He then suggested giving the CPG an explanation of the factors at their next meeting so that they would be more informed for the prioritization exercise in March. The rest of the group agreed and T. Daniel offered to give the explanation.

### **Old Business**

None

### **New Business**

None

### **Review/Next Steps**

- The PPC continued planning the process by which the CPG would weight the factors for prioritizing populations.
- For Worksheet 1, they decided to remove a factor (substance use), delay a decision on a factor until they knew what data was available (multiple high risk behaviors), and note that the last three factors were more subjective than the others.
- For Worksheet 2, they decided to use a scale that included the numbers 1, 3, 5, & 8 instead of 1 – 5, and to limit the highest number (8) to being selected for only three factors per target population.
- The next meeting of the PPC will be on Monday, March 22<sup>nd</sup>, from 1:00 – 3:00 pm.

### **Announcements**

None

### **Adjournment**

The meeting was adjourned by general consensus at 2:04 pm.

Respectfully Submitted,

Joseph Ellis, Staff

### **Handouts Distributed at the Meeting:**

- Meeting Agenda
- Meeting Minutes (*January 25<sup>th</sup>, 2010*)
- Worksheet 1: Determining Factors for Target Populations
- Worksheet 2: Weighting Factors for Target Populations
- OHP Meeting Calendar

# WORKSHEET 2

## Weighting Factors for Target Populations

**Purpose:** *To assign weights to target population factors to indicate the relative importance of each factor for assessing the risk of the target population.*

**Directions:** *For each factor listed below, consider how well the factor demonstrates the prevention needs of your target populations and to what extent the factor focuses on a greater risk for HIV infections among your target populations. Assign a 1, 3, 5 or 8 to each factor below.*

**Please limit the weight of 8 (very high value) to only three of the factors below.**

*Discuss and agree on how each factor will be weighted among the CPG.*

Factor	Factor Information	Assign Weight
<b>HIV Prevalence</b>	How many people in the target population are living with HIV?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
<b>HIV Incidence</b>	How many people in the target population tested positive for HIV in the past year?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
<b>AIDS Prevalence</b>	How many people in the target population are living with AIDS?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
<b>AIDS Incidence</b>	How many people in the target population tested positive for AIDS in the past year?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value

Factor	Factor Information	Assign Weight
<b>Key indicators of risk behaviors: STDs</b>	What were the reported STDs cases among the target population? (Syphilis)	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
<b>Key indicators of risk behaviors substance use injection drugs.</b>	How many people in the target population obtained substance abuse treatment for injection drugs or are identified as injection drug users through prevalence data?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
<b>Riskiness of population behaviors</b>	What is the primary HIV risk behavior known to occur among the target population?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
<b>Multiple high risk behaviors</b>	Are there multiple high-risk behaviors occurring within the target?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
<b>Difficulty of meeting population needs</b>	Has the target population's complex needs been reached by current programs?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value
<b>Barriers to reaching the population</b>	Are there significant barriers to reaching the target population with HIV prevention interventions?	1-Low Value 3-Medium Value 5-High Value 8-Very High Value

# WORKSHEET 2

## Large Scale Rating Model for Target Populations

**Purpose:** *To assign a rating to each factor based on the information available for each target population.*

**Directions:** *Select a numeric value based on the scale provided for each factor. (Please note: The staff applied rating for many of the factors based on available data which had been provided to the CPG. Some data was not available for the specified population. Where this occurred the population was assigned a mean value of 3.*

### Target Population: Heterosexual Males

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Factor	Rating Information	Scale	Rating
<b>HIV Prevalence</b>	How many people in the target population are living with HIV? (1,139 in 2007)	1: 0-300 2: 301-600 3: 601-900 4: 901-1,200 5: >1,200	4
<b>HIV Incidence</b>	How many people in the target population are living with HIV? (206 in 2007)	1: 0-50 2: 51-100 3: 101-150 4: 151-200 5: >200	5
<b>AIDS Prevalence</b>	How many people in the target population are living with AIDS? (1,443 in 2007)	1: 0-700 2: 701-1,400 3: 1,401-2,100 4: 2,101-2,800 5: >2,800	3
<b>AIDS Incidence</b>	How many people in the target population tested positive for AIDS in the past year? (172 in 2007)	1: 0-50 2: 51-100 3: 101-150 4: 151-200 5: >200	4

Factor	Rating Information	Scale	Rating
<b>Key indicators of risk behaviors: STDs</b>	What were the reported syphilis cases among the target population? (mean value)	1: 0-250 2: 251-1,000 3: 1,001-2,000 4: 2,001 – 4,000 5: >4,000	
<b>Key indicators of risk behaviors substance use injection drugs.</b>	How many people in the target population obtained substance abuse treatment for injection drugs or are identified as injection drug users through prevalence data? (mean value)	1: 0-50 2: 51-100 3: 101- 250 4: 251- 500 5: >500	
<b>Riskiness of population behaviors</b>	What is the primary HIV risk behavior known to occur among the target population?	1: None, unknown or low-risk 2: Oral sex w/infected partner 3: Vaginal sex w/infected partner 4: Anal sex with infected partner 5: Sharing contaminated injection equipment	

Factor	Rating Information	Scale	Rating
<b>Multiple high risk behaviors</b>	Are there multiple high-risk behaviors occurring within the target?	1: No additional high risk behaviors occur within this population 3: Moderate multiple high risk behaviors occur within this population 5: Substantial multiple high risk behaviors occur within this population	
<b>Difficulty of meeting population needs</b>	Has the target population's complex needs been reached by current programs?	1: Substantial programs exist to meet the target population's complex needs 3: Moderate programs exist to meet the target population's complex needs 5: Few or virtually no programs exist to meet the target population's complex needs	
<b>Barriers to reaching the population</b>	Are there significant barriers to reaching the target population with HIV prevention interventions?	1: Few or virtually no barriers 3: Moderate barriers 5: Substantial barriers	

# WORKSHEET 2

## Large Scale Rating Model for Target Populations

**Purpose:** *To assign a rating to each factor based on the information available for each target population.*

**Directions:** *Select a numeric value based on the scale provided for each factor. (Please note: The staff applied rating for many of the factors based on available data which had been provided to the CPG. Some data was not available for the specified population. Where this occurred the population was assigned a mean value of 3.*

### Target Population: Heterosexual Females

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Factor	Rating Information	Scale	Rating
<b>HIV Prevalence</b>	How many people in the target population are living with HIV? (1,509 in 2007)	1: 0-300 2: 301-600 3: 601-900 4: 901-1,200 5: >1,200	5
<b>HIV Incidence</b>	How many people in the target population are living with HIV? (181 in 2007)	1: 0-50 2: 51-100 3: 101-150 4: 151-200 5: >200	4
<b>AIDS Prevalence</b>	How many people in the target population are living with AIDS? (1,620 in 2007)	1: 0-700 2: 701-1,400 3: 1,401-2,100 4: 2,101-2,800 5: >2,800	3
<b>AIDS Incidence</b>	How many people in the target population tested positive for AIDS in the past year? (169 in 2007)	1: 0-50 2: 51-100 3: 101-150 4: 151-200 5: >200	4

Factor	Rating Information	Scale	Rating
<b>Key indicators of risk behaviors: STDs</b>	What were the reported syphilis cases among the target population? ( <b>mean value</b> )	1: 0-250 2: 251-1,000 3: 1,001-2,000 4: 2,001 – 4,000 5: >4,000	
<b>Key indicators of risk behaviors substance use injection drugs.</b>	How many people in the target population obtained substance abuse treatment for injection drugs or are identified as injection drug users through prevalence data? ( <b>mean value</b> )	1: 0-50 2: 51-100 3: 101- 250 4: 251- 500 5: >500	
<b>Riskiness of population behaviors</b>	What is the primary HIV risk behavior known to occur among the target population?	1: None, unknown or low-risk 2: Oral sex w/infected partner 3: Vaginal sex w/infected partner 4: Anal sex with infected partner 5: Sharing contaminated injection equipment	

Factor	Rating Information	Scale	Rating
<b>Multiple high risk behaviors</b>	Are there multiple high-risk behaviors occurring within the target?	1: No additional high risk behaviors occur within this population 3: Moderate multiple high risk behaviors occur within this population 5: Substantial multiple high risk behaviors occur within this population	
<b>Difficulty of meeting population needs</b>	Has the target population's complex needs been reached by current programs?	1: Substantial programs exist to meet the target population's complex needs 3: Moderate programs exist to meet the target population's complex needs 5: Few or virtually no programs exist to meet the target population's complex needs	
<b>Barriers to reaching the population</b>	Are there significant barriers to reaching the target population with HIV prevention interventions?	1: Few or virtually no barriers 3: Moderate barriers 5: Substantial barriers	