

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

Monday, October 26th, 2009

1:00 – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: David Acosta, Marné Castillo (Co-Chair), Tony Daniel (Co-Chair), Rick Feely

Guest: Dr. Kathleen Brady

Staff: Joseph Ellis, Monica Getahun, Michael Milsop

Call to Order

M. Castillo 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 (*September 21st, 2009*)

The group spent some time reviewing a draft of the minutes from their last meeting. Afterwards, they approved the document by general consensus.

Report of Staff

M. Milsop reported that the Ryan White Care Act had finally been passed. He told the group that, as part of the legislation, HRSA was required to conduct 5 million HIV tests, which he felt would require greater collaboration with the CDC in order to find best testing practices. D. Acosta informed the group that PSO 768, the expanded testing initiative, was likely to be extended, which he felt could help increase the number of tests performed. However, he said that he did not believe that performing 5 millions tests would be realistic unless changes were made in Pennsylvania's laws of consent.

Report of Co-Chair

None

Discussion Items:

• **Preparing for the CPG Presentation in November**

M. Milsop directed the group's attention to the handout he had compiled, which reviewed the decisions the committee had made over the past few months concerning prioritized populations and general population cofactors. He clarified that the PPC had developed their list of cofactors from the results of the CPG focus group activity. The group spent some time reviewing the handout and explaining some aspects of the process to members who had not been in attendance at all the meetings (see handout for more details).

D. Acosta told the group that social determinants, such as the number of infected people within an individual's social network, were largely overlooked factors that were driving the epidemic. He felt that the prevention programs in the current CDC compendium could be

limited because they all focused on individual behavior as the sole determinant of risk. R. Feely agreed and said that the committee should mention in their presentation that an individual's risk was affected not only by their behavior, but also by context. M. Castillo supported the idea that factors other than behavior affected risk. However, she informed the group that, according to a logic model used in a recent CHOP project, communication and knowing one's status also affected the risk level caused by partner selection. D. Acosta reported that a model developed in Los Angeles allowed health planners to place HIV within different social structures to show how context affected risk. He said that, when the model was used on Trans communities, it showed that numerous factors other than those addressed by current prevention programs affected the population's risk levels. He then asked the group whether they wanted to meet with the Lit & Ed Committee before giving their presentation to the CPG in order to discuss the need for more structural interventions in the next Prevention Plan. However, M. Castillo felt that a joint committee meeting would be more sensible after the presentation in order to keep the PPC focused on their discussion of prioritizing populations until their draft list was completed and approved. The rest of the group agreed.

M. Castillo suggested that the committee start their presentation by reviewing their draft of general cofactors and the decisions that had led to its development. She felt that the cofactors were the most important deviation from how targeted populations had been prioritized in the last plan and would therefore require the most thorough explanation. R. Feely supported the idea; however, he suggested beginning the presentation with a brief disclaimer about how different social contexts affected the risk level of behaviors. The rest of the group agreed and K. Brady proposed saying simply that individual, community, and social factors all affected risk.

M. Castillo suggested starting their discussion on the general cofactors by reminding the CPG of their focus group discussions which had led to the development of the draft list. She said that the group could show the CPG how they had taken the results of the discussions and linked them to more overarching factors, using the available data. M. Milsop agreed, noting that, although many of the ideas for factors that developed from the discussions were important, they could not be supported without data. M. Castillo asked the group whether they felt the CPG could use another review of the epidemiological data as part of the presentation. R. Feely did not believe that the CPG needed to review the epidemiological data again since it had only been a few months since the information was initially presented. He suggested reminding the group of the data instead and stating that the PPC had used it to support their decisions. T. Daniel agreed but proposed having a copy of the data available in case anyone wished to review it. K. Brady felt that new diagnosis data would be sufficient for supporting the group's decisions. She said that she had just received the 2008 data and offered to forward it to the committee in time for the presentation. R. Feely asked whether the other data used to support the cofactors would be included in the presentation, such as crime statistics and surveillance information. M. Castillo suggested including the data in the handouts and potentially giving the CPG a chance to review it. However, she did not feel that it would be necessary to include an explanation of the data in the presentation. The rest of the group agreed.

Moving on to the draft list of prioritized populations, R. Feely noted that the committee had neglected to consider sexual risks for Trans populations. He said that, while the sharing of injection paraphernalia for the delivery of hormones posed a great risk of infection to Trans

individuals, the fact often overshadowed the very serious sexual risks facing the population. As a result, he suggested including TSM (Trans who have Sex with Men) in the box for Trans MSM and Trans Heterosexuals. T. Daniel agreed with the suggestion and pointed out that, because Trans individuals often identified as either gay or heterosexual, they could be missed by prevention programs targeting them. M. Castillo asked whether the prioritization of TSM should include specifics on age and race, as had been done for the other populations. R. Feely did not feel that specific subpopulations would be necessary for TSM because one had already been listed for Trans populations in general under the SIPs category, namely, African American MTF under the age of forty.

R. Feely pointed out that, during their presentation, the committee would have to stress to the CPG that the draft list of populations would not be used to exclude other at-risk populations. The rest of the group agreed and M. Milsop offered some language for the reminder, saying that the list was developed from available epidemiological data to signify priority subpopulations of at-risk groups. R. Feely noted that the list of populations could also mislead people into thinking that everyone within the specified groups was at high risk for contracting HIV. For clarification, he said that an African American male between the ages of twenty-four and sixty-four who lived in North Philadelphia would not necessarily be at high risk if he was not sexually active. M. Castillo asked the group how they wanted to stress to the CPG that the populations on the draft list would not be the only focus of prevention efforts. M. Milsop felt that reviewing the cofactors for general populations before discussing the draft list of priority populations could clarify that all at-risk groups would be targeted by prevention efforts. M. Castillo agreed, saying that examples of other at-risk populations, such as young MSM with unstable housing, would denote that the prioritized populations would not be the only groups targeted. The rest of the group supported the idea.

As the group continued to review the draft list of prioritized populations, K. Brady asked why there was no mention of female IDUs. M. Milsop recalled that epidemiological data had not shown female IDUs to be a very large population in Philadelphia. K. Brady asked the committee whether female IDUs should be included in the list regardless of the data because they were at such high risk of infection. R. Feely agreed, noting that members of the CPG would possibly take issue with the list if it did not include the population. M. Castillo reminded the group that the prioritization list would not be used to exclude at-risk populations from prevention services. She said that the list was only intended to denote priority populations that could be supported by available data. M. Milsop pointed out that if the group added to the list one population that was not supported by data, then others could be included as well. R. Feely asked which subcategories of female IDUs had the highest infection rates. K. Brady believed that African American and Latina female IDUs had the highest incidence rates; however, she said that she would have to check her data to be sure. M. Castillo suggested that the committee refrain from making a decision on whether to add female IDUs to the draft prioritization list until after they had reviewed available data on the population. The rest of the group agreed.

M. Milsop offered to develop a draft of slides for the presentation and distribute them to the group by email. He said that the committee could review the slides and comment on them by email so that he could make any revisions before their next meeting. M. Castillo supported the idea and suggested that the committee spend their next meeting deciding who would discuss the various sections of the presentation. The rest of the group agreed.

- **Next Meeting Date**

After taking a moment to review their schedules, the members of the PPC scheduled their next meeting for Tuesday, November 10th, from 11:00 am – 1:00 pm.

Old Business

None

New Business

M. Milsop pointed out that he had included the CDC's recommended factors for prioritizing populations within the handouts. He said that the committee could review the factors and decide whether they wanted to use any of them for their weights. However, the group decided not to review the factors until after they had completed their presentation for the CPG.

Review/Next Steps

- The members of the PPC spent most of their meeting planning for their presentation at the November CPG meeting. They reviewed their draft lists of prioritized populations and general cofactors and discussed the thought processes behind their decisions
- Additionally, the committee moved the date of their next meeting to Tuesday, November 10th, from 11:00 am – 1:00 pm.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 2:11 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*September 21st, 2009*)
- CPG Focus Group Results, General Cofactors, and Draft Prioritized Populations
- Factors for Setting Priorities for Target Populations
- OHP Meeting Calendar

COMMUNITY PLANNING GROUP (CPG)

Planning Priorities Committee

Meeting Agenda

Monday, October 26, 2009

1:00 – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Call to Order/Introductions

Approval of Agenda

Approval of Minutes

Report of Staff

Report of Co-Chairs

Discussion Items:

- **Preparing for the CPG presentation in November**
- **Next Meeting Date**

Old Business

New Business

Announcements

Adjournment

*The next meeting of the Planning Priorities Committee is **TBD**
The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia
Please refer to the Office of HIV Planning's attached Calendar of Events or its website, 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, September 21st, 2009

1:00 – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Marné Castillo (Co-Chair), Tony Daniel (Co-Chair), Rick Feely

Excused: David Acosta

Absent: Suk Gu Lee

Guest: Dr. Kathleen Brady

Staff: Joseph Ellis, Michael Milsop

Call to Order

R. Feely called the meeting to order at 1:30 pm.

Approval of Agenda

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

Approval of Minutes (*August 24th, 2009 & July 20th, 2009*)

K. Brady noted that, in the second paragraph on page three of the minutes, the term “menu-based” should have been written as “venue-based.” With the correction noted, the group approved the draft of the minutes by general consensus.

Report of Staff

None

Report of Co-Chair

None

Discussion Items:

• **High Risk Heterosexual Population Discussion**

As the group was looking over the handouts for the meeting, M. Milsop took a moment to review the definition of high-risk heterosexuals. He told the group that, according to the CDC, a heterosexual was considered at high-risk for HIV if, within the past year, he or she had been treated for an STD; had used crack; or had had sex with a PLWHA, an IDU, or a MSM. K. Brady voiced some surprise over hearing that the CDC did not distinguish between the STDs that put an individual at high-risk. She said that, because of populations such as college students, having chlamydia within the past year did not necessarily indicate that an individual was at high-risk for HIV infection. She then informed the group that the Surveillance Unit also considered geographic location in

determining the level of risk for heterosexual populations, a factor which she said was also under consideration at the CDC level. She explained that heterosexuals were more likely to contract the disease if they lived in areas with high rates of HIV infection through heterosexual transmission. Those areas, she continued, were usually poverty stricken and defined at the census tract level. She said that, although the Surveillance Unit had also wanted to include STD data in making its determinations (specifically syphilis and gonorrhea), the rates for the diseases at the census tract level were difficult to obtain due to missing or incorrect data. T. Daniel noted that syphilis numbers had recently doubled among heterosexual women in Philadelphia, according to the most recent figures from the STD Control Unit.

R. Feely asked whether sex work was also one of the CDC's defining factors for at-risk heterosexuals. M. Milsop replied negatively; however, he reminded the group that they had included sex work in their list of general cofactors. K. Brady said that the majority of women who had contracted HIV through heterosexual contact were not sex workers, citing CDC data which stated that the most of the women were monogamous.

K. Brady directed the group's attention to the handout entitled *Newly Diagnosed HIV Among Persons with Heterosexual Risk - Philadelphia Residents, 2008*. Reading over the document, she noted that the rate of newly diagnosed heterosexual Latinos was nearly equal to that of African Americans. However, she continued, the rate appeared less significant because the Latino population in Philadelphia was much smaller than the African American population. However, she noted that, while heterosexual transmission was the most significant risk category for African Americans, IDU was still the greatest risk factor for Latino populations. Also while reading over the handout, K. Brady pointed out that heterosexual transmission was a much greater risk for women because it was the only other risk category they fit into besides IDU. Additionally, she stressed that the women contracting the disease were not just those who were newly sexually active, noting that 40 – 49 years olds had the highest percentage rates. She said that she had seen a fair number of women in that age group at her practice who had recently contracted the disease from a new partner.

K. Brady moved on to the handout entitled, *Concurrent HIV/AIDS, Demographics and Transmission Risk among Incident HIV Diagnoses, Philadelphia Residents, 2007*. She told the group that the document was still in draft form but would be officially released soon. She reported that the number of late presenters, those who progressed to AIDS within a year of an HIV diagnosis, had declined from approximately 40% to 35%. She said that about 36% of positive heterosexuals were late presenters, which was good because it was not much higher than the positive population in general. She noted that the number of late presenting heterosexuals had been very high in the past because members of the population did not generally perceive themselves as being at risk. She then speculated that the number of late-presenting Latinos was very low because the population tended to be better connected to care than others. However, she stated that she was not sure what the actual causes of the numbers were. M. Castillo stated that Latinos usually had a better cultural perception of doctors and, therefore, tended to listen

to them and follow their orders. K. Brady replied that service providers were also usually well known within Latino communities.

K. Brady directed the group's attention to the map of HIV counseling and testing sites and newly diagnosed HIV infections by census tract. She felt that the map exemplified why the Surveillance Department took geographic location into consideration when assessing levels of risk for heterosexuals. She noted that the red section in the northeast part of the city was the prison while the other was North Philadelphia, west of Broad Street. She said that, according to the CDC, geographic location was important to determining heterosexuals' risk level because they tended to find sex partners in their own neighborhoods, more so than other populations. M. Castillo agreed with the idea, saying that, in areas with high transmission rates, one did not even have to have many sex partners in order to be at high risk. K. Brady agreed; however, she informed the group that, during the mapping process, the Surveillance Unit had tested many heterosexuals within their neighborhoods and got very low positivity rates. She clarified that positivity rates were still very low among heterosexuals when compared with other populations.

Lastly, K. Brady told the group that data on epidemiology and HIV testing in the city could be found in the handout containing slides from a recent presentation. As the group looked over the document, she stated that she had been unable to compile any information on non-injecting drug use because all that was available was unreliable. Additionally, she said that the Surveillance Unit did not have any data on individuals who comorbidly tested positive with another STD.

After the group had finished reviewing all of the available data, R. Feely stated that African American men and women over the age of 24 seemed to be the most at risk subpopulation in the heterosexual category. M. Milsop asked the group whether they wanted to add Latinos to the list as well since their rate of new infections was nearly the same as African Americans. R. Feely agreed but felt that African Americans should still be more highly targeted. The rest of the group agreed.

R. Feely asked whether the committee should include geographic location as one of the factors in their priority list. K. Brady responded positively, pointing out that African American heterosexuals over the age of 24 was an enormous population in Philadelphia and that geographic risk would help to focus the group's targeting. M. Castillo supported the suggestion and asked whether location should be used as a risk determinant for all populations. However, R. Feely did not believe that geographic targeting was necessary for all populations, saying that MSM often found sexual partners outside of their own neighborhoods. M. Castillo agreed but asked whether data was available to support their belief that location was not an important risk determinant for populations other than heterosexuals. K. Brady replied that the Surveillance Department had maps of newly diagnosed HIV infections for all at-risk populations. She told the group that, in every one of the maps, the census tract in which the prison was located came up red. However, she continued, the MSM map was otherwise comprised of mostly grey squares with a few pink ones around the center city area. Additionally, she said that, while the IDU map did have some concentrations in North Philadelphia and Kensington, those areas were mostly

where the population obtained and injected drugs, not necessarily where they lived. M. Milsop asked K. Brady whether she would suggest including geographic risk for IDUs since newly diagnosed cases of the population were concentrated in some areas. K. Brady replied that geographic risk was far more important for heterosexuals than it was for IDUs. However, she suggested that the committee look at some drug arrest maps, which would give some indication of the areas in which IDUs were most at-risk. M. Castillo proposed including geographic risk for heterosexual populations only and stating in the plan why they had not included location as a risk factor for the other populations. Looking at the map, she then suggested listing North and West Philadelphia as the risky areas for heterosexuals in order to avoid having to describe the locations by census tract. The rest of the group agreed and K. Brady said that she would forward the newly diagnosed HIV infections maps for the other populations.

Old Business

J. Ellis reminded the group that they had not yet approved the minutes from their July meeting because those in attendance had not been present at the committee's last meeting. T. Daniel and M. Castillo took a moment to review the draft and then approved the document by general consensus.

New Business

M. Castillo suggested that the committee give a presentation to the CPG in which they explained their current process of prioritizing populations. She reminded the group that the Lit & Ed Committee had recently given a similar presentation in which they explained their ongoing review of prevention programs. She said that she had found the presentation helpful and thought that it may have aroused some interest in the group's process. J. Ellis clarified that the Lit & Ed Committee's presentation had been given in order to get the CPG's approval for the factors they were using to review interventions. Therefore, he suggested that the committee explain their process to the CPG when they sought approval from the planning body for their draft of prioritized populations. The rest of the group agreed and T. Daniel proposed scheduling the presentation for November in order to allow time for preparation. The rest of the group agreed.

Review/Next Steps

The committee took a moment to review their decisions and next steps:

- After reviewing all of the available epidemiological data on Heterosexuals in Philadelphia, the PPC selected African American male and female heterosexuals over the age of 24 who live in either West or North Philadelphia as the priority population under heterosexuals.
- Additionally, the group decided to present their draft of prioritized populations for the next Prevention Plan to the CPG at their November meeting.
- The committee will next convene on October 26th from 1:00 – 3:00 pm.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 2:39 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*August 24th, 2009*)
- Meeting Minutes (*July 20th, 2009*)
- What are Heterosexual Men's HIV Prevention Needs?
- Newly Diagnosed HIV among Persons with Heterosexual Risk, Philadelphia Residents, 2008
- Concurrent HIV/AIDS, Demographics and Transmission Risk among Incident HIV Diagnoses, Philadelphia Residents, 2007
- HIV/AIDS among Women
- HIV Counseling and Testing Sites and Newly Diagnosed HIV Infections by Census Tract – Heterosexual Transmission
- Slides from Epi Data Presentation
- OHP Meeting Calendar

CPG Focus Group Results

Planning Priorities Results Co-Factors

- | | |
|--|---------------------------|
| • Religion, which prevents condoms | Stigma |
| • Fear or Stigma | Stigma |
| • The desire for love, identity & identity affirmations | Stigma |
| • Lack of literacy or education | Education |
| • Economy, lack of money making power & poverty in general | Poverty |
| • Lack of Transportation (geographic isolation) | Poverty |
| • Lack of insurance | Access to care |
| • Ignoring Homeless Populations | Homelessness ¹ |
| • Lack of autonomy of one's body | Sex Work |

CPG Focus Group Results with no hard data to support the Co-Factor

- Culture
- Domestic Violence (originally paired with lack of autonomy above but there is hard no data)
- Mental Health (Research shows that specific diagnosis codes contribute to risk taking behaviors, however we haven't got the data about the numbers of people with the corresponding codes.)
- History of incarceration²
- Disability³

Additional Co-Factors Developed by Planning Priorities

- STD history
- Substance Abuse
- Immigrants
- Crime & Violence

Draft List of Populations

| | Men | Women | Trans |
|---------------|--|--|----------------------------|
| | PLWHA | PLWHA | PLWHA |
| IDUs (SIPs) | African Americans & Latinos 25 years + | | AA MTF under the age of 40 |
| MSM | African Americans & Latinos 14 – 64; Caucasians 25 – 64 | | |
| Heterosexuals | AA Men 24-64 in North & West Philadelphia | AA Women 24- 64 in North & West Philadelphia | |

One point to consider is that HIV positive people, their sex partners as well as sex partners of IDUs need to be prioritized first.

¹M. Castillo suggested adding a statement to the prevention plan that would denote the need to develop interventions for individuals with unstable housing.

²M. Castillo suggested that the committee include incarceration in the plan as a concern but not as a full cofactor. She felt that the scope of the Prison AIDS Project negated the need for the committee to be concerned about adding programs for prison populations. The committee agreed with the suggestion

³R. Feely suggested that all items on the list including disabilities be included as a cofactor if sufficient data could be found to link them to increased risk for HIV. If supportive data could not be found for an item, he proposed including it in the plan as another point of concern. The rest of the group agreed.

Step 3: Weight Factors

Assign a weight (level of importance) to each factor.

| <p>FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS</p> <p><i>Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.</i></p> | | |
|--|--|--|
| FACTOR | DEFINITION | DISCUSSION |
| HIV/AIDS Surveillance | | This factor shows the extent of the HIV/AIDS epidemic among the target population. |
| AIDS incidence | The number of AIDS cases diagnosed in a defined population in a specified period, often a year | <p>Because of a comprehensive national AIDS surveillance system, AIDS incidence data are among the most reliable and complete population-based epidemiologic data available. AIDS incidence data may help CPGs understand the extent to which AIDS has affected a given population relative to another.</p> <p>In considering AIDS incidence data, however, CPGs should be aware that recent declines in AIDS incidence are attributable in large part to antiretroviral therapies. Currently, differences in AIDS incidence among groups (e.g., by race/ethnicity or age) may represent differences in treatment success or in access to or use of health care.</p> |
| AIDS prevalence | The number of people living with AIDS in a defined population on a specified date | AIDS prevalence data show the number of people living with advanced HIV disease. While AIDS incidence data show the total number of AIDS diagnoses in a specified period in time, prevalence data show how many people are living with AIDS, regardless of when they were diagnosed. |

FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS

Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.

| FACTOR | DEFINITION | DISCUSSION |
|---|--|---|
| AIDS mortality | <p>The number of deaths among people with AIDS in a specified period, often a year</p> | <p>Like AIDS incidence and AIDS prevalence data, AIDS mortality data can be useful in understanding the extent to which the epidemic has affected a given population relative to another.</p> <p>Recent declines in AIDS deaths are attributable in large part to antiretroviral therapies. Differences in AIDS deaths among groups (e.g., by race/ethnicity or age) may represent differences in treatment success or differences in access to or use of health care.</p> |
| HIV incidence (diagnosed) | <p>The number of HIV cases diagnosed in a defined population in a specified period, often a year</p> | <p>The number of HIV infections diagnosed among people who received HIV tests during a specified period of time, usually a year. The data do not show the total number of HIV infections because not everyone is tested. Nor do the data show when HIV infections occurred, for people may be tested years after infection.</p> <p>To distinguish between HIV incidence among people with and without AIDS, we refer to diagnosed HIV (including AIDS) incidence and diagnosed HIV (not AIDS) incidence. In general, diagnosed HIV (not AIDS) incidence represents people infected with HIV more recently than people represented by AIDS incidence data.</p> |
| HIV prevalence (diagnosed, including AIDS) | <p>The number of people living with diagnosed HIV (including people with AIDS) in a defined population on a specified date</p> | <p>This factor shows the total number of people diagnosed with HIV or AIDS, minus those who have died, at a given point in time. Diagnosed HIV prevalence includes only people who have been tested, diagnosed, and reported; people who were tested anonymously are not included.</p> <p>Almost all areas now have HIV reporting; however, two years of HIV reporting data are considered the minimum for projecting trends. Diagnosed HIV (not AIDS) prevalence represents those people living with HIV infection but not AIDS.</p> |

| FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS <i>Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.</i> | | |
|---|--|---|
| FACTOR | DEFINITION | DISCUSSION |
| Documentation of HIV-Risk Behaviors | | This factor provides data about behaviors that may lead to HIV transmission/acquisition. |
| Key indicators of HIV-risk behaviors | Data sets that document that HIV-risk behaviors are occurring within the target population | <p>Although it's impossible to know how often target populations engage in HIV-risk behaviors, CPGs may use a variety of data to estimate occurrences.</p> <p>Sexually transmitted diseases (STDs): Gonorrhea, syphilis, and chlamydia are reportable STDs in most project areas. Because STD rates are reliable indicators of high-risk behavior (unprotected sex), groups with high rates of STDs are potentially at increased risk for HIV infection. Additionally, some STDs increase the risk of transmission in individuals who are exposed to HIV. The extent to which STD rates correlate with HIV risk will depend on the HIV prevalence (diagnosed) within the sexual network of persons practicing unsafe sex and on the local dynamics of STD transmission.</p> <p>Note: STD data alone do not indicate a risk for HIV infection. For example, if HIV prevalence (diagnosed) is extremely low, even high STD rates do not indicate a high risk. If HIV prevalence (diagnosed) is extremely high, even low STD rates do not indicate a low risk for HIV infection.</p> <p>Youth Risk Behavioral Surveillance System (YRBSS): This study measures health-risk behaviors among adolescents in school through representative biennial national, state, and local surveys. Out-of-school youth may have higher levels of HIV risk behaviors.</p> |

FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS

Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.

| FACTOR | DEFINITION | DISCUSSION |
|--|--|---|
| <p>Other indicators of risk behaviors</p> | <p>Other data sets that may signal HIV risk behaviors occurring within the target population</p> | <p>Adolescent sexual activity: Teenage pregnancy is sometimes a marker for early initiation of unprotected sex, and an indication of high-risk behaviors. Take care in interpreting these data because teenage pregnancy may be intentional.</p> <p>Other behavioral data: Depending on local data collection and research systems, CPGs may be able to access local population studies of behaviors associated with HIV transmission, such as anal intercourse or needle sharing, and studies of the determinants of high-risk behaviors.</p> <p>CPGs should work with epidemiologists, behavioral scientists, etc., to determine whether other studies that collect behavioral data exist (especially any funded by federal — e.g., NIMH, NIDA, CDC — or state agencies).</p> |
| <p>Riskiness of population behaviors</p> | <p>The nature and relative risk of behaviors that occur in the target population</p> | <p>This factor considers the relative risk of behaviors among target populations. The risk for HIV transmission and acquisition associated with the highest-risk behaviors is well understood. The three most risky behaviors for transmitting HIV are, in descending order of risk, the use of HIV-infected injection equipment, unprotected receptive anal sex with an infected partner, and unprotected vaginal sex with an infected male partner.</p> |
| <p>Multiple high-risk behaviors</p> | <p>The extent to which multiple high-risk behaviors occur within the target population</p> | <p>This factor considers the occurrence of more than one high-risk behavior within a given population. For example, men who have unsafe sex with men and inject drugs are engaging in multiple high-risk behaviors.</p> |

FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS

Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.

| FACTOR | DEFINITION | DISCUSSION |
|---|--|--|
| Sociodemographic Characteristics | | This factor, which can be measured in several different ways, examines complex issues that may affect the provision of HIV prevention interventions. |
| Size of target population | The estimated size of the target population in the geographic area where the program will be implemented. | Estimating target population size has been difficult for many project areas. CDC recommends using a World Health Organization methodology available at: http://www.who.int/docstore/hiv/Core/Chapter_9.10.html |
| Difficulty of meeting population needs | The complexity of needs and whether the population has been reached by current programs, whether service providers have capacity, etc. | <p>CPGs may use a variety of data sets, such as racial/ethnic composition, population density (urban, rural, frontier), education (especially level of completion and literacy rates), socioeconomics, service utilization data (services mapping, services access and utilization, etc.) to determine risk in a population.</p> <p>Review all available data and information sets, including the results of the gap analysis. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.</p> |
| Barriers to reaching the population | The extent to which barriers to providing HIV prevention programs exist in a high-risk population. | <p>CPGs may consider the following sociodemographic characteristics when looking for indicators of barriers — cultural, linguistic, socioeconomic status, family or social network structures, gender and sexual orientation studies, religion and spiritual beliefs, consumer preferences, provider preferences, and community norms and values. Studies that focus on knowledge, attitudes, behaviors, and beliefs will also provide information about barriers.</p> <p>Review all available data and information sets. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.</p> |

When your CPG has decided which factors to consider, you are ready to determine the relative importance (weight) of each factor. Weighting is optional, but if you don't do it, all factors will have the same importance. Faced with complex decisions, many CPGs find that weighting factors eases the priority setting process and increases objectivity. It helps with one of the hardest steps, comparing two or more options. No formula tells you which factors are most important, but it helps to ask:

- How well does this factor demonstrate the prevention needs of the target population?
- To what extent does the factor focus on a greater risk for HIV infections among the target population?

W By weighting factors, your CPG shows how important it thinks each factor is compared to the other factors. For example, you may believe that “HIV incidence (diagnosed),” “AIDS incidence,” and “multiple high-risk behaviors” are more important factors for determining the target populations than “AIDS mortality” and “barriers to reaching the population.” The last two factors, then, carry less weight.

| DATA SOURCES FOR TARGET POPULATION FACTORS | |
|---|---|
| TARGET POPULATION FACTOR | DATA SOURCES |
| AIDS incidence AIDS prevalence AIDS mortality HIV incidence (diagnosed) HIV prevalence (diagnosed) | Epidemiologic profile |
| Key indicators of risk behavior | Epidemiologic profile, state/local STD departments, Youth Risk Behavior Surveillance Survey (YRBSS) |
| Other indicators of risk behavior | Epidemiologic profile, other state/local statistics |
| Riskiness of population behaviors | Local behavioral data/research systems |
| Multiple high-risk behaviors | Local behavioral data/research systems |
| Size of the population | Estimated from epidemiologic data |
| Difficulty of meeting population needs | Community services assessment (HIV Prevention Community Planning and Ryan White CARE Planning), including qualitative research, state/local vital statistics, state/local health utilization surveys, education surveys, services mapping |
| Barriers to reaching the population | Community services assessment (HIV Prevention Community Planning and Ryan White CARE Planning), including qualitative research, state/local vital statistics, state/local health utilization surveys |
| For data sources in your project area, see <i>Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning, Appendix B: Data Sources by Jurisdiction</i> , available online at: http://www.cdc.gov/hiv/pubs/guidelines.htm . | |

You can use numeric or non-numeric weights.

- **Numeric weights** — Numeric weights are based on a scale, such as 1 (least important) through 3 (most important).

Numeric weights have the advantage of being precise. In a 1-to-5 (least-to-most important) scale, 4 always beats 2.

Although using a large scale (such as 1 to 100) may be tempting, it's probably unnecessary as the factors' weights won't differ a great deal. Large scales also take more calculation time.

- **Non-numeric weights** — Non-numeric weights are words or symbols, such as low, medium, and high; not important, somewhat important, and very important; and plus (+) and minus (-). It's important to choose words or symbols everyone understands.

While words aren't as precise as numbers, many CPG members may find using words easier.

When you begin to compare words or symbols, however, you may have to assign a numeric value to each, such as low=1, medium=2, and high=3.

TASKS — What do you need to do?

Perform the following basic task. Decide whether a small group, such as a priority setting committee, or the full CPG should do it.

Use Worksheet 8 on page 95 to help you assign weights to the factors for each target population. The worksheet will help you:

- Determine whether to use numeric or non-numeric weights.
- Clarify the scale — which number is highest or most important, which is lowest or least important.
- Assign a weight to each factor.

Step 4: Rate Target Populations Using Factors

Using each factor as a measure, rate each target population.

Key sub-tasks include:

APPLYING THE CONCEPT! The Advantages of Using Numerical Values

The process of assigning numeric weights to factors often helps CPG members clarify their thinking and share their thoughts.

Example: A CPG assigned a numeric weight to each factor, with 5 representing most important and 1 least important. Here is how they weighted their factors.

| FACTOR | WEIGHT | ORDER OF FACTORS |
|--|--------|------------------|
| HIV incidence (diagnosed) | 5 | 1 |
| HIV prevalence (diagnosed) | 5 | 1 |
| Riskiness of population behaviors | 4 | 2 |
| AIDS prevalence | 2 | 3 |
| Key indicators of risk behavior (STD data) | 2 | 4 |
| Difficulty of meeting need | 2 | 4 |

Because the CPG used numeric weights, everyone understood the importance of each factor, accepted the process, and the group had no trouble explaining its decisions to others.

- Assembling necessary data
- Developing a rating scale for each factor
- Rating target populations using each factor

W

You're ready to use the weighted factors to rate each of the potential target populations.

Why is it important to rate factors? To compare different factors, you need an identical scale for each factor. That is, the scale must have the same number of values. For example, you may want to find out which CPG member loves chocolate the most. You pass out dark chocolates and ask the members how much they love this chocolate. Two individuals report, "Not at all...hate chocolate." Some say, "I only like milk chocolate." A few write, "Good." Adora tells the group, "I love this chocolate! I give it a 10." Frank says, "I love it too. I give it a 100!" Who loves the chocolate the most — Adora or Frank? You can't tell because they used two different rating systems. Is 100 ten times greater than 10 here? Does Frank love the chocolate ten times more than Adora? If we ask them both to rate their choices