



METRO

Service Planning Area **SPA**

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Chapter 4: Priority Populations

Overview

This chapter:

- Describes the priority setting process implemented for the *Los Angeles County HIV Prevention Plan 2009-2013*;
 - Presents the results of the 2009-2013 priority setting process, including the new priority populations and critical target populations within each; and
 - Details the allocation recommendations and rationale for priority populations.
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Establishing the priority populations to be targeted and identifying appropriate intervention strategies to reach these populations are among the primary mandates for jurisdictions that receive HIV prevention funding from the Centers for Disease Control and Prevention (CDC). As such, it is a core responsibility of the Los Angeles County HIV Prevention Planning Committee (PPC), the County's local community planning group. In April 2007, the PPC formally created the Prevention Plan Work Group to shoulder the task of priority-setting as part of Los Angeles County's 2009-2013 comprehensive planning process. Priority-setting is not an isolated event but takes place within the larger framework of the planning process, which includes (1) examining trends in the epidemic through an analysis of the data available to identify the populations at greatest risk, (2) assessing the community's need for HIV testing and HIV prevention services, (3) identifying effective strategies to address identified needs, and (4) compiling an inventory of the available resources in order to identify service gaps.

Other chapters of the *County of Los Angeles HIV Prevention Plan 2009-2013* describe the other components of Los Angeles' comprehensive planning process. This chapter details the process used by the Prevention Plan Work Group to create an evidence based approach for establishing priority populations. The Prevention Plan Work Group members engaged in hundreds of hours of information gathering, analysis, and discussion to ensure the integrity of the process. Much of this work is presented in other chapters and forms the foundation for priority-setting.

Los Angeles County's Priority Setting Process

Two themes stand out as the hallmark of Los Angeles County's 2009-2013 priority setting process: (1) an outstanding level of community commitment and participation in the process, and (2) a strong desire to establish priorities that are data driven and reflect the County's epidemic. Through the 2009-2013 community planning process, Los Angeles County has experienced a new level of excellence, both in terms of community participation as well as quality; this will likely remain the benchmark for future planning cycles.

■ Background

In April 2007, the PPC passed a motion to establish the ad hoc Prevention Plan Work Group. They invited both PPC members as well as other community members to attend the first meeting in late April 2007. The purpose of the group was to develop a countywide strategic plan for delivering HIV prevention services for the five-year period from 2009 to 2013. This plan would establish HIV prevention priorities for the County's request for Proposals (RFP) process administered through the County of Los Angeles Department of Public Health, Office of AIDS Programs and Policy (OAPP).

The Prevention Plan Work Group scheduled bi-monthly meetings for the first and third Monday of the month through October 2007 to complete several key tasks, including but not limited to:

1. Vote on the term of the multi-year HIV prevention plan;
2. Endorse development and findings of the Epidemiologic Profile and the Resource Inventory;
3. Prioritize target populations and determine funding allocations;
4. Identify interventions that will reach communities at risk for HIV in Los Angeles County; and
5. Make recommendations on resource allocations by service type (e.g., HIV counseling and testing, etc.).

The Prevention Plan Work Group was a group open to community stakeholders and all of the meetings were open, with representatives from the PPC, OAPP, Los Angeles County's eight service provider networks (SPNs), and other community members. The group elected a Chairperson and Deputy Chairperson to lead the meetings. The Prevention Plan Work Group reviewed and approved work of various PPC subcommittees that related to the HIV Prevention Plan (e.g., Standards and Best Practices Subcommittee identified evidence-based interventions to be included in the plan). To guide decision-making, the Prevention Plan Work Group implemented a simple majority voting process (i.e., motions would pass with a greater than 50% member vote). They also established voting eligibility guidelines. To be eligible to vote in any given meeting, an individual had to attend the previous two meetings as well as the meeting in which they would be allowed to vote. This process allowed the Prevention Plan Work Group to maintain its open door policy for having community members participate in the process at times when they were able, while assuring that a single person or group who had not attended previous meetings would not stall the process and prevent it from moving forward. Thus, decisions were made and voted upon by Prevention Plan Work Group members who benefitted from the discussions and information presented at previous meetings.

To guide discussion and decisions, the Prevention Plan Work Group adopted a set of core operating values also used by the Los Angeles County Commission on HIV during their deliberations. These values included:

- Quality of Care
- Beneficence
- Representation
- Access

Throughout the planning process, the Chairperson and Deputy Chairperson reaffirmed the role of the members on the Prevention Plan Work Group as *planners* versus *advocates*. In order to effectively plan for the County as a whole, Prevention Plan Work Group members, many of whom represented specific agencies and constituents, had to set aside any personal or organizational agenda that he or she might have in order to identify the HIV prevention-related needs of communities at risk for acquiring or transmitting HIV. For example, although females are approximately 50% of Los Angeles County's population, they comprise less than 13% of total PLWHA in the County. Thus, although everyone acknowledged the need to target services to women, this need had to be placed within the overall context of Los Angeles County's epidemic. A closer examination of HIV/AIDS prevalence among women shed light on the disparities within this population and identified key racial/ethnic groups disproportionately impacted by HIV/AIDS. Thus as planners, the Prevention Plan Work Group members were able to make informed decisions about the extent of need and available services that were based on available data. This focus and emphasis on making data driven decisions focused discussions regarding specific groups. In addition, from their experience in working with specific impacted communities, Prevention Plan Work Group members were also able to share nuances about risk behavior within their specific target population that enhanced understanding of that population.

In July 2007, OAPP engaged the services of an external consultant to write the final version of the plan, as well as to assist with the priority-setting process. As time progressed, the Prevention Plan Work Group recognized that additional meetings would be needed in order to complete all the work needed for priority-setting as well as the subcommittee work responsible for various sections of the plan. In response, the Prevention Plan Work Group members added additional meetings, lengthened scheduled meetings, and extended the planning time period beyond the original October 2007 timeline. This flexibility put into practice several of the group's operating values. It was critical that everyone who participated had access to all aspects of the process and that their voice was represented during discussions. This supported the inclusive environment that the Prevention Plan Work Group sought to create.

■ Decision Making Process

The PPC entrusted all aspects of the priority setting process to the Prevention Plan Work Group, including decision making. It was then the responsibility of the Prevention Plan Work Group to develop and agree on a set of recommendations regarding priority populations to present to the PPC for approval. With the assistance of the OAPP staff, subject matter experts, and the external consultant, the Prevention Plan Work Group embarked upon this momentous task.

In July, the consultant emphasized the importance of the priority setting process as described in the Centers for Disease Control and Prevention's (CDC) *Setting HIV Prevention Priorities: A Guide for Community Planning Groups* [1]. This conversation sparked extensive discussion in subsequent meetings regarding the work group's desire to have a priority setting process that: (1) fostered discussion and sharing of ideas so that everyone felt heard, and (2) reflected the current HIV/AIDS epidemic in Los Angeles County and highly impacted communities.

Thus, although the Prevention Plan Work Group had already established a voting process for decision making, they re-examined this methodology in light of their expressed desire to provide an open environment that promoted discussion. In August, the consultant briefly presented four decision making methods outlined in the CDC's guide. They were:

1. Consensus decision making;
2. Voting;
3. Combined method using consensus decision making and voting; and
4. Nominal Group Technique

The Prevention Plan Work Group carefully assessed the pros and cons of each method within the context of a limited time frame to complete the work. They agreed that the strength of consensus decision making was that it promoted a forum in which everyone could be heard. Rather than voting, the consensus method *tests for consensus* among group members to see if they support the decision or can accept it. When consensus is not reached, the facilitator asks the individual(s) blocking consensus to state their concern and offer a solution that will address the concern. The major challenge of this model is that it can be very time consuming and a group needs to allow sufficient time for decision making in order for consensus to work well.

It became clear that the Prevention Plan Work Group wanted to use consensus decision making for their foundation for decision making. As the Prevention Plan Work Group grew in size they wanted to ensure a structure that allowed everyone to have a voice during the intensive discussions regarding priorities. This was particularly important due to mixed community sentiment about the County's current priority populations. However, work group participants also recognized that the time constraint to complete the prevention plan was very real. As a result, the Prevention Plan Work Group adopted a combined decision making method (also outlined by the CDC) that was grounded in the consensus approach but provided a voting process as a backup for consensus when consensus could not be reached after multiple attempts. The combined consensus/voting decision making methodology adopted by the Prevention Plan Work Group included:

1. *Using a consensus approach as the foundation for decision-making.*

Rationale: The primary element of consensus decision-making is the active and full participation of group members. The Prevention Plan Work Group determined that utilizing a consensus decision-making process would best support its four core operating values: quality of care, beneficence, representation, and access.

2. *Implementing a super majority (67%) vote among eligible attendees (present at previous two and current meeting) in the event consensus could not be reached.*

Rationale: For priority setting decisions, the Prevention Plan Work Group would call for a vote if consensus could not be reached after at least two attempts. For the vote to pass, a super majority would have to be reached (67%). This honored the consensus approach, which promoted inclusiveness and resolution of differing viewpoints.

The entire membership of the Prevention Plan Work Group recognized that a consensus approach is the most inclusive model for decision-making and that it provides a structure for resolving issues and concerns among the group. The consensus model allows everyone to be heard, creates opportunities for new ideas and options, and if consensus is reached, it means that all participants can accept the decision. Thus, implementing a combined consensus/voting model allowed the Prevention Plan Work Group to maintain a balance between being true to the intent and spirit of consensus decision-making, while still being able to move the process forward during times when consensus could not be reached.

To ensure that all members had a common understanding of how consensus decision making worked, the consultant delivered a brief training to educate the Prevention Plan Work Group members. This training resulted in further clarification of the process. During the training, the Prevention Plan Work Group clarified their procedure for testing for consensus and voting. Participants agreed that everyone in attendance would be allowed to participate fully in all discussion as well as testing for consensus. However, if consensus could not be reached, the Prevention Plan Work Group would move to the super majority vote of eligible participants (i.e., a person had to attend the previous two meetings as well as the current meeting in order to participate in the super majority vote. In this way, the process adhered to the previously established voting eligibility requirements.

Although, participants expressed concerns about trusting the process, trust was built over time. The consensus-based approach provided a strong foundation for building trust, and although it was not a perfect process, it encouraged and supported open discussion of the many issues confronting the group.

Once the Prevention Plan Work Group had agreed upon the decision making method, the group discussed the need to inform the decision making process with the most up-to-date information available. During the two years leading up to the formal priority setting process, the PPC had convened four ad hoc committees, which resulted in key recommendations regarding specific populations and interventions. These ad hoc committees included: (1) the Venue-Based Task Force, (2) the African American MSM Task Force, (3) the Crystal Methamphetamine Task Force, and (4) the HIV Counseling and Testing (HCT) Work Group. The first three Task Forces presented their findings to the PPC in 2006. The HCT Work Group completed its work in time for the priority setting process. In addition to these ad hoc committees, the PPC offered numerous colloquia and had key subject matter experts provide information on a variety of topics. Lastly, to ensure that all participants had access to the most up-to-date HIV surveillance and other relevant data, the Prevention Plan Work Group and OAPP convened a three day *Data Summit*, which began in late September 2007 and concluded in early October 2007. During this data summit, the Prevention Plan Work Group members received information, which included but was not limited to: (1) local HIV/AIDS surveillance data and studies; (2) Los Angeles Coordinated HIV Needs Assessment (LACHNA) data; (3) findings from Focus Groups and Key Informant Interviews; (4) HIV counseling and testing data; (5) City of Long Beach HIV epidemiology data; and (6) STD data.

■ Existing Planning Models

Before priority-setting, several members of the Prevention Plan Work Group expressed concern regarding the current hybrid Behavioral Risk Group (BRG) planning model used by Los Angeles County. This planning model was developed as part of the priority setting process designed to guide development of Los Angeles County's *HIV Prevention Plan 2000*. Similar to this current planning process, the PPC engaged in extensive discussions regarding an existing population-based model, which did not necessarily account for behavioral risk for acquiring or transmitting HIV. The development of the BRG model represented a landmark shift in how Los Angeles County prioritized populations based upon their risk behaviors. The PPC adopted a revised version of this planning model during the 2004-2008 planning process. However, despite the good work and herculean effort among many community members and OAPP staff during these periods, an undercurrent of concern regarding the effectiveness of the BRG model has remained over the years. One of the primary concerns was the potential for individuals at risk for infection

not being captured with the model. Among other issues, many community members expressed concerns regarding identity issues and the role identity may play as both a protective factor against acquiring or transmitting HIV or as a barrier to identifying risk and/or accessing services. After extensive discussion regarding the strengths and weaknesses of the now eight-year old BRG model, the Prevention Plan Work Group agreed to re-visit the planning model that would be used in Los Angeles County to guide priorities. After gathering information regarding the planning models used in other jurisdictions across the United States (U.S.), the Prevention Plan Work Group examined four potential planning models (Behavioral, Geographic, Population, and Hybrid). The following grid guided their discussion of the benefits and challenges of each model:

Table 4.1 Planning Models Used by Other Jurisdictions Across the United States

<p style="text-align: center;"><u>Behavioral Model</u></p> <ul style="list-style-type: none"> • Oregon (2005 update) – IDU, MSM, HIV+ • Wisconsin (2005-2008) – MSM, IDU, MSM/IDU, Heterosexual Risk, HIV+ • Hawaii (2007) – 3 “at risk” populations identified: African Americans, Transgenders, IDUs 	<p style="text-align: center;"><u>Geographic Model</u></p> <ul style="list-style-type: none"> • Nevada (2006-2008): Primary populations were determined for Nevada and subpopulations were prioritized by County for Clark and Washoe Counties
<p style="text-align: center;"><u>Population Model</u></p> <ul style="list-style-type: none"> • Houston (2004-2006) - Population groups prioritized with racial/ethnic subpopulations 	<p style="text-align: center;"><u>Hybrid Model</u></p> <ul style="list-style-type: none"> • Los Angeles County (2000 and 2004) – Behaviorally based with identified target populations • San Francisco (2004) – Behaviorally based with identified target subpopulations; cofactors also identified • Alaska (2001-2003) – Behaviorally based with targeted subpopulations • Connecticut (2005-2008) – Behaviorally based with racial/ethnic subpopulations • Delaware (2005-2009) – Behaviorally based with subpopulations; HIV+ with subpopulations; zip code targets included by behavioral population • Maine (2004-2008) – Behaviorally based with identified subpopulations by gender and race/ethnicity; specific counties also prioritized • Broward County (2007-2009) – Behaviorally based with racial/ethnic target populations • Chicago (2001-2003) – Behaviorally based with subpopulations by gender, age; also incarcerated

Complementing the discussion around these four planning models, the Prevention Plan Work Group also discussed issues of identity and how identity impacts a person’s access to services. For example, if a gay or bisexual man does not identify with the terminology “men who have sex with men” (MSM), he may not access services because he does not see how he fits into this description. The Prevention Plan Work Group acknowledged the importance of integrating identity and how someone self-identifies into the fabric of Los Angeles County’s planning model.

After much discussion, the Prevention Plan Work Group reaffirmed that a Hybrid Planning Model would continue to give Los Angeles County the flexibility to address multiple concerns and needs, including issues of identity. However, the Prevention Plan Work Group continued to discuss the elements of the hybrid model and whether the current BRG hybrid model was best suited to meet Los Angeles County's current and evolving needs.

❖ **A NEW PLANNING MODEL**

In 2000, the PPC embarked on a new era of HIV prevention planning when it designed the behaviorally-based BRG planning model. At that time, it was a bold move for the PPC to challenge the existing paradigm, which supported targeting HIV prevention and testing services to population-based groups. The current Prevention Plan Work Group continued Los Angeles County's heritage of challenging paradigms in order to best meet the needs of communities impacted by HIV/AIDS.

The Prevention Plan Work Group sought to modify its current hybrid planning model to address concerns raised about the BRG model and meet the needs of high risk communities. A major concern raised about the BRG model was that certain groups of high-risk individuals, particularly men who engage in sex with men (MSM) but do not identify as gay, bisexual, queer, same-gender loving, questioning, or other comparable identity might "fall through the cracks" of this planning approach. For example, men who identify as heterosexual or straight might not identify their risk for HIV despite their behavior (e.g., unprotected sex with transgender individuals, unprotected sex with men, unprotected sex during periods of incarceration, etc.), which clearly puts them at risk for HIV, STDs, and hepatitis. Prevention Plan Work Group members also acknowledged that although the BRG model was intended as a planning model, some organizations and communities misunderstood its intent. These agencies and staff used BRGs to strictly define participant eligibility and this became a barrier to services for some at-risk individuals and communities. Thus, although the planning model was sound, the translation of the model into program implementation was not always smooth. Lastly, the Prevention Plan Work Group expressed concerns regarding "highly impacted" geographic areas (i.e., zip codes of residence where higher rates of HIV seropositive results among individuals tested for HIV) and the need to integrate geography into a redesigned model.

The Prevention Plan Work Group identified important factors to consider in the refinement of their planning model, including highly impacted populations, behavior, identity, and geography. In determining which of these factors would serve as the primary lens through which Los Angeles County would view its epidemic, the Prevention Plan Work Group's focused its discussion around five key questions:

1. "Who are the populations at risk for HIV/AIDS?"
2. "What are the behaviors that put an individual at risk?"
3. "What are the cofactors that heighten a person's risk for HIV/AIDS?"
4. "Where are the people at risk for HIV/AIDS (i.e., live, work, play, seek services)?"
5. "How do identity issues influence a person's perception of risk, actual risk for HIV, and access to prevention and testing services?"

This discussion led to the creation of a new paradigm and planning model in Los Angeles County. The Prevention Plan Work Group agreed on the following five components to be a part of the revised planning model:

1. “Population groups” need to be the first lens through which priority populations are determined in order to ensure that everyone at risk for HIV has access to services;
2. Unprotected sexual behavior and sharing injection paraphernalia (SIP) are the primary means through which a person is at risk for acquiring or transmitting HIV *and* only persons who engage in such behaviors are at risk for HIV;
3. How an individual self-identifies (i.e., one’s identity) influences his/her perception of risk as well as whether or not he/she will likely access services;
4. There is a set of critical co-factors (e.g., poverty, STDs, stigma, discrimination, etc.) shared by all populations that heighten a person’s risk for HIV and a set of co-factors that are unique to a specific population (e.g., lack of employment among transgender individuals); and
5. Where a person lives, works, and plays varies greatly across the County; this results in broad variation regarding where they access HIV testing, prevention, and care services.

The Prevention Plan Work Group reached consensus on redesigning Los Angeles County’s planning model. Shifting from the established BRG model, Los Angeles County’s new model integrates all five components, using population as the primary lens for defining priority populations. However, this population-based approach must be informed by behavioral risk, identity, and geography, as well as the co-factors that contribute to an increased vulnerability and risk for acquiring or transmitting HIV.

■ Prioritizing Populations

The Prevention Plan Work Group extensively discussed the best method for prioritizing populations. They unanimously agreed to implement a data driven process that would accurately reflect the HIV/AIDS epidemic in Los Angeles County. The participants also agreed on implementing a weighted methodology (discussed below), similar to that described in the CDC’s planning guidance [1]. However, to create a data driven process, the Prevention Plan Work Group needed to take into consideration the limitations of available data sources and begin with a group of populations that had sufficient data available. This posed a challenge due to the fact that the County has collected data/information based on behaviorally-defined groups (e.g., men who have sex with men, women at sexual risk, injection drug users, etc.) for the past six years. Thus, the Prevention Plan Work Group needed to select broader populations for whom there was available public health data (e.g., STDs, AIDS prevalence, etc.) to gather and analyze.

❖ IDENTIFY BROAD POPULATION CATEGORIES

To identify the broad population categories to be used, the Prevention Plan Work Group posed the question, “Who is at greatest risk for acquiring or transmitting HIV?” From the lengthy list developed, the Prevention Plan Work Group honed the list into six broad population groups for consideration:

1. HIV-Positive Individuals
2. Men
3. Women
4. Transgender Individuals
5. Youth (12-24)
6. People who Share Needles and/or Works (i.e., “sharing injection paraphernalia”)

Los Angeles County’s previous BRG model consisted of seven mutually exclusive, behaviorally-defined categories (e.g., MSM, women at sexual risk, etc.). In this model, individuals were defined by their risk behavior and the labels applied to that risk behavior. Thus, if a person at high risk did not identify with those planning categories, they might not seek services. Therefore, an important group of people at risk for acquiring or transmitting HIV was likely lost due to the planning model utilized.

Adopting broad population categories allows everyone at risk for HIV to identify with one or more of the categories. This inclusive approach minimizes the chance that people who are at risk for HIV will “fall through the cracks” of the model. One hundred percent of the population will fall into one or more of these categories. The first five population categories represent individuals at sexual risk of acquiring or transmitting HIV; the sixth group represents those individuals who are at risk of acquiring or transmitting HIV via sharing injection paraphernalia. These broad categories are not mutually exclusive. For example, an HIV positive person might also be a woman. Depending upon the individual, that HIV positive woman might prefer to access services specifically targeting women rather than those services targeting HIV positive individuals or vice versa. However, it is behavior that puts an individual at risk for acquiring or transmitting HIV and not simply falling into one of the population-based categories listed. Thus, behavioral risk further defines and clarifies the target population for services.

To accurately reflect behavioral risk, the Prevention Plan Work Group examined current language used, specifically referring to injection drug users (i.e., IDUs). Although IDU will continue to be the language used by the CDC to describe exposure mode, the Prevention Plan Work Group adopted language that more accurately reflects the behavior that puts people at risk for HIV. As such, the Prevention Plan Work Group has adopted the term “sharing injection paraphernalia” (i.e., SIPs) to refer to the group of people whose risk for acquiring or transmitting HIV is the result of sharing needles or works. This language does not have the negative connotation associated with the term IDU (i.e., someone who injects illegal substances). This language is more inclusive and encompasses all individuals who share paraphernalia that do not identify with IDU (e.g., transgender individuals who inject hormones or silicone, individuals who inject steroids, etc.).

In this early phase, the Prevention Plan Work Group also discussed the possibility of subdividing the data further by race/ethnicity for analysis. For example, each of the six categories would be divided by the major racial/ethnic groups in Los Angeles County prior to applying the weighted methodology. Thus, all people living with HIV, men, women, transgender individuals, youth,

and SIPs would be divided into the major racial/ethnic populations: White, African American or Black, Latino or Hispanic, Asian or Pacific Islander, and Native American. Other jurisdictions (e.g., Houston) had utilized such an approach prior to applying their weighted methodology. The advantage of this approach was that it would clearly rank priority populations by racial/ethnic group. However, the Prevention Plan Work Group expressed concern that subdividing smaller population categories (e.g., HIV positive individuals, transgender individuals, and individuals who share injection paraphernalia) by race/ethnicity would dilute the results, and a critical population might receive a lower ranking than warranted. Thus, applying the weighted methodology to the larger population categories would improve the strength of the results and appropriately rank populations.

Another concern was the time required to divide available data by race/ethnicity and population category. The priority setting process was scheduled in October 2007 and was implemented in early November. OAPP was just beginning to analyze the results of the Los Angeles Coordinated HIV Needs Assessment (LACHNA) data and there was not sufficient time to gather all of the data and have it available by race/ethnicity to include in the weighted methodology. Thus, in consideration of the time element, as well as the size of the populations to be divided, the Prevention Planning Work Group decided to examine highly impacted communities as well as disproportionately impacted communities by race/ethnicity in their final resource recommendations. In this way, the Prevention Plan ensured that dedicated resources and services would target highly impacted racial/ethnic groups within each priority population.

❖ **WEIGHTED METHODOLOGY**

The Prevention Plan Work Group's decision to use a weighted methodology to rank priority populations in Los Angeles County marks a new era in local planning for the County. Although the PPC had used data extensively during previous priority setting processes, the weighted approach implemented, which was outlined by the CDC [1], took these previous efforts to new heights. Thus, Los Angeles County's 2009-2013 planning period is the first in which priority populations were ranked using a weighted approach.

As a starting point for their discussion, the Prevention Plan Work Group reviewed the weighted methodology outlined by the CDC and implemented by several jurisdictions, including Houston as described in its *2004-2006 Comprehensive Plan*. The CDC's method included the following:

- STEP 1: Identify and define target populations.
- STEP 2: Determine relevant factors.
- STEP 3: Assign a weight (level of importance) to each factor.
- STEP 4: Assign a rating scale to the factor.
- STEP 5: Score target populations using factors.
- STEP 6: Rank target populations.

The following describes each of the six steps in detail:

STEP 1: Identify and define target populations.

- As noted earlier, the Prevention Plan Work Group discussed the question, "Who is at greatest risk for acquiring or transmitting HIV?"
- The work group created an extensive list of identified populations.

- Identified populations were collapsed into six broad population categories: (1) HIV positive individuals, (2) youth, (3) men, (4) women, (5) transgender individuals, and (6) people who share needles and/or works.

STEP 2: Determine relevant factors.

- The Prevention Plan Work Group selected 10 weighting factors that provided information related to the HIV epidemic and risk behavior. The factors selected had data that could be easily gathered from a reliable data source within a relatively short time period. HIV/AIDS surveillance was a primary data source, as well as LACHNA data, which asked respondents about their risk behaviors, including substance use, inconsistent condom use, and sex exchange. The factors included in the weighting are:
 - AIDS Incidence
 - AIDS Prevalence
 - HIV Incidence Estimates
 - Estimated Population Size
 - Gonorrhea & Chlamydia rates
 - Primary & Secondary Syphilis rates
 - Substance Use rates (includes all substances)
 - Inconsistent Condom Use
 - Use of the “Hard Core 4” Substances: methamphetamine, crack, cocaine, and heroin
 - Sex Exchange: exchanged sex for money, drugs, or to meet some other need

STEP 3: Assign a weight to each factor.

- The Prevention Plan Work Group assigned weights to each of the ten factors:

Table 4.2 Factors, Assigned Weights, and Data Source

FACTOR	ASSIGNED WEIGHT	DATA SOURCE
AIDS Incidence	3	HIV Epidemiology Program
AIDS Prevalence	3	HIV Epidemiology Program
HIV Incidence Estimates	2	HIV Counseling and Testing Data
Estimated Population Size	2	HIV Epidemiology Program
Gonorrhea & Chlamydia	1	STD Program (also includes data from City of Pasadena and City of Long Beach)
Primary & Secondary Syphilis	2	STD Program (also includes data from City of Pasadena and City of Long Beach)
Substance Use	2	HIV Counseling and Testing Data
Inconsistent Condom Use	1	Los Angeles Coordinated HIV Needs Assessment (LACHNA) data
“Hard Core 4” (methamphetamine, crack, cocaine, heroin)	2	LACHNA data
Sex exchange: engaged in exchange of sex for money, drugs, or other need	1	LACHNA data

STEP 4: Assign a rating scale to each factor.

- OAPP developed a 1 to 4 numeric rating scale for each of the ten factors.
- The following is an example for “AIDS Incidence.”

Table 4.3 Example of Method to Determine Rating Scale for AIDS Incidence

Target Population	Data (counts)
HIV Positive	21,841 (high)
Youth	220 (low)
Men	19,452
Women	2,389
Transgenders	Unknown
Sharing Injection Paraphernalia	3,237.38
Data Range	220 – 21,841

Note: The data counts were obtained from the HIV Epidemiology Program surveillance reports (AIDS incidence from 2002-2006).

- The data range for each factor was divided into four quartiles to create the rating scale. For AIDS Incidence, the rating scale was as follows:

DATA RANGE: $21,841 - 220 = 21,621$

QUARTILES: $21,621 \div 4 = 5,405.25$

RATINGS:

1 =	220	to	5,625.25
2 =	5,625.26	to	11,030.50
3 =	11,030.51	to	16,435.75
4 =	16,435.76	to	21,841

This same method was used to create the rating scale for each of the remaining nine factors.

- The rating scale was applied to the data counts for AIDS Incidence, which resulted in the following ratings for the six target populations:

Table 4.4 Example of Method to Determine Rating Scale for AIDS Incidence

Target Population	Data (Counts)	Rating
HIV Positive	21,841	4
Youth	220	1
Men	19,452	4
Women	2,389	1
Transgenders	Unknown ¹	1
Sharing Injection Paraphernalia	3,237.38	1

¹ Transgenders were given a ranking of 1 since there was no data available for them.

STEP 5: Score target populations using factors.

- For each target population, the rating for each factor was multiplied by the weight. All factors were added together to obtain the total.

The following table illustrates this method for HIV Positive individuals:

Table 4.5 Scoring Methodology Applied to HIV Positive Individuals

FACTOR	RATING	WEIGHT	HIV POSITIVE (TARGET POPULATION)
AIDS Incidence	4	3	4 x (3) = 12
AIDS Prevalence	4	3	4 x (3) = 12
HIV Incidence	4	2	4 x (2) = 8
Estimated Population Size	1	2	1 x (2) = 2
Gonorrhea/Chlamydia	1	1	1 x (1) = 1
Primary & Secondary Syphilis	1	2	1 x (2) = 2
Substance Use ¹	1	2	1 x (2) = 2
Inconsistent Condom Use	3	1	3 x (1) = 3
Hard Core 4 ²	1	2	1 x (2) = 2
Sex Exchange	1	1	1 x (1) = 1
TOTAL			45

¹ Substance use includes all substance (HCT question: list of drugs checklist).

² Hard Core 4 consists of any use of: methamphetamine, cocaine, crack, and heroin.

STEP 6: Rank target populations.

- The target population receiving the highest total score ranked 1st to the lowest scoring population, which ranked 6th. The results are as follows:

- #1 Men
- #2 HIV Positive Individuals
- #3a People who Share Needles/Works
- #3b Women
- #4 Youth
- #5 Transgender Individuals

STEP 7: Determine funding allocation (Health Education/Risk Reduction interventions) for Priority Populations.

- The scores for all six target populations were added together; this totaled 222.
- To determine the percentage of Health Education/Risk Reduction interventions funding to be targeted to each priority population, the score for the priority population was divided by the total score for all six populations.

Using HIV positive individuals as an example:

<u>Population</u>	<u>Population Score ÷ Total Score = Percent of Funding</u>
HIV Positive Individuals	45 ÷ 222 = 20.3%

Results & Recommendations

■ Priority Populations and Critical Target Populations

After ranking Los Angeles County's priority populations (see STEP 6 above), the Prevention Plan Work Group identified the critical target populations within each priority population that are most highly impacted by the epidemic and who may be at higher risk of acquiring or transmitting HIV. Table 4.6 depicts Los Angeles County's final priority populations, including critical target populations, as well as the recommended health education and risk reduction (HE/RR) resources dedicated to target these populations.

As discussed earlier, the Prevention Plan Work Group extensively discussed the disproportionate burden of HIV/AIDS by race/ethnicity. Latinos or Hispanics and Whites comprise the majority of PLWHA in Los Angeles County. However, African Americans or Blacks continue to be the most disproportionately impacted racial/ethnic group, followed by Native Americans. The impact on African Americans or Blacks was specifically highlighted by the PPC's ad hoc African American MSM Task Force Recommendations to address the disproportionate impact among gay and non-gay identified African American MSM (see *Chapter 3: Community Assessment Attachment 2-PPC Task Force Recommendations*). This important work resulted in a set of recommendations that were included in the 2006 Addendum to the *HIV Prevention Plan 2004-2008* and informed the recommendations in this current plan.

As seen in Table 4.6, the Prevention Plan Work Group established that 23% of funding for services target African American or Black gay and non-gay identified men across two priority populations: HIV Positive Individuals and Youth. Among Men, 33% of services and funding should target African American or Black gay and non-gay identified men. These percentages were established due to the high estimated seroprevalence of 36.9% among African American gay men and non-gay identified MSM (see *Chapter 2: Epidemiologic Profile, Table 2.11*).

Table 4.6 Priority and Critical Target Populations at Risk for Acquiring/Transmitting HIV

Priority Population	HIV Positive Individuals	Youth	Men	Women	Transgender Individuals	People who Share Needles/ Works
Mode of Transmission	Sexual	Sexual	Sexual	Sexual	Sexual	Sharing Injection Paraphernalia
Critical Target Populations	-Gay men -Non-Gay identified men who have sex with men/ transgenders/ multiple genders -Transgender -Women at risk for transmitting HIV	-Gay men -Non-Gay identified men who have sex with men/ transgenders/ multiple genders -Transgender -Sex workers -Young women who have sex with partners of unknown HIV status/risk and/or in highly impacted geographic areas/zip codes*	-Gay men -Non-Gay identified men who have sex with men/ transgenders/ multiple genders	-Women who have sex with partners of unknown HIV status/ risk and/or in highly impacted geographic areas / zip codes*	ALL	ALL
Race/ Ethnicity	All races/ ethnicities Minimum of 23% of services to target African American/ Black HIV positive men	All races/ ethnicities Minimum of 23% of services to target African American/ Black male youth	All races/ ethnicities Minimum of 33% of services to target African American/ Black men	All races/ ethnicities Minimum of 70% of services to target African American/ Black women and Latinas or Hispanics	All races/ ethnicities	All races/ ethnicities
	A minimum of one percent (1%) of available funding will target Native Americans; services targeted to Native Americans should include multiple Priority Populations.					
Percent of Funding	20.3%	11.2%	30.6%	14.0%	9.9%	14.0%

* Highly impacted geographic areas/zip codes must be based on surveillance, HCT, and other relevant data.

Similarly, the Prevention Plan Work Group established a minimum target of 70% of services to target African American or Black and Latino or Hispanic women, *within* the Women priority population. This recommendation follows the trend of the HIV/AIDS epidemic among women and higher seroprevalence rates among these racial/ethnic groups. Lastly, although the absolute number of Native Americans living with HIV/AIDS is small, this group is disproportionately impacted like African Americans. Thus, the PPC approved the recommendation that a minimum of 1% of HE/RR services target Native Americans across multiple priority populations.

■ Contributing Co-Factors & Other Considerations

The Prevention Plan Work Group discussed extensively the role co-factors play in contributing to a person's risk for acquiring or transmitting HIV. They defined co-factors as *a condition that can increase risk for HIV, increase susceptibility to infection, or decrease the ability to act upon HIV prevention messages*. This conversation emerged through the process used in identifying the persons most at risk for HIV. Participants identified population groups such as homeless individuals, persons with STDs, commercial sex workers, etc. The Prevention Plan Work Group determined that the consideration of co-factors is especially important at the agency level when describing the needs, as well as barriers to services of specific target populations. These co-factors need to be considered when selecting and/or designing interventions for the population. For example, if homelessness is a co-factor among runaway youth, an agency targeting this population needs to discuss how their prevention program will reach a population that is focused on meeting basic survival needs as well as stable housing. How will an agency recruit participants who are homeless? For agencies targeting gay men who use crystal methamphetamine, the agency may need to describe how crystal methamphetamine increases sexual risk-taking behavior. The agency may need to describe how the selected intervention addresses the specific behavioral issues that result from this co-factor.

Table 4.7 outlines the co-factors that are common to ALL priority populations as well as those that are especially pertinent to a specific priority population. The prevalence of some of these co-factors are described in *Chapter 2: Epidemiologic Profile* (e.g., poverty, mental health issues, etc.). This chapter also includes extensive web resources where the most current information is available regarding many of these co-factors. Other co-factors, such as stigma and discrimination, are more difficult to describe in terms of prevalence. These are co-factors that prevent individuals from accessing services, but there is little quantitative data available to describe prevalence. Instead, agencies may have their own experience, such as a needs assessment with a specific target population that better describes such co-factors.

Table 4.7 Common Co-Factors that Contribute to a Person's Risk for Acquiring or Transmitting HIV Shared by All Priority Populations

CO-FACTORS IMPACTING ALL PRIORITY POPULATIONS		
▪ Poverty	▪ STDs	▪ Homelessness
▪ Stigma	▪ Mental Health Issues	▪ Immigration Status
▪ Discrimination	▪ Violence	▪ Language
▪ Racism	▪ Sexual Assault	▪ Sex Work
▪ Educational Level	▪ Incarceration	▪ Other Substance Use

The Prevention Plan Work Group also identified co-factors that are more specific to one or more priority populations (see Table 4.8). For example, crystal methamphetamine use is a co-factor for all priority populations except women. Yet for women, the use of crack is a more significant co-factor. In all cases, it is critically important that organizations identify the co-factors that heighten the risk for acquiring or transmitting HIV among their specific target population(s).

Table 4.8 Co-Factors that Contribute to a Person’s Risk for Acquiring or Transmitting HIV by Priority Population

HIV POSITIVE INDIVIDUALS	YOUTH	MEN
<ul style="list-style-type: none"> ▪ Methamphetamine ▪ Undiagnosed HIV ▪ Homophobia ▪ Transphobia ▪ Age 	<ul style="list-style-type: none"> ▪ Developmental Issues ▪ Legal ▪ Homeless/ Runaway ▪ Methamphetamine ▪ Transphobia ▪ Homophobia 	<ul style="list-style-type: none"> ▪ Individuals who engage in Day Labor ▪ Methamphetamine ▪ Internet for Anonymous Sex ▪ Homophobia
WOMEN	TRANSGENDER INDIVIDUALS	PEOPLE WHO SHARE NEEDLES / WORKS
<ul style="list-style-type: none"> ▪ Sexism ▪ Crack 	<ul style="list-style-type: none"> ▪ Methamphetamine and Other Substance Use ▪ Lack of Employment ▪ Transphobia 	<ul style="list-style-type: none"> ▪ Methamphetamine ▪ Transphobia ▪ Homophobia

■ Service Categories

The PPWG utilized several data sources to develop recommended allocations for HIV prevention services. These data sources included: (1) HIV Counseling & Testing Workgroup Recommendations; (2) PPC Evaluation Subcommittee Recommendations; (3) Findings from Key Informant Interviews and Focus Groups; and a (4) Presentation of Recommendations for HIV Prevention Funding Categories by OAPP. The PPWG deliberated and made funding allocation recommendations for each service category, as illustrated in Table 4.9. These recommendations were approved by the PPC at its November 16, 2007 meeting.

In summary, the PPC recommends a broad range of HIV prevention services targeting individuals and communities. The following are types of HIV prevention interventions and other critical services directed towards Los Angeles County’s priority risk groups, in order to improve the County’s response to the HIV epidemic:

1. Health Education Risk Reduction
2. HIV Counseling and Testing and Partner Counseling & Referral Services
3. Evaluation
4. Programmatic Support

Table 4.9 PPC Approved Funding Allocations by Service Category

Service Category	Percentage of Funding
Health Education/Risk Reduction: <ul style="list-style-type: none"> • Interventions Delivered to Groups • Interventions Delivered to Individuals • Comprehensive Risk Counseling and Services • School Based • Faith Based • Social Marketing 	51.0%
HIV Counseling and Testing	30.0%
Partner Counseling & Referral Services	2.0%
Evaluation	8.5%
Programmatic Support (Capacity Building, PPC Support, Collaboration and Coordination Activities- Service Provider Networks and Referral Directory)	8.5%
Total	100%

■ Implications for Program Planning and Development

Unlike its previous two planning cycles, Los Angeles County for the first time has clarified the impact of co-factors and identity on a person's risk for acquiring or transmitting HIV. Some co-factors also contribute to a person's decision to access HIV testing and/or prevention services. For example, many non-gay identified men may not access HIV testing or prevention services because of stigma, discrimination, and/or homophobia. This has been shown to be true for some men of color who are at risk for HIV infection.

Identity plays an important role in determining an individual's access to services. Thus, it is critical that specific programming be developed to target gay men and non-gay identified men, and that these programs take into account identity, culture, and transitioning issues. Studies have shown that "gay identity" serves as a protective factor in HIV risk. That is, a man who clearly identifies as a gay man is more likely to be tested for HIV and access HIV prevention services than a non-gay identified MSM.

Women, on the other hand, may not even perceive their risk for HIV infection, especially if they think they are in a mutually monogamous relationship. However, not all women are in monogamous relationships; they may not know their partner's HIV status or risk for HIV and/or may live in highly impacted geographic areas. Los Angeles County HCT data confirms that the majority (96%) of women seeking testing are at high risk. This information is teased out during the risk assessment process.

As a final example, some transgender women identify as women and not transgender, yet their risk for HIV may be significantly different. Some transgender women prefer to access services targeting women versus services targeting transgender individuals. Thus, it is imperative that organizations understand their target population(s), and the co-factors and identity issues that contribute to their risk for acquiring or transmitting HIV. Co-factors, identity, and culture will guide organizations as they design services to target priority populations at highest risk for acquiring or transmitting HIV.

■ Lessons Learned for Future Planning Cycles

Overall, Los Angeles County's HIV prevention community planning process has been a great effort. The level of community commitment and support as demonstrated through the active participation of over 30 regular participants is impressive. Although utilizing a consensus decision-making model was, at times, frustrating and very time consuming, it created space for everyone to speak their voice and come together as a community with final decisions that everyone could support. However, through this process, the Prevention Plan Work Group learned several important lessons, including:

1. Start the HIV prevention planning process much earlier and allow at least 12-18 months to complete the work;
2. Establish a process that allows for flexibility;
3. Have clear communication between OAPP, chairs, facilitators, and participants;
4. Clarify the pros and cons of decision-making methods at the beginning; and
5. Use smaller groups to hammer out some decisions, which can be brought to the large group for final decision-making.

Addressing these lessons in future planning cycles will serve to continue to strengthen Los Angeles County's planning process.

Chapter References

1. Centers for Disease Control and Prevention. Setting HIV Prevention Priorities: A Guide for Community Planning Groups. Developed by AED Center on AIDS & Community Health. March 2005. Available at:
http://www.cdc.gov/hiv/topics/cba/resources/guidelines/SettingPriorities_March2005.pdf.