3 Priority Setting

**CHAPTER
OUTLINE**

3

Chapter 3

Introduction

PURPOSE OF CHAPTER

The primary purpose of this chapter is to outline the priority populations for HIV prevention funding in San Francisco based on local epidemiologic data. This chapter complements the Community Assessment chapter. The Priority Setting Chapter outlines *who and what issues* are prioritized for funding, whereas the Community Assessment Chapter discusses the needs of different populations and the HIV Prevention Planning Council's (HPPC') recommendations for *how* to conduct HIV prevention with these groups.

The ultimate goal of HIV prevention is to eliminate new HIV infections. In order to accomplish this, HIV prevention must address the complex needs of people and communities. The HPPC has determined that the best way to eliminate new infections is to focus the greatest resources on the highest risk populations. The HPPC uses a blend of data analysis and community values to determine priorities, which are described throughout this chapter.

HIV prevention is no longer just about education: it is about dealing with a focused set of issues in order to promote health and wellness among individuals and communities. This chapter is the foundation for this focused approach to HIV prevention. It identifies the highest priority populations and the highest priority issues that must be addressed in order to do effective prevention, and it recommends funding accordingly, from a planning perspective. It is supplemented by the Community Assessment Chapter, which describes the broader HIV prevention needs and issues of people at risk for HIV, and the Strategies and Interventions Chapter, which gives providers the tools they need to design and implement HIV prevention programs. Together, these three chapters represent San Francisco's approach to HIV prevention.

HOW TO READ THIS CHAPTER

Readers who are familiar with the history and structure of San Francisco's priority setting model may choose to focus on Section II, which outlines the priorities for 2010. Readers needing more context for the model are invited to read the whole chapter.

There are five distinct Behavioral Risk Populations (BRPs) identified in the priority setting model (see Exhibit 2, p. 156). Generally, these five BRPs fall into two groups: (1) The BRPs in which the bulk of new infections occur, which include Males who have sex with Males (MSM), Transfemales who have sex with Males (TFSM), and Injection Drug Users (IDU), and (2) the BRPs with a very small number of new infections each year, which include Females who have sex with Males (FSM) and Males who have sex with Females (MSF). Throughout this chapter, these two groupings of BRPs are referred to as the "high-risk" and "low-risk" BRPs respectively.

TERMS & DEFINITIONS

BEHAVIORAL RISK POPULATION (BRP) A category that describes behavioral risk for HIV infection. The HPPC uses BRPs to identify who is at risk for HIV in San Francisco and how HIV prevention priorities should be set. The BRPs for 2010 are listed in Exhibit 4.

COFACTOR A condition that can increase risk for HIV, increase susceptibility to infection, or decrease ability to receive and act upon HIV prevention messages. Prioritized cofactors for 2010 are listed in Exhibit 7.

DRIVER An underlying condition that is directly linked to a large number of new infections throughout San Francisco. By definition, drivers are factors that affect the high-risk BRPs (MSM, TFSM, and/or IDU), since they account for the bulk of new infections. Drivers for 2010 are listed in Exhibit 6.

PRIORITY SETTING The process that community planning groups, such as the HPPC, use to determine recommendations for which populations and issues should be prioritized.

SUBPOPULATION A demographic group defined by race/ethnicity, age, gender, or another factor. Prioritized subpopulations for 2010 are listed in Exhibit 5.

SECTION I

The Current Model and Its History

San Francisco's first priority setting model was developed in 1995. Although it has gone through several iterations since then, the underlying philosophy has remained the same: the priorities for San Francisco are designed to reflect the local trends in HIV and are based on local epidemiologic evidence, research, and practice. Exhibit 1 presents the evolution of the model, along with a summary of its strengths and weaknesses over time.

The priority setting model for 2010 attempts to build on the strengths of the 2004 model, while simultaneously addressing its limitations. The new model is presented in Section III (p. 158)

EXHIBIT 1   **History of the HPPC's Priority Setting Model**

YEAR	COMPONENTS OF MODEL	STRENGTHS	LIMITATIONS
1995	• A population's level of risk was determined based on: (1) the odds of being exposed, (2) physiological cofactors, and (3) behavioral cofactors	• Accounted for both biological and social influences on risk	• No specific criteria for setting priorities, so prioritization was subjective
1997	• Twelve BRPs were created and then ranked by anticipated number of new HIV infections per year	• Focused on behavior through identification of populations at risk • Established specific epidemiologic criteria for setting priorities • Provided an effective tool for planning	• It was difficult to implement priorities effectively because existing data did not conform to the BRP categories • Did not address important high-risk subpopulations within each BRP
2001	• The twelve BRPs from the 1997 model were collapsed into eight BRPs, which were then ranked by anticipated number of new HIV infections per year • Subpopulations within each BRP that had 8% or higher seroprevalence were identified and ensured funding • BRPs were grouped into three tiers, and recommendations regarding the percentage of funding to be allocated to each tier were made	• Focused on behavior through identification of populations at risk • Included specific epidemiologic criteria for setting priorities • Provided an effective tool for planning • Ensured funding for identified high risk populations • Guided resource allocation in line with current epidemiology • Used data and estimates that were reported in BRP format	• The model could be overemphasizing behavioral risks, instead of promoting a holistic approach to HIV prevention that addresses the context of individuals' lives
2004	• The eight BRPs were ranked by anticipated number of new infections per year • Both subpopulations and cofactors were identified and prioritized for funding, based on prevalence, incidence, and behavioral data • BRPs were grouped into four tiers, and recommendations were made regarding the percentage of funding to be allocated to each tier	• Focused on behavior through identification of populations at risk • Included specific epidemiologic criteria for setting priorities • Provided an effective tool for planning • Identified high-risk subpopulations and cofactors to be prioritized for funding • Used epidemiology to guide resource allocation • Used data and estimates reported in BRP format • Was accompanied by a community assessment that described the needs of people, rather than BRPs	• Grouped all transpeople together without differentiation of behaviors or risks • Did not focus on the factors driving HIV infections • Was challenging to implement because of the number of BRPs • Was based on consensus estimates developed three years earlier

YEAR	COMPONENTS OF MODEL	STRENGTHS	LIMITATIONS
2010	• The eight BRPs from the 2004 model are collapsed into five BRPs, which continue to be ranked by the anticipated number of new HIV infections per year • High risk behaviors for acquisition of HIV are described for each of the BRPs • Drivers are identified for the high-risk BRPs based on the driver's prevalence in those BRPs and their direct link to new HIV infections • Subpopulations are identified for all BRPs and prioritized for funding, based on prevalence, incidence, and behavioral data • Prioritized cofactors are identified for low-risk BRPs based on prevalence, incidence, and behavioral data • Each BRP is assigned a recommended percentage of overall funding • The Priority Setting Considerations Box was added to allow the HPPC to respond to HIV prevention community needs by strongly recommending research or assessments on populations or issues with limited data	• Focuses on behavior through identification of populations at risk • Includes specific epidemiologic criteria for setting priorities • Provides an effective tool for planning • Identifies high-risk subpopulations and cofactors to be prioritized for funding • Guides resource allocation in line with epidemiology • Uses data and estimates reported in BRP format • Simplifies the BRP model • BRPs separate transmales from transfemales, acknowledging the different risks of these populations • Emphasizes the importance of substance use risk behaviors among all BRPs • Highlights drivers, the most critical factors driving HIV infections citywide, and prioritizes them for funding • Promotes staying ahead of the epidemic by recommending research on populations or issues with limited data	Still to be determined

SECTION II **Priorities for 2010**

Overview of Priorities

Exhibit 2 presents the priorities for 2010, based on the new priority setting model approved by the HPPC in 2009. (The model is explained in greater detail in Section III.)

The priorities in Exhibit 2 are organized in the following manner:

- **Behavioral Risk Populations (BRPs).** BRPs are categories that define people by their risk behavior, not their demographics. BRPs are listed from highest to lowest priority (Exhibit 2).

- **Subpopulations.** Within each BRP, the highest-risk subgroups are identified. Unlike BRPs, these groups are defined by demographics (Exhibit 2).

- **Drivers.** A driver is an underlying condition that is directly linked to a large number of new infections throughout San Francisco. Drivers are identified for the high-risk BRPs (MSM, TFSM, and IDU), since that is where the bulk of new HIV infections occur (Exhibit 2).

- **Cofactors.** Cofactors known to increase risk for HIV are prioritized for the low-risk BRPs (FSM and MSF) (Exhibit 2).

- **Resource Allocation Guidelines.** Each BRP is assigned a recommended proportion of funds based on the estimated number of new HIV infections (Exhibit 2). The higher the level of risk in the BRP, as shown by incidence numbers, the higher the recommended level of funding.

- **Priority Setting Considerations Box.** The Priority Setting Considerations Box allows the HPPC to respond to HIV prevention community needs by strongly recommending research or assessments on populations or issues with limited data (Exhibit 2). The HPPC Co-chairs will ensure that a well thought-out and balanced process is in place to determine which items to place in the Box on an annual basis.

Interpretation of Priorities

Several points are important to remember when interpreting Exhibit 2:

- The HPPC reviewed a wealth of data to prioritize subpopulations, drivers, and cofactors, looking at published studies, needs assessments, anonymous and confidential counseling and testing data, and many other data sources. The subpopulations, drivers, and cofactors were selected based on an objective set of criteria applied to as much relevant data as was available. The background and rationale for each component of the model are described in Section III of this chapter.

- As the epidemic evolves, the HPPC will adjust the priorities accordingly and issue updates to the community.

- The demographic subpopulations, drivers, and cofactors listed in Exhibit 2 are the *highest* priorities for receiving funding; they are not the *only* priorities for HIV prevention in San Francisco. For example, depression is not a driver due to lack of data conclusively demonstrating that it doubles one's risk for acquiring HIV, which is one condition for qualification as a driver. However, this does not mean that HIV prevention programs should neglect addressing mental health issues with their clients.

- Because drivers are linked to a large number of new infections citywide and may be propelling the spread of HIV in San Francisco, it is appropriate that they receive a higher priority than cofactors. Cofactors are highly important within BRPs 4 and 5, but overall they influence a much smaller number of new infections than drivers.

- Although the HPPC reviewed numerous sources of data, it is impossible to review all available data. Therefore, providers are invited to make a case in their proposals for funding subpopulations, drivers, or cofactors that meet the criteria outlined in Steps 2, 3, and 4 of the model (see Exhibit 3, p. 158) but are not listed here. In addition, the HPPC will review new data and studies annually and/or prioritize needs assessments to determine whether other high-risk subpopulations, drivers, or cofactors should be included in the priorities.

- Although a subpopulation, driver, or cofactor is listed, that does not necessarily mean San Francisco needs a program specifically prioritizing that population or issue – it simply means that there is a need to ensure that the population is reached or the driver or cofactor is addressed. (Further guidance on the prioritized strategies and approaches for the various subpopulations, drivers, and cofactors can be found in Chapter 2: Community Assessment, pp. 60-147).

- Exhibit 2 does not illustrate how the subpopulations, drivers, and cofactors relate to each other or how HIV prevention should address them in the real world. Agencies are encouraged to develop programs that address the whole person and the complexity of risk, using the Community Assessment chapter and Strategies and Interventions chapter to guide the focus of programs.

Drivers of HIV as a Priority

As described in the Introduction (pp. 1-7) and the Community Assessment Chapter, pp. 60-147, addressing drivers of HIV is one of the five priority areas highlighted throughout this Plan. By definition, drivers are factors that independently increase individuals' susceptibility to HIV and are associated with a large number of new infections throughout San Francisco. Unlike cofactors (which apply only to the low-risk BRPs) or subpopulations (which narrow the focus of risk within BRPs), drivers apply to the highest-risk BRPs in which the bulk of new infections occur and propel the spread of HIV as a whole. Because of this, interventions addressing drivers are of particular importance to reducing the spread of HIV in San Francisco and thus should be given special priority. This priority is reflected in the guidelines for implementing interventions to address drivers, which indicate that every HIV prevention program serving a high-risk BRP (MSM, IDU, and/or TFSM) should address at least one driver (see the Strategies and Interventions Chapter, pp. 170-279).

Programs that address drivers should also acknowledge and address the larger contextual factors that may influence the ways in which individuals are affected by drivers. For example, contextual factors such as racism, sexism, homophobia, depression, loneliness, or lack of access to health care may increase the likelihood that an individual uses substances such as methamphetamine or crack, has an STI or has multiple sexual partners. For this reason, providers should consider the whole person and his or her life experience as a necessary component in addressing drivers of HIV. While HIV prevention efforts alone cannot end contextual factors such as racism, in order for prevention efforts to succeed, the influence of these factors must not be ignored.

Prevention with Positives as a Priority

Individuals living with HIV have been and continue to be a high priority in every BRP, in addition to high-risk HIV-negative individuals and those who do not know their HIV status. In order to reduce new infections, it is of primary importance that programs reach people living with HIV, as HIV prevention is not just for HIV-negative people. Further, interventions for people living with HIV (including both those who know their status and those high-risk individuals who are unaware that they are positive) should be designed to meet their specific needs.

An overview of how providers can integrate PWP work into their programs appears in the Strategies and Interventions Chapter, p. 192. In addition, the HIV prevention needs of people living with HIV are outlined in the Community Assessment Chapter, p. 63.

EXHIBIT 2   **Summary of 2010 Funding Priorities for HIV Prevention in San Francisco**

For each BRP, the risk is based on who an individual has sex or shares needles with.

PLEASE NOTE that risk of transmission is from right to left. For example TFSM (transfemales who have sex with males) indicates a transfemale at risk of being infected by a male partner.

BEHAVIORAL RISK POPULATION	HIGH RISK BEHAVIORS FOR ACQUISITION OF HIV
1. MALES WHO HAVE SEX WITH MALES MALES WHO HAVE SEX WITH MALES AND FEMALES TRANSMALES WHO HAVE SEX WITH MALES	**SEXUAL RISK BEHAVIOR:** The primary risk for this BRP is HIV– males/transmales engaging in unprotected receptive or insertive anal intercourse with HIV+ males. Transmales may also engage in frontal receptive intercourse with HIV+ males. These risks may be enhanced by the use of alcohol or drugs.
2. INJECTION DRUG USERS	**SUBSTANCE USE BEHAVIOR:** The primary risk for this BRP is HIV– individuals who engage in needle sharing with HIV+ individual(s). This risk may be enhanced by the use of alcohol or drugs, injected or not. **SEXUAL RISK BEHAVIOR:** The secondary risk for this BRP is HIV– individuals who engage in unprotected anal receptive or insertive intercourse and/or unprotected vaginal intercourse with HIV+ individual(s). This risk may be enhanced by the use of alcohol or drugs, injected or not.
3. TRANSFEMALES WHO HAVE SEX WITH MALES	**SEXUAL RISK BEHAVIOR:** The primary risk for this BRP is HIV– transfemales who engage in unprotected anal receptive or insertive intercourse and/or unprotected vaginal intercourse with HIV+ individual(s). This risk may be enhanced by the use of alcohol or drugs.
4. FEMALES WHO HAVE SEX WITH MALES	**SEXUAL RISK BEHAVIOR:** The primary risk for this BRP is HIV– females who engage in unprotected vaginal intercourse and/or unprotected anal receptive intercourse with HIV+ male(s). This risk may be enhanced by the use of alcohol or drugs.
5. MALES WHO HAVE SEX WITH FEMALES	**SEXUAL RISK BEHAVIOR:** The primary risk for this BRP is HIV– males who engage in unprotected vaginal or insertive anal intercourse with HIV+ female(s). This risk may be enhanced by the use of alcohol or drugs.

PRIORITY SETTING CONSIDERATIONS BOX   This box will allow for the HPPC to respond to HIV prevention community needs by strongly recommending research or assessments on populations or issues with limited data that are not adequately covered elsewhere in this model. The HPPC recommends that 1% of prevention funds be set aside to fund items in this box until these needs have been met.

Note: Populations or items in this box will be identified and updated by the HPPC on an annual basis.

PRIORITIZED SUBPOPULATIONS	PRIORITIZED DRIVERS OR COFACTORS	RECOMMENDED FUNDING %
MSM • African Americans • Asians and Pacific Islanders • Latinos • Native Americans • Whites • Gay Men • Adults 30 and older • Youth 29 and younger	**DRIVERS** • Cocaine/Crack • Gonorrhea • Heavy alcohol use • Methamphetamine • Multiple partners • Poppers	**MSM, MSM/F** 70 – 79% - - - - - - - - - - - - - - - - - **TMSM** 1 – 2%
MSM–IDU • African Americans • Asians and Pacific Islanders • Whites • Bisexual Men • Gay Men • Heterosexually identified men • Adults 30 and older • Youth 29 and younger **TFSM–IDU** • African Americans • Asians and Pacific Islanders • Latinas • Native Americans • Whites • Youth 29 and younger **FEMALE–IDU** • African Americans • Native Americans • Youth 29 and younger **MSF–IDU** • African Americans • Youth 29 and younger	**DRIVERS** • Cocaine/Crack • Gonorrhea • Heavy alcohol use • Methamphetamine • Multiple partners • Poppers	**IDU** 15 – 20%* *Approximately half of these funds should reach MSM-IDUs*
TFSM • African Americans • Asians and Pacific Islanders • Latinas • Native Americans • Whites • Adults 30 and older • Youth 29 and younger	**DRIVERS** • Cocaine/Crack • Gonorrhea • Heavy alcohol use • Methamphetamine • Multiple partners • Poppers	**TFSM** 5 – 8%
FSM • African Americans • Native Americans • Adults 30 and older	**COFACTORS** • Chlamydia • Crack use • Having an HIV+ partner • Having an IDU partner • Incarceration • Methamphetamine use • Sex work	**FSM** 1 – 4%
MSF • African Americans • Adults 30 and older	**COFACTORS** • Having an HIV+ partner	**MSF** < 1%

Background and Rationale

Priority Setting Model for 2010

Exhibit 3 outlines the complete HPPC priority setting model for 2010, which was developed by the HPPC with feedback from providers who were consulted throughout the process and who attended a providers meeting in late 2008. Following Exhibit 3, the rationale and process for each step is explained.

EXHIBIT 3   HPPC 2010 Priority Setting Model

STEP	PROCESS AND RATIONALE
STEP 1	BRPs are prioritized by incidence number (i.e., the estimated number of new infections per year).
STEP 2	Subpopulations within each BRP are prioritized for funding if they meet <u>one or more</u> of the following criteria:*† a) The subpopulation has an HIV seroprevalence of 8% or higher in San Francisco, as documented in published literature. b) A comparison of the HIV positivity rate among people in a subpopulation to people who are not in the subpopulation yields a statistically significant ($p \le .10$) relative risk of 1.5 or greater, based on San Francisco HIV counseling and testing data. c) There is evidence from at least two studies conducted in San Francisco demonstrating that the group is a high–risk subpopulation (i.e., behavioral risk in the subpopulation is greater than that for the BRP as a whole).
STEP 3	Drivers are prioritized for funding within the highest risk BRPs if they meet <u>both</u> of the following criteria:*† a) A driver has at least 10% prevalence among one of the BRPs where the bulk of new infections occur. These include MSM, IDU, and TFSM. b) A driver is an independent factor for HIV, making a person in a high–risk BRP at least twice as likely to contract HIV compared to someone who is not affected by the driver.
STEP 4	Cofactors within other BRPs are prioritized for funding if they meet <u>one or more</u> of the following criteria:*† a) The group with the cofactor has an HIV seroprevalence of 8% or higher in San Francisco, as documented in published literature. b) A comparison of the HIV positivity rate among people with a cofactor to people who do not have the cofactor yields a statistically significant ($p \le .10$) relative risk of 1.5 or greater, based on San Francisco HIV counseling and testing data. c) There is evidence from at least two studies conducted in San Francisco demonstrating that a cofactor is associated with increased HIV risk (i.e., behavioral risk among people affected by the cofactor is greater than that for the BRP as a whole).
STEP 5	Guidelines are developed for allocating resources based on incidence numbers, and taking into consideration factors such as funding needed to ensure culturally competent programs for the BRPs, disproportionate affect on populations, etc.
STEP 6	The Priority Setting Considerations Box is completed by developing research recommendations for populations or issues with limited data using the following guidelines: a) The population(s) or issue(s) must pertain to HIV prevention in San Francisco; b) The population(s) or issue(s) is not covered adequately elsewhere in the Priority Setting Model; c) The HPPC Co–chairs will ensure that a well thought–out and balanced process is in place to decide which items to place in the Box on an annual basis; d) Research findings must be presented back to the HPPC within 12 months after funding is issued. Ideally the research should be publishable.

* *"Prioritized for funding" means that these subpopulations, drivers, and cofactors will receive first consideration for allocation of resources. Funding for individual subpopulations, drivers or cofactors is not ensured.*

† *The HPPC developed specific guidelines for acceptable evidence to ensure the validity of the prioritized subpopulations, drivers, and cofactors.*

Step 1

BRPs are prioritized by incidence number (i.e., the estimated number of new infections per year).

Background and Rationale

The ranking of the five BRPs by incidence number lays the foundation for the allocation of resources based on current epidemiological trends. Evaluations of the priority setting model have indicated that it helps to ensure a consistent approach and smooth implementation of planning and resource allocation at the citywide level.

The 2010 model includes several changes to the BRP categories. In a time of dwindling resources, the HPPC has grappled with the question of whether to include populations with very low HIV seroprevalence in the priority setting model. In order to place emphasis on the greatest prevention needs, several very low-risk BRPs were removed from the model. The HPPC reviewed AIDS case data from 2004 to 2008 in order to identify which sexual behaviors in San Francisco had low seroprevalence.[1] The data indicated very low risk for individuals who have sex with females, a behavior that carries a minimal chance of acquiring HIV in San Francisco. Consequently, 2004 BRPs that reported AIDS cases amounting to less than one half of one percent of the BRP over the four year period were removed from the 2010 model. These groups include Females who have sex with Females (FSF), Females who have sex with Males and Females (FSM/F), Trans who have sex with Females (TSF), and Trans who have sex with Males and Females (TSM/F).

In 2004, the BRPs grouped all trans persons together (e.g., trans who have sex with males, trans who have sex with females, etc.). The 2010 BRPs acknowledge the differences between transmales and transfemales in terms of their sexual risk behaviors, sexual networks, and biological differences by separating these two populations. For example, the 2004 BRP Transpeople who have sex with Males (TSM) was split into Transmales who have sex with Males (TMSM) and Transfemales who have sex with men (TFSM) in the 2010 model.

Although epidemiologic data on TMSM in San Francisco are scarce, behavioral studies indicate that TMSM have similar high-risk sexual behaviors (receptive anal and frontal intercourse) and overlapping sexual networks with gay males, a group with very high HIV prevalence. In addition, transmales experience a thinning and breakdown of tissue due to injecting testosterone that may increase risk for HIV infection. Since BRPs are created and grouped together based on HIV risk behaviors, not data, the HPPC believes that TMSM are most appropriately placed together with MSM in the priority setting model even though the HIV incidence of these two BRPs may be different. In order to address the potential differences in incidence and limited data on population size and prevalence, TMSM have been assigned their own recommended funding percentage, separate from MSM.

A final change to the 2010 BRPs is that IDU populations are grouped together into one BRP. In 2004, IDU populations were identified in four BRPs, which were based on sexual risk behaviors as well as injection drug behaviors. The HPPC grouped the IDU populations into one BRP to simplify the model and make it more user friendly. Because subsets of the IDU BRP have unique subpopulations who are at greatest risk, IDU subpopulations continue to be identified by gender and the genders of their sex partners.

Appendix 1 outlines the differences between the 2004 and the 2010 BRPs.

Results When Step 1 Is Applied

Exhibit 4 shows the five BRPs in prioritized order based on incidence number. The data source for the estimated number of new infections is the SFDPH AIDS Office Epidemiology Section. The Epidemiology Section developed estimates at the 2006 HIV Consensus Meeting. Although

1   Although AIDS case data tracks infections that happened in the past, over the long term this data is more reliable than data on new HIV infections when looking at trends.

these numbers represent the *anticipated* incidence numbers for 2007-2009, there is no evidence to suggest a shift in the epidemic that would alter the ranking of the BRPs for the duration of this Plan, even if the exact numbers of new infections are slightly different.

EXHIBIT 4

BRPs Ranked by Incidence Number

BRP	INCIDENCE NUMBER (ANTICIPATED NUMBER OF NEW INFECTIONS PER YEAR)	INCIDENCE NUMBER
1. MSM, MSM/F, TMSM*	772	79%
2. IDU	144	15%
3. TFSM	42	4%
4. FSM	12	1%
5. MSF	5	<1%

* Reliable incidence data are currently unavailable for TMSM. Please see pp. 80-82 for further explanation.

Note: For a more detailed table summarizing the 2006 Consensus Estimates, see Chapter 1: Epidemiologic Profile, p. 37.

Step 2

**Subpopulations will be prioritized for funding if the subpopulation
(a) has an 8% or higher HIV seroprevalence; and/or
(b) has an HIV positivity rate demonstrating a relative risk at least
     1.5 times higher than those outside the subpopulation; and/or
(c) has a behavioral risk greater than the BRP as a whole.**

Background and Rationale

The HPPC's inclusion of subpopulations in the Priority Setting Model represents recognition that certain groups are disproportionately affected by HIV or by cofactors that affect HIV risk. Subpopulations help focus prevention efforts within BRPs, since not everyone in a BRP should be assumed to be at risk. HIV prevention programs need to focus on these narrower subgroups in order to maximize the influence of their work.

The prioritized subpopulations are listed in Exhibit 5. However, just because a population is not listed here does not mean it is specifically excluded from consideration. Providers are invited to make a case under this step of the model for prioritizing a population that they serve. This can be done by providing evidence that meet any of the three criteria in a proposal for funding (see Exhibit 3, Step 2, p. 158).

As with drivers, due to funding uncertainties, no subpopulation is "ensured" funding. Instead, these subpopulations are highest priority for funding.

Results When Step 2 Is Applied

Exhibit 5 lists the subpopulations prioritized for each BRP. Additional subpopulations may be prioritized during the duration of the 2010 Plan based on (1) new data, or (2) existing data to which the HPPC did not have access during the priority setting process.

EXHIBIT 5   **Prioritized Subpopulations for Each BRP**

BRP	PRIORITIZED DEMOGRAPHIC SUBPOPULATIONS
1. MSM, MSM/F, TMSM	• African Americans • Asians and Pacific Islanders • Latinos • Native Americans • Whites • Gay men • Adults 30 and older • Youth 29 and younger
2. IDU	**MSM–IDU:** • African Americans • Asians and Pacific Islanders • Whites • Bisexual men • Gay men • Heterosexually identified men • Youth 29 and younger • Adults 30 and older **TFSM–IDU:** • African Americans • Asians and Pacific Islanders • Latinas • Native Americans • Whites • Youth 29 and younger **FEMALE–IDU:** • African Americans • Native Americans • Youth 29 and younger **MSF–IDU:** • African Americans • Adults 30 and older
3. TFSM	• African Americans • Asians and Pacific Islanders • Latinas • Native Americans • Whites • Adults 30 and older • Youth 29 and younger
4. FSM	• African Americans • Native Americans • Adults 30 and older
5. MSF	• African Americans • Adults 30 and older

Step 3

**Drivers are prioritized for funding in highest risk BRPs if they
(a) have at least 10% prevalence among one of the high-risk BRPs
     where the bulk of new infections occur; and
(b) are an independent factor for HIV, making a person in a high-risk BRP at
     least twice as likely to contract HIV as a person not affected by the driver.**

Background and Rationale

The prioritized drivers of HIV are listed in Exhibit 6. This list may continue to evolve as the HPPC gains access to new research, which could provide evidence that additional factors meet the driver criteria or that current drivers no longer meet the driver criteria. Providers are invited to make a case under this step of the model for prioritizing a driver currently not on the list. This can be done by providing evidence that a potential driver meets both criteria (see Exhibit 3, Step 3, p. 158).

   Due to funding uncertainties, funding is not necessarily "ensured" for every driver. Instead, drivers are highest priority for funding.

Results When Step 3 Is Applied

Exhibit 6 lists the drivers of HIV prioritized by the HPPC for 2010. Note that drivers apply only to BRPs 1, 2 and 3; cofactors replace drivers for the lower-risk BRPs. Additional drivers may be identified during the duration of the 2010 Plan based on (1) new data, or (2) existing data to which the HPPC did not have access during the priority setting process.

EXHIBIT 6   **Drivers of HIV**

BRP	DRIVERS
1. MSM, MSM/F, TMSM 2. IDU 3. TFSM	• Cocaine/Crack • Gonorrhea • Heavy alcohol use • Methamphetamine • Multiple partners • Poppers

Step 4

**Cofactors will be prioritized for funding in other BRPs if the group
with the cofactor
(a) has an 8% or higher HIV seroprevalence; and/or
(b) has an HIV positivity rate demonstrating a relative risk at least
     1.5 times higher than those without the cofactor; and/or
(c) has a behavioral risk greater than the BRP as a whole.**

Background and Rationale

Like with subpopulations, the HPPC's inclusion of cofactors in the Priority Setting Model represents recognition that certain groups are especially vulnerable to HIV because of cofactors that affect their HIV risk. Cofactors help focus prevention efforts within BRPs, since not everyone in a BRP should be assumed to be at risk. HIV prevention programs need to focus on these narrower subgroups in order to maximize the influence of their work.

   The prioritized cofactors are listed in Exhibit 7. However, just because a cofactor is not listed here does not mean it is specifically excluded from consideration. Providers are invited to

make a case under this step of the model for prioritizing a population that they serve. This can be done by providing evidence that meet any of the three criteria in a proposal for funding (see Exhibit 3, Step 4, p. 158).

As with drivers, due to funding uncertainties, no cofactor is "ensured" funding. Instead, these cofactors are highest priority for funding.

Results When Step 4 Is Applied

Exhibit 7 lists the cofactors prioritized by the HPPC for 2010. Note that cofactors apply only to BRPs 4 and 5; drivers have replaced cofactors for the high-risk BRPs. Additional cofactors may be prioritized during the duration of the 2010 Plan based on (1) new data, or (2) existing data to which the HPPC did not have access during the priority setting process.

EXHIBIT 7 **Prioritized Cofactors within BRPs 4 and 5**

BRP	PRIORITIZED COFACTORS
1. MSM, MSM/F, TMSM	None (See Drivers)
2. IDU	None (See Drivers)
3. TFSM	None (See Drivers)
4. FSM	• Chlamydia • Crack use • Having an HIV+ partner • Having an IDU partner • Incarceration • Methamphetamine use • Sex work
5. MSF	Having an HIV+ partner

Step 5   Guidelines are developed for allocating resources.

Background and Rationale

This step effectively links resource allocation with the epidemiologic data on new HIV infections in San Francisco. The purpose of the resource allocation guidelines is to provide guidance to the HIV Prevention Section when selecting proposals for funding.

Results When Step 5 Is Applied

The HPPC recommends that resources be allocated to each of the five BRPs as outlined in Exhibit 8. The funding percentages correspond to the estimated percentage of new infections occurring within each BRP. However, in some cases the funding percentages are comparatively greater than the proportion of new infections occurring in those BRPs because a substantial baseline dollar amount is required in order to do meaningful prevention for each group and to ensure culturally competent programming. It is recommended that approximately half of the funds dedicated to IDUs reach MSM-IDUs, since half of all estimated new infections among IDUs occur among this group. Exhibit 8 provides a recommended range of funding for each BRP, as opposed to an exact percentage, since it would be impossible for the HIV Prevention Section to allocate an exact percentage of funds.

EXHIBIT 8   **2010 Resource Allocation Guidelines**

	RECOMMENDED PERCENTAGE OF FUNDING
1. MSM, MSM/F, TMSM	MSM, MSM/F: 70 – 79% TMSM: 1 – 2%
2. IDU	15 – 20%* *Approximately half of these funds should reach MSM-IDUs*
3. TFSM	5 – 8%
4. FSM	1 – 4%
5. MSF	<1%
Priority Setting Considerations Box	1%

Step 6

The Priority Setting Considerations Box is completed by developing research recommendations for populations or issues with limited data.

Background and Rationale

The Priority Setting Considerations Box was added to the 2010 Priority Setting Model to allow the HPPC to respond to HIV prevention community needs by strongly recommending research or assessments on populations or issues with limited data. Doing so will help San Francisco stay ahead of the epidemic and remain flexible in responding to changing HIV risks. Exhibit 9 formally describes the purpose of the Priority Setting Considerations Box.

Following are guidelines for the Priority Setting Considerations Box:

- The population(s) or issue(s) must pertain to HIV prevention in San Francisco;

- The population(s) or issue(s) is not covered adequately elsewhere in the Priority Setting Model;

- The HPPC Co-chairs will ensure that a well thought-out and balanced process is in place to decide which items to place in the Box on an annual basis.

- Research findings must be presented back to the HPPC within 12 months after funding is issued. Ideally the research should be publishable.

Results When Step 6 Is Applied

The HPPC Co-chairs will assign responsibility for completing the Box by including the task in committees' scopes of work each year. Items in the Box will be reviewed and updated on an annual basis.

EXHIBIT 9   **Priority Setting Considerations Box**

PRIORITY SETTING CONSIDERATIONS

* This box will allow for the HPPC to respond to HIV prevention community needs by strongly recommending research or assessments on populations or issues with limited data that are not adequately covered elsewhere in this model. The HPPC recommends that 1% of prevention funds be set aside to fund items in this box until these needs have been met.

Note: Populations or items in this box will be identified and updated by the HPPC on an annual basis.
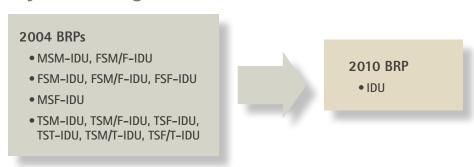
Changes in Behavioral Risk Populations from 2004 to 2010
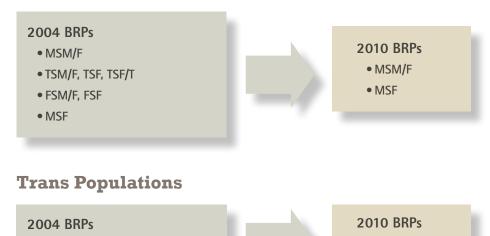
APPENDIX 1

People Who Have Sex with Males

2004 BRPs
- MSM
- FSM

→

2010 BRPs
- MSM
- FSM

Injection Drug Users

2004 BRPs
- MSM–IDU, FSM/F–IDU
- FSM–IDU, FSM/F–IDU, FSF–IDU
- MSF–IDU
- TSM–IDU, TSM/F–IDU, TSF–IDU, TST–IDU, TSM/T–IDU, TSF/T–IDU

→

2010 BRP
- IDU

People Who Have Sex with Females

2004 BRPs
- MSM/F
- TSM/F, TSF, TSF/T
- FSM/F, FSF
- MSF

→

2010 BRPs
- MSM/F
- MSF

Trans Populations

2004 BRPs
- TSM, TSM/F, TSF, TST, TSM/T, TSF/T

→

2010 BRPs
- TFSM
- TMSM

Process for Determining Drivers, Priority Subpopulations, and Cofactors

APPENDIX 2

The HIV prevention community planning process combines scientific methods with community values. The Show Me the Data committee, which was charged with developing the 2010 priority setting model, applied this principle to the prioritization of drivers, subpopulations, and cofactors in the following manner:

Drivers

1. The committee engaged in several lengthy discussions to create a definition and common understanding of what drivers mean for HIV prevention in San Francisco. The committee decided that a driver is an underlying condition that is directly linked to a large number of new infections throughout San Francisco. By definition, drivers should be factors that are affecting the high-risk BRPs (MSM, TFSM, or IDU), since this is where the bulk of new infections occur.

2. The committee brainstormed a list of potential drivers it thought should be considered based on its members' collective community experience.

3. After much deliberation, factors such as racism, sexism, homophobia, and transphobia were removed from the list of potential drivers. The committee decided that, while highly important, these contextual factors were not proximal enough to the point of HIV transmission to meet the committee's definition of a driver. Other factors, such as unprotected anal intercourse or sharing syringes, were deemed too close to, and nearly synonymous with, the point of transmission, and that these behaviors are covered by BRPs.

4. The committee developed two criteria, described in the model above, to help narrow the definition of drivers and allow for an objective selection process. Given the elevated importance of drivers, criteria were purposefully designed to be more stringent than the criteria for subpopulations and cofactors.

5. The committee then reviewed available research to determine whether each potential driver met both of the criteria proposed in the model. The committee developed specific guidelines for acceptable evidence to ensure the integrity of the prioritized drivers:

   • The research must be conducted in San Francisco.

   • The study can be qualitative or quantitative.

   • The data must be from more than one agency's clients.

   • The study must have a publication date of 2002 or later. If no recent studies can be found, the committee may consider earlier or national studies if relevance to San Francisco can be established.

6. A driver was considered to have met the criteria if it satisfied both of the following conditions:

   • **Prevalence 10% or greater.** A driver has at least 10% prevalence among one of the high-risk BRPs where the bulk of new infections occur. These include MSM, IDU, and TFSM.

   • **Two-fold increase in risk.** A driver is an independent factor for HIV, making a person in a high-risk BRP at least twice as likely to contract HIV compared to someone who is not affected by the driver.

Subpopulations and Cofactors

1. Committee members brainstormed a list of potential subpopulations within each BRP and cofactors within BRPs 4 and 5 (FSM and MSF) that they thought should be considered for prioritization. The brainstorm drew on members' collective community experience and included everything that had been prioritized in 2004.

2. Several themes were noted among these subpopulations and cofactors. The themes were:

   - Sexual orientation;

   - Gender identity;

   - HIV status;

   - Age;

   - Race/ethnicity;

   - Country of birth;

   - Substance use;

   - Mental health;

   - Incarceration;

   - Housing status;

   - STIs;

   - Socioeconomic status;

   - People with high-risk partners; and

   - People with HIV+ partners

3. The committee then made a final list of potential subpopulations/cofactors based on these themes. For example, for "age," all age groups were considered for prioritization within each BRP.

4. The committee then reviewed available literature, studies, and data to determine whether each subpopulation or cofactor met any of the three criteria proposed in the model. Once a subpopulation or cofactor was found to meet one of the criteria, no further data was explored for that population (e.g., if a population or a group affected by a particular cofactor was documented to have 8% or higher seroprevalence, a literature review seeking two relevant behavioral studies was not performed). The committee developed specific guidelines for acceptable evidence to ensure the validity of the prioritized subpopulations and cofactors:

   - The research must be conducted in San Francisco;

   - The study can be qualitative or quantitative;

   - The data must be from more than one agency's clients; and

   - The study must have a publication date of 2002 or later. If no recent studies can be found, the committee may consider earlier or national studies if relevance to San Francisco can be established.

5. A subpopulation or cofactor was considered to have met the criteria under one of the following conditions:

   - **Seroprevalence of 8% or higher.** A published study had to document a seroprevalence of 8% or higher for the specific San Francisco subpopulation or group affected by the cofactor.

   - **An HIV positivity rate demonstrating a relative risk at least 1.5 times higher than those outside the subpopulation or without the cofactor.** HIV counseling and testing data had to demonstrate a statistically significant ($p \leq .10$) relative risk at least 1.5 times higher than the comparison group outside the subpopulation or without the cofactor. The reference point used to measure the HIV positivity rate for the comparison group was also from HIV counseling and testing data,

not the 2006 Consensus Meeting estimates used to rank the BRPs. This methodology was used to ensure that the committee compared "apples with apples," as the Consensus Meeting estimates were derived from multiple data sources.

- **Evidence of high-risk behavior.** Two scientifically sound behavioral studies, needs assessments, or other data had to demonstrate that the subpopulation or group with the cofactor was at higher risk than the BRP overall.

6. In situations in which the evidence was not clear-cut, the committee used its best judgment based on the weight of the evidence regarding whether to prioritize a subpopulation or cofactor for funding.