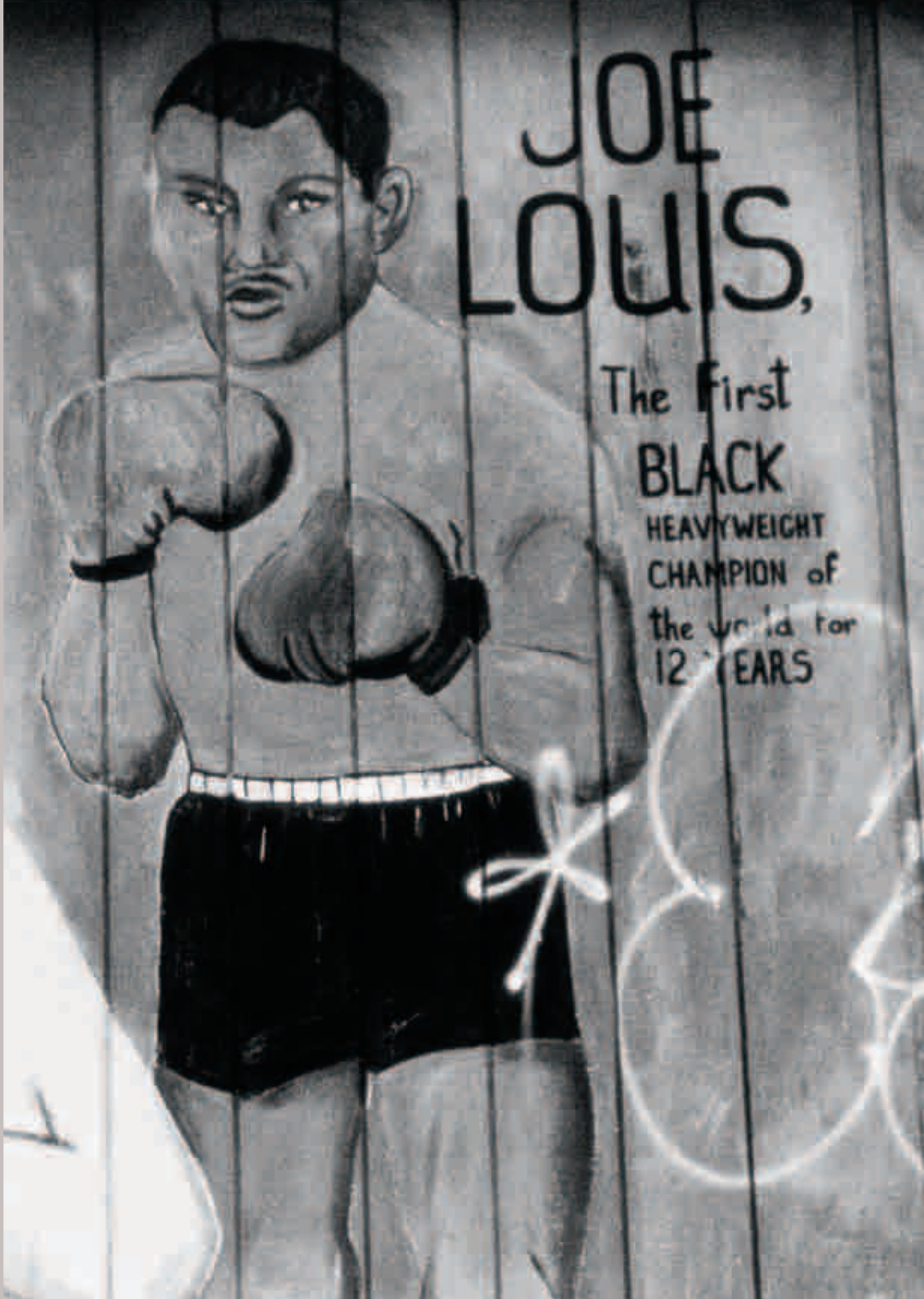
Chapter 4 Priority-Setting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Introduction

Purpose

The primary purpose of this chapter is to outline the priorities for HIV prevention funding in San Francisco. This chapter complements the Community Assessment chapter, which also outlines priorities. The difference is that the Priority-Setting chapter outlines ***who and what issues*** are prioritized for funding, whereas the Community Assessment chapter discusses the priorities for ***how*** to conduct HIV prevention with different populations.

The ultimate priority 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. HIV prevention is challenging because it is no longer just about education – for example, handing out condoms and bleach kits and showing people how to use them. It is about dealing with a much broader set of issues in order to promote health and wellness among individuals and communities.

This chapter is the foundation for this expanded 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 directs the 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. Together, these two 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 2004 and beyond. Readers needing more context for the model are invited to read the whole chapter.

Terms and Definitions

Cofactor — A condition that can increase risk for HIV, increase susceptibility to infection, or decrease ability to receive and act upon HIV prevention messages.

Priority-setting — The process that community planning groups, such as the HPPC, use to determine recommendations for the distribution of available HIV prevention funds.

Subpopulation — A demographic group defined by race/ethnicity, age, gender, or other factor.

Chapter Outline

Section I: History of the Model
Reviews the evolution of the priority-setting model since its inception in 1995.

Section II: Priorities for 2004 Through 2008
Summarizes the priorities for 2004 through 2008 that result from the application of the priority-setting model.

Section III: Background and Rationale
Outlines each step in the model, how and why it was developed, and how it was applied to establish the final priorities for 2004 through 2008.

Appendix 1: 2001 and 2004 Behavioral Risk Populations

Appendix 2: Process for Determining Priority Subpopulations and Cofactors

SECTION I
History of The Model

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 epidemic 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 2004 through 2008 attempts to build on the strengths of the 2001 model, while simultaneously addressing its limitations. The new model is presented in Section III (pp. 146-152).

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 funding priorities, so funding prioritization was subjective
1997	• Twelve behavioral risk populations (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 • Identified high-risk subpopulations to be ensured funding • Guided resource allocation in line with current epidemiology • Used data and estimates that were reported in BRP format*	• The model could tend to put too much emphasis on looking at the world in terms of BRPs, instead of promoting a holistic approach to HIV prevention that addresses what happens in the real world
2004	• The eight BRPs are ranked by anticipated number of new infections per year • Both subpopulations and cofactors are identified and prioritized for funding, based on prevalence, incidence, and behavioral data • BRPs are grouped into four tiers, and recommendations regarding the percentage of funding to be allocated to each tier are made	• 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 that are reported in BRP format • Is accompanied by a community assessment that talks about the broader needs of individuals and communities, not limited to behavioral risk	• Is based on consensus estimates developed three years ago, although epidemiologists believe that there has not been a substantial change in new infection rates since then

*At a 2001 convening of HIV researchers called the Consensus Meeting, communication and collaboration between the HPPC and researchers resulted in the generation of information that could be directly incorporated into the planning process.

SECTION II

Priorities for 2004 Through 2008

Overview of Priorities

Exhibits 2 and 3 present the priorities for 2004 through 2008, based on the new priority-setting model approved by the HPPC in 2003. (The model is explained in greater detail in Section IV.)

The priorities in Exhibits 2 and 3 are organized in the following manner:

- **Behavioral Risk Populations (BRPs).** BRPs are categories that define people by their risk behavior, not their demographics. The highest risk BRPs are the highest priorities. BRPs are listed from highest to lowest priority (Exhibit 2).
- **Subpopulations and Cofactors.** Within each BRP, the highest risk groups and issues are prioritized. Unlike BRPs, these groups are defined by demographics (subpopulations) or factors that increase risk for HIV (cofactors) (Exhibit 2).
- **Resource Allocation Tiers and Guidelines.** The BRPs are grouped into tiers, and a recommended proportion of funds is given for each tier (Exhibit 2). The higher the level of risk in the tier, the higher the recommended level of funding.
- **Other Considerations.** Additional considerations to guide the selection of proposals and allocation of resources are offered (Exhibit 3). When the HIV Prevention Section issues a request for proposals (RFP) for HIV prevention programs, these considerations should be taken into account when deciding which programs to fund.

Interpretation of Priorities

Several points are important to remember when interpreting Exhibits 2 and 3:

- The HPPC reviewed a wealth of data to prioritize subpopulations and cofactors, looking at both unpublished and published studies, needs assessments, anonymous and confidential counseling and testing data, and many other data sources. The subpopulations and cofactors listed represent an objective review of as much data as was available.
- As the epidemic evolves over 2004 to 2008, the HPPC will adjust the priorities accordingly and issue updates to the community.
- The demographic subpopulations and cofactors listed in Exhibit 2 are the highest priorities for receiving funding. These are not the only priorities for HIV prevention in San Francisco. Proposals that address subpopulations or cofactors not on this list will still be considered for funding. (See Chapter 3: Community Assessment, pp. 45-136, for a full description of San Francisco's high-risk populations, the important cofactors, and the HPPC's priorities for how HIV prevention should be implemented with these populations.) For example, sex work is not a prioritized cofactor under BRP 2 due to lack of data to conclusively demonstrate that MTF transgendered sex workers are at higher risk than non-sex workers. However, the Community Assessment chapter recommends that risks related to sex work get addressed in prevention programs for MTF persons.

- Although the HPPC reviewed numerous sources of data, it is impossible to get access to all available data. Therefore, providers are invited to make a case in their applications for subpopulations or cofactors that meet the criteria outlined in Step 2 of the model (see pp. 148-149) but are not listed here. In addition, the HPPC will review new data and studies annually and/or prioritize needs assessments to determine if other high-risk subpopulations or cofactors should be included in the priorities.
- Although a demographic subpopulation or cofactor is listed, it does not necessarily mean that San Francisco needs a program that is designed specifically for that subpopulation or cofactor. It simply means that there is a need to ensure that this population is reached or the cofactor addressed. For example, under BRP 1: MSM, MSM/F, speed use is prioritized. However, it may be more effective to address speed use through a program designed to reach gay men, as opposed to implementing a program that only addresses speed use or speed users. (Further guidance on the prioritized HIV prevention approaches for these various subpopulations and cofactors can be found in Chapter 3: Community Assessment.)
- Exhibit 2 does not illustrate how the subpopulations 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 to guide the focus of programs.

Prevention with Positives As a Priority

HIV-positive individuals 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 serostatus. In order to bring about a reduction in new infections, it is of primary importance that programs reach HIV-positive individuals. HIV prevention is not just for HIV-negative people. Further, interventions for HIV-positive people (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.

There are several examples of how HIV-positive people have been the focus of increased attention in recent years. An assessment of how existing HIV prevention programs address the needs of HIV-positive individuals was commissioned in 2002. The assessment found that many HIV prevention agencies in San Francisco have adjusted their programs to include messages or components relevant for HIV-positive people, even if they do not have a formal prevention with positives program or intervention (DeMayo 2003). Based on these findings, the HIV Prevention Section will implement a capacity-building plan in 2004 to train providers on standards and guidelines for conducting prevention with positives. These standards and guidelines are currently being developed through a collaboration between the HPPC and the HIV Health Services Planning Council (CARE Council), and the preliminary standards appear in Chapter 5: Strategies and Interventions (pp. 181-184). In addition, the priority HIV prevention needs of HIV-positive people are outlined in Chapter 3: Community Assessment (pp. 47-49).

EXHIBIT 2

Summary of Funding Priorities for HIV Prevention in San Francisco

BEHAVIORAL RISK POPULATION (BRP)	PRIORITIZED DEMOGRAPHIC SUBPOPULATIONS*	PRIORITIZED COFACTORS*	RESOURCE ALLOCATION TIER	RECOMMENDED FUNDING PERCENTAGE†
1. MSM, MSM/F	• Gay men • African Americans • Asian/Pacific Islanders • Latinos • Native Americans • Whites • Age 29 and under • Age 30 and over	• Drug use (non-IDU) • Speed use • Poppers use • Homelessness/marginal housing • Incarceration • Sex work • STDs • Internet use • Having an HIV+ partner • Having an IDU partner	**1**	**73-81%**
2. TSM, TSM/F, TSF, TST, TSM/T, TSF/T	• African American MTF • Asian/Pacific Islander MTF • Latina MTF • Native American MTF • White MTF • MTF age 29 and under • MTF age 30 and over	• The formal data available does not provide enough evidence to prioritize any cofactors for funding. See Chapter 3: Community Assessment for the research that does exist and the important cofactors not listed here.		
3. MSM-IDU, MSM/F-IDU	• Gay men • Bisexual men • African Americans • Asian/Pacific Islanders • Latinos • Native Americans • Whites • Age 29 and under • Age 30 and over	• Drug use (non-IDU) • Speed use • Poppers use • Homelessness/marginal housing • Incarceration • Sex work • STDs • Internet use • Having an HIV+ male partner • Having an IDU partner	**2**	**18-22%**
4. FSM-IDU, FSM/F-IDU, FSF-IDU	• The formal data available does not provide enough evidence to prioritize any subpopulations for funding. See Chapter 3: Community Assessment for the research that does exist and the important subpopulations not listed here.	• Sex work		

BEHAVIORAL RISK POPULATION (BRP)	PRIORITIZED DEMOGRAPHIC SUBPOPULATIONS*	PRIORITIZED COFACTORS*	RESOURCE ALLOCATION TIER	RECOMMENDED FUNDING PERCENTAGE†
5. MSF-IDU	• African Americans • Age 30 and over	• The formal data available does not provide enough evidence to prioritize any cofactors for funding. See Chapter 3: Community Assessment for the research that does exist and the important cofactors not listed here.	**2**	**18-22%**
6. TSM-IDU, TSM/F-IDU, TSF-IDU, TST-IDU, TSM/T-IDU, TSF/T-IDU	• African American MTF • Asian/Pacific Islander MTF • Latina MTF • Native American MTF • White MTF • MTF age 29 and under • MTF age 30 and over	• The formal data available does not provide enough evidence to prioritize any cofactors for funding. See Chapter 3: Community Assessment for the research that does exist and the important cofactors not listed here.		
7. FSM, FSM/F, FSF	• African Americans • Age 30 and over	• Sex work • STDs • Having an HIV+ partner • Having an IDU partner	**3**	**1-5%**
8. MSF	• African Americans • Age 30 to 39	• Having an IDU partner	**4**	**<1%**

Note: HIV-positive individuals are a priority in every BRP. See narrative for how this will be implemented.
*See Chapter 3: Community Assessment for additional high-risk demographic subpopulations and cofactors that are of concern to the HPPC.
†Percent of total funding available.

Exhibit 3 offers guiding principles for SFDPH to use when selecting proposals to fund and in allocating resources. Not all of the guiding principles may be relevant to every proposed program, and the HIV Prevention Section should take into account only those that are appropriate for each proposal. Because this is a new step in the priority-setting model, the HPPC will review its impact every six months based on a report from the HIV Prevention Section to determine whether it is effective.

EXHIBIT 3

Guiding Principles for Proposal Selection and Resource Allocation*

QUESTION	RATIONALE
1. Are the proposed programs effective?	Programs with documented effectiveness offer the best opportunity for reaching the overall goal of reducing new infections, especially if they can be shown to lead to behavior change. Examples of documentation include evaluations of existing programs and evaluations of similar programs (if the proposed program is new).
2. How well do the proposed programs address the range of needs that individuals have?	HIV prevention is no longer just about education – for example, giving people condoms and bleach kits and showing them how to use them. It is about addressing the multiple factors that affect risk – including drug use, mental health, poverty, skills-building, and a host of other issues. Programs should demonstrate their capacity to address the issues and cofactors that are relevant for the populations they are trying to reach.
3. How well do the proposed programs link clients to needed services that cannot be provided by the program?	Because programs cannot provide everything a client needs, HIV prevention programs must establish linkages to other programs within or outside of their agency. In addition, HIV prevention programs must have effective referral and follow-up procedures in place and a demonstrated ability to build and maintain appropriate referral networks. They must also have mechanisms for documenting referrals.
4. How well do the proposed programs work with people in the context of their lives, apart from meeting the needs of the BRP they are funded to serve?	Programs should work with people in the context of their lives, even if it means having to serve someone who does not fit neatly into a BRP. For example, a program working with female IDUs may find that the best HIV prevention for some clients includes working with their male sexual partners as well, even though the program is officially funded to serve only females. A client-driven approach to HIV prevention is encouraged.
5. How well do the proposed programs address the prevention needs of HIV+ individuals?	Stopping the spread of the epidemic means working with all affected individuals – high-risk HIV-negative individuals, HIV-positive individuals who know their status, and HIV-positive individuals who do not know they are HIV-positive. In the past, HIV prevention was implemented broadly, for both positive and negative individuals, followed by a period in which the specific needs of HIV-negative persons were the focus. Now we are in an era in which the specific needs of high-risk HIV-negative and HIV-positive persons, as well as those who do not know their serostatus, must be identified and addressed. Therefore, prevention with positives is a key strategy for the future.
6. How well do the proposed programs promote HIV testing among people who do not know their serostatus?	HIV testing is an opportunity to provide HIV prevention education and to link people to health care and social services (including testing for STDs), for both HIV-positive and HIV-negative individuals. Therefore, reaching people who have never been tested or who have not been tested recently is important.

EXHIBIT 3 (continued)

QUESTION	RATIONALE
7. Have the proposed programs performed well in the past?	Solid past performance (e.g., ability to meet contractual requirements) suggests that a program will continue to perform well. However, new programs should not be penalized for not having had a previous contract with the HIV Prevention Section.
8. Are the proposed programs cost-effective?	In an era of uncertain resources, San Francisco needs to ensure that programs use their resources appropriately. Although San Francisco has not yet adopted a formal cost-effectiveness model, agencies may have their own anecdotes or evidence of program cost-effectiveness. For more on cost-effectiveness in HIV prevention, see a report prepared by the Rand Corporation "Maximizing the Benefit: HIV Prevention Planning Based on Cost-Effectiveness" at *http://www.rand.org/publications/DRU/DRU3092.pdf*.
9. Are the grant award amounts allocated to individual programs sufficient to implement an effective program and meet SFDPH administrative requirements?	Target population size, accessibility of the population, administrative costs, and other factors should be taken into account when deciding on award amounts. For example, a small target population requires fewer resources overall than a larger target population. Difficult-to-reach populations may require a higher level of resources per person reached. Programs with multiple intervention types may require more evaluation resources.
10. How can San Francisco make the best use of all available resources to address the HPPC's priorities?	As funding restrictions increase, San Francisco must be thoughtful about how it uses the available resources and how it can diversify its funding sources to ensure the needs are met.

*It is recommended that the HIV Prevention Section take these guiding principles into account when issuing a request for proposals (RFP) to conduct HIV prevention programs and when reviewing agencies' proposal submissions.

Priority-Setting Model for 2004 Through 2008

Exhibit 4 outlines the complete HPPC Priority-Setting Model for 2004 through 2008, which was developed by the HPPC Plan Policies Committee and approved by the HPPC, with input from providers who attended two focus groups in early 2003. Following Exhibit 4, the rationale and process behind each step is explained.

EXHIBIT 4

HPPC Priority-Setting Model, 2004–2008

Step 1:	BRPs shall be prioritized by incidence number (i.e., the estimated number of new infections).
Step 2:	Subpopulations/cofactors within each BRP will be prioritized for funding if they meet one or more of the following criteria:* a) The subpopulation (or group affected by the cofactor) has a seroprevalence of 8% or higher; b) The subpopulation (or group affected by the cofactor) has an incidence rate that is at least 1.5 times greater than that of the BRP as a whole, based on repeat tester† counseling and testing data, detuned ELISA† counseling and testing data, and/or an incidence study; OR c) There is evidence from at least two relevant studies conducted in San Francisco demonstrating that the group is a high-risk subpopulation (i.e., behavioral risk among the subpopulation is greater than that for the BRP as a whole) or 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). This evidence may be qualitative or quantitative. The data must have been collect ed from a broad range of subjects (i.e., not just one agency's clients). The data collection must have been completed since the beginning of 1997. (If no relevant or local studies have been completed since 1997, earlier studies or national studies may be considered if relevance to San Francisco's current epidemic can be established.)
Step 3:	Identify populations at high risk or with increasing incidence using behavioral and other data from researchers, providers, and community members.
Step 4:	Develop guidelines for allocating resources.
Step 5:	Develop a list of considerations for resource allocation that should be taken into account during the technical review of proposals, the proposal selection process, and the awarding of funds. These considerations should promote provider flexibility and ensure that San Francisco has cutting-edge, high quality HIV prevention programs and services.

*No subpopulation or cofactor is "ensured" funding. "Prioritized for funding" means that these subpopulations and cofactors will receive first consideration for allocation of resources. Studies completed since 1997 were considered, and in some cases, earlier studies were considered. See Appendix 3 for more information.
†For an explanation of repeat tester and detuned ELISA data, see Chapter 2: Epidemiologic Profile, p. 41.

Background and Rationale for Each Step in The Model

Step 1: BRPs shall be prioritized by incidence number (i.e., the estimated number of new infections).

BACKGROUND AND RATIONALE

The ranking of the eight BRPs by incidence number lays the foundation for the allocation of resources based on current epidemiologic trends. Evaluation of the model's effectiveness in 2001 indicated that it made planning and resource allocation relatively easy to implement at the citywide level.

The 2004 model includes one change to the BRP categories. In the 2001 model, the partners of transgendered persons were included in BRPs 2 and 6, along with transgendered persons themselves. In 2004, the partners are instead considered as possible subpopulations under Step 2 of the model. This was done to make these BRPs consistent with the rest of the model; partners are not included in the other BRPs (e.g., male partners of FSM are not included in BRP 7). Further, partners of transgendered persons have a lower level of risk, incidence, and prevalence than transgendered persons. Therefore, the male partners of MTF would be more appropriately placed as prioritized subpopulations (if they meet the model's criteria) in the BRPs where their level of risk "matches" that of the BRP. Appendix 1 outlines the difference between the 2001 and 2004 BRPs.

RESULTS WHEN STEP 1 IS APPLIED

Exhibit 5 shows the BRPs in prioritized order based on incidence number. The data source for the anticipated number of new infections is the 2001 HIV Consensus Meeting. Although these numbers represent the anticipated incidence numbers for 2001, there is no evidence to suggest a shift in the epidemic that would alter the ranking of the BRPs for 2004, even if the exact numbers of new infections have changed slightly.

EXHIBIT 5

BRPs Ranked by Incidence Number

BRP	INCIDENCE NUMBER (ANTICIPATED NUMBER OF NEW INFECTIONS)
1. MSM, MSM/F	748
2. TSM, TSM/F, TSF, TST, TSM/T, TSF/T	102
3. MSM-IDU, MSM/F-IDU	87
4. FSM-IDU, FSM/F-IDU, FSF-IDU	48
5. MSF-IDU	45
6. TSM-IDU, TSM/F-IDU, TSF-IDU, TST-IDU, TSM/T-IDU, TSF/T-IDU	40
7. FSM, FSM/F, FSF	10
8. MSF	2

Note: For a more detailed table of prevalence, incidence, and population size for each BRP, see Chapter 2: Epidemiologic Profile, pp. 29-30.

Step 2. Subpopulations/cofactors within each BRP will be prioritized for funding if they meet one or more of the following criteria: (a) the subpopulation (or group affected by the cofactor) has an 8% or higher seroprevalence; (b) the subpopulation (or group affected by the cofactor) has an HIV incidence rate 1.5 times higher than the BRP as a whole; or (c) the subpopulation (or group affected by the cofactor) has a behavioral risk greater than that of the BRP as a whole.

BACKGROUND AND RATIONALE

The HPPC's inclusion of subpopulations and cofactors into the priority-setting model represents a recognition that certain groups are disproportionately impacted by HIV or by cofactors that affect HIV risk. Therefore, HIV prevention programs need to focus on these groups in order to have an impact on the city's HIV epidemic.

This step of the 2004 model improves upon the 2001 model because it expands the scope of the priorities. First, the new model expands the criteria under which subpopulations can be prioritized for funding. In 2001, only subpopulations with a documented HIV seroprevalence of 8% or higher (i.e., four times that of the citywide prevalence) could be considered for prioritization. The criteria were expanded for two reasons: (1) not all high-risk subpopulations have seroprevalence data, and they should not be excluded due to lack of research; and (2) providers may have their own relevant data that the HPPC is unaware of that could be used to justify the prioritization of a subpopulation.

Second, the new model considers not only demographic populations but also cofactors (i.e., conditions that put people at higher risk for HIV). The HPPC voted to include cofactors in the model because HIV prevention is not just about reaching populations, it is also about addressing the most important factors that affect HIV risk.

The prioritized subpopulations are listed in Exhibit 6. However, just because a population is not listed here does not mean it is excluded from the priorities. 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 4, Step 2, p. 146).

Finally, due to funding uncertainties, no subpopulation is "ensured" funding. Instead, these subpopulations are "prioritized" for funding, which means that pending available funds, they will receive first consideration for allocation of resources.

RESULTS WHEN STEP 2 IS APPLIED

Exhibit 6 lists the subpopulations and cofactors prioritized by the HPPC for 2004 through 2008. The precise methodology for how the model was applied to determine the subpopulations is described in detail in Appendix 2. Additional funding priorities may arise during the five-year period based on (1) new data, or (2) existing data to which the HPPC did not have access during the priority-setting process.

EXHIBIT 6

Prioritized Subpopulations and Cofactors Within Each BRP

BRP	PRIORITIZED DEMOGRAPHIC SUBPOPULATIONS	PRIORITIZED COFACTORS
1. MSM, MSM/F	• Gay men • African Americans • Asian/Pacific Islanders • Latinos • Native Americans • Whites • Age 29 and under • Age 30 and over	• Drug use (non-IDU) • Speed use • Poppers use • Homelessness/marginal housing • Incarceration • Sex work • STDs • Internet use • Having an HIV+ partner • Having an IDU partner
2. TSM, TSM/F, TSF, TST, TSM/T, TSF/T	• African American MTF • Asian/Pacific Islander MTF • Latina MTF • Native American MTF • White MTF • MTF age 29 and under • MTF age 30 and over	• The formal data available does not provide enough evidence to prioritize any cofactors for funding. See Chapter 3: Community Assessment for the research that does exist and the important cofactors not listed here.
3. MSM-IDU, MSM/F-IDU	• Gay men • Bisexual men • African Americans • Asian/Pacific Islanders • Latinos • Native Americans • Whites • Age 29 and under • Age 30 and over	• Drug use (non-IDU) • Speed use • Poppers use • Homelessness/marginal housing • Incarceration • Sex work • STDs • Internet use • Having an HIV+ male partner • Having an IDU partner
4. FSM-IDU, FSF-IDU, FSF/M-IDU	• The formal data available does not provide enough evidence to prioritize any subpopulations for funding. See Chapter 3: Community Assessment for the research that does exist and the important subpopulations not listed here.	• Sex work
5. MSF-IDU	• African Americans • Age 30 and over	• The formal data available does not provide enough evidence to prioritize any cofactors for funding. See Chapter 3: Community Assessment for the research that does exist and the important cofactors not listed here.
6. TSM-IDU, TSM/F-IDU, TSF-IDU, TST-IDU, TSM/T-IDU, TSF/T-IDU	• African American MTF • Asian/Pacific Islander MTF • Latina MTF • Native American MTF • White MTF • MTF age 29 and under • MTF age 30 and over	• The formal data available does not provide enough evidence to prioritize any cofactors for funding. See Chapter 3: Community Assessment for the research that does exist and the important cofactors not listed here.
7. FSM, FSF/M, FSF	• African Americans • Age 30 and over	• Sex work • STDs • Having an HIV+ partner • Having an IDU partner
8. MSF	• African Americans • Age 30 to 39	• Having an IDU partner

Step 3: Identify populations at high risk or with increasing incidence using behavioral and other data from researchers, providers, and community members.

BACKGROUND AND RATIONALE

The purpose of this step is to provide a method for staying one step ahead of the epidemic. When new high-risk populations are identified, the HPPC shall consider how to best meet the needs of these groups. This step allows the model to be flexible throughout the five-year period of this plan, as the epidemic may shift during that time.

RESULTS WHEN STEP 3 IS APPLIED

There are two main mechanisms the HPPC has put in place to address this step in the model:

- Twice a year, epidemiologists or researchers present an update on the epidemic to the HPPC.
- When funds are available, the HPPC prioritizes needs assessments or other types of primary research with particular populations for whom there is little data.

As new data from these and other sources becomes available, the HPPC will issue updates on the priorities.

Step 4: Develop guidelines 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 4 IS APPLIED

The HPPC recommends that resources be allocated to each of the four tiers as outlined in Exhibit 7. The tiers group the BRPs by high, medium, low, and very low numbers of new infections. The funding percentages correspond to the estimated percentage of new infections occurring within each tier. However, for Tiers 3 and 4, the funding percentages are comparatively greater than the proportion of new infections occurring in those tiers, because a substantial baseline dollar amount is required in order to do meaningful prevention for a group. A recommended range of funding for each tier is given as opposed to an exact percentage because it would be impossible for the HIV Prevention Section to allocate an exact percentage of funds.

EXHIBIT 7

Resource Allocation Guidelines, 2004 – 2008

TIER	BRPs	RECOMMENDED PERCENTAGE OF FUNDING
1	**1.** MSM, MSM/F **2.** TSM, TSM/F, TSF, TST, TSM/T, TSF/T	73-81%
2	**3.** MSM-IDU, MSM/F-IDU **4.** FSM-IDU, FSF-IDU, FSF/M-IDU **5.** MSF-IDU **6.** TSM-IDU, TSM/F-IDU, TSF-IDU, TST-IDU, TSM/T-IDU, TSF/T-IDU	18-22%
3	**7.** FSM, FSM/F, FSF	1-5%
4	**8.** MSF	<1%

Step 5: Develop a list of considerations for resource allocation that should be taken into account during the technical review of proposals, the proposal selection process, and the awarding of funds. These considerations should promote provider flexibility and ensure that San Francisco has cutting-edge, high quality HIV prevention programs and services.

BACKGROUND AND RATIONALE

The HPPC recognizes that doing effective HIV prevention in San Francisco means more than just implementing the details outlined in Steps 1 through 4 of the model. Steps 1 through 4 have epidemiology at their core, but there are some important considerations that go beyond epidemiology.

First, HIV prevention providers need to have the flexibility to use their experience to decide how best to provide HIV prevention to populations. During focus groups with providers conducted in early 2003 to obtain feedback on the 2001 San Francisco HIV Prevention Plan, providers noted that the main challenge associated with the 2001 priority-setting model was that it did not allow sufficient flexibility during program implementation. In other words, providers felt constrained in their ability to serve populations that do not "fit neatly" into the BRPs or subpopulations. For example, an agency funded to serve MTF transgendered persons may find that it is appropriate to include their male partners in programs, even if the agency is not funded for this population, because it would make the HIV prevention program stronger and more relevant.

Second, HIV prevention in San Francisco needs to be efficient and effective in order to reduce the number of new infections. It must also be delivered in the local cultural context – San Francisco's at-risk populations have very different needs compared with other parts of the country. These factors need to be considered when resources are allocated.

To encourage and support these approaches, the HPPC added this fifth step to the priority-setting model.

RESULTS WHEN STEP 5 IS APPLIED

The HPPC developed a list of questions to consider during proposal selection and resource allocation. The list of questions was presented earlier, in Exhibit 3 on pp. 144-145).

APPENDIX 1

2001 and 2004 Behavioral Risk Populations

EXHIBIT 8

2001 BRPs Compared with 2004 BRPs

2001 BRPs*	2004 BRPs, WITH PARTNERS OF TRANSGENDERED PERSONS REMOVED FROM BRPs 2 AND 6
1. MSM, MSM/F • Males who have sex with Males • Males who have sex with Males and Females	1. MSM, MSM/F • Males who have sex with Males • Males who have sex with Males and Females
2. TSM, TSM/F, TSF, TST, TSM/T, TSF/T, MST, MST/M, MST/F, FST, FST/M, FST/F • Transgendered persons who have sex with Males • Transgendered persons who have sex with Males/Females • Transgendered persons who have sex with Females • Transgendered persons who have sex with Transgendered persons • Transgendered persons who have sex with Males/Transgendered persons • Transgendered persons who have sex with Females/Transgendered persons • Males who have sex with Transgendered persons • Males who have sex with Transgendered persons/Males • Males who have sex with Transgendered persons/Females • Females who have sex with Transgendered persons • Females who have sex with Transgendered persons/Males • Females who have sex with Transgendered persons/Females	2. TSM, TSM/F, TSF, TST, TSM/T, TSF/T • Transgendered persons who have sex with Males • Transgendered persons who have sex with Males/Females • Transgendered persons who have sex with Females • Transgendered persons who have sex with Transgendered persons • Transgendered persons who have sex with Males/Transgendered persons • Transgendered persons who have sex with Females/Transgendered persons
3. MSM-IDU, MSM/F-IDU • Males who have sex with Males and Inject Drugs • Males who have sex with Males and Females and Inject Drugs	3. MSM-IDU, MSM/F-IDU • Males who have sex with Males and Inject Drugs • Males who have sex with Males and Females and Inject Drugs
4. FSM-IDU, FSF-IDU, FSF/M-IDU • Females who have sex with Males and Inject Drugs • Females who have sex with Females and Inject Drugs • Females who have sex with Females and Males and Inject Drugs	4. FSM-IDU, FSF-IDU, FSF/M-IDU • Females who have sex with Males and Inject Drugs • Females who have sex with Females and Inject Drugs • Females who have sex with Females and Males and Inject Drugs
5. MSF-IDU • Males who have sex with Females and Inject Drugs	MSF-IDU • Males who have sex with Females and Inject Drugs

EXHIBIT 8 (continued)

2001 BRPs*	2004 BRPs, WITH PARTNERS OF TRANSGENDERED PERSONS REMOVED FROM BRPs 2 AND 6
6. TSM-IDU, TSM/F-IDU, TSF-IDU, TST-IDU, TSM/T-IDU, TSF/T-IDU,MST-IDU, MST/M-IDU, MST/F-IDU, FST-IDU, FST/M-IDU, FST/F-IDU • Transgendered persons who have sex with Males and Inject Drugs • Transgendered persons who have sex with Males/Females and Inject Drugs • Transgendered persons who have sex with Females and Inject Drugs • Transgendered persons who have sex with Transgendered persons and Inject Drugs • Transgendered persons who have sex with Males/Transgendered persons and Inject Drugs • Transgendered persons who have sex with Females/Transgendered persons and Inject Drugs • Males who have sex with Transgendered persons and Inject Drugs • Males who have sex with Transgendered persons/Males and Inject Drugs • Males who have sex with Transgendered persons/Females and Inject Drugs • Females who have sex with Transgendered persons and Inject Drugs • Females who have sex with Transgendered persons/Males and Inject Drugs • Females who have sex with Transgendered persons/Females and Inject Drugs	6. TSM-IDU, TSM/F-IDU, TSF-IDU, TST-IDU, TSM/T-IDU, TSF/T-IDU • Transgendered persons who have sex with Males and Inject Drugs • Transgendered persons who have sex with Males/Females and Inject Drugs • Transgendered persons who have sex with Females and Inject Drugs • Transgendered persons who have sex with Transgendered persons • Transgendered persons who have sex with Males/Transgendered persons and Inject Drugs • Transgendered persons who have sex with Females/Transgendered persons and Inject Drugs
7. FSM, FSF/M, FSF • Females who have sex with Males • Females who have sex with Females and Males • Females who have sex with Females	7. FSM, FSF/M, FSF • Females who have sex with Males • Females who have sex with Females and Males • Females who have sex with Females
8. MSF • Males who have sex with Females	8. MSF • Males who have sex with Females

*The RED TEXT indicates the populations that were removed from BRPs 2 and 6.

APPENDIX 2
Process for Determining Priority Subpopulations and Cofactors

The HIV prevention community planning process combines scientific methods with community values. The Plan Policies Committee, which was charged with developing the 2004 priority-setting model, applied this principle to the prioritization of subpopulations/cofactors in the following manner:

1. The committee brainstormed subpopulations/cofactors within each BRP that they thought should be considered for prioritization based on their collective community experience.

2. Several themes were noted among these subpopulations/cofactors in terms of how they were defined (e.g., based on gender, race/ethnicity). The themes were:

- Sexual orientation
- Gender identity
- HIV status
- Age
- Race/ethnicity
- Substance use
- Mental health
- Incarceration
- Housing status
- STDs
- Socioeconomic status
- People with high-risk partners
- 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 see if each subpopulation/cofactor met any of the three criteria proposed in the model. Once a subpopulation/cofactor was found to meet one of the criteria, no further data was explored for that population (e.g., if a population or a population affected by a particular cofactor was documented to have 8% or higher seroprevalence, a literature review seeking two relevant behavioral studies was not pursued). Studies and data were considered relevant if they seemed on the face to be methodologically sound and did not have any serious limitations that might make the applicability of the results questionable.

5. The criteria were considered met under the following conditions:

a. Seroprevalence of 8% of higher. A published or unpublished study had to document a seroprevalence of 8% or higher for the specific San Francisco subpopulation in question, or a group affected by a cofactor. There was no restriction regarding the date of data collection, unless there was evidence to suggest that the results of a study completed before 1997 were no longer applicable.

b. Incidence 1.5 times that of the BRP as a whole. Counseling and testing or other incidence data had to demonstrate an incidence rate 1.5 times greater than the BRP overall for a subpopulation or a group affected by a cofactor. The reference point used to measure the incidence rate for the BRP overall was from the data source under consideration, not the 2001 Consensus meeting estimates used to rank the BRPs. For example, if looking at detuned counseling and testing data for the subpopulation "MSM drug users (non-IDU)," the incidence rate had to be greater than the detuned incidence rate for the "MSM, MSM/F" BRP. This methodology was used to ensure that the committee compared "apples with apples," as the Consensus Meeting estimates were derived from multiple data sources.

c. Evidence of High-Risk Behavior. Two scientifically sound behavioral studies, needs assessments, or other data had to demonstrate that the subpopulation was at higher risk than the BRP overall or that the group affected by a cofactor was at higher risk compared with the BRP overall. The determination regarding what constitutes "higher risk" was made by the committee.

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