

EPIDEMIOLOGY / POPULATIONS COMMITTEE NARRATIVE

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Edited and approved by the Epidemiology/Populations Committee

In February of 2010, the Epidemiology/Populations Committee began to deliberate on the most appropriate way to proceed with the prioritization process. It was the collective decision of the committee to seek outside technical assistance from a Capacity Building Assistance Provider to help the committee better understand its role as a committee as well as educate the committee on best practices for the prioritization process. In July of 2010, the National Minority AIDS Council (NMAC) delivered a webinar to the full CPG that helped members understand what is expected of the committee, the importance of the process, and best practices in developing a methodology for that process.

In order to best prioritize populations in greatest need of HIV prevention services, in January 2011, the Epidemiology/Populations Committee began working diligently to develop a methodology for review and approval by the full body. In May 2011, the full CPG membership approved the methodology presented by the committee with the expectations that during the prioritization process, some adjustments may need to be made in order to accurately prioritize populations in need of services. Below is the process that was approved to use when selecting prioritized populations:

Step 1: The committee first identified and defined the target populations to be considered in the priority setting process. The populations were defined by risk behavior initially then by a combination of demographics such as age, race, ethnicity and gender.

Step 2: The committee then decided on the factors to be considered relevant when determining populations at highest risk for HIV infection. The following factors were selected and approved by the full CPG:

- AIDS incidence
- AIDS prevalence
- AIDS rate
- HIV incidence
- HIV prevalence
- HIV rate
- Riskiness of population behaviors
- Difficulty of meeting population need
- Barriers to reaching the population

Step 3: Once the factors had been chosen, the committee began determining the relative importance, or weight, of each chosen factor. By weighting each factor the committee was able to demonstrate the level of importance each factor carries in comparison to the other factors. A numeric scale was created from 1 through 5, with 1 being of least importance and 5 being of greatest importance.

The committee assigned weights to the factors as shown in the table below:

FACTOR	WEIGHT
AIDS incidence	3
AIDS prevalence	2
HIV/AIDS prevalence rate	3
HIV incidence	4
HIV prevalence	3
HIV/AIDS incidence rate	4
Difficulty of meeting population needs¹	5
Barriers to reaching the population²	5
Riskiness of population behaviors	4

Step 4: This step required the committee to create a rating scale for assessing each factor and to rate each population according to the developed scale. This scale worked to ensure that the most important factors would have the most significant impact on the final score for each population. In addition to the epidemiological profile, the committee also utilized additional data sources such as past needs assessments, updated gap analyses, care/services data, and other various anecdotal data. Below are the listed factors with their final individual point scale:

AIDS incidence (per case)	Points
0 – 9	1
10 – 19	2
20 – 29	3
30 – 39	4
40 – 49	5
50 or above	6

AIDS prevalence (per case)	Points
Less than 100	1
101 – 200	2
201 – 300	3
301 – 400	4
401 – 500	5
501 or above	6

HIV/AIDS prevalence rate (per 100,000)	Points
0 – 25	1
26 – 50	2
51 – 75	3
76 – 100	4
101 – 125	5
126 or higher	6

HIV incidence (per case)	Points
0 – 9	1
10 – 19	2
20 – 29	3
30 – 39	4
40 – 49	5
50 or above	6

¹ Indicates populations that have never been reached.

² Indicates populations that has existing resources, but continue to have barriers that actually address population needs.

HIV prevalence (<i>per case</i>)	Points
Less than 100	1
101 – 200	2
201 – 300	3
301 – 400	4
401 – 500	5
501 or above	6

HIV/AIDS incidence rate (<i>per 100,000</i>)	Points
0 – 2	1
2.1 – 4	2
4.1 – 6	3
6.1 – 8	4
8.1 – 10	5
10.1 or above	6

Difficulty of meeting population needs	Points
Few or no resources	2
Moderate number of resources	1
Substantial number of resources	0

Barriers to reaching population	Points
Cultural barriers	1
Linguistic barriers	1
Stigma of behavior	1
Stigma of HIV/AIDS	1
Geographic barriers	1
Socio-economic barriers	1

When creating a point system for the factor *Riskiness of Population Behavior* it was determined that it was necessary to create an additional scaling system to accurately weight each factor. In addition to assigning a point system to the behavior, it was necessary to create a scale for the total Behavior Points relative to the points received when totaling the Behavior Risk Points. Below are the two (2) scales that were created for this factor:

Behavior Risk	Points
Sharing needles	10
Performing oral sex	2
Receiving oral sex	1
Insertive vaginal sex	3
Insertive anal sex	4
Receptive vaginal sex	7
Receptive anal sex	9

Total Behavior Points per population	Points
0 – 5	1
6 – 11	2
12 – 17	3
18 – 23	4
24 – 29	5
30 or above	6

Example: Population X receives 2 pts for Performing oral sex, 1 pt for receiving oral sex, and 3 pts for insertive vaginal sex for a total of 6 Behavior Risk Points. Therefore, Population X would receive 6 Total Behavior Points.

Step 5: Following the completion of all scales and point systems, the committee began to calculate final scores for each population. To assist in this process, the committee developed a table for each population. The following is an example of a completed scoring table for White MSM:

MSM-WHITE*				
FACTOR	WEIGHT	RATING INFORMATION	RATING	SCORE
AIDS incidence	3	19	2	6
AIDS prevalence	2	651	6	12
HIV/AIDS prevalence rate	3	41.2	2	6
HIV incidence	4	77	6	24
HIV prevalence	3	679	6	18
HIV/AIDS incidence rate	4	3	2	8
Difficulty of meeting population needs	5	1	1	5
Barriers to reaching population	5	0+0+1+1+1+1=4	4	20
Riskiness of population behaviors	4	2+1+0+4+0+9=16	3	12
<i>* Not actual numbers. For purposes of example only.</i>			TOTAL	111

Step 6: In both May and June, the committee convened to apply the methodology, calculate scores, and finalize the priority populations. Once a final score was tallied for each population, the committee ranked the populations from highest to lowest. During the September 2011 full body CPG meeting, the committee recommended and the full CPG approved the following priority populations:

- 1. People Living with HIV/AIDS**
- 2. Black Men who Have Sex with Men (MSM)**
- 3. White Men who Have Sex with Men (MSM)**
- 4. Hispanic Men who Have Sex with Men (MSM)**
- 5. Black Heterosexual Women**

(Please note that all populations include individuals aged 13 years and older)

PRIORITY POPULATION DESCRIPTIONS

Priority Population is a term that refers to groups of people who are at increased risk for HIV transmission or acquisition because they engage in certain behavior(s), such as injection drug use and/or unprotected anal or vaginal sex, that have been demonstrated to transmit the virus. These groups are the focus of HIV prevention efforts because the behaviors correlate with high rates of HIV infection as evidenced in HIV epidemiologic data and reported by clients who are HIV positive. The following populations are at highest risk in Indiana:

Population One: People Living with HIV/AIDS (PLWH/A)

With the goal of reducing new infections, the Indiana CPG recognizes the importance of providing ongoing prevention support for persons living with HIV/AIDS. In order to achieve this goal, the behavior change, disclosure support, and needs related to social determinants of health of PLWH/A must be addressed. In recognition of this and in accordance with the goals set forth by the NHAS, PLWH/A have been selected as the top priority population. It is crucial that HIV positive persons are receiving prevention services that focus on changing high risk behaviors such as high-risk sexual practices and/or sharing injection equipment.

Population Two: Black Men who have sex with men (MSM)

Due to the excessively high HIV/AIDS incidence (26.6 per 100,000) and prevalence (406.1 per 100,000) rates among Black MSM aged 13 and up, that risk group was chosen as the second priority population. The culturally specific needs of that group, in addition to the disproportionately high prevalence and incidence rates, set them apart from MSM of other racial and ethnic backgrounds.

Population Three: White MSM

The HIV (1891) and AIDS (50) prevalence numbers among White MSM aged 13 and up garnered them the position as the third priority population in the state of Indiana. Each year this group continues to far outpace all others in terms of both current and new infections.

Population Four: Hispanic MSM

The HIV/AIDS incidence (8.4 per 100,000) and prevalence (143.1 per 100,000) rates, combined with the riskiness of population behaviors, and cultural/linguistic specific needs of Hispanic MSM aged 13 and up placed them as the fourth ranked priority population.

Population Five: Black Heterosexual Women

According to the 2010 Epidemiologic data for HIV/AIDS in Indiana, Black females have an HIV/AIDS prevalence rate (183.6 per 100,000) that is nearly four times higher than their Hispanic counterparts (53.7 per 100,000) and more than 11 times higher than their white counterparts (15.7 per 100,000). Additionally, the incidence (HIV=22, AIDS=8) and prevalence (HIV=262, AIDS=289) numbers for Black women are higher than both their Hispanic (HIV Incidence=3, AIDS Incidence=0, HIV Prevalence=31, AIDS Prevalence=51) and White counterparts (HIV Incidence=10, AIDS Incidence=3, HIV Prevalence=234, AIDS Prevalence=212). According to the Center for AIDS Prevention Studies (CAPS), women are less likely to use two methods of protection, for example using both birth control and condoms (2009). HIV among Black women is not simply about individual behavior, but a complex system of social, cultural, economic, geographic, religious and political factors that combine to affect health. Therefore, to maximize effectiveness, HIV prevention programs targeting Black women should include job training, couples counseling, food banks, housing assistance, mental health services, substance abuse treatment and family services.

POPULATIONS TO WATCH

As an adjunct to the Priority Populations, the Indiana CPG has identified the following Populations to Watch. These groups did not demonstrate the need to be ranked among the Priority Populations, however, their numbers are on the rise locally, they have been shown to be at extremely high risk elsewhere in the U.S., and/or they have particularly unique needs with regard to HIV prevention services. As a result, the following groups are being presented as potentially emerging populations worthy of attention (in alphabetical order):

Black Heterosexual Men

Black heterosexual men have shown to be of priority in this state. According to the 2010 Epidemiologic data for HIV/AIDS in Indiana, black males have a prevalence rate that is almost 3 times higher than their male counterparts. We have often confused the sexual behavior and the sexual identification of black men in Indiana. For example, if a black male admits to engaging in sexual activities with another male, he may or may not categorize himself as gay, bisexual, or MSM. Agencies must acknowledge the underlying cultural and social factors that exist within the black community when developing HIV prevention strategies that target black males. According to the Center for AIDS prevention Studies (CAPS), *“prevention programs should link with other programs such as drug treatment, violence prevention, scholastic enrichment, family planning, cultural strengthening and business organizations to help support Black men as a whole, working with the richness and complexities of modern Black male life”* (2004).

Commercial Sex Workers

Although exchanging sexual activities for money or goods is illegal in Indiana, the CPG recognizes that some individuals see sex work as a livelihood and often their only means of income. Given that sex work is illegal in Indiana, it is difficult to get an accurate depiction of the industry as it relates to HIV/AIDS. When developing programs that serve this population it is important to understand what force drove these individuals into the sex work industry. According to the UNAIDS technical update titled *Sex work and HIV/AIDS*, factors that appear to heighten sex workers' vulnerability to, and risk of HIV infection include: a) stigmatization and marginalization; b) limited economic options, in particular for women; c) limited access to health, social and legal services; d) limited access to information and prevention means; e) gender-related differences and inequalities; f) sexual exploitation and trafficking; g) harmful, or lack of protective, legislation and policies; and h) exposure to risks associated with lifestyle (e.g. violence, substance use, mobility) (2002).

Hispanic Women

In 2009, Hispanics showed an increase in the rate of persons living with HIV/AIDS (201.1 per 100,000). When looking at gender the average Hispanic male rate is 4 times higher than the Hispanic female rate (295.4 vs. 74.2 per 100,000). However, the increase in the HIV rate among Hispanics over time (2007-2009) is almost the same between genders (male=4% vs. female=3%). Additionally, due to infrequent HIV testing, Latinas are often diagnosed in a later stage of HIV infection and therefore progress to AIDS at a more rapid rate than that of white woman, following an HIV diagnosis. Given the strong culture aspects of both Hispanic men and women, safer sex strategies among Latinas may be quite difficult. The concept of *machismo* is significant in the Hispanic culture. The idea of machismo outlines the male responsibilities and rights. These responsibilities include providing economically for the family, defending its

welfare, and procreating children to carry out the family name. A man's rights include controlling the behavior of family members and having authority over them. Males are socialized to be sexually active and virile, and extramarital activity is considered a male prerogative. The female gender role known as *marianismo* is the cultural expectation of Latinas to be modest, pure, dependent, weak, and abstinent until marriage. This in return acts an obstacle to HIV prevention efforts.

Injection Drug Users (IDUs) and Other Substance Users

Sharing injection equipment to either inject or split drugs, including syringes, cookers, water and cotton is a high risk factor for persons with regard to the transmission and acquisition of HIV. Due to social, economic, and psychological factors, IDUs often struggle with multiple health risks. Persons with substance abuse issues, particularly those who inject drugs, face many daily challenges including, but not limited to: addiction, poverty, incarceration, homelessness, stigma, depression, mental illness and past trauma, leaving HIV low on the list of concerns.

The possibility of HIV transmission is plausible when an individual is a routine, occasional, or even a one-time substance user. When addressing the complicated effects of drugs, the following substances should be considered: 1) Heroin; 2) Cocaine; 3) Crystal methamphetamine; 4) Ritalin (as a stimulus in adults); 5) Talwin; 6) Anabolic steroids and other hormones; 7) "Club Drugs" (i.e. ecstasy, ketamine, GHB, and nitrates); 8) Marijuana; and 9) alcohol. Issues such as the behavioral effects of the drug, the equipment used to consume the drug, and the behaviors that drive the individual to drug use all have the potential to put a substance user at an increased risk for HIV infection. While under the influence of a drug, individuals may be less inhibited and be more likely to engage in risky behavior. Due to decreased inhibitions and less control of one's own surroundings, persons under the influence may engage in unsafe sex or improper use of condoms during intercourse.

Transgender Persons

As defined by CDC, transgender refers to those individuals whose gender identity, expression, or behavior is not traditionally associated with their birth sex. When providing services and reaching out to the transgender community it is very important to remember that there is distinction between ones biological sex, ones gender expression, and ones sexual orientation. Transgender persons may identify as heterosexual, bisexual, pansexual, or homosexual. Since transgender persons experience gender identity as incongruent with their anatomical sex, some may seek to undergo some or all of the following: sex reassignment surgery, hormonal intake, or other cosmetic procedures.

Although there are not a significant number of transgender persons documented to be HIV positive in Indiana, several behaviors continue to put them at risk. There have been several studies around transgender persons that suggest that risk factors include, but are not limited to: multiple sex partners, irregular condom use, unsafe injection practices (such as drugs and other substances including hormones and silicone), as well as lack of transgender-appropriate education and prevention activities. The stigma and discrimination continues to increase their risk for HIV, by contributing to low-esteem, depression and other mental health issues, and participation in behaviors that seemingly increase the likelihood of fitting into society.