



Brother to Brother

Inspiration

I, TOO

I, too, sing America.
 I am the darker brother.
 They send me to eat in the kitchen
 When company comes,
 But I laugh,
 And eat well,
 And grow strong.
 To-morrow,
 I'll be at the table
 When company comes.
 Nobody'll dare
 Say to me,
 "Eat in the kitchen,"
 Then.
 Besides,
 They'll see how beautiful I am
 And be ashamed, —
 I, too, am America.
 ~ Langston Hughes

SAM CBA Presentations

- [The African American Leadership Conference](#)
Cleveland, OHAug. 1-4, 2002
- [African American Conference on HIV/AIDS](#)
Louisville, KYAug. 9-11, 2002
- [United States Conference on AIDS](#)
Anaheim, CASept. 19-22, 2002

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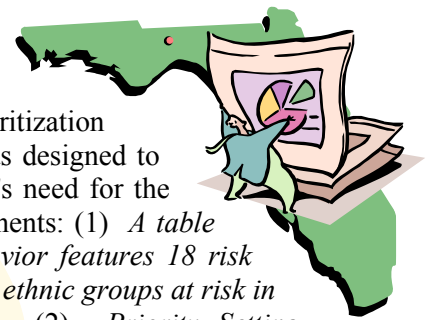
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SOUTHERN AFRICAN-AMERICAN MEN'S CBA PROJECT

Needs Assessment/Gap Analysis and Prioritization State of Florida 2001 - 2003 HIV/AIDS Prevention Plan

Sources: The Florida Department of Health, Florida HIV/AIDS Community Planning Group

In 1999, the Florida Community Planning Group (FCPG) developed a methodology for comparing and ultimately prioritizing groups of individuals for HIV prevention efforts. The prioritization instrument, developed by an FCPG workgroup, was designed to assist each partnership to assess a local population's need for the prevention efforts. The tool consists of two components: (1) *A table that shows populations by gender, race, and behavior features 18 risk populations to be evaluated based on behaviors and ethnic groups at risk in Florida based on current epidemiological data.* (2) *Priority Setting Worksheet was developed for areas to rank each of their 18 target populations using nine primary criteria and five optional data sets:*



• AIDS Case Data	• HIV Case Data
• Disproportionate Impact	• Riskiness of Behavior
• Prevalence of Risk Behavior/Increased Susceptibility	• Size of Population
• Barriers to Reaching Population	• Other Epidemiological Data, Behavior Data, Population Data, Barriers/Special Data and Risk Indicators Data
• Gap Analysis	
• Epidemiological Trends	

Each of the 18 populations was ranked on a scale of 1-5, (using the examples of AIDS cases) a score of 1 being assigned to a population with a low number of AIDS cases, such as heterosexual white males. That score was then multiplied by a weight assigned to the criterion to reflect its relative importance in determining the impact of HIV on a segment of society. For example, AIDS case data were determined to strongly indicate the impact of HIV disease on populations, and so it was assigned the greatest weight of all the criteria. The maximum cumulative score for any given target population was 100 points.

For the three planning process, the FCPG modified the prioritization tool based on feedback from the local partnerships. The modifications centered on two issues:

WEIGHTING OF FACTORS - The partnerships expressed concern that the original tool placed too much weight on AIDS case data rather than the newly available HIV case data. It was felt AIDS case data reflected the epidemic's course over the past decade. HIV case data, on the other hand, provide a more timely view of where the epidemic is or where it may be headed. Epidemiologists from the bureau

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Developing and Priority Setting Process in Louisiana

Sources: Louisiana HIV Prevention Community Planning Statewide Group

During 1997, the Statewide Community Planning Group (SCPG) established a comprehensive HIV prevention plan which was set to expire in December 2000. In early 1998, the SCPG began planning to identify priority interventions and target populations which would become effective in 2001.

Planning for how to conduct the priority setting process began in August 1998 when the statewide group appointed a priority setting ad-hoc committee. The committee's assignment was to develop recommendations for the priority setting process. The committee received technical assistance from the Academy for Education Development (AED), a national technical assistance provider funded by the Centers for Disease Control and Prevention (CDC). Between August and December 1998, committee members reviewed priority setting models used by Louisiana in the past and models developed by other states. The committee held a face-to-face meeting on Jan. 8, 1999 which was facilitated by David Napp, a consultant provided by AED. Members participated in exercises which clarified the use of numerical methods to set priorities. The training established the benefits of having a clearly defined process and provided a theoretical foundation to continue with the process. The meeting resulted in a timeline which served as the framework to be used in the priority setting process and improved methods for accepting input into the process, including a news bulletin, the *CPG Update*. The ad-hoc committee presented recommendations to the statewide group for approval.

The ad-hoc committee also developed the following recommendations to ensure that the priority setting process was objective. The recommendations were approved by the statewide group on March 18, 1999 and they are as follows:

- | |
|--|
| 1. Developing Scores for Priority Setting |
| 2. Time period for adoption of target populations and intervention strategies |
| 3. Soliciting Community Input |
| 4. How Rankings Can Change |
| 5. Statewide Group Membership Term Length |

The role of the target populations committee was to develop the methods for establishing prioritized populations to be targeted with HIV prevention activities. Over the course of seven conference calls, the target populations committee reviewed the prevention comprehensive plan's epidemiological profile for Louisiana. In evaluating methods for grouping target populations for consideration, the committee reviewed documentation of the target populations and priority setting processes used in Louisiana during 1997 and those used in San Francisco, North Carolina, Washington, and Tennessee. The committee proposed three options for consideration by the statewide group: 1) *The board group - demographic based with risk categories under these.* 2) *Behavior specific (like San Francisco) or* 3) *Continuing with mixed list (behavioral and demographic).* Strengths and weaknesses of each option were presented. The options were printed in the *CPG Update* for review and feedback was provided by individual planning group members and/or regional planning groups above-mentioned states as well as the CDC guidance. Regional and statewide group members were given opportunity to provide input. Committee members and the HIV/AIDS Program Surveillance Section collected data for each factor and each target population. Standardized fact sheets were developed for each target population to report the data. Data from the fact sheets is summarized in Section VI. Statewide Priority Target Population. The statewide group used a nominal group process to rank the target populations. The individual scores for each target population were then averaged to determine the final score. The target population with the highest score was determined to be the highest priority target population.

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Needs Assessment/Gap Analysis continued...

used this feedback to provide HIV data in addition to AIDS case data in subsequent area epidemiological profiles. AIDS data was given the greatest weight of the 14 criteria.

COMMUNITY INPUT - FCPG members expressed concern that the prioritization process had become heavily data driven, leaving little opportunity for subjective input. To address this issue, community input process points (CIPPs) were created. These points were to be freely assigned to populations based on the knowledge and expertise of community members.

BARRIERS - FCPG members felt the original tool did not adequately address the difficulties inherent in providing HIV prevention services to culturally diverse populations. To address this, the workgroup expanded barriers into two components:

▶ **BARRIERS FOR PREVENTION PROVIDERS TO REACH THE POPULATION**

These barriers could include the capacity of agencies to provide culturally appropriate interventions by hiring age and gender appropriate staff, insufficient number of staff. Other barriers could include lack of culturally and/or linguistically appropriate materials, restricted access to youth and incarcerated populations, and safety issues associated with street outreach.

▶ **BARRIERS FOR TARGET POPULATION TO ACCESS PREVENTION SERVICES**

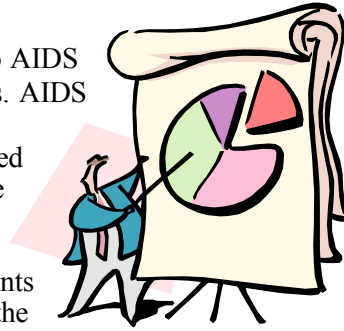
Such obstacles could include distrust of providers, lack of transportation/access to services, fear of legal consequences for active drug users, sex workers, and illegal residents, language barriers, negative or fatalistic attitudes and beliefs about HIV/AIDS.

To determine the priority target populations for the state, each of the area scores for their populations was placed on a grid. The resulting area scores were then averaged and ranked with the highest scoring populations selected as priority targeted populations for state prevention efforts.

Because nine of the 17 local Community Planning Processes (CPPs) are predominantly rural and have important differences when compared with their urban counterparts, separate analyses were run for urban and rural CPPs. This comparison revealed striking similarity between scores for the two groups, which were also highly similar to the top scores for the state.

In an effort to maximize the efficiency, effectiveness and allocation of limited HIV prevention resources throughout the state, the FCPG decided to focus on the top seven prioritized target populations. This will allow a concentrated focus statewide in delivery of HIV prevention services. The primary target groups for the state of Florida, in their order of priority, are: 1) *Black Men Who Have Sex With Other Men*, 2) *Black Heterosexual Males*, 3) *Black Heterosexual Females*, 4) *Black Injection Drug Using Males*, 5) *White Men Who Have Sex With Men*, 6) *Black Injection Drug Using Females*, and 7) *Hispanic Men Who Have Sex With Men*.

The Florida HIV/AIDS Community Planning Group, in collaboration with the Bureau of HIV/AIDS, will evaluate the process used this year to prioritize target populations and continue refining and improving the developed tools. Any concerns and issues will be addressed and the efforts to ensure that the priority populations are determined through findings of scientific research, behavioral theory and epidemiological data will continue. By standardizing this process at the local community planning level, the state is able to demonstrate the shifting of the HIV/AIDS epidemic from one population to another, and provide goals, objectives and strategies which are relevant, effective, efficient and productive to our HIV/AIDS prevention efforts.





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Focus

The Southern African-American Men's Capacity-Building Assistance Project seeks to motivate, mobilize, increase participation and involvement of African-American men who have sex with other men (MSM) in the delivery of HIV prevention services and the community planning process. This project also seeks to foster collaborations and linkages of HIV prevention programs targeting African-American (MSM) with these stakeholders and community leaders.

The Southern African-American Men's Capacity-Building Assistance Project's geographical area of coverage is as follows: AL, AR, FL, KY, LA, MS, OK, TN, TX.

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The Developing and Priority Setting continued...

The ranking for the target population is:	3. Males who have Sex with Males
1. Racial and Ethnic Minor	4. Youth
2. Sexually Active Females	5. Substance Users



Skills-Building Course Calendar

Community Mobilization.....March 22 & 23
Tulsa, Oklahoma

Community Planning.....April 19 & 20
Louisville, Kentucky

Community Mobilization.....May 16 & 17
New Orleans, Louisiana

Community Mobilization.....July 6 & 8
Nashville, Tennessee

Community Planning.....August 6 & 7
Nashville, Tennessee

For information about these courses, please call the Southern African-American Men's Capacity-Building Assistance Project, toll-free, at 1-866-JSU-MURC (578-6872).

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