

**Men Who Have Sex with Men  
And Injection Drug Users**

**Population Estimates, HIV Prevalence Estimates and Geographic Distribution**

**An Evaluation of Prototype Presentations by the Bureau of HIV/AIDS**

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**Florida Department of Health  
Bureau of HIV/AIDS  
June 2003**

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## EXECUTIVE SUMMARY

Behavioral surveillance and targeting of resources for HIV community-based planning, prevention and treatment programs can be improved with more accurate estimates of the size and residential location of groups at increased risk for HIV. Both the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) require that HIV/AIDS grantees document in their applications estimates of the size of at-risk populations. However, scant guidance is provided to develop such estimates. Population-based data are not available and would be difficult and costly to obtain for certain groups such as men who have sex with men (MSM) and injection drug users (IDUs).

To address the need for estimates, in May 2002, the Bureau of HIV/AIDS contacted Gary J. Gates, PhD, of the Urban Institute in Washington D.C. Dr. Gates was known to have been working on analyzing data concerning male householders who had indicated on the 2000 census form that they were living with a male partner. Under a contract with the bureau, Dr. Gates created census tract maps and estimates of the number of MSM for Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach and Pinellas counties.

The maps provided a stimulus for bureau staff to independently develop a novel procedure and model to estimate the size of the population of MSM and IDUs by county. Work on the model began in June 2002. Additionally, zip-code maps of persons living with HIV/AIDS (PLWHAs) by county and risk group were prepared for comparison with the census tract maps. Following positive feedback from an August 2002 presentation to the Florida HIV/AIDS Community Planning Group by Spencer Lieb, MPH, the bureau's senior epidemiologist, a decision was made to develop prototypical presentations for three counties: Hillsborough, Palm Beach and Miami-Dade. Presentations occurred from December 2002 through February 2003 to key community planners and providers. An evaluation was designed and implemented by Mary Beth Zeni, ScD, to obtain opinions of invitees to the three meetings.

Nine recommendations emerged from the evaluation and are presented in the report. Three of the nine recommendations address illustrative changes to some of the maps. For example, shaded maps of general locations and numbers of people living with HIV/AIDS (PLWHAs) were preferred over random dot placement.

In summary, participants from the three areas emphasized and supported the need for reliable HIV prevalence estimates and estimates of the number of MSM for effective planning and delivery of services. There was a preference for the HIV prevalence-based estimates rather than the census-based information. The bureau's estimates are sound and should be made available to areas with sufficient numbers of reported PLWHAs. In addition, the bureau may want to provide additional zip code data for risk group by race/ethnicity. The release of zip code data is consistent with the current DOH data release policy, Security 17.1. It would be beneficial to have a local contact person serve as a resource to assure correct use of the information. The bureau could provide consultation and technical assistance to the designated resource person.

## **INTRODUCTION**

### Background

Both the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) require that HIV/AIDS grantees document in their applications estimates of the size of populations at increased risk for HIV. However, scant guidance is provided to develop such estimates. Population-based estimates are not available and would be difficult and costly to conduct with certain groups at-risk, such as men who have sex with men (MSM) and injection drug users (IDUs).

To address the need for estimates, in May 2002, the Bureau of HIV/AIDS contacted Gary J. Gates, PhD, of the Urban Institute in Washington D.C. Dr. Gates was known to have been working on analyzing data concerning male householders who had indicated on the 2000 census form that they were living with a male partner. He made the assumption that these census-based data could serve as a proxy measure in order to create maps showing the relative population density of men who have sex with men (MSM) by census tract within each county. A secondary objective of his research was to construct quantitative estimates of the number of MSM by county. Under the contract with Dr. Gates census tract maps (and estimates of the number of MSM) were created for Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach and Pinellas counties. The maps provided a stimulus for Bureau staff to independently develop a novel procedure and model to estimate the size of the population of MSM by county. Work on the model began in June 2002. Additionally, zip-code maps of persons living with HIV/AIDS (PLWHAs) by county and risk group were prepared for comparison with the census tract maps. In August, Spencer Lieb, MPH, the Bureau's Senior Epidemiologist, presented preliminary findings at a meeting of the Florida HIV/AIDS Community Planning Group. Following positive feedback, a decision was made to develop prototypical presentations for three counties: Hillsborough, Palm Beach and Miami-Dade.

### Purpose

The overall purpose of the presentations was to elicit feedback from participants regarding the novel approaches to identify groups at risk for or infected with HIV, with a particular focus on MSM. The Bureau of HIV/AIDS sought the opinions of key community HIV planners and providers concerning the further dissemination of the information. The prototypes for the three counties could then be modified and adapted for other selected counties. A variety of planners and providers from the community attended each session, representing a good cross-section of the various levels of expertise in the HIV/AIDS arena.

Part I of the presentation addressed modeled estimates of the size of the MSM population in the county. The census-based estimates of the number of MSM by county were presented. These were compared with the MSM estimates derived from reported HIV/AIDS data, HIV prevalence estimates (and plausible ranges) developed by the Bureau, and HIV seroprevalence rates from empirical studies. This latter methodological approach had not been attempted before in Florida or elsewhere. Because of the number of inherent assumptions and the potential implications for resource allocation, the MSM population estimates needed to be reconciled with the knowledge and experience of those who live and work in the county. IDU estimates were also produced for each county.

Part II addressed the geographic distribution by zip code of MSM, IDUs and heterosexuals who had been reported with HIV/AIDS. Zip code maps were also produced for non-Hispanic white, non-Hispanic black and Hispanic persons living with HIV/AIDS (PLWHAs). While the maps relied on reported HIV/AIDS data – and thus involved fewer assumptions than the estimates in Part I – the Bureau recognized that the potential benefits of releasing data at this level of detail could possibly be offset by the risks of inadvertent misinterpretation or misuse of the data. The participants were thus requested to evaluate these practical and ethical considerations from the community's perspective. The potential benefits and risks of releasing the census tract maps developed by Gates were also discussed.

The presentations and ensuing discussions, lasting an average of three hours, were given at the following dates and locations in Florida:

- December 9, 2002 at Hillsborough County Health Department (formal evaluation)
- January 15, 2003 at Palm Beach County Health Department (formal evaluation)
- February 11, 2003 at Miami-Dade County Health Department (formal evaluation)
- June 3, 2003 at Duval County Health Department (discussion)
- June 13, 2003 at Broward County Health Department (discussion)

An evaluation was developed and conducted by the evaluation consultant to the bureau, Mary Beth Zeni, ScD, to obtain the opinions of local experts and to ascertain the perceived risk in the presentation and release of the data. An overview and the results of the evaluation are presented in this report.

## **EVALUATION METHODOLOGY**

Two approaches were selected to gather the opinions of participants at the three sites in a consistent manner. The methods represent quantitative and qualitative methods and involve group and individual level responses. The framework for the evaluation is based on the concept of triangulation, meaning the use of a combination of methodologies to strengthen an evaluation design (Patton, Michael Quinn. *Qualitative Evaluation and Research Methods, second edition*. SAGE Publications, 1990).

First, an expert review panel was conducted at the end of each presentation with the entire group of participants. A semi-structured interview was developed for use with the three groups to promote standardization in the discussion. Upon completion of the presentations, the evaluator led a group discussion using the interview form. Each group discussion lasted about 45 minutes. The semi-structured interview is located in Appendix A.

Second, an email survey was developed to obtain written opinions on an individual level. An email survey was sent to each participant within a week after the presentation with a request to return the survey within a week and a half. A reminder email was sent to encourage participants to complete and return their survey. The email survey is located in Appendix B.

In addition to the above two methods, the evaluator recorded the questions and discussions that took place during the presentations to identify both areas of strength and areas in need of clarification and/or revisions.

## RESULTS

### Expert Review Panel

Notes were reviewed from the semi-structured discussions that occurred at the end of the presentations. The following summary highlights the most common themes that emerged during the three expert review panels.

- Overall, the participants thought the presentations were excellent and beneficial.
- No group thought the information was too risky or the estimates unsound. The participants knew that the numbers are estimates and understood the concept of ranges. The participants understood that the method would not be appropriate for smaller areas, including rural areas.
- The participants noted that the information would be very helpful in planning both primary and secondary HIV prevention efforts. Specifically, the information provides sounder estimates for the local CPGs to use for the identification and prioritization of risk groups. The information is valuable for Ryan White planning initiatives and other grant applications.
- The estimates will assist with a more precise, cost-effective approach in allocating resources. Participants appreciated the ratio of MSM to IDUs for their planning areas. Currently, the providers “guess” on the numbers of MSM and IDUs at-risk for HIV and one area noted they overestimated the numbers of IDUs during their local community planning process.
- The information will also be helpful in targeting areas for HIV prevention interventions by risk groups.
- The presentation provided an opportunity to discuss and clarify terms, such as the definition of MSM, prevalence estimates, cases with no identified risk (NIRs), and other concepts. The Appendix included definitions and explanations of these key concepts.
- Some groups would appreciate detailed (zip code) information for risk groups by race/ethnicity for planning purposes. Some participants in the groups noted the need for estimates of minority MSM since many minority men do not self-disclose their sexual activity with other men due to stigmatization and cultural norms.
- The participants preferred the prevalence maps of PLWHAs compared to the census maps. There was concern that the census maps could be misinterpreted and result in “political fall-out” in an already politically charged arena. Although the census maps assisted in the conceptualization of the project, it may not be necessary to include these maps in any released information. One group did think that it was helpful to see the location of Hispanic men from the census data since this information will help with locating HIV prevention efforts in an area they did not know.
- The participants thought the randomly placed dot maps were subject to misinterpretation and suggested shading instead of dots.

- Participants in one group noted that if the maps were printed in black and white instead of color, then the shading that is now done in color may not be seen and thus the map would not be correctly interpreted. The shading could also be difficult for a person who is colorblind. Participants recommended using patterns (i.e., stripes, dots) instead of shading.
- Participants in all groups were concerned with “political fallout” in releasing the maps outside of the group of planners and providers. Although there was consensus that legislators and elected officials would benefit from the information with an explanation and in the correct context, there was concern that if the information was released to the media without an educational component, then the information was subject to serious misinterpretation. The participants recommended top leadership at DOH (i.e., the Secretary of Health) address this situation and decide on a course of action. One participant recommended releasing the information internally with the same confidentiality guidelines as counseling and testing data.
- One group identified a local resource person who could present the final version at the community level. This person would receive training and support from the Bureau.
- Future needs were identified during the presentation and included: estimates of the number of PLWHAs who migrate into an area for services; estimates of the number of undocumented people; examine available STD and ADAP data and overlay with this information; ways to determine people at-risk who travel to other areas (bars, bath houses) and participate in risk behaviors; and estimates of average number of partners of a person infected with HIV to determine spread of HIV.

In addition, Palm Beach County Health Department, under the direction of director Dr. Malecki, held a meeting shortly after their presentation to further discuss the expert review panel questions. Key leaders from the county health department and community attended this meeting. The following consensus was reached at this meeting:

- Place results into color graduated zip code breakout for the whole county.
- Present the information in aggregate form first (i.e., all characteristics by all variables. For example: The total cumulative number of AIDS cases in Palm Beach County since 1980; the total number of HIV cases in Palm Beach County since 1997; and the total estimated HIV prevalence in Palm Beach County by color-graduated zip code analyses).
- Present next, in a color graduated zip code format, breakout by exposure; race/ethnicity; and gender for AIDS (cumulative prevalence) and HIV (incidence since 1997 and estimated prevalence).
- The scatter plots are not requested.
- Palm Beach County requests census tract break out to substantiate the need for more in-depth analyses in the future.

## Email Survey

Email surveys were sent to all participants. The following table presents information regarding the number of attendees, the number of surveys returned and response, or return, rates.

| Location of Presentation | Number of Participants | Number of Email Surveys Returned | Estimated Return Rate |
|--------------------------|------------------------|----------------------------------|-----------------------|
| Hillsborough County      | 29                     | 6                                | 20 %                  |
| Palm Beach County        | 21                     | 11 (1 returned by post)          | 52 %                  |
| Miami-Dade County        | 16                     | 7                                | 44%                   |

Overall, **66 people received email surveys and 24 people completed and returned their surveys, resulting in a 36% return rate**. A 36% return rate is considered good for a mail survey.

The 24 people who returned their email survey represented community agencies, health care planners for Ryan White services, and county health departments. Twelve (50%) were members of their local HIV/AIDS community planning group and 12 (50%) were not. Variation among answers was not noted between the three sites, so the results of the email survey were aggregated for all three sites and summarized.

- A majority of the 24 respondents, 23 or **96% thought the materials they received were very complete**, representing the highest choice on a three-point scale. One respondent selected “Somewhat complete” and suggested the materials could be more complete by “comments on possible use and limitations”.
- When respondents were asked to rate on a five-point scale **how helpful the materials were for local HIV/AIDS planning efforts, 9 (37%) selected “Extremely Helpful”; 13 (54%) “Quite Helpful; and 2(9%) “Somewhat Helpful”**.

Thirteen respondents provided comments regarding how the materials were helpful. Most noted that the information will assist in determining locations to deliver primary and secondary services. A few respondents requested maps for all modes of transmission, a map that included services areas of area agencies, and maps that included socio-economic factors that may contribute to the epidemic (i.e., drug use, prostitution, and poverty levels).

- Respondents were asked to rate **how helpful the information in Part 1 (the quantitative MSM estimates) was** to local planning efforts. The following responses were provided, based on a five-point scale: **8 (33%) “Extremely Helpful”; 13 (54%) “Quite Helpful”; and 3 (13%) “Somewhat Helpful”**.
- Respondents were asked to rate **how helpful the information in Part 2 (the mapping of the data) was** to local planning efforts. The following responses were provided, based on a five-point scale: **8 (33%) “Extremely Helpful”; 10 (41%) “Quite Helpful”; and 6 (26%) “Somewhat Helpful”**.

- When asked if the **information received would lead a respondent to conduct business differently**, **11 (46%) selected “Yes”**; **11 (46%) “No”**; and **2 (8%) wrote “Somewhat”**.

If the information would lead to one conducting business differently, then the respondent was asked to describe what would be done differently. A majority of the explanations noted that the information would assist with planning services and with grant applications. For example, respondents wrote that funding could be reallocated and services provided in certain areas; a housing program could use the information to locate units; and the information would be used in local community planning initiatives.

One respondent wrote, “The information can assist our area in future planning efforts, especially efforts to target the underserved and unmet needs of the area. The information is also useful to confirm and support services that are already being funded, strengthen the continuum of care, and will possibly identify/enhance service gaps.”

The question may have a high number of “no” responses since it may be a somewhat “loaded” question, meaning if a person answered “Yes”, then the implication was that they were not presently conducting business well.

- From a five-point scale, the respondents **rated the overall comprehension level of the materials for use by people at the local level as: 4 (about 17%) “Very High”** (over 75% of the people would have no difficulty with comprehension); **6 (25%) “High”** (over 50% of the people would have no difficulty with comprehension with some opportunity for questions and discussion); **10 (41%) “Average”** (around 50% would understand the materials with the opportunity for questions and discussion) **and 4 (17%) “Low”** (over 50% would have difficulty with comprehension without the opportunity for questions and discussions).
- Respondents were asked if any of the **materials needed to be changed or revised in any way: 14 (58%) selected “No”**; **8 (34%) “Yes”**; **1 (4%) wrote “Not Sure”**; and **1 (4%) did not respond**.

Respondents were asked how they would change the materials if they answered “Yes”. The following recommendations were provided: add youth (13 – 25 years old); the information needs to be changed depending on who would receive the information due to the technical language and the possible misinterpretation of the information; develop a detailed presentation for an experienced audience and another with essential information for the general public; the maps with the dots need to be further explained if used; the press has a hard time understanding the difference between MSM and gay; and “a lot of explanations” would need to be included with the graphs since many do not understand this information. One respondent wrote “Simplified versions of geographic maps with major streets displayed should be available which would indicate that virtually every neighborhood was affected. In addition, explanation/discussion of how individuals cross these boundaries...”

- When asked how informative the Appendix was in providing detailed explanations of certain concepts addressed in the slides, 14 (58%) selected “Very Informative”; 3 (13%) “Somewhat”; 1 (4%) “Not at All”; and 6 (25%) noted they did not read the Appendix.

The respondents who selected “Somewhat” or “Not at All” were asked to describe how the Appendix could be more informative. They explained that some of the information was new, some already known, and the bureau may want to add a page with acronyms and what the acronyms mean. One respondent suggested adding more explanations to some sections of the Appendix, but did not specify which sections.

- A majority, 21 (88%), of the respondents thought the maps would be useful to locate MSM in their communities; 2 (8%) did not think the maps would be useful and 1 (4%) respondent did not answer the question.
- A majority, 20 (83%), of the respondents thought the maps would be useful to locate high-risk heterosexuals; 2 (9%) did not think the maps would be useful, 1 (4%) wrote “Maybe”, and 1 (4%) person did not answer the question.
- Seventeen (71%) thought the maps would be useful to locate IDUs in their communities; 4 (16%) did not think the maps would be useful, 1 (4%) wrote “Maybe”, and 2 (9%) people did not answer the question.
- When asked if the census-based MSM maps should be distributed and made available to the general public, 10 (41%) responded “Yes”; 11 (46%) “No”; and 3 (13%) wrote “No Opinion”.

Explanations for a “No” response included the concern that the maps could be misinterpreted; result in confusion; reinforce stigmatization and prejudice; may result in people choosing not to live in an area; and was described as “political suicide” by one respondent. Another respondent wrote that these maps should not be released at this time and noted “the need to be prepared to explain to the media in a manner suitable for understanding and meeting their needs”.

Explanations for a “Yes” could be summarized with the following statement: the maps would assist in planning and targeting efforts, including primary and secondary HIV prevention efforts. One respondent wrote: “Accurate information is the basis of effective planning”.

- When asked if the race/ethnicity PLWHA MSM maps should be released to the public, 13 (54%) selected “No”; 9 (38%) “Yes”; and 2 (8%) wrote “No Opinion”.

The major concern noted by respondents who selected “No” dealt with possible discrimination, ostracism, and stigmatization (including hate crimes) of communities and members of these communities who would be identified as having a high number of residents with HIV/AIDS. One respondent described the potential public release of this information as “political suicide”.

There was concern that the general public would not understand the information. A few respondents suggested keeping the information within the health department and community groups responsible for the planning and delivery of services, and not releasing the information to the public.

Respondents who advocated the release of the information generally noted “accurate information is the basis of effective planning”. Others wrote that the public may then support increased funding for HIV services since they would be aware of the needs in their communities.

A few respondents reiterated their preference for using shading on these maps and not dots since the dots may be misinterpreted, even though randomly placed.

- Respondents were asked to provide any **other comments on the maps and community confidentiality issues.**

In summary, respondents who did add comments requested that shading be used and not the dots for the maps designating PLWHA.

A few respondents again expressed their concern of releasing the maps to the general public since the information may not be correctly interpreted, but noted that releasing to a selected group of planners would be beneficial.

Respondents also used this open-ended question as an opportunity to state their opposition or support to the release of information to the public, as noted in the following two statements.

One respondent emphasized that public release may result in mistrust between communities and the government since:

“Confidentiality is important in communities of color and the government does not have a strong reputation within these communities and releasing the information would only widen the gap”.

One respondent presented the rationale for releasing the information, writing:

“If this problem was presented to a major corporation, they would embark on a major public relations campaign to steer the information to the direction that best suited the organization. The notion of “community confidentiality” infers that your right to have a disease and maintain your privacy exceeds my expectation that the government should intervene in outbreaks of communicable diseases.”

Another respondent recommended showing an overlay of HIV services by census tract. Another voiced support of reporting HIV since reporting leads to effective prevention services.

- Respondents were asked **if there was a local person that could present the materials in their area. Twelve (50%) selected “Not Sure”; 11 (46%) replied**

**“Yes”;** and 1 (4%) person did not answer the question. No one selected “No” as an answer.

## **SUMMARY AND RECOMMENDATIONS**

In summary, HIV prevalence estimates are needed to effectively plan primary and secondary prevention services for at-risk groups. Sound estimates can assist planners in determining needed services for selected at-risk groups. Funders, including the CDC and HRSA, request estimates in grant applications. If estimates based on a methodological approach are not available to health services planners, then planners may have to resort to “best guesses”. While best guesses may be on target, there is the strong possibility that these guesses may not be accurate and, if used to determine allocation of resources, will result in incorrect allocations. Thus, inaccurate estimates do not support a cost-effective approach in the delivery of services.

Determining estimates is a challenge with groups where population-based data are not available, such as MSM and IDUs. Furthermore, stigmatization experienced by MSM and IDUs for behaviors generally not sanctioned by society result in further barriers to accurately determine risk behaviors that may lead to HIV infection. For example, these at-risk groups may be less open to reveal risk behaviors, especially those deemed illegal and unacceptable. The need for determining the best possible estimates is imperative for effective health planning.

The Bureau of HIV/AIDS developed a novel approach for determining HIV prevalence estimates. This prototype was presented at three epicenters in Florida: Hillsborough County, Palm Beach County, and Miami-Dade County. An evaluation was conducted to determine the response to the prototype, resulting in the following nine recommendations. These recommendations are based on evaluation data and what could be viewed as beneficial to public health practice.

1. Sound HIV prevalence estimates and estimates of the number of MSM are needed and desired for planning effective community-based HIV primary and secondary prevention. The Bureau of HIV/AIDS is viewed as the resource for providing these estimates to communities.
2. In general, HIV prevalence-based estimates of the number of MSM appear more plausible for planning purposes than the census-based quantitative information.
3. The bureau’s estimates of size of MSM and IDUs populations are epidemiologically sound and should be made available for areas with an adequate number of cases (more than 750 PLWHAs).
4. The geographic distribution by zip code of the total number of PLWHAs by MSM, IDUs, and heterosexual risk using shading is an acceptable way to present the data.
5. The bureau may want to consider providing additional zip code data for risk groups by race/ethnicity, as requested by some groups and individuals, using shading.

6. Visual presentations of general locations and numbers of PLWHAs should be shaded instead of using the random placement of dots (i.e., dot maps) since the dot maps are subject to potential misinterpretation.
7. The current maps that use different colors in their scales should be changed to patterns and/or shading since if these maps are printed in black and white, it may be difficult to correctly read the colors used in the scales. Also, patterns would be easier to read for people who are visually challenged in their ability to discern colors.
8. The release of zip code data seems consistent with the current DOH data release policy, Security 17.1.
9. A local contact person could serve as a resource regarding the interpretation and use of the data, with the bureau providing continual consultation and technical support.

## APPENDIX A

12/05/02

Expert Review Panel Discussion  
Questions

**Introduction: Thank you for your attention. We know you just heard a lot of information, but we want to spend the next 15 minutes getting some overall reactions and feedback to what you heard since we are relying on your expertise. This will help us determine the future direction of the project. We will be emailing you a short survey next week after you have had the opportunity to revisit the slides in your handouts and review the Appendix. We feel the Appendix is an integral part of this packet since it addresses some key HIV/AIDS and public health concepts.**

Date of Presentation: \_\_\_/\_\_\_/\_\_\_

Location: \_\_\_\_\_

Number Present: \_\_\_\_\_ (attach sign-in sheet)

1. What is your overall response to the presentation?
2. What new information did you obtain from the presentation?
3. How could you use this new information in your work?
  - 3.a. Probe: Would the information you received lead you to conduct business any differently? If so, then how? (Please explain)
4. What did you find of most interest to you in this presentation?
5. What was vague or unclear to you in this presentation? (Discuss what concepts are vague/unclear and attempt to ascertain how to clarify the concepts.)
  - 5.a. (Probe) Do you think that the explanations on how to read the figures and graphs are clear?
6. Is the information on the plausible numbers of MSM too wide of a range – or too narrow?
  - 6.a. Given what you know and what we presented, what percent of MSM in Hillsborough County do you think are living with HIV infection, including those who do not know they are infected?  
Probe: 5%? 35% - some other percent?
7. Was there anything that was not new to you – or seemed rather obvious?

8. Would the maps be useful for local targeting and/or planning?
  - 8.a. Probe for how the maps would be useful – or not.
  - 8.b. Probe: applicability to outlying counties? (Point out info is in the packet and please read prior to email survey)

Note that the Surveillance Section is currently preparing data sheets with the number of PLWHA cases by zip codes for all counties in the state. DO you think mapping the data for small counties is beneficial?

9. Who in your area do you think would benefit from this information?
  - 9.a. Probe: exactly who and what is his/her role in HIV prevention.
10. What is the best way to get this information to others who may find the information beneficial to their work?
  - 10.a. Is the slide set self-explanatory? For example, if we emailed this slide set and appendix instead of having someone present the information, would the information stand up on its own without misinterpretation?
  - 10.b. What do you think is the best way to get this information out to the people who could use the information?
  - 10.c.. Is there a local resource person who could present this information and answer questions for this area? (this person would be able to contact the Bureau for additional assistance and questions).
11. As you can see, there is an important context for these findings, and we have tried to avoid being pinned down to the exact estimates of the number of MSM and the percent HIV infected. How do you think we should address the inevitable chance that we will be quoted out of context once we distribute a final version of the estimates?
12. Do you have any other comments or suggestions regarding this material?

Thank you for being here this morning. We are indebted to you for taking time out of your busy schedule to be here.

## **APPENDIX B**

**MSM Population Estimates and Maps for All Modes of HIV Exposure  
February 2003  
Bureau of HIV/AIDS**

**Opinion Form**

Thank you for attending the recent meeting in \_\_\_\_\_ County. We appreciate your willingness to review the MSM population estimates and maps for all transmission modes. Now that you may have had the opportunity to review the materials (including the Appendix), we are asking that you take about 15 minutes to complete this brief survey. We appreciate your opinion since your comments will assist in any revisions to the materials prior to future presentations. If you need additional space for your answers, please feel free to attach any comments to this survey.

Please email your completed survey to [MaryBeth\\_Zeni@doh.state.fl.us](mailto:MaryBeth_Zeni@doh.state.fl.us) or Fax to (850) 487-1521/SC 277-1521 or mail: Bureau of HIV/AIDS (HSDHIV), 4052 Bald Cypress Way, BIN A09, Tallahassee, FL 32399-1715

1. How complete are the materials you received? (Select one)

- Very complete
- Somewhat complete
- Incomplete

If you selected "Somewhat complete" or "Incomplete", please describe how the materials could be more complete:

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2. Overall, how helpful are the materials for local planning efforts related to HIV/AIDS? (Select one)

- Not at all helpful
- Minimally helpful
- Somewhat helpful
- Quite helpful
- Extremely helpful

Please tell us what you found helpful or not helpful with the materials:

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3. Part 1 of the presentation addresses estimated number of MSM, the percent of MSM among adult males in the community, and HIV prevalence rates (infection rates) among MSM. How helpful is this information to your local planning efforts?

- Not at all helpful
- Minimally helpful
- Somewhat helpful
- Quite helpful
- Extremely helpful

4. Part 2 of the presentation addresses geographic location/distribution of MSM (and others) in the community. How helpful is this information to your local planning efforts?

- Not at all helpful
- Minimally helpful
- Somewhat helpful
- Quite helpful
- Extremely helpful

5. Will the information you received lead you to conduct business any differently?

- Yes  No

If you answered "Yes", then tell us what you can or will do differently now that you have this information:

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6. How would you rate the overall comprehension level of the materials for people who would use these materials at the local level?

Very high level- over 75% of the people would have no difficulty comprehending the materials with minimal explanation and discussion

High level – over 50% would have no difficulty comprehending the materials with some opportunity for questions and discussion

Average level –around 50% would understand the materials with the opportunity for questions and discussion

Low Level – over 50% would have difficulty comprehending the materials without the opportunity for questions and discussion

Very low level – over 75% would have difficulty comprehending the materials without a detailed explanation and discussion

7. Do you think any of the materials need to be changed or revised in any way?

Yes  No

If you answered “yes”, please explain what you would change:

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8. How informative is the Appendix in providing detailed explanations of certain concepts addressed in the slides? (Select one)

Very informative

Somewhat informative – much of the information was new to me

Not informative at all – I knew most of it already

I have not read the Appendix

If you selected “Somewhat informative” or “Not informative at all”, please describe how the Appendix could be more informative to you:

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9. Would the maps be useful to help you locate MSM in the community?

Yes  No

a. Would the maps be useful to help you locate high-risk heterosexuals?

Yes  No

b. Would the maps be useful to help you locate IDUs?

Yes  No

10. There was discussion about whether the maps showing MSM might cause problems for the community if published in the press. Two types of MSM maps were presented: Census-based and data for PLWHA. The next four questions deal with these two types of MSM maps:

a. Do you think the census-based MSM maps should be released (distributed and therefore made available to the general public)?

Yes  
 No  
 No opinion

Please explain if you answered "Yes" or "No":

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b. Do you think the PLWHA (persons living with HIV/AIDS) MSM maps should be released (distributed and therefore made available to the general public)?

Yes  
 No  
 No opinion

Please explain if you answered "Yes" or "No":

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c. If you replied "No" to one of the above questions and "Yes" to the other, then please explain why there is a difference:

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- d. Please feel free to provide any other comments on the maps and “community confidentiality” issues:

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11. Is there a local resource person that could present the materials in your area and answer questions? (This person would be able to contact the Bureau of HIV/AIDS with questions.)

Yes  No  Not sure

If you answered “Yes”, then who would you recommend as the local contact?

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12. Which of the following best describes your role in relation to HIV/AIDS? (Select one)

CBO (supervisor, outreach staff, planner, etc)  
 County health department (Surveillance, STD, HAPC, etc)  
 Title I Planning Council  
 Title II Consortia  
 Other – please describe: \_\_\_\_\_

- 12.a. Are you a member of your local HIV/AIDS Community Planning Group?

Yes  No

13. If you have any other comments, please feel free to write the comments on this page, or the following page.