Community-Based HIV Prevention in San Francisco

Community Health Equity & Promotion Branch

Objective:

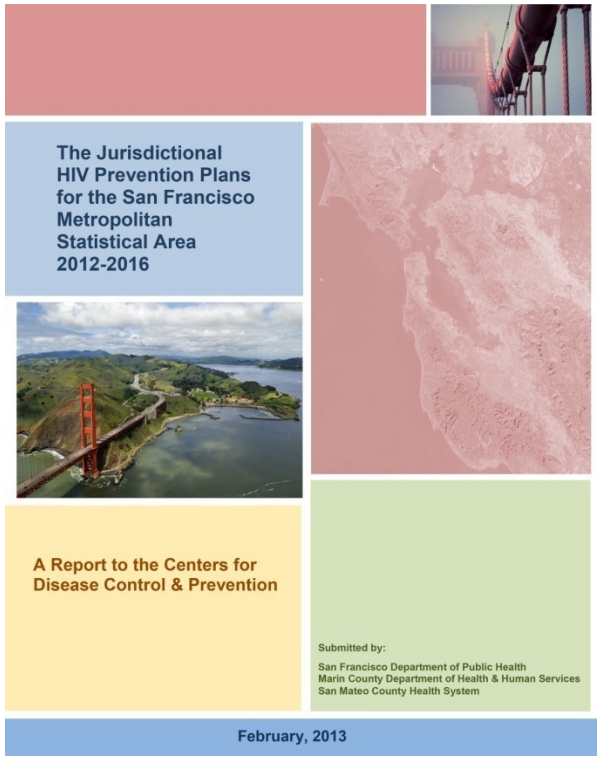
- To provide members of the HIV Community Planning Council with background information about HIV prevention planning in preparation for their September vote on the letter of concurrence

How HPPC Sets Priorities

1. Rank behavioral risk populations (BRPs) by incidence number
2. Identify drivers and cofactors within BRPs
3. Consider emerging trends
4. Make funding recommendations based on above data and other considerations

The Health Department then develops a plan to allocate funding and asks HPPC to vote on whether they think the plan is in line with the epidemiology (“Letter of Concurrence”).

Then the Health Department incorporates the HPPC recommendations and funding plan into a request for proposals



Epidemiology Riddle: Why Incidence Number?

Incidence: New infections within a period of time

Incidence number: # of new infections within a period of time

Incidence rate: % of the HIV-negative population that becomes HIV-positive in a given period of time

- Why don't we use **prevalence** (number of people living with HIV)?
- Why don't we use **incidence rate**?

Priority-Setting Step 1

1. **Rank behavioral risk populations (BRPs) by incidence number**
2. Identify drivers and cofactors within BRPs
3. Consider emerging trends
4. Make funding recommendations based on above data and other considerations

Populations with highest incidence numbers are:

- Males who have sex with Males **(MSM)**
- People who inject drugs **(PWID)**
- Transfemales who have sex with males **(TFSM)**

Priority-Setting Step 2

1. Rank behavioral risk populations (BRPs) by incidence number
2. **Identify drivers and cofactors within BRPs**
3. Consider emerging trends
4. Make funding recommendations based on above data and other considerations

Drivers:

- By definition, are only among high prevalence populations
- **6 drivers:**
  - Meth, crack/cocaine, poppers, heave alcohol use
  - Gonorrhea
  - Multiple partners

Priority-Setting Step 3

1. Rank behavioral risk populations (BRPs) by incidence number
2. Identify drivers and cofactors within BRPs
3. **Consider emerging trends**
4. Make funding recommendations based on above data and other considerations

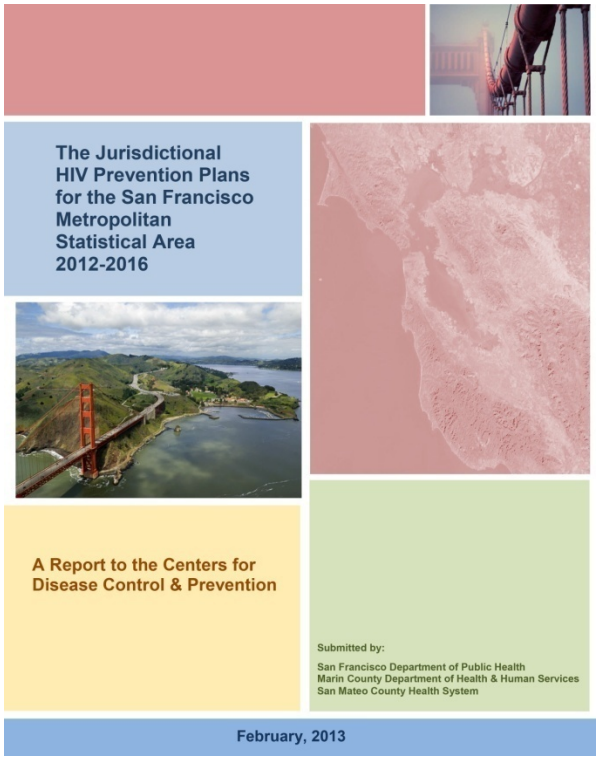
Past examples:

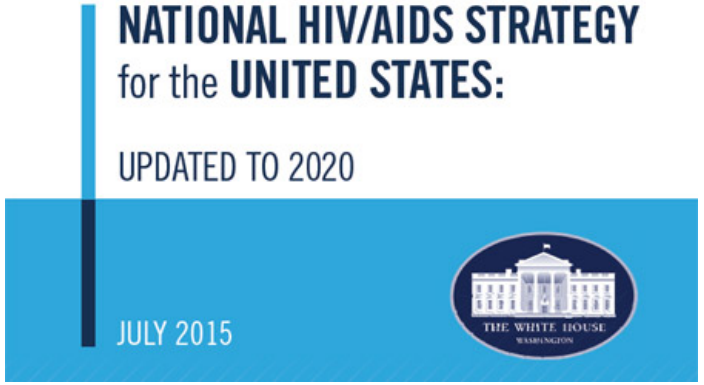
- Men who have sex with transgender women
- Heterosexually identified men who have sex with men
- Latino immigrant men who have sex with me

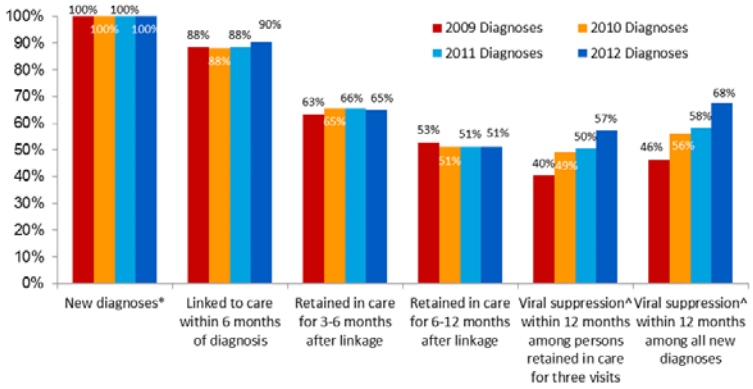
Priority-Setting Step 4

1. Rank behavioral risk populations (BRPs) by incidence number
2. Identify drivers and cofactors within BRPs
3. Consider emerging trends
4. **Make funding recommendations based on above data and other considerations**

Aligned Efforts



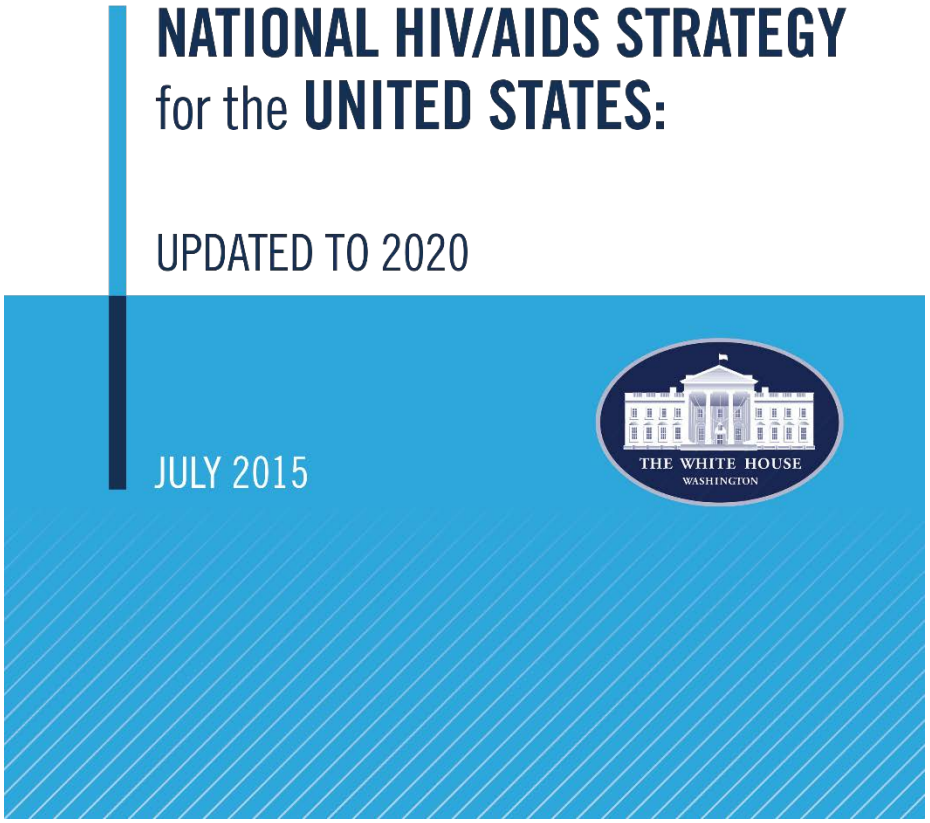




GETTING TO ZERO
SAN FRANCISCO

ZERO INFECTIONS
ZERO DEATHS
ZERO STIGMA

THE GOALS



- Reducing new HIV infections
- Improving access to care and health outcomes
- Reducing HIV-related health disparities
- Achieving a more coordinated national response

High Impact Prevention

To advance the prevention of goals of NHAS and maximize the effectiveness of current HIV prevention methods, CDC pursues a High-Impact Prevention approach. By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to greatly increase the impact of HIV prevention efforts.

In the High-Impact Prevention approach, HIV prevention efforts are guided by five major considerations:

- **Effectiveness and cost**
- **Feasibility of full-scale implementation**
- **Coverage in the target populations**
- **Interaction and targeting**
- **Prioritization**

Any door is the right door

Any contact with the service system should lead to appropriate linkage to more intensive health-related services, when appropriate. Structural barriers to access must be addressed with creative solutions.

Continuum of HIV Prevention, Care, &Treatment

Comprehensive health screening, assessment, and referral; retention interventions; and risk reduction for people living with and at risk for HIV should be integrated and available within the service system, whether in primary care, community-based services, substance use treatment, or other services.

Health Outcomes

Our goal is healthy people. We envision an SF MSA where there are no new HIV infections and all PLWH have achieved viral suppression.

Access to Care & Services

Examples of services:

- Linkage support/care navigation
- Health Insurance enrollment
- Benefits eligibility

Examples of entry points:

- (HIV-inclusive) Primary care
- HIV testing
- Substance use treatment
- Mental health services

Screening, Assessment, & Referral

- STIs and other co-infections (e.g., hepatitis C)
- Mental health & substance use disorders
- Trauma history
- Basic needs
- Sexual & injection risks, as well as risk reduction practices
- Resiliency factors

- HIV

Risk Reduction

- Harm reduction
- Mental health & substance use services
- Condoms
- Syringe access
- Sexual health education & risk reduction
- Medication adherence

- Post Exposure Prophylaxis (PEP)
- Pre Exposure Prophylaxis (PrEP)

- Antiretroviral therapy
- Prevention with positives

Retention

- Case management
- Linkage to housing & other ancillary services
- Mental health & substance use services
- Patient navigation
- Peer support
- Outreach & re-engagement
- Appointment reminders

- Health/HIV literacy and education

Getting to Zero

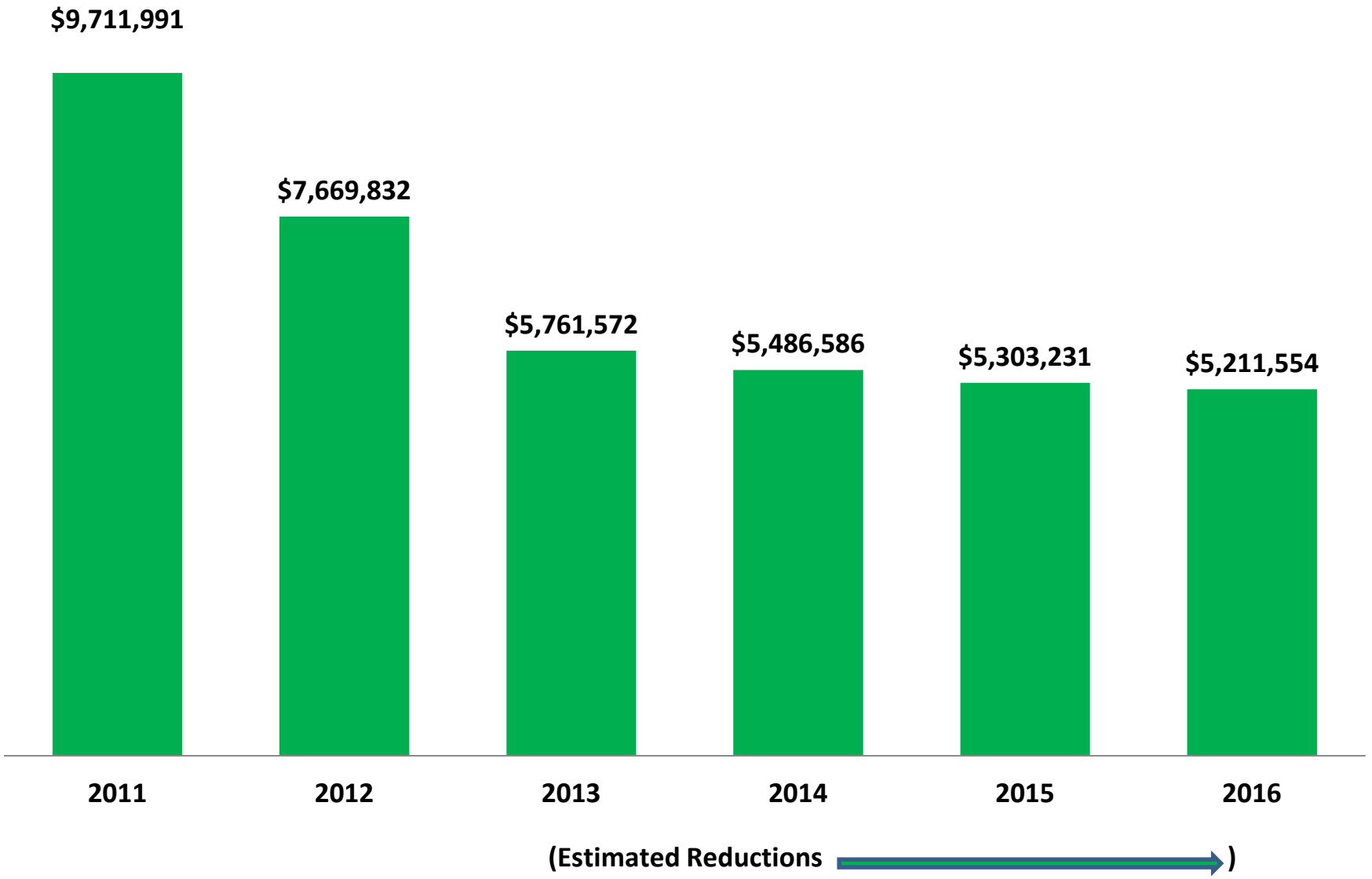
- Zero stigma
- Zero new HIV infections
- Zero AIDS-related deaths

Strategies for all, regardless of HIV status

Strategies for HIV negative individuals

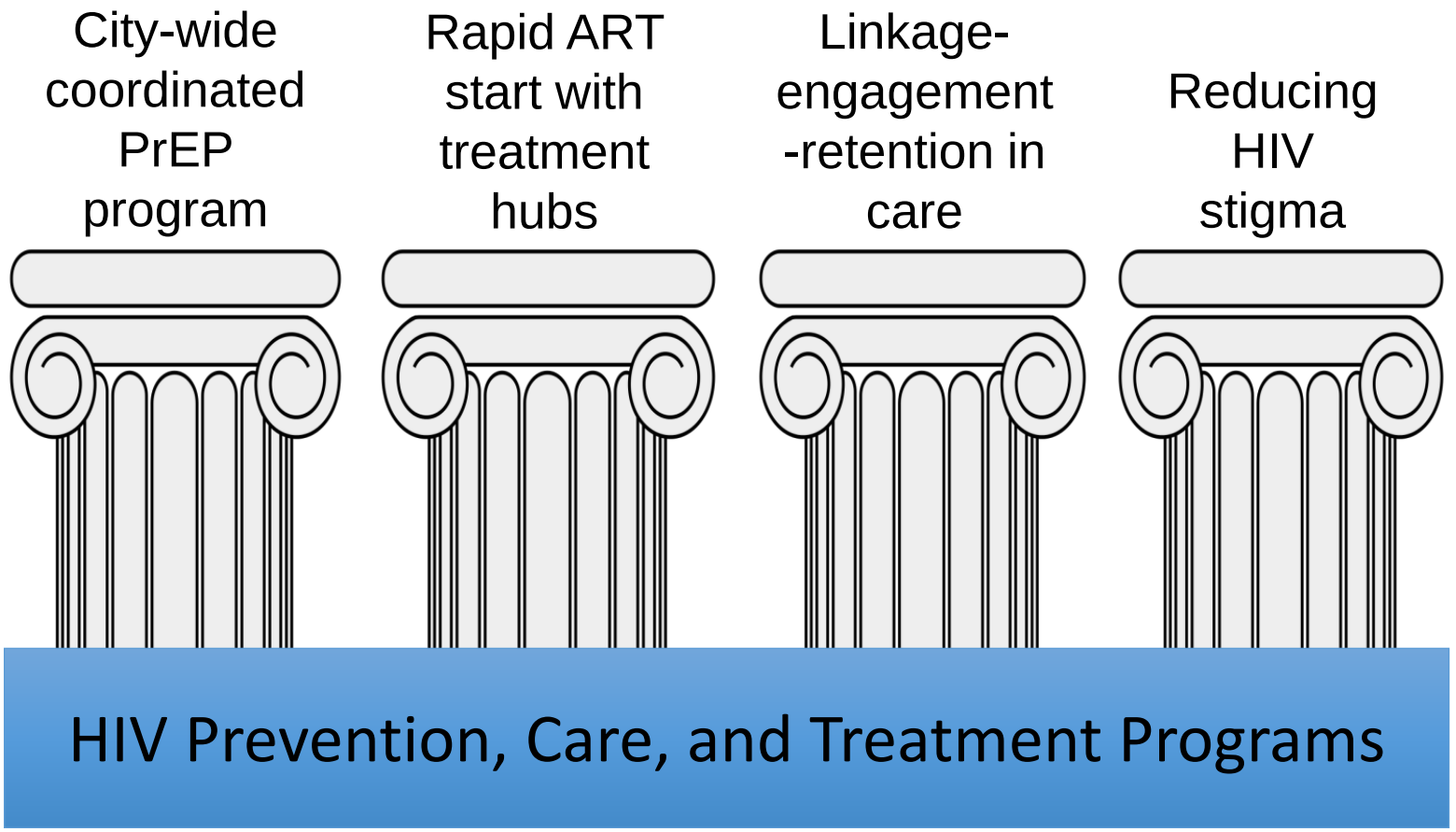
Strategies for HIV positive individuals

CDC Base Funding to San Francisco: 2011 - 2016 by Calendar Year



Funding cuts for HIV prevention have been back filled by the Mayor's Office

Getting to Zero Consortium Strategic Priorities



From priorities to funding: An example from 2010

Behavioral Risk Population	Incidence Number (Anticipated number of new infections per year)	Incidence Number
• Males who have sex with males • Males who have sex with males and females • Transmales who have sex with Males	772	79%
• People who inject drugs	144	15%
• Transfemales who have sex with Males	42	4%
• Females who have sex with Males	12	1%
• Males who have sex with Females	5	<1%

2010 San Francisco HIV Prevention Plan

Summary of 2010Fundig Priorities for HIV Prevention in San Francisco

Behavioral Risk Population	High Risk Behaviors for Acquisition of HIV	Prioritized Subpopulations	Prioritized Drivers or Cofactors	Recommended Funding %
1. Males who have sex with Males **Males who have sex with Males and Females** **Transmales who have sex with Males**	Sexual Risk Behavior: The primary risk for this BRP is HIV- males/transmales engaging in unprotected receptive or insertive anal intercourse with HIV+ males. Transmales may also engage in frontal receptive intercourse with HIV+ males. These risks may be enhanced by the use of alcohol or drugs.	MsM ■ African Americans ■ Asians/Pacific Islanders ■ Latinos ■ Native Americans ■ Whites ■ Gay men ■ Adults 30 and older ■ Youth 29 and younger	Drivers: ■ Cocaine/Crack ■ Gonorrhea ■ Heavy alcohol use ■ Methamphetamines ■ Multiple partners ■ Poppers	**MsM, MsM/F** **70 – 79%** **TMsM** **1 – 2%**
2. People who inject drugs	Substance Use Behavior: The primary risk for this BRP is HIV- individuals who engage in needle sharing with HIV+ individual(s). This risk may be enhanced by the use of alcohol or drugs, injected or not. Sexual Risk Behavior: The secondary risk for this BRP is HIV- individuals who engage in unprotected anal receptive or insertive intercourse and/or unprotected vaginal intercourse with HIV+ individual(s). This risk may be enhanced by the use of alcohol or drugs, injected or not.	MsM-IDU: ■ African Americans ■ Asians/Pacific Islanders ■ Whites ■ Bisexual men ■ Gay men ■ Heterosexually identified men ■ Adults 30 and older ■ Youth 29 and younger TFsM-IDU: ■ African Americans ■ Asians/Pacific Islanders ■ Latinas ■ Native Americans ■ Whites ■ Youth 29 and younger Female IDU ■ African Americans ■ Native Americans ■ Youth 29 and younger MsF-IDU ■ African Americans ■ Adults 30 and older		**IDU** **15 – 20%*** *** Approximately half of these funds should reach MsM-IDUs**
3. Transfemales who have sex with Males	Sexual Risk Behavior: The primary risk for this BRP is HIV- transfemales who engage in unprotected anal receptive or insertive intercourse and/or unprotected vaginal intercourse with HIV+ individual(s). This risk may be enhanced by the use of alcohol or drugs.	■ African Americans ■ Asians/Pacific Islanders ■ Latinas ■ Native Americans ■ Whites ■ Adults 30 and older ■ Youth 29 and younger		**TFsM** **5 – 8%**
4. Females who have sex with Males	Sexual Risk Behavior: The primary risk for this BRP is HIV- females who engage in unprotected vaginal intercourse and/or unprotected anal receptive intercourse with HIV+ male(s). This risk may be enhanced by the use of alcohol or drugs.	■ African Americans ■ Native Americans ■ Adults 30 and older	Cofactors: ■ Chlamydia ■ Crack use ■ Having an HIV+ partner ■ Having an IDU partner ■ Incarceration ■ Methamphetamine use ■ Sex work	**FsM** **1 – 4%**
5. Males who have sex with Females	**Sexual Risk Behavior: The primary risk for this BRP is HIV- males who engage in unprotected vaginal or insertive anal intercourse with HIV+ female(s). This risk may be enhanced by the use of alcohol or drugs.**	■ **African American** ■ **Adults 30 and older**	**Cofactors:** ■ **Having an HIV+ partner**	**MsF** **<1%**

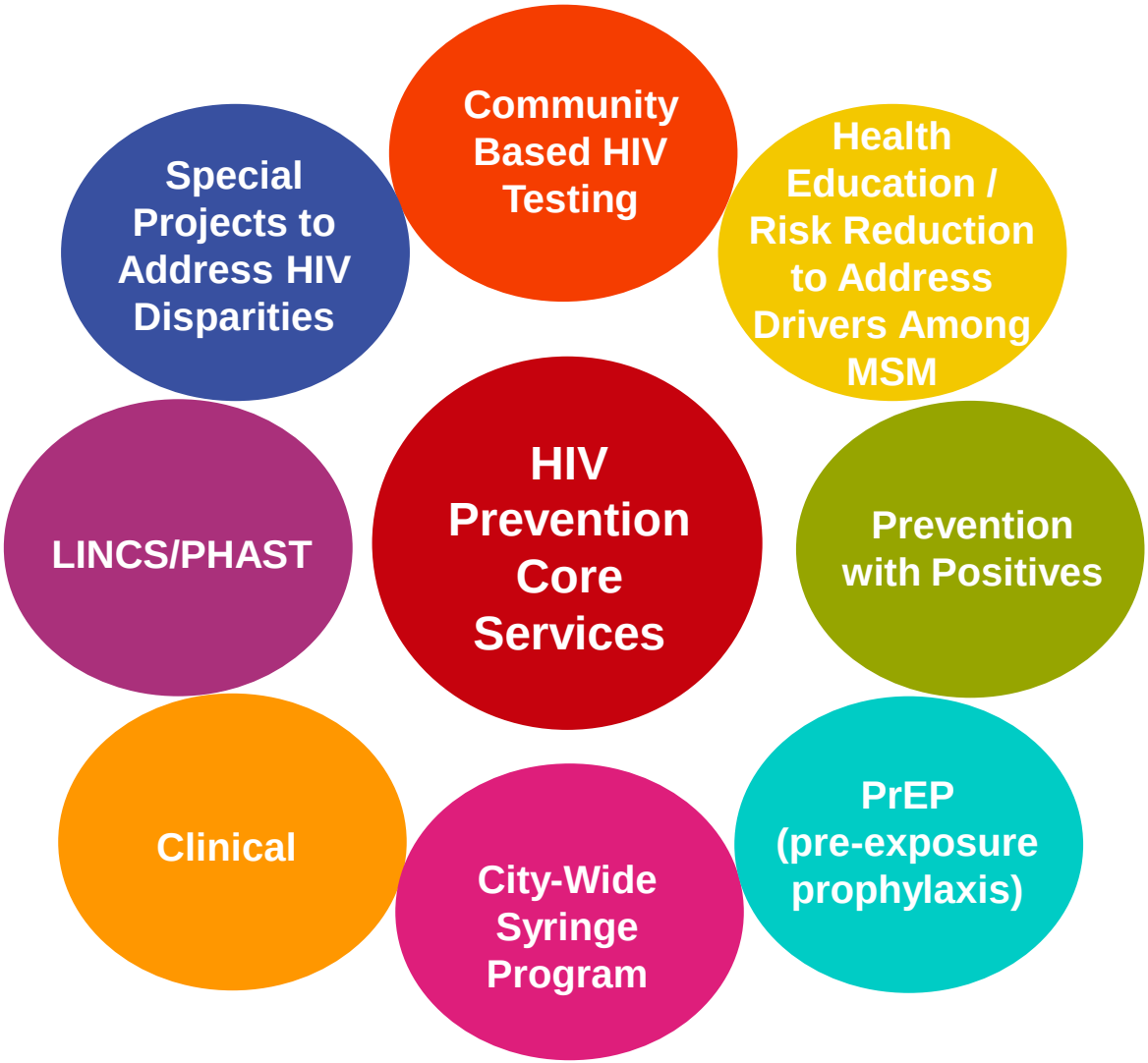
Priority Setting Considerations

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

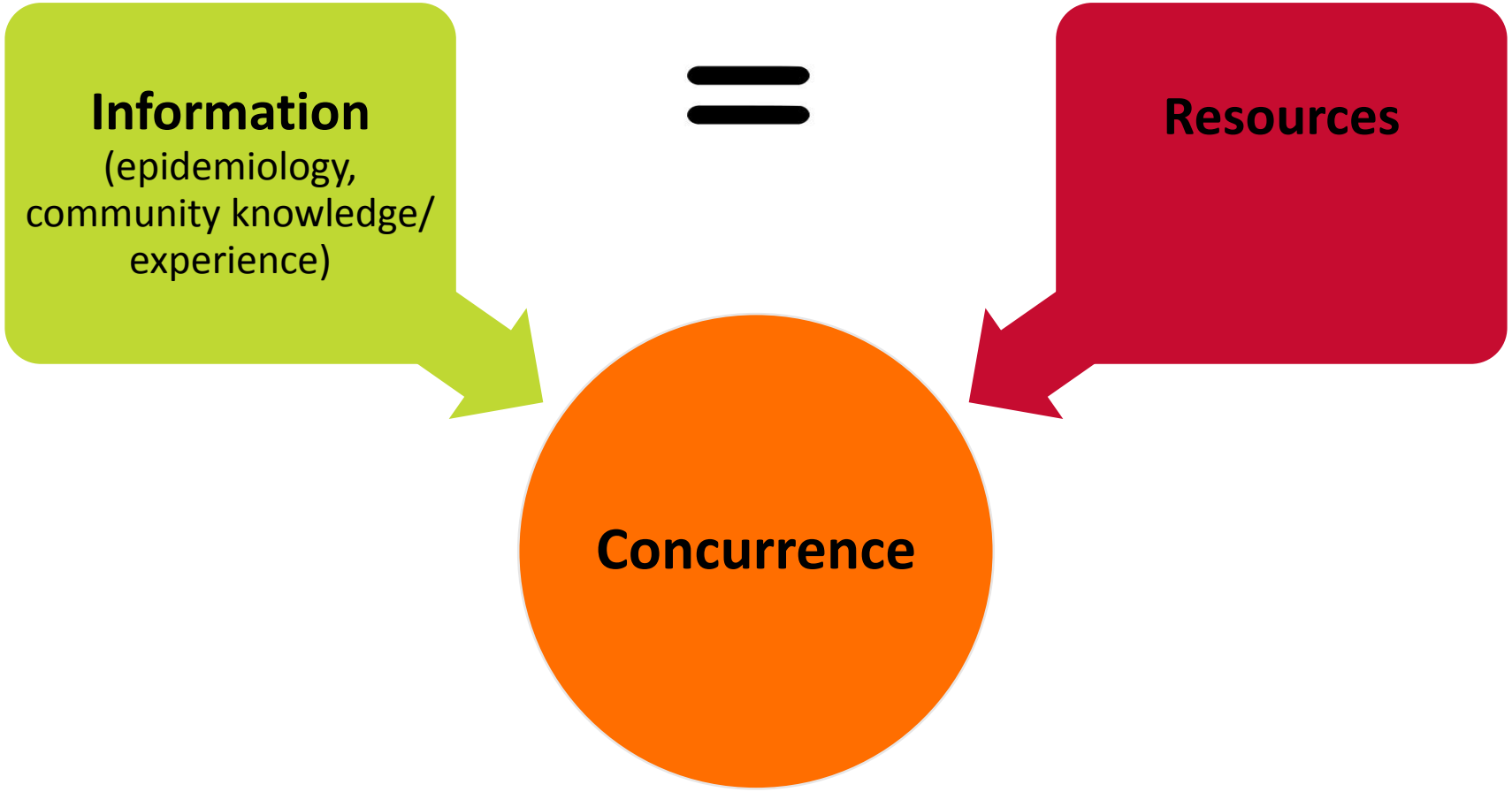
Note: Populations or items in this box will be identified and updated by the HPPC on an annual basis.

2010 San Francisco HIV Prevention Plan

Example (cont.): HIV Prevention Core Services, from 2010 RFP

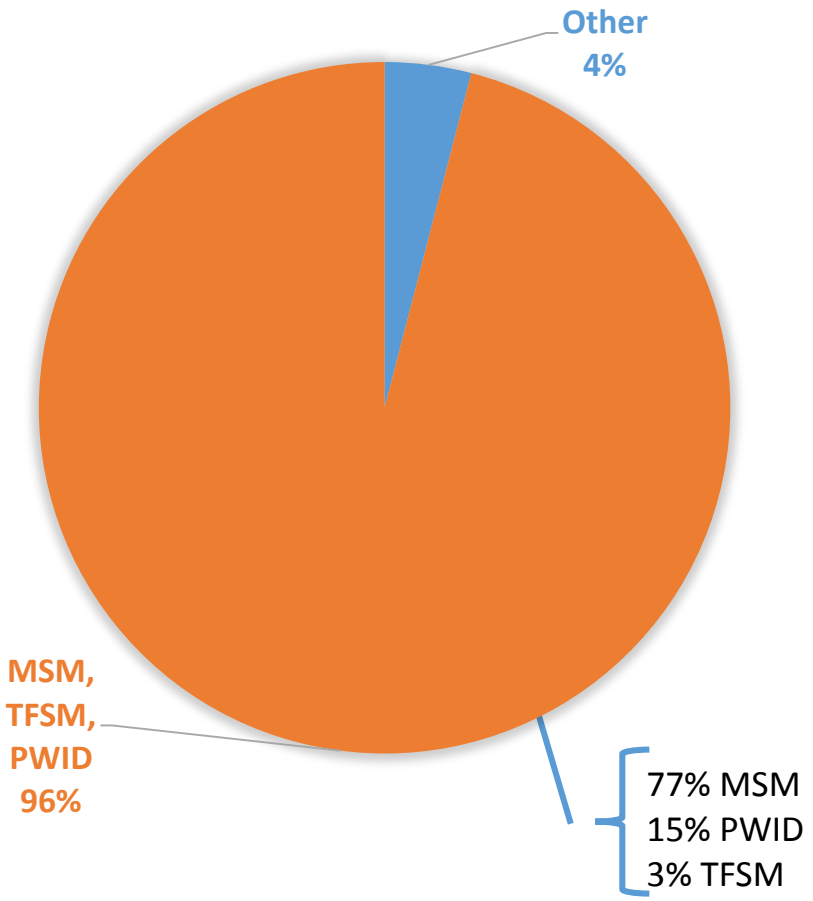


Letter of Concurrence

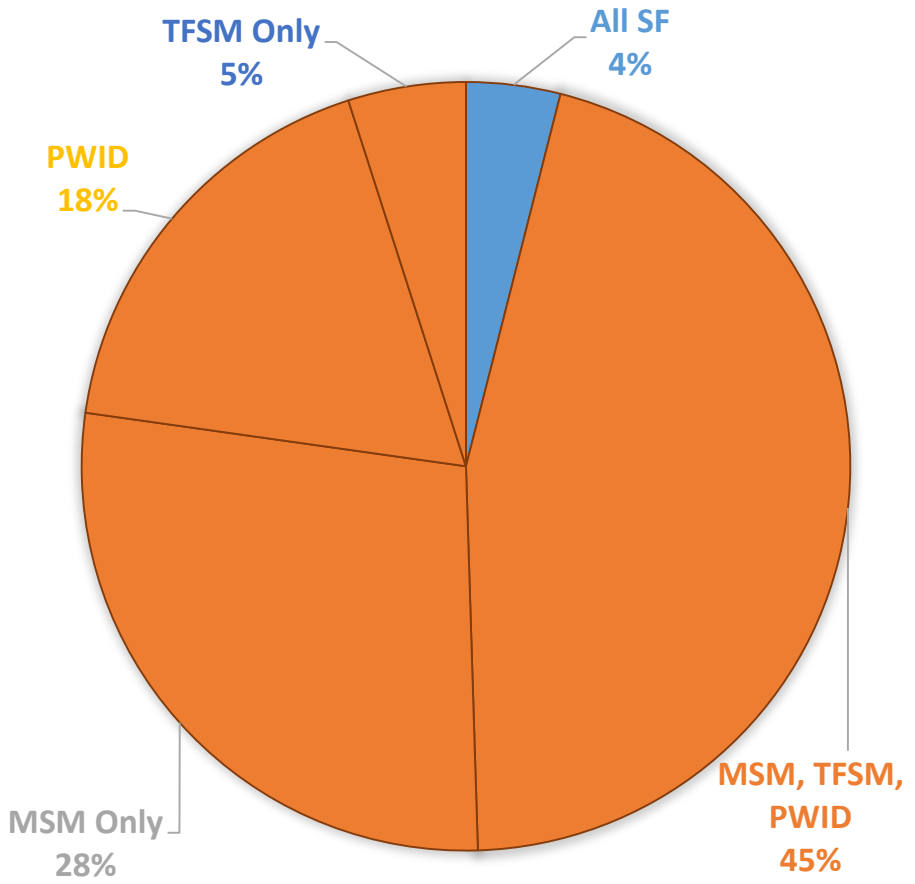


Epidemiologic Profile & Resource Allocation

New HIV Diagnoses, 2014
(n=302)



Resource Allocation, 2015
($13,210,763)



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