San Francisco ECHPP Plan
Executive Summary

HIV is no longer epidemic in San Francisco; it is endemic, and thus requires a shift in how we approach HIV prevention. When HIV was epidemic, behavioral interventions for HIV-positive and high-risk HIV-negative people were the centerpiece of the local strategy. In 2011, it is apparent that we have maximized the impact of behavioral interventions; they are not sufficient in scale to achieve population-level outcomes. Local data demonstrates the need for new strategies. Approximately 500 – 1,000 people continue to become infected each year in San Francisco.[1] It is estimated that 15% of the nearly 19,000 people living with HIV/AIDS (PLWHA) are unaware of their status.[2] Current HIV testing frequency among high-risk groups is insufficient to reduce the unknown infection rate (70,000 more tests are needed annually).[3] One in four PLWHA are not engaged in primary medical care,[4] and 28% of PLWHA who know their status have unsuppressed viral load.[5] In order to address these unmet needs and reduce new HIV infections, San Francisco needs to implement a more upstream, structural approach to HIV prevention.

The San Francisco ECHPP Plan represents such an approach by proposing a combination of interventions that reduce community-level risk for HIV. **The goal is to suppress both individual and community viral load, thereby improving individual health and reducing HIV transmission risk at the community level,** based on a growing body of evidence that viral load suppression greatly reduces transmissibility.[6] Specifically, **a primary focus of this Plan is a scale up of a continuum of services for HIV-positive people, from initial diagnosis through accessing and maintaining care and treatment.** This scale up will include increased HIV testing (both targeted community-based testing as well as routine screening in clinical settings), expanded partner services, and augmentation of existing linkage to care, re-engagement in care, and treatment adherence efforts.

The benefits of this new upstream approach will not be realized if community and individual norms and skills for practicing safer sex are not supported and promoted. Therefore, **San Francisco will continue to support behavioral interventions for HIV-positive and HIV-negative people, at lower levels,** but in a more focused way. Such interventions will focus on the highest risk individuals and groups with the greatest HIV disparities: HIV-positive individuals with unsuppressed viral load, males who have sex with males (MSM), African American MSM, Latino MSM, transfemales who have sex with males (TFSM), and MSM substance users.

Finally, **San Francisco seeks to improve in areas where we have already shown substantial success: condom access, syringe access, perinatal prevention, and post-exposure prophylaxis (PEP).** National HIV Behavioral Surveillance (NHBS) data for San Francisco shows that MSM and IDU report high levels of access to condoms and IDU report high levels of access to syringes. With a relatively small increase in investment, we can strive to increase access even further and potentially realize a great impact. Other successful efforts, such as perinatal prevention and post-exposure prophylaxis (PEP), will be maintained at current levels. A summary of the San Francisco ECHPP Plan is provided in the table below.

Ample scientific evidence exists to support San Francisco's ECHPP Plan. The Plan was developed by taking into account the effectiveness, scalability, cost, and potential impact of each intervention. Recent modeling shows that focusing on expanding testing and treatment access could achieve a 76% reduction in new HIV infections by 2014.[7] We will evaluate the efforts of our "high-impact" combination prevention approach to determine if our goal of reducing new HIV infections is achieved.

Summary of the San Francisco ECHPP Plan

Type of Intervention/ Service	Examples	Scale	Related National HIV/AIDS Strategy Goals*
Continuum of services that will ultimately reduce community viral load (CVL)	HIV testing (in clinical and non-clinical settings), linkage to HIV primary care, partner services, retention/re-engagement in care, treatment adherence	Scale up	1, 3
Behavioral interventions	Behavioral risk screening and behavioral risk reduction interventions for HIV-positive and high-risk HIV-negative people	Scale down	1, 2
Low-cost, high impact interventions	Condom distribution, syringe access and disposal	Scale up	1
Successful cost-effective efforts	Perinatal prevention, PEP	No change in scale	1

*(1) Reduce new HIV infections; (2) Reduce health disparities; (3) Increase access to care/improve health outcomes for people living with HIV.

[1] H. Fisher Raymond, January 2011: http://sfhiv.org/documents/0113UpdateonHIVinSF.pdf
[2] H. Fisher Raymond, January 2011: http://sfhiv.org/documents/0113UpdateonHIVinSF.pdf
[3] Estimates derived from National HIV Behavioral Surveillance data for San Francisco, 2005 and 2008
[4] SFDPH HIV/AIDS Epidemiology Annual Report 2009
[5] Das et al., PLoS One, 2010: http://www.plosone.org/article/info:doi/10.1371/journal.pone.0011068
[6] Donnell et al., Lancet 2010
[7] Charlebois et al, CID, 2011