

**New Directions in HIV Prevention  
Grant Colfax  
Meeting on 2/23/10  
101 Grove, Room 300**

The meeting was convened at 3:05 pm.

Grant Colfax, Director of the HIV Prevention Section, presented on New Directions in HIV Prevention. He began with a moment of silence in honor of those affected by the HIV epidemic. The presentation slides are attached.

After the presentation, Grant invited the attendees to make comments and/or ask questions.

Kyriell Noon from STOP AIDS Project asked to what extent does the HIV Prevention Section's (HPS's) implementation take into account the African American Action Plan recommendations, particularly with regards to social stigma and isolation?

Grant responded that stigma and discrimination are big issues and that the HPS will support interventions that address these factors as they related to the five focus areas. For example, stigma and discrimination affect whether people seek HIV testing, so we would want to address this.

Jen Hecht from STOP AIDS Project asked besides Status Awareness and substance use, what is the HPS doing for HIV-negative guys?

Grant responded that the HPS will support interventions for negative MSM who are affected by multiple drivers – meth, alcohol, gonorrhea, etc. Status Awareness is also a big piece of our services for this group. He stated that he would love to do more, but we have limited resources and we need to get the testing rates up. The question is how can we best use our resources to meet the goal of reducing new infections, and we need to look to the evidence.

Ben Hays from Black Coalition on AIDS asked 1) How will these new directions change HIV prevention from how it's been in the past, and 2) Does PWP move from community-based organizations into medical centers, or does HPS envision a different sort of integration?

Grant responded that our existing HIV prevention models have been successful up to a point. With this new approach, HPS will put more money to Status Awareness and Health Education/Risk Reduction (HERR) efforts that promote testing. For PWP, one of the goals is linkage/engagement in care and HPS wants to reinforce this.

Maritza Penagos from Mission Neighborhood Health Center commented that in her research, she hasn't found any evidence-based interventions for provider-based PWP.

Grant responded that there are adherence interventions that are evidence-based. These interventions could happen in medical or community-based settings; HPS would support both models.

Estela Garcia from Instituto Familiar de la Raza commented that she agrees that substance use is a driver, but there are other drivers and we should have more conversation about that. Secondly, HPS is talking about linkages, but linkage to what? She noted that many of the health and social service system is being deconstructed – substance use, mental health, etc. - and this will have a great impact on the proposed model.

Grant responded that when he talks about drivers, he is referring to drivers as defined in the 2010 HIV Prevention Plan. He acknowledged that people may have other definitions of drivers. Regarding the impact of budget cuts, he acknowledged that there are structural issues that create many challenges as we move forward.

Alexandra Byerly from the El/La Program commented on the importance of pre-test counseling. She also noted that it is important to address high-risk behavior among HIV-positive people. She emphasized the need for services among monolingual undocumented trans women with respect to these two areas.

Grant agreed that it is a priority to link high-risk HIV-positive people to care, and we need to work with this group in order to reduce high-risk behavior.

Jason Riggs from STOP AIDS stated that someone once said we should get rid of HIV prevention and put all that money into treatment for HIV-positive people, and if we don't do this, we are abandoning HIV-positive people. Jason is concerned that with this new model we are abandoning HIV-negative people who are not substance users. These individuals need more than testing. What efforts in non-medical settings will HPS support to help ensure that an HIV-negative man who is tested and gets a negative result doesn't show up 6 months later and get a positive test? How can this be achieved if resources for HERR reduce from 50% to 15-20%?

Grant responded that we have a testing deficit of greater than 30,000. Testing is one of the most effective strategies we have. In the endemic state we are in, it is what's needed. We need to serve HIV-negative people in the way that works, with a focus on the highest risk negative people. He noted that it is inaccurate to say that HERR resources are being reduced from 50% to 15-20%. HERR activities will be distributed across the other areas, for example, campaigns to address stigma and discrimination with regard to HIV testing can be supported under Status Awareness.

Jason responded that there are programs that work and are cost-effective, such as sexual networks approaches, but it's not clear how these will be funded under the proposed plan. This proposed new model is really testing equals prevention.

Grant answered that we need to consider how to best focus our limited resources. There are many social injustices related to HIV, but we can't address them all. Behavioral interventions are resource-intensive and they don't reach large numbers of people. Some may be cost-effective but you have to have a very large budget to implement. The HPS needs to make decisions about resources based on evidence as well as scalability of the intervention.

Lance Toma from Asian & Pacific Islander Wellness Center asked about the priorities for structural change related to stigma and discrimination in communities of color. He also asked about the vision around how HPS's work links with other DPH and city work in terms of facilitating a comprehensive approach to HIV prevention.

Grant responded that HPS works with Community Behavioral Health Services (CBHS) to support HIV prevention interventions. He pointed out that right now, the HIV prevention data systems are independent and we need to link both the programs and the data systems so that HIV prevention can be better integrated into other areas. Regarding structural interventions, Grant noted that HPS is advocating within the context of the National HIV/AIDS Strategy, promoting the need for more resources for MSM, MSM of color, and trans females. HPS is also engaged in promoting policy changes, such as using the San Francisco model for syringe access nationally now that the federal ban on funding has been lifted. HPS is looking for interventions for stigma and discrimination within program to address populations who have the greatest disparities.

Isela Gonzalez from Forensic AIDS Project (FAP) commented that the new model might feel scary for everyone. At FAP they recently went from five to one staff person as they transitioned to a medical testing model, but they were successful in shifting their model and they've been able to be very resourceful and creative. The shift really pushed them to think outside of the box, and they've been able to identify 13 new HIV-positive people since they changed. Now the nurses there feel like they are more a part of the treatment and care of people affected by HIV, and HIV issues are not segmented within the jails. She also asked Grant to keep his door open because the community really values a continued dialogue around these issues.

Grant responded that his door is open.

Michael Siever from San Francisco AIDS Foundation (SFAF) noted that he felt like the lack of mention of mental health in this new model is a glaring gap. He stated that SFAF receives funding from multiple DPH departments – HIV, mental health, and substance use – and that the departments don't communicate. Mental health

dollars only address severe mental illness, but what about people who are depressed and thus have risks but don't meet the criteria for severe mental illness?

Grant responded that HPS works with CBHS to try to get the services that are needed. Mental health was not identified as a driver. However, we do know that mental health is tied to treatment adherence, and we would support programs that address mental health if they achieve the outcome of adherence. HPS wants to address factors to the extent that this can help achieve the stated outcomes.

Michael indicated that many agencies have multiple funding streams and it's frustrating that requests for proposals (RFPs) are separate. People don't exist in separate funding streams.

Grant stated that within DPH, sections are trying to integrate more but much work needs to be done. Barbara Garcia as head of Community Programs is trying to move things toward this goal. If anyone has ideas for how to improve integration, let him or other DPH staff know.

Ed Byrom from Black Coalition on AIDS expressed his concern about the medicalization of prevention. He does not agree that 50% of resources should go to testing when the number of testers and repeat testers is going up. Why should HERR and pre-test counseling be reduced if we are already testing people who don't need to be tested? He also asked what is the rationale/evidence for PWP in clinical settings.

Grant responded that 15-20% of resources is for intensive behavioral interventions but HERR is still supported under other areas. He pointed out that we do not want to use HPS funds to test low-risk individuals. The city needs new models of testing and we need to all think about how these can be implemented. If we sit where we are now, we won't be able to increase the testing numbers.

Alfred McGugin from Native American Health Center asked how is it cost-effective to testing without pre-test counseling? It sounds like the goal is to test more people.

Grant responded that the HPS will support models with and without pre-test counseling. Counseling should be for people who want it and are high risk.

The meeting was adjourned at 4:20 pm.