2014 - 2016
ALAMEDA COUNTY, CALIFORNIA
COMPREHENSIVE HIV PREVENTION PLAN

JULY 2014

Prepared by the Oakland TGA Collaborative
Community Planning Council
HIV Prevention Committee & the Alameda County
Office of AIDS Administration

OAKLAND TGA COLLABORATIVE COMMUNITY PLANNING COUNCIL &
THE ALAMEDA COUNTY OFFICE OF AIDS ADMINISTRATION
2014 - 2016 COMPREHENSIVE HIV PREVENTION PLAN
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ACKNOWLEDGMENTS

We would like to extend our sincere thanks to the following individuals who contributed to the development of the 2014-2016 Alameda County Comprehensive HIV Prevention Plan as members of the HIV Prevention Committee of the Oakland TGA Collaborative Community Planning Council:

Gay Calhoun

Cynthia Carey-Grant, Co-Chair

Scott Carroll

Holvis Delgadillo, Former Co-Chair

Craig S. Hutchinson

Dr. Nick Moss

Loren Jones

Gloria Lockett

Shelley Stinson, Co-Chair

Keith C. Waltrip

Robert Whirry, Consultant

1. Summary of 2012-2014 Comprehensive Plan Goals & Objectives

Overarching Goal: The overarching goal of the 2014 - 2016 Alameda County HIV Prevention Plan is to reduce the number and incidence of new HIV infections in Alameda County, California through focused, sustained, and evidence-based interventions which work toward the CDC's goal of reducing the number of HIV infections in the US by 5% each year.

- **Objective # 1:** To ensure widespread, accessible, and culturally competent HIV testing services, including routine, opt-out testing in health care and treatment settings and targeted HIV testing outreach to high-risk populations.

- **Objective # 2:** To provide culturally competent partner services (PS) which inform the sexual and drug-using partners of persons with HIV of their potential infection risk and provide them with HIV testing options.

- **Objective # 3:** To quickly and effectively link newly identified persons with HIV, including persons leaving incarceration settings, to all needed health and psychosocial services, including using evidence-based linkage interventions and providing follow-up support to ensure care engagement.

- **Objective # 4:** To identify, locate, and effectively re-link previously diagnosed persons with HIV who are not in care, including persons leaving incarceration settings, to all needed health and psychosocial services, including using evidence-based linkage interventions and providing follow-up support to ensure care engagement.

- **Objective # 5:** To provide culturally competent support services both inside and outside the health care setting that promote HIV medication and treatment adherence and that help retain persons with HIV in care, including peer-based services.

- **Objective # 6:** To provide culturally competent risk assessment and risk reduction support services for persons with HIV in health care settings, including interventions to reduce HIV risk-related behaviors.

- **Objective # 7:** To ensure widespread, accessible, and well-publicized syringe distribution and syringe exchange services.

- **Objective # 8:** To promote expanded hepatitis C testing and to link persons who test positive for hepatitis C to appropriate assessment and treatment programs.

- **Objective # 9:** To utilize targeted social marketing, media, mobilization programs, and condom distribution programs to raise awareness of HIV risk and the importance of HIV testing among both HIV-infected and non-HIV-infected populations wherever possible.

- **Objective # 10:** To continually evaluate the effectiveness of HIV prevention efforts and to utilize evaluation findings to refine and improve local HIV prevention interventions and activities.

Collaborative Community Planning Council
OAKLAND TRANSITIONAL GRANT AREA (TGA)
Serving Alameda and Contra Costa Counties

710 East 22nd Street, Suite 101 Oakland, CA 94606 (510) 326-3476 www.HIVCCPC.org

July 24, 2014

Keith C. Waltrip, Director
Office of AIDS Administration
1000 Broadway, Suite 310
Oakland, CA 94607

Dear Mr. Waltrip:

As Co-Chairs of the HIV Prevention Committee of the Oakland Transitional Grant Area HIV Collaborative Community Planning Council, we are pleased to endorse the 2014 - 2016 Comprehensive HIV Prevenion Plan for Alameda County, California.

The HIV Prevention Committee conducts HIV prevention planning, assess emerging HIV prevention needs, and provide input to the Office of AIDS Administrationon and the Planning Council on HIV prevention priorities and funding. One of the Committee's ongoing responsibilities is to develop a new Comprehensive HIV Prevention Plan for Alameda County every three years both to respond to federal and state requirements and to ensure that an effective prevention blueprint is in place for our region.

The Prevention Committee began work on the current Plan at a time of intense local change in regard to prevention services and funding. The Committee met on a monthly basis to discuss the Plan, assign tasks, and develop individual Plan components. The Committee completed an initial draft of the Plan in late 2013 which was further revised through a collaborative process in early 2014, leading to the current and final version which was adopted unanimously by the Prevention Committee on July 8, 2014.

The 2014 - 2016 Comprehensive HIV Prevention Plan represents an important step forward in our region's ongoing efforts to reduce new cases of HIV while maximizing linkage to care and adherence to treatment. Both the Prevention Comimittee and the Planning Council will use the Plan as a living document to help guide our future course at a time of unprecedented challenge and change.

Sincerely,

Cynthia Carey-Grant
Prevention Committee Co-Chair

Shelley Stinson
Prevention Committee Co-Chair

3. Summary of HIV Prevention Planning Process

The Alameda County comprehensive HIV planning process began in 2012 when the **HIV Prevention Committee** of the Oakland TGA Collaborative Community Planning Council began outlining and gathering information and data to produce a new three-year comprehensive HIV Prevention Plan. As the group that has specific responsibility for planning and developing recommendations for HIV prevention services allocations and priorities in Alameda County, the HIV Prevention Committee is fully empowered to develop and produce the Comprehensive Plan following timelines established by the State of California Office of AIDS in collaboration with the US Centers for Disease Control and Prevention (CDC).

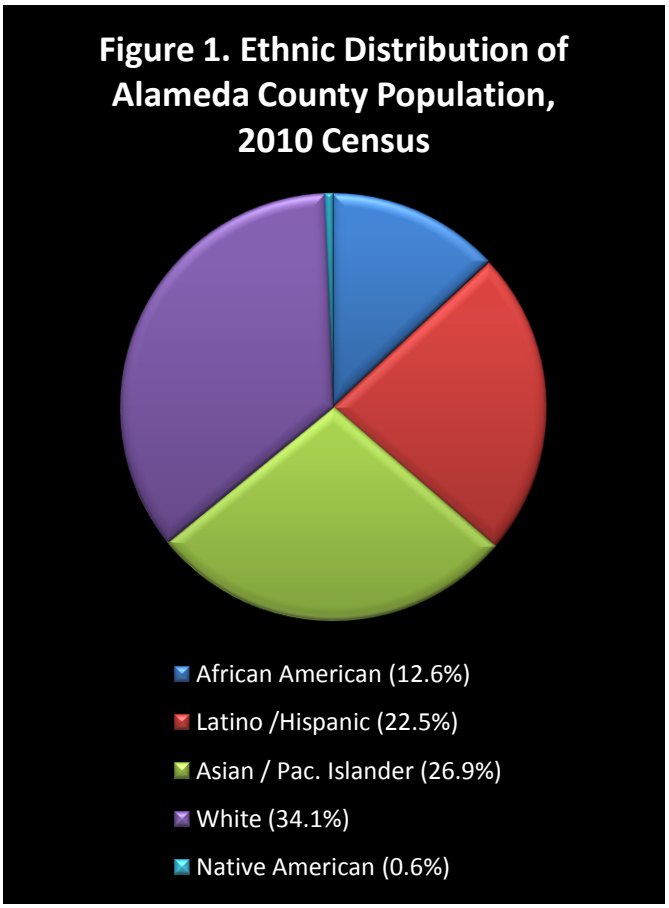
The launching of the prevention process came at a complex time for the Oakland TGA and for Alameda County. In the summer of 2009, the California legislature had responded to the State's budget crisis by eliminating over **$85 million** from the budget of the State Office of AIDS for Fiscal Year 2009-2010, including virtually all funding for direct HIV prevention services outside of testing. These cuts were devastating for a county that was seeing continually increasing HIV caseloads while trying to deliver services with an already small prevention budget. Further contractions in funding along with dramatically shifting HIV prevention priorities from the CDC and the State also created a climate of change which made the planning process challenging.

Nevertheless, by June 2013, the HIV Prevention Committee had produced its first full draft of the new three-year HIV Prevention Plan. The Committee made the decision to take advantage of a technical assistance program through the State of California and to have the Plan draft reviewed and critiqued by a contracted organization specializing in HIV planning, prevention and policymaking. The County forwarded the draft to the assigned organization, AIDS Project Los Angeles (APLA), in early July 2013 and received a response in later October 2013 which, though largely supportive, was also critical of some key Plan section. The Prevention Committee met in November 2013 to consider the feedback by the TA organization and made the decision to hire an independent consultant - Robert Whirry - to assist the Committee in revising and expanding the Plan to address the APLA feedback and to incorporate further responses to the changing HIV prevention landscape.

The Prevention Committee met again at two regular meetings in early 2014 to work further on the Plan. At the first meeting - in February 2014 - the Committee discussed possible revisions and expansions to the Plan with the consultant, and gave in put into specific Committee responses related to shifts in HIV prevention priorities at the federal level. The Committee met again in March 2014 to review and critique a first draft of the revised Plan. The consultant then prepared a second Plan draft for final Prevention Committee review in June 2014.

4. Overview of the HIV Epidemic in Alameda County, California

The region addressed by the current HIV Prevention Plan is **Alameda County, California,** the easternmost county of the San Francisco Bay Area, with a 2010 Census population of **1,510,271**, representing just over **4%** of the population of California.[1] The city of **Oakland**, in Alameda County, the nation's 39th largest city, had a 2010 population of **390,724**. Alameda County's population is one of the most ethnically diverse in the nation, with a population that is **12.6%** African American, **22.5%** Latino/Hispanic, **26.9%** Asian/Pacific Islander, **34.1%** white, and **0.6%** Native American (see **Figure 1**). The city of Oakland is even more diverse, with persons of color comprising **71.4%** of local residents.[2] According to the US Census, nearly **one-third** of the County's residents (**30.7%**) were born outside of the US while **42.8%** speak a language other than English at home.



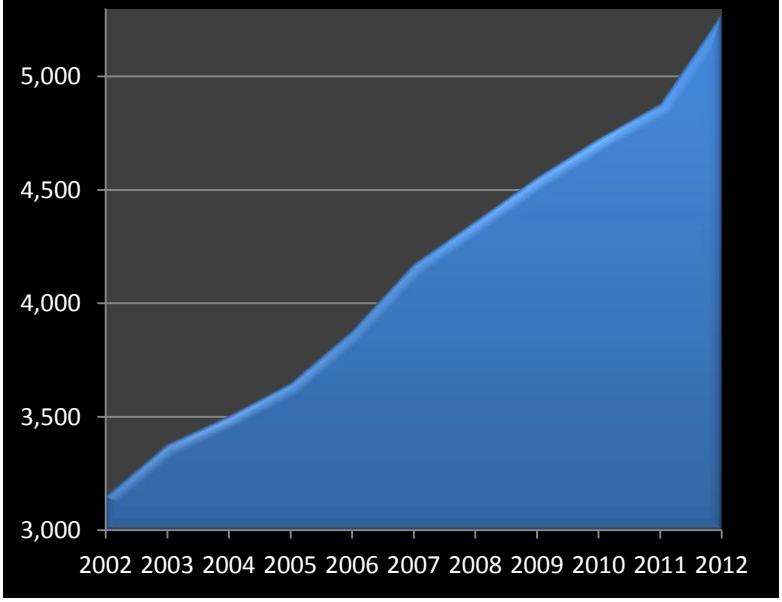
While containing many affluent, largely white communities, the region also contains many areas in which lower-income African Americans and Latinos are in the majority, and in which problems of poverty, unemployment, racism, and despair contribute to deep-seated epidemics of substance abuse, homelessness, and STIs. Alameda County has the **second highest** tuberculosis incidence rate,[3] the **fourth highest** syphilis incidence rate,[4] and the **fourth highest** gonorrhea incidence rate of any county in California.[5] It is estimated that at least **17,534** men, women, and young people over the age of 18 in Alameda County are active injection drug users, and all at extreme risk for HIV and HCV infection.[6] Analysis of US Census data reveals that African-Americans experience nearly **four times** the poverty rates of whites, while other racial and ethnic minorities also show higher rates of poverty than whites.[7]

The crisis of HIV infection continues to have devastating and tragic consequences for the residents of Alameda County, California. As of December 31, 2013, a total of **10,404** HIV and AIDS cases had been diagnosed in our county since the start of the epidemic - the **4th highest total** of any county in California, after only Los Angeles, San Francisco, and San Diego, even though Alameda is the **7th largest** county in California in terms of population.[8] A total of **4,756** Alameda County residents had died from HIV-related illnesses as of the end of 2013.

As of December 31, 2012 - the last date for which accurate statistics are available - a total of **5,274** persons were known to be living with HIV infection in Alameda County (HIV or AIDS), meaning that **1 out of every 287** residents was infected with HIV at the end of 2012. However, according to National HIV/AIDS Strategy, at least **20%** of people living with HIV are unaware of their status, which means that **1,000 or more** additional Alameda County residents may be living with HIV infection but do not yet know it.[9]

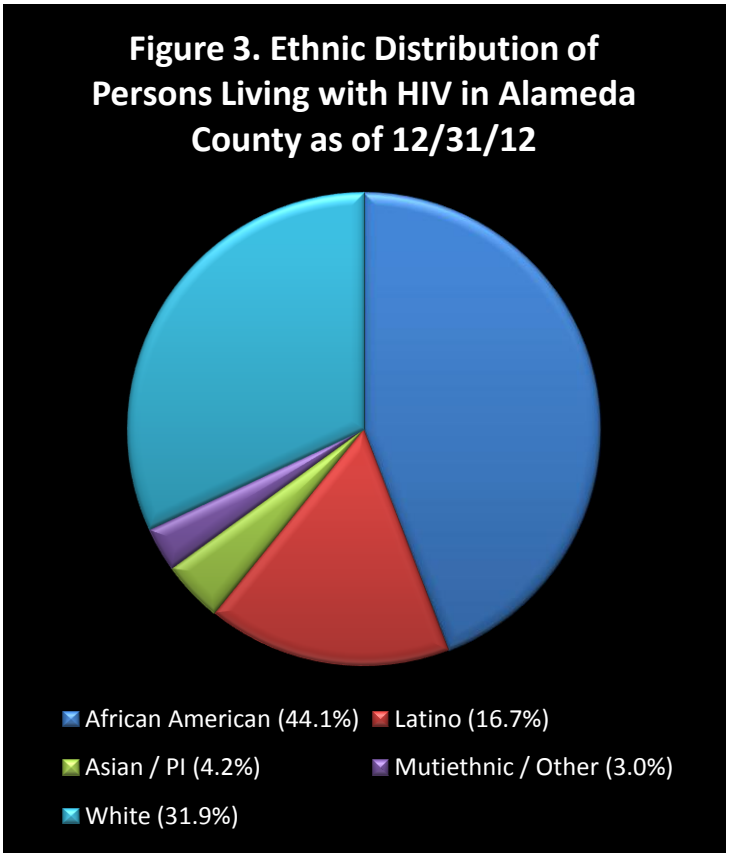
As persons with HIV continue to live longer and longer lives as a result of combination therapies, the number of persons living with HIV has risen dramatically, even as funding for HIV prevention has declined dramatically. **Between 2002 and 2012 alone, the number of persons living with HIV (PLWH) in Alameda County increased by 68%, from 3,149 at the end of 2002 to 5,274 by the end of 2012 (see Figure 2).** This increase has increased the burden of care in the county, making it more difficult to link and retain people on HIV treatment.

Figure 2. Persons Living with Confirmed HIV/AIDS in Alameda County 2002 - 2012



The diversity of persons living with HIV in our region reflects the impressive diversity of Alameda County as a whole. But at the same time, it reflects the disproportionate impact the local HIV epidemic has on communities of color, particularly African Americans. As of December 31, 2012, nearly **70%** of all persons living with HIV infection in Alameda County are persons of color, including a population that is **44.1%** African American, **16.7%** Latino, **4.2%** Asian / Pacific Islander, and **3.0%** multiethnic and other (see **Figure 3**). Disparities in the HIV epidemic reflect broader health disparities in our nation as a whole - disparities related to issues such as racism, discrimination, institutionalized poverty, and a lack of access to basic health services.

Figure 3. Ethnic Distribution of Persons Living with HIV in Alameda County as of 12/31/12

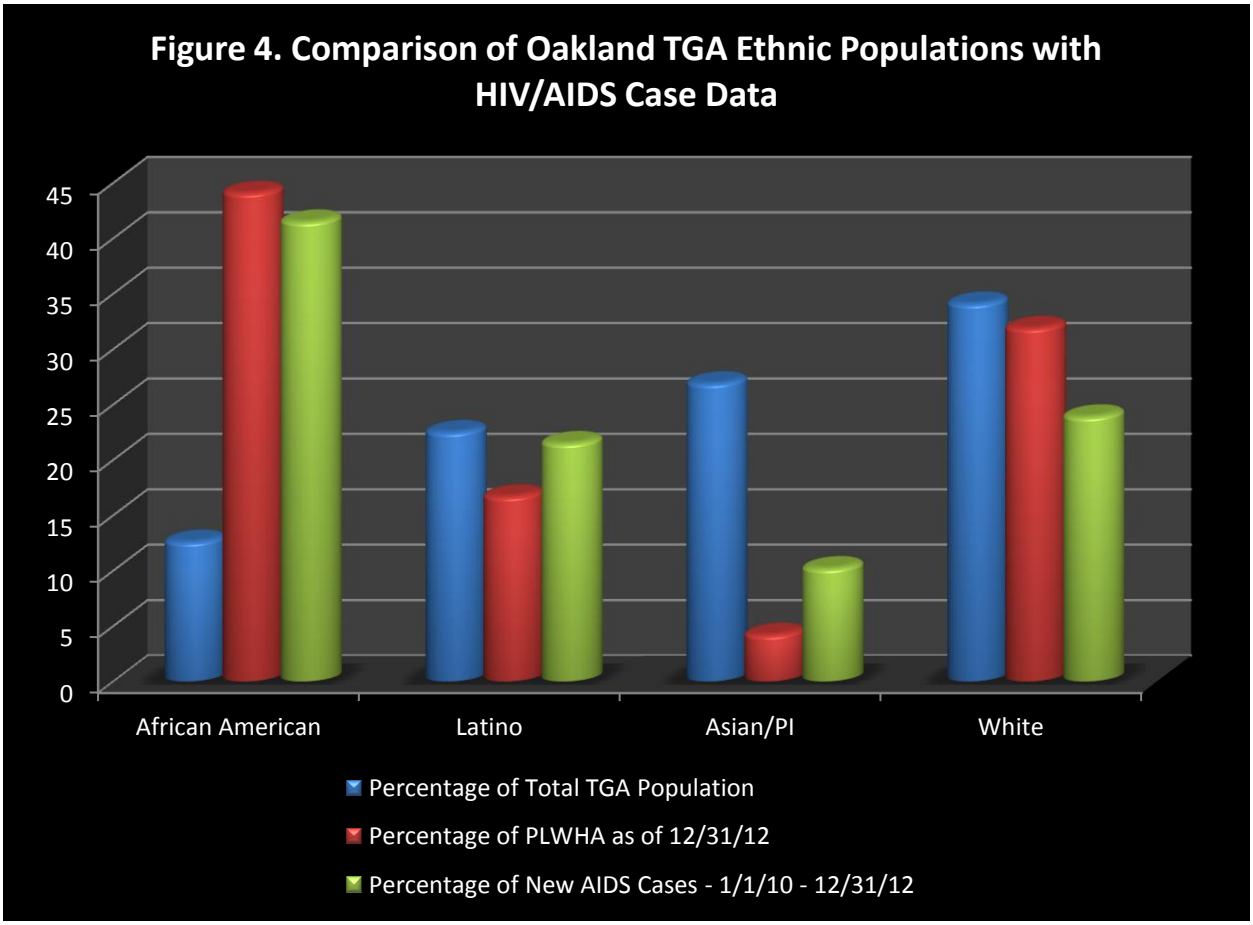


The percentage of African Americans infected with HIV in Alameda County is dramatically higher than the percentage of African Americans living in Alameda County as a whole. While blacks make up **44.1%** of all persons living with HIV in the county, they make up only **12.6%** of the county's total population (see **Figure 4** on following page). By contrast, non-Hispanic whites make up **34.1%** of the county's population but only **31.9%** of persons living with HIV while Latinos make up **22.5%** of the population while comprising **16.7%** of PLWH. **The crisis of HIV among African Americans is so acute that in 1998 Alameda County took the unprecedented step of declaring a State of Emergency in relation to the African American HIV/AIDS epidemic, the first time that a local jurisdiction had taken such an action.**

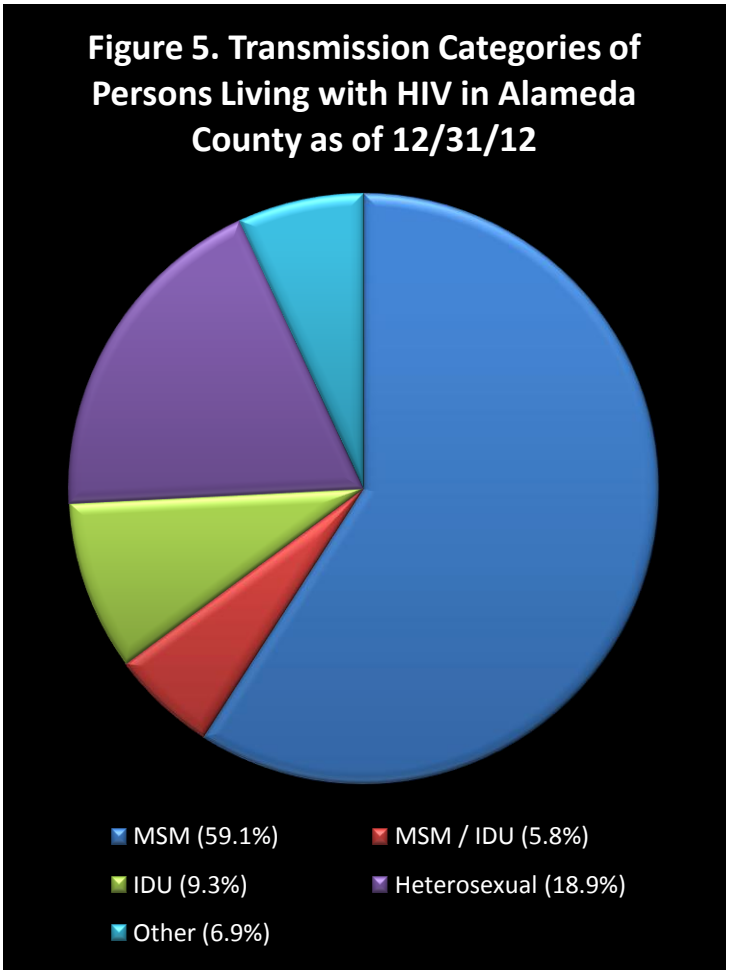
There are also indications that the impact of HIV may be expanding among **Latinos** and **Asian / Pacific Islanders** in Alameda County. While **16.7%** of all

persons living with HIV at the end of 2012 were Latino, **21.5%** of new HIV infections from January 1, 2010 through December 31, 2012 were among Latinos. The rate of expansion is even higher among Asians and Pacific Islanders, who represented **4.2%** of PLWH at the end of 2012 but represented **10.2%** of all new infections between 2010 and 2012.

Figure 4. Comparison of Oakland TGA Ethnic Populations with HIV/AIDS Case Data



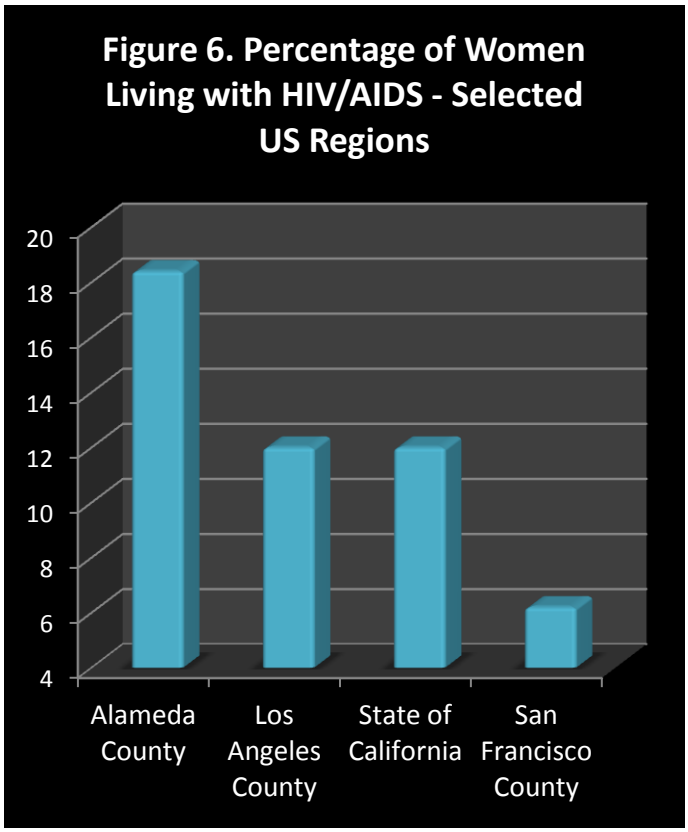
As in most jurisdictions in the western United States, **men who have sex with men (MSM)** make up the majority of persons living with HIV in Alameda County. MSM who do not inject drugs made up **59.1%** of all PLWH as of the end of 2012 while MSM who do inject drugs made up another **5.8%**, for a total of **64.9%** of cases among MSM - nearly **two-thirds** of of all persons living with HIV In our region (see **Figure 5** on following page). However, **heterosexuals** make up a large percentage of persons living with HIV, accounting for **18.9%** of all PLWH in Alameda County - nearly **one in every five** local PLWH. **Injection drug users** make up another **9.3%** of persons living with HIV while **5.8%** of cases do not have an



identified transmission factor, mainly because of how difficult is often is to determine the source of HIV infection among women.

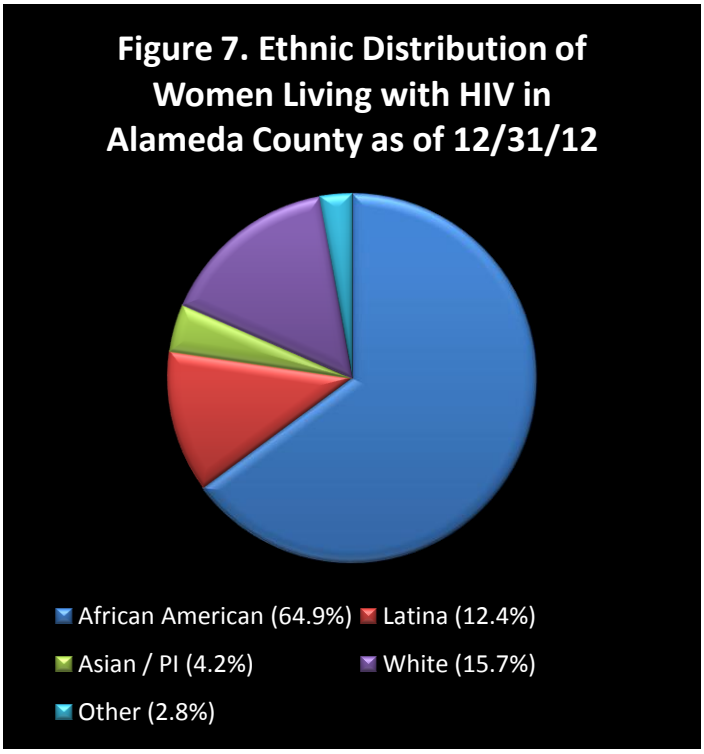
It is important to note, however, that new HIV infection rates appear to be increasing among MSM while decreasing among heterosexuals. While heterosexuals made up **18.9%** of all persons living with HIV at the end of 2012, they made up only **9.8%** of new HIV infections between 2010 and 2012 - a potential sign of our region's success in raising awareness of HIV risk and identifying and linking persons with HIV to care. However, while MSM made up **64.9%** of all persons living with HIV at the end of 2012, they made up **73.2%** of all newly diagnosed cases from 2010 to 2012. This may be an indication of increased risk behaviors among MSM populations - particularly among young MSM of color.

The epidemic of HIV infection among men who have sex with men in Alameda County has a disproportionate impact on African American and Latino MSM. African American and Latino MSM make up **53.0%** of all MSM living with HIV in Alameda County - including MSM who inject drugs - with African Americans making up **34.9%** of MSM PLWH (**1.195** cases) and Latinos making up **18.0%** of MSM PLWH (**616** cases). Among newly identified HIV cases from 2010 through 2012, this percentage is even higher, with African American and Latino men comprising **59.8%** of all MSM HIV cases, including percentages of **36.9%** among African Americans (n=**177**) and **22.9%** among Latinos (n=**110**).



In terms of gender, Alameda County contains the highest percentage of women living with HIV of any major metropolitan area in the western United States. As of December 31, 2012, **18.4%** of all people living with HIV and AIDS in the county were women, as compared to percentages of **12.2%** for Los Angeles County, **12.0%** for the State of California, and **6.8.%** for San Francisco County (see **Figure 6**).[10] As of December 31, 2012, a total of at least **969** women were living with HIV in Alameda County, making up a total of **18.4%** of all persons living with HIV in our region.

The high prevalence of HIV and AIDS cases among women in our region has a highly disproportionate impact on African Americans. Fully **64.9%** of all women living with diagnosed HIV/AIDS in Alameda County as of December 31, 2012 were African American. Meanwhile, **12.4%** of women living with HIV/AIDS were Latina; **15.7%** were white; and **4.2%** were Asian / Pacific Islander (see **Figure 7**). **The disproportionate incidence of AIDS cases among African American women highlights the deadly magnitude of the HIV/AIDS epidemic within our region's communities of color, with**

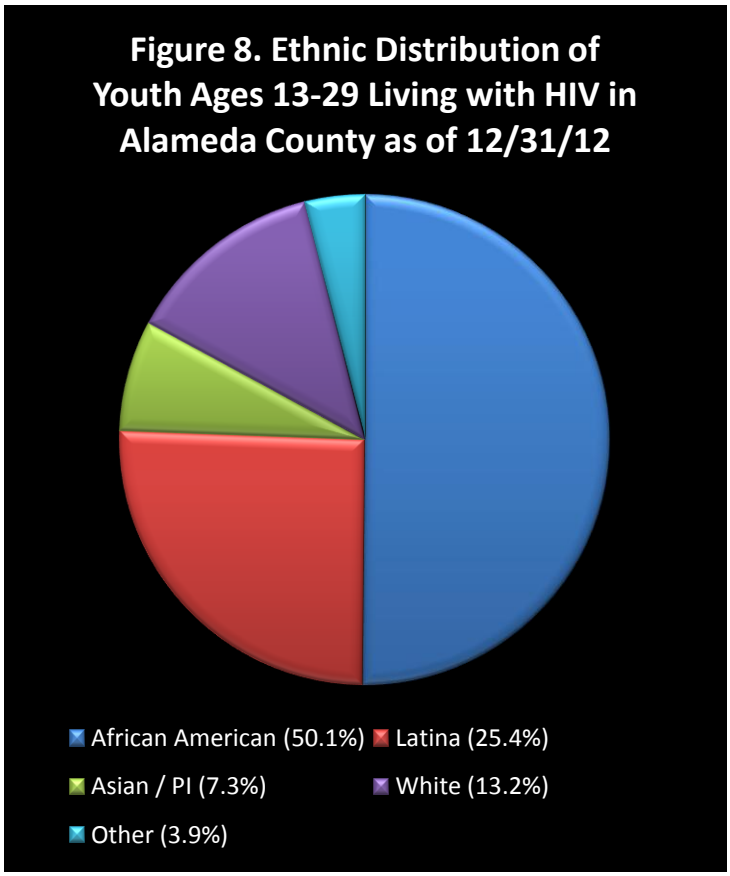


84.3% of all women living with HIV being women of color. In terms of transmission categories, the majority of HIV/AIDS cases among women - **62.8%** - result from heterosexual transmission while injection drug use accounts for **21.3%** of female PLWHA through 2012.

Alameda County also includes a large percentage of **transgender persons** living with HIV, virtually all of whom are male to female transgender persons. Transgender persons are generally defined as those whose gender identity, expression, or behavior is not traditionally associated with their birth sex. Extraordinarily high HIV prevalence rates exist among transgender women, especially transgender women of color. Among the **2.6 million** HIV antibody tests conducted in the US in 2009, the infection rate all transgender women was **2.6%** versus **0.9%** of non-transgender males and **0.3%** of non-transgender females. However, the positivity rate was **4.4%** among African American transgender women and **2.9%** among Latina transgender women.[11] In Alameda County, at least **61** transgender persons are known to be living with HIV, making up **1.2%** of the region's total HIV population. However, the percentage among newly diagnosed HIV cases between January 1, 2010 and December 31, 2012 is significantly higher, with transgender persons making up **1.8%** of all newly identified cases of HIV infection (n=**12**).

In terms of the age of persons living with HIV, there continue to be significant shifts toward <u>younger</u> populations becoming infected with HIV in Alameda County. As of December 31, 2012, young people between the ages of 13 and 29 made up only **7.7%** of all persons living with HIV in the region, in large part because so many individuals infected with HIV have been able to live extended lives through the use of combination therapies. However, between the period January 1, 2010 and December 31, 2012, young people ages 13-29 made up **32.8%** of all newly identified HIV cases - nearly two-thirds of all cases identified during that period. This includes **159** newly identified cases among young people ages 18-24 and another **239** cases among young people 25-29. These increases can in part be attributed to more focused efforts to outreach to and test high-risk young people - particularly young MSM. But they also suggest that new HIV infections may be on the rise among Alameda County youth, presenting an ominous possibility for the future of the local epidemic.

The youth HIV epidemic in Alameda County is being driven in large part by increases in new HIV infections among young men of color who have sex with men. Men who have sex with men made up fully **71.7%** of all PLWH between the ages of 18 and 29 living in Alameda County as of December 31, 2012, and a shocking **81.4%** of all youth HIV cases diagnosed between 2010 and 2012. Among young people living with HIV, persons of color made up **86.8%** of all PLWH as of the end of 2012 and **82.8%** of all newly diagnosed HIV cases between 2010 and 2012. African American young people made up **half** (**50.1%**) of 18-29-year-olds living with HIV in Alameda County as of December 31, 2012 while Latino youth made up another **quarter** (**25.4%**) of youth HIV cases (see **Figure 9**).



Despite the rise in new youth HIV cases, however, **persons 50 and older** make up the largest group of persons living with HIV in Alameda County, comprising **47.4%** of all PLWH cases as of December 31, 2012. The rapid and continued growth in 50 and older HIV cases is attributable to the success of combination HIV therapies, which have allowed persons with HIV to live long and healthy lives despite their infection. As older adult cases continue to increase in Alameda County, advanced models of prevention and care will need to be developed that take into account the needs of older populations and that integrate geriatric care approaches into the HIV clinical setting.

Finally, it is important to note that ongoing statistics reveal that across all ethnicities, roughly **40%** of all persons diagnosed with HIV in Alameda County meet the definition of **"late HIV testers",** defined by the US Centers for Disease Control and Prevention as persons who receive a diagnosis of AIDS **within one**

year of receiving a positive HIV test. Many of these individuals are persons who are admitted to hospital emergency rooms for HIV-related conditions and who receive an HIV and AIDS diagnosis **at the same time**. **High rates of late HIV testing in Alameda County clearly indicates that far too many individuals are not learning of their HIV infection or seeking HIV treatment at an early enough stage in the disease to be able to prevent the progression to AIDS.** This also means that too many individuals with HIV are living with non-suppressed viral loads, significantly increasing their risk of passing the virus on to others. Improving access to regular and ongoing HIV testing, coupled with aggressive treatment linkage such as that already initiative by the County, could significantly impact both the long-term health of persons with HIV and the overall rate of new HIV infections in Alameda County.

Figure 9 on the following page provides an overview table of the HIV epidemic in Alameda County through December 31, 2012 as it impacts major demographic categories.

Figure 9.

Alameda County HIV Statistical Summary Table through 12/31/12

Group / Exposure Category	People Living with HIV/AIDS as of 12/31/12		Newly Diagnosed HIV/AIDS Cases - 1/1/10 - 12/31/12		Variance
	#	%	#	%	
Ethnicity					
African American	2,325	44.1%	272	41.5%	-2.6%
Latino	882	16.7%	141	21.5%	+4.8%
Asian / Pacific Islander	223	4.2%	67	10.2%	+6.0%
White	1,685	31.9%	157	23.9%	-8.0%
Other / Multiethnic	159	3.0%	19	2.9%	-0.1%
Gender					
Male	4,224	80.5%	553	84.3%	+3.8%
Female	969	18.4%	91	13.9%	-4.5%
Transgender	61	1.2%	12	1.8%	+0.6%
Age Group*					
0 - 12	12	0.2%	1	0.2%	
13 - 17	11	0.2%	6	0.9%	+0.7%
18 - 24	159	3.0%	122	18.6%	+15.6%
25 - 29	239	4.5%	87	13.3%	+8.8%
30 - 39	757	14.4%	158	24.1%	+9.7%
40 - 49	1,596	30.3%	171	26.1%	-4.2%
50 - 59	1,643	31.2%	89	13.6%	-17.6%
60 - 69	697	13.2%	19	2.9%	-10.3%
70 - 79	145	2.7%	3	0.5%	-2.2%
80 - 89	15	0.3%	0	0.0%	-0.3%
Transmission Categories					
MSM	3,115	59.1%	449	68.4%	+9.3%
MSM / IDU	305	5.8%	31	4.7%	-1.1%
IDU	488	9.3%	22	3.4%	-5.9%
Non-IDU Heterosexual	996	18.9%	64	9.8%	-9.1%
Pediatric Exposure	44	0.8%	1	0.1%	-0.7%
Other / Unknown	326	6.1%	89	13.6%	+7.5%
Total	5,274	100%	656	100%	

* Age for people living with HIV/AIDS is current age while age for newly diagnosed is age at diagnosis

5. Chart of Local HIV Prevention System

The chart below provides a list of Alameda County agencies that incorporate HIV prevention activities in their roster of services and that currently receive direct HIV funding from the Alameda County Office of AIDS Administration. Many additional agencies provide one or more HIV prevention services that are not funded by the County but are supported through other reimbursement streams, including expanded Medicaid funding through Affordable Care Act. These include a wide range of public and private sites providing HIV outreach, testing, and linkage services and sites providing HIV prevention counseling and adherence support incorporated into primary care for persons living with HIV.

Agency Name and Contact Information	Prevention Services Provided													
	HIV Testing Outreach	HIV Testing	STD Testing	Hep C Testing	HIV Service Linkage	HIV Treatment Adherence Services	Prevention Counseling for Positives	HIV Care Re-Linkage	Pre-Exposure Prophylaxis	Post-Exposure Prophylaxis	Primary Prevention for HIV-Negative	HIV Social Marketing	Condom Distribution	OAA Grantee
AIDS Healthcare Foundation / Magic Johnson Clinic 400 30 Street, Suite 300 Oakland, CA 94609	X	X	X		X		X	X				X	X	X
AIDS Project of the East Bay (APEB) 1320 Webster Street Oakland, CA 94612	X	X	X			X	X	X					X	X
Alameda County Medical Center HIV Services – Fairmont Campus 15400 Foothill Blvd San Leandro, CA 94578		X	X		X	X	X	X						X

Agency Name and Contact Information	Prevention Services Provided													
	HIV Testing Outreach	HIV Testing	STD Testing	Hep C Testing	HIV Service Linkage	HIV Treatment Adherence Services	Prevention Counseling for Positives	HIV Care Re-Linkage	Pre-Exposure Prophylaxis	Post-Exposure Prophylaxis	Primary Prevention for HIV-Negative	HIV Social Marketing	Condom Distribution	OAA Grantee
Alameda County Medical Center Adult Immunology Clinic – Highland Campus 1411 E. 31st Street Oakland, CA 94602		X	X		X	X	X	X					X	X
Alameda County Office of AIDS Administration (OAA) 1000 Broadway, #310 Oakland, CA 94607													X	
California Prostitutes Education Project (Cal-PEP) 2811 Adeline Street Oakland, CA 94608	X	X	X	X	X		X	X				X	X	X
East Bay AIDS Center (EBAC) Alta Bates Summit Medical Center 3100 Summit Street Oakland, CA 94609		X	X	X	X	X	X	X	X	X			X	X
HEPPAC **P.O. Box 7522** Oakland, CA 94601	X	X	X	X	X								X	X
La Clinica de la Raza 1515 Fruitvale Ave. Oakland, CA 94601	X	X	X	X	X									X

Agency Name and Contact Information	Prevention Services Provided													
	HIV Testing Outreach	HIV Testing	STD Testing	Hep C Testing	HIV Service Linkage	HIV Treatment Adherence Services	Prevention Counseling for Positives	HIV Care Re-Linkage	Pre-Exposure Prophylaxis	Post-Exposure Prophylaxis	Primary Prevention for HIV-Negative	HIV Social Marketing	Condom Distribution	OAA Grantee
LifeLong Medical Care 2001 Dwight Way Berkeley, CA 94704 and 10700 MacArthur Blvd. (Foothill Square) Oakland, CA 94605	X	X	X	X										X
Tri -City Health Center (TCHC) HIV / Hepatitis Services 39184 State Street Fremont, CA 94538		X	X	X	X	X	X	X					X	X
Women Organized to Respond to Life-threatening Disease (WORLD) 449 15th Street, Suite 303 Oakland, CA 94612	X	X			X	X	X					X	X	X

6. Issues in HIV Prevention

By far the most important event over the last 10 years in regard to HIV prevention was the landmark announcement in the New England Journal of Medicine in 2011 of a study by Cohen, at al. that showed a **96% reduction in HIV transmission** from HIV-positive to HIV-negative partners when HIV-positive partners received early and consistent antiretroviral therapy.[12] This key study provided conclusive evidence showing that if a person with HIV is linked to HIV care and treatment, consistently adheres to prescribed combination therapies, and achieves an undetectable or nearly undetectable level of HIV virus in their body (viral load), then it becomes extremely difficult if not impossible for them to pass the HIV virus on to others, regardless of the prevention precautions they may take.

The Cohen study caused shock waves in the HIV prevention community that are still being felt today. Researchers realized that if a person infected with HIV was unable to pass the virus on to others because of an undetectable viral load, then it would be possible to prevent many, perhaps even hundreds of new cases of HIV infection among the people with whom that person had unsafe sexual contact. This prevention impact would take place **whether or not** an individual took precautions to prevent HIV, since the amount of HIV in the person's bloodstream would simply not be enough to allow the virus to pass to another person. Since every new case of HIV involves contact with someone infected with HIV, reducing viral load to an undetectable level in an individual would in effect remove one source of HIV infection from the community entirely.

Researchers also saw that if enough people with HIV were linked to care and given support to help them stay on drug treatment, then it might be possible to gradually reduce the overall number of new HIV infections that take place in a given community or group. By this process, and with enough effort, it might be possible to slow or even eventually stop the spread of HIV entirely, if enough people with HIV were linked to care and treatment and were able to achieve an undetectable viral load.

These major findings have become the foundation of the so-called "test-and-treat" model of HIV prevention. The fundamental idea behind "test-and-treat" is that HIV/AIDS can be eliminated from society if all adults are tested

regularly for HIV and all infected persons are put on antiretroviral therapy (ART) regardless of their CD4 level. Test-and-treat, it is theorized, will both increase the health status of persons with HIV while reducing the current transmission rate of HIV. Of course, to be successful, this effort will require a monumental public health effort that would need to include the following components:

- Standardized and frequent HIV antibody testing in the widest possible range of health care settings for all persons at risk of contracting HIV;

- Enhanced programs to quickly and effectively link persons to HIV care and treatment following diagnosis so that they are not lost to care before they can be placed on ART;

- High-quality medical care and access to antiretroviral medications for all individuals regardless of factors such as income or insurance status, socioeconomic status, personal beliefs or behaviors, languages spoken, gender identity, sexual orientation, etc;

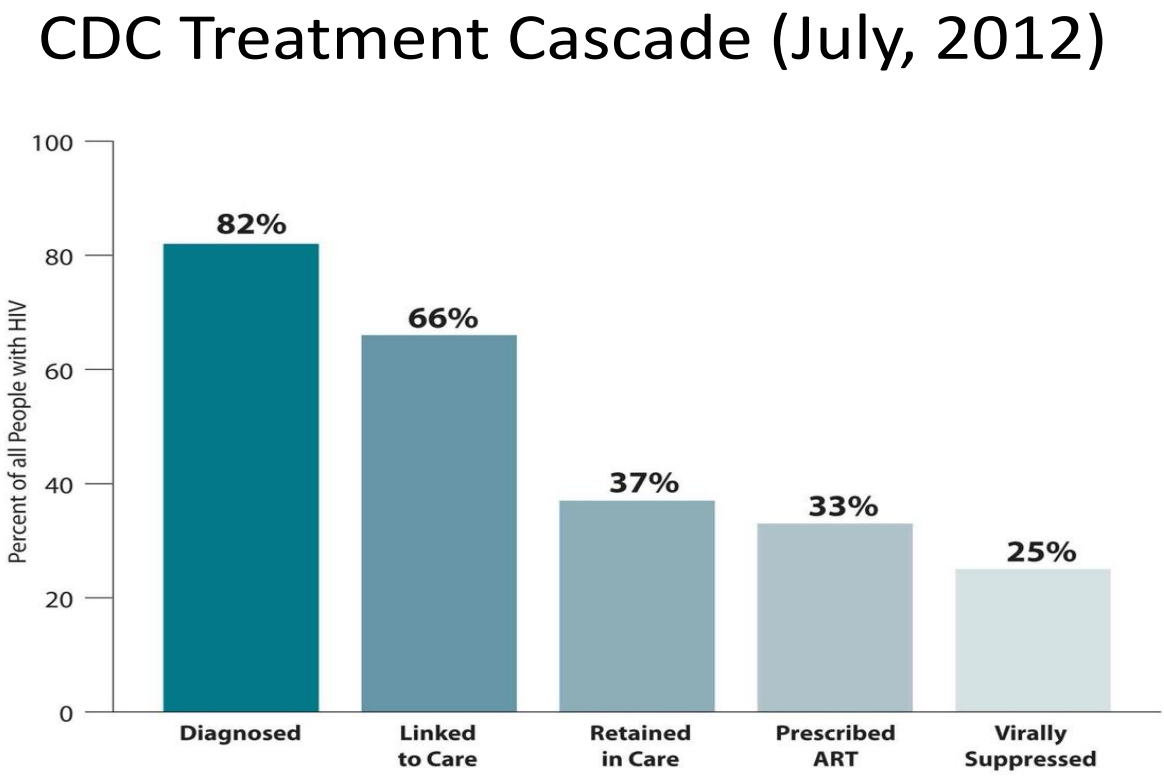
- Effective programs to help people remain in care over time while providing support to help them consistently take their medications over time;

- Programs to help individuals deal with and address factors that can serve as barriers to HIV treatment and medication adherence, including mental health conditions, substance abuse, co-occurring medical and health disorders, and a lack of access to basic necessities such as food, housing, and a lack of transportation; and

- Programs to locate, contact, and re-link to care persons with HIV who drop out of or become lost to care for a variety of reasons.

Clearly, the financial and public health commitment that will be needed to make test-and-treat a success will be monumental, and governmental entities have as yet shown no indication that they are ready to commit the massive funding that will be required. The so-called **"treatment cascade"** developed by Dr. Edward Gardner and his colleagues in 2011 demonstrates just how far our nation has to go in making the slowing or elimination of HIV possible through the test-and-treat approach.[13] The cascade shows the various stages of engagement in HIV

care, from the percent of persons diagnosed with HIV, to those on ART, to those who have achieved viral load suppression. According to the CDC's most recent treatment cascade analysis, of the more than 1 million Americans who are currently infected with HIV, only **82%** know their status; **66%** have been linked to care; **37%** are currently retained in care; **33%** are currently prescribed ART; and **25%** have achieved viral load suppression (see below). These percentages indicate just how far we have yet to travel in order to achieve test-and-treat's laudable goals.



Some individuals in the Alameda County prevention community - individuals who are intimately connected with their communities and who have spent decades working in HIV prevention - worry that the system may have leapt too quickly to embrace the test-and-treat approach before a thorough analysis has been conducted and before a true commitment has been made to dedicate the kind of resources needed to make this approach a reality. These providers are concerned that a nearly exclusive focus on persons already infected with HIV could mean that uninfected individuals will gradually lose awareness of the importance of HIV and will no longer have the skills or the motivation to take measures to prevent HIV infection on their own. Yet the test-and-treat revolution

already has led to a widespread redirection of prevention resources that has changed the landscape of HIV prevention, perhaps forever. Funding has rapidly moved away from "primary prevention" models in which providers worked with uninfected persons and communities to help them learn about the risks of HIV and adopt measures to protect themselves from infection. Instead, prevention resources have shifted to more care-focused models that concentrate on identifying as many persons living with HIV as possible. This includes expanded resources for "opt-out" HIV testing, an approach in which HIV tests are routinely included in standard medical examinations unless a patient specifically requests otherwise. Such an approach can not only identify more cases of HIV, but helps "de-stigmatize" HIV by placing it on the same level as other medical conditions. Prevention resources now also support expanded linkage to care, access to medical and health resources, and support to help individuals remain on ART and address ongoing barriers to ART adherence.

The shift to a prevention focus on persons already infected with HIV reflects in part a response to the National HIV/AIDS Strategy (NHAS) released in July 2010 which lays out three broad HIV goals: 1) to reduce new HIV infections; 2) to increase access to care and improve health outcomes for persons living with HIV; and 3) to reduce HIV-related health disparities.[14] Current prevention priorities - including those of the US Centers for Disease Control and Prevention which supports federal prevention efforts nationally - now strive to advance the first goal by placing an emphasis on identifying individuals who are unaware of their HIV-positive status and on providing HIV care and treatment as an effective prevention approach. The CDC's "high impact prevention" strategy - unveiled in late 2013 - goes further by seeking to target resources to regions where test-and-treat methods can have the greatest effectiveness in reducing the future course of the epidemic.

Regardless of one's feelings in relation to test-and-treat, there can be no doubt that linkage to continuous HIV medical care as soon as possible after an HIV diagnosis leads to improved health outcomes and offers an opportunity to provide behavior change counseling that can reduce the risk of HIV transmission to others.[15] According to Mugavero et al. (2012), early retention in HIV care is associated with a shorter length of time needed to achieve viral load suppression and lower viral load levels.[16] One study found that negative medical impacts were significantly lower among those who had at least four medical over a two-year period than among those who had less frequent medical visits.[17] In the words of

Giordano (2011), "Retention in HIV care is a **modifiable risk factor** that profoundly affects outcomes of HIV disease at the individual and population levels."[18]

It is important to note that the move toward more medically-based models of HIV prevention is also evident in the emergence of new pre-exposure and post-exposure prophylaxis approaches to prevention for persons not yet infected with HIV. **Pre-exposure prophylaxis (PrEP)** is a new HIV prevention method in which people who do not have HIV take a daily pill to reduce their risk of becoming infected with HIV. When used consistently, PrEP has been shown to reduce the risk of HIV infection among adult men and women at very high risk for HIV infection through sex or injecting drug use.[19] PrEP may be especially useful in helping prevent HIV infection among persons who have difficulty maintaining safe behaviors on their own - such as among substance users - and among women and MSM who cannot enforce condom use with their male partners. PrEP is currently being widely studied to test its effectiveness in a range of populations, including a large-scale study among high-risk young MSM being conducted by East Bay AIDS Center.

Meanwhile, **post-exposure prophylaxis (PEP)** involves taking anti-HIV drugs as soon as possible after having been exposed to HIV in order to prevent HIV infection. To be effective, PEP must begin **within 72 hours** of exposure, before the virus has time to rapidly multiply in the body. PEP usually consists of 2-3 different antiretroviral drugs taken over the course of **28 days**. PEP is now widely available in public and private clinics, although it has largely been publicized through word of mouth approaches. One of the difficulties involved in PEP is that individuals do not always know when they may have been exposed to HIV, or are not always aware of the 72-hour window needed to make PEP use effective.

7. Goals and Objectives of the 2014 - 2016 Plan

The following goals and objectives list the broad intent, focus, and direction of HIV activities in Alameda County over the next three years. Because of continually shifting funding streams, priorities, and changes in the epidemic, these objectives do not include specific target numbers or percentages for most objectives. The Plan objectives, however, do encompass all potential activities for which funding will be available through the Alameda County Office of AIDS Administration via the State of California as known at this time, although not all activities may be funded throughout the course of the Plan period.

Overarching Goal: The overarching goal of the 2014 - 2016 Alameda County HIV Prevention Plan is to reduce the number and incidence of new HIV infections in Alameda County, California through focused, sustained, and evidence-based interventions which work toward the CDC's goal of reducing the number of HIV infections in the US by 5% each year.

- **Objective # 1:** To ensure widespread, accessible, and culturally competent HIV testing services, including routine, opt-out testing in health care and treatment settings and targeted HIV testing outreach to high-risk populations.

- **Objective # 2:** To provide culturally competent partner services (PS) which inform the sexual and drug-using partners of persons with HIV of their potential infection risk and provide them with HIV testing options.

- **Objective # 3:** To quickly and effectively link newly identified persons with HIV, including persons leaving incarceration settings, to all needed health and psychosocial services, including using evidence-based linkage interventions and providing follow-up support to ensure care engagement.

- **Objective # 4:** To identify, locate, and effectively re-link previously diagnosed persons with HIV who are not in care, including persons leaving incarceration settings, to all needed health and psychosocial services, including using evidence-based linkage interventions and providing follow-up support to ensure care engagement.

- **Objective # 5:** To provide culturally competent support services both inside and outside the health care setting that promote HIV medication and treatment adherence and that help retain persons with HIV in care, including peer-based services.

- **Objective # 6:** To provide culturally competent risk assessment and risk reduction support services for persons with HIV in health care settings, including interventions to reduce HIV risk-related behaviors.

- **Objective # 7:** To ensure widespread, accessible, and well-publicized syringe distribution and syringe exchange services.

- **Objective # 8:** To promote expanded hepatitis C testing and to link persons who test positive for hepatitis C to appropriate assessment and treatment programs.

- **Objective # 9:** To utilize targeted social marketing, media, mobilization programs, and condom distribution programs to raise awareness of HIV risk and the importance of HIV testing among both HIV-infected and non-HIV-infected populations wherever possible.

- **Objective # 10:** To continually evaluate the effectiveness of HIV prevention efforts and to utilize evaluation findings to refine and improve local HIV prevention interventions and activities.

8. Methods for Achieving Plan Objectives

Alameda County is fortunate to have in place a robust and highly diverse network of public and private providers and agencies that are committed to addressing the HIV epidemic by reducing new cases of HIV infection and improving the health and well-being of persons living with HIV. While expanded resources for HIV care and treatment services through implementation of the Affordable Care Act has been a welcome development, local HIV prevention providers continue to struggle to deliver primary prevention services with continually declining resources.

The Alameda County Office of Administration (OAA) receives federal funding to support local HIV prevention efforts through the State of California Office of AIDS. The State Office of AIDS in turn receives funds through the US Centers for Disease Control and Prevention (CDC) and distributes these funds proportionately to 18 local health jurisdictions in California counties based on HIV incidence and prevalence (Los Angeles and San Francisco receive direct funding from the CDC and do not receive HIV prevention funding through the State of California). The State's current HIV prevention funding approach mirrors that of the CDC by placing an emphasis on identifying persons who are not yet aware of their HIV status and by focusing on HIV care and treatment as an effective prevention strategy.

In 2014, the Alameda County Office of AIDS Administration will work to achieve its Plan objectives by releasing a new Request for Applications (RFA) whose activities and priorities are aligned with those described by the California Office of AIDS in its 2014 Prevention Program Guidance. This Guidance requires all local health jurisdictions (LHJs) funded for prevention services through the Office of AIDS to:

- Provide targeted HIV testing when positivity yield is sufficient to warrant it;
- Offer HIV testing through an alternate test site (ATS);
- Provide Partner Services;
- Provide linkage to treatment and care services;
- Assign a staff member to attend to health care reform issues; and
- Meet monitoring and evaluation requirements set by OA.

Additionally, at least 75% of prevention funds must be directed to support primary or so-called "Tier 1" services while no more than 25% of grant funds may be spent on recommended or "Tier 2" services. The following is the roster of Tier 1 and Tier 2 services established by the State of California for prevention funding beginning in 2012:

TIER I ACTIVITIES (At least 75% of Funding):

Core Services:

- HIV Testing
- Linkage to Care
- Partner Services

Other Tier I Activities:

- Routine, Opt-Out HIV Testing in Health Care Settings
- Retention and Re-Engagement in Care
- HIV-Positive Risk Assessment, Linkage to Services, and Behavioral Interventions in Health Care Settings
- HIV Medication Treatment Adherence
- Integrated Health Services for HIV-Positive People
- Syringe Services Programs
- Condom Distribution

TIER II ACTIVITIES (No More Than 25% of Funding):

Core Services:

- Hepatitis C Testing
- Behavioral Interventions for Prioritized High-Risk Negative People
- Social Marketing, Media, and Mobilization

The Alameda County prevention contracting process will also take into consideration the **priority populations** listed in the State's 2014 Prevention Program Guidance. In general, these populations correspond to the high need and emerging Alameda County HIV populations identified in the epidemiological

section of this Plan, although our County prevention contracts may not directly reflect all of the following groups in the following order. The State's 2014 identified priority populations are as follows:

- HIV-positive individuals;
- Gay men and MSM, with an emphasis on African American and Latino men;
- Transgender individuals, with an emphasis on African Americans and Latinos;
- IDUs;
- Sexual and needle-sharing partners of HIV-positive individuals; and
- Women at high risk of acquiring HIV via their sexual partners, injection drug use, and/or sex work.

The Alameda County Office of AIDS Administration will work in concert with the HIV Prevention Committee of the Oakland TGA Collaborative Community Planning Council to ensure that prevention funding is distributed to meet the diverse needs and populations in Alameda County while addressing **health disparities** in regard to HIV prevention and care access and outcomes. The State OA traces health disparities to circumstances in which populations and communities experience excessively high rates of HIV infection, late entry into HIV care, or a lack of comprehensive and consistent HIV care. Alameda County HIV prevention funding will be particularly targeted toward the State's goals of: 1) increasing the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%; 2) increasing the proportion of HIV-diagnosed Blacks with undetectable viral load by 20%; and 3) increasing the proportion of HIV-diagnosed Latinos with undetectable viral load by 20%.

9. How the Prevention Plan will be Tracked and Monitored

Responsibility for tracking progress toward the goals and objectives contained in the 2014 - 2016 Alameda County HIV Prevention Plan will lie with the **HIV Prevention Committee** of the Oakland TGA Collaborative Community Planning Council (CCPC), working in collaboration with staff of the Alameda County Office of AIDS Administration (OAA). The Committee will have a standing agenda item related to the Prevention Plan, and will conduct at least **semi-annual reviews** to ensure that local prevention activities are continuing to match Plan priorities. To inform this process, OAA staff will provide ongoing information to the Prevention Committee on funding prevention activities in the County, including information on contract activities and revisions. In turn, the HIV Prevention Committee will provide information on progress related to the Prevention Plan in its regular presentations to the Planning Council as a whole, including soliciting Council input as needed.

While the HIV Prevention Plan is intended to provide a blueprint through which the region's limited HIV prevention resources can be allocated in a manner that has the greatest impact on the future spread of the epidemic, the HIV prevention environment is also changing at an unprecedented pace. It is therefore critical that both the region's response to HIV and the Prevention Plan itself remain **highly flexible**, with the ability to respond rapidly to changing needs and circumstances as they emerge. For this reason, any element of this Plan can be altered or amended by the HIV Prevention Committee and the Office of AIDS Administration at any time the two entities deem it necessary. This includes adding or eliminating Plan objectives; changing the methods for implementing Plan objectives; or adding greater detail and scope to the implementation description. Any changes to the HIV Prevention Plan will be reviewed and voted on by the Prevention Committee and reported to the CCPC on an ongoing basis.

The growing emphasis on medical approaches to HIV prevention also raises the possibility that the entire context of HIV prevention planning may be changed by national or State entities in the near future. The US Health Resources and Services Administration overseeing the Ryan White CARE Act has suggested that jurisdictions may be required to develop and produce **merged or integrated HIV prevention and care plans** as early as 2015, which could mean that the entire prevention planning process will need to be revisited soon in an entirely new

context. For this reason, it is vital that both Alameda County and the HIV Prevention Committee continue to look at HIV prevention planning not as a set of endpoints but as an **ongoing process** in which plans, perspectives, and approaches are continually being reviewed, revisited, and revised. This perspective will continue to allow us to make the best use of emerging technologies and to respond to those groups and populations in our county who continue to face the greatest disparities in regard to HIV infection and care.

Endnotes

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