County of Los Angeles
HIV Prevention Plan
2004 - 2008

County of Los Angeles Department of Health Services
Office of AIDS Programs and Policy

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

County of Los Angeles
HIV Prevention Plan
2004 - 2008

Developed by the
County of Los Angeles HIV Prevention Planning Committee

In Partnership with the
County of Los Angeles Department of Health Services
Office of AIDS Programs and Policy

Los Angeles County

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Executive Summary

In 2003, the Los Angeles County HIV Prevention Planning Committee (PPC) launched the development and implementation of the *County of Los Angeles HIV Prevention Plan 2004-2008*. In partnership with the Los Angeles County Department of Health Services Office of AIDS Programs and Policy (OAPP) and Los Angeles County Department of Health Services HIV Epidemiology Program (HIV Epidemiology Program), the PPC proudly presents the completed *County of Los Angeles HIV Prevention Plan 2004-2008*, which will guide programs and services in Los Angeles County over the next five years.

The completed *County of Los Angeles HIV Prevention Plan 2004-2008* is the culmination of work that has spanned more than two years. This document represents the tireless efforts of all members of the PPC, staff of OAPP and the HIV Epidemiology Program, and countless others who have made significant contributions. The *County of Los Angeles HIV Prevention Plan 2004-2008* builds upon the work of the *County of Los Angeles HIV Prevention Plan 2000* and offers enhanced HIV specific information and guidance to community based organizations, government leaders, policy makers, and other key stakeholders. It is expected that the *County of Los Angeles HIV Prevention Plan 2004-2008* will be a living document, which can be revised as its content is updated and as new information is available.

There are seven major sections to the *County of Los Angeles HIV Prevention Plan 2004-2008,* excluding the Appendix. These sections include:

1. Overview of HIV Community Planning
2. HIV Epidemiologic Profile
3. Community Assessment
4. Priority Populations
5. Interventions
6. Evaluation
7. Geographic Snapshots

This new HIV prevention plan reaffirms the PPC's emphasis on prioritizing populations based upon behavior versus a general population-based approach. Being consistent with this approach, three previous stand alone priority populations (i.e., Transgenders, Youth, and Persons Living with HIV/AIDS) that were developed for the *County of Los Angeles HIV Prevention Plan 2000* have been revised. As part of this new document, a seventh behavioral risk group (BRG) has been added -- "Transgenders at sexual risk and Transgender injection drug users" and their partners, retaining the focus on risky behavior as the source of transmission. The PPC recommended the integration of "Youth" and "Persons Living with HIV/AIDS" (PLWH/A) across all seven BRGs. Thus, youth and PLWH/A are no longer stand alone priority populations but incorporated into the existing BRGs, thereby retaining the emphasis on behavior that puts one at risk of becoming infected or transmitting infection. Finally, the new BRG model expands the "Women at Sexual Risk" category to include their partners.

Although a work in progress, the *County of Los Angeles HIV Prevention Plan 2004-2008* provides a more exhaustive Community Assessment than in the previous plan. In particular, the review of current resources and research that are available in Los Angeles County to address the needs of this diverse community is more complete. This section also includes a preliminary

analysis of gaps in the County. Several important pieces of work are still in progress including the completion of the data gathering regarding HIV prevention needs of individuals not receiving services and other critical hard-to-reach populations. With OAPP's resolicitation of HIV prevention funds in the County, a comprehensive gap analysis will need to be completed.

Another new element of the *County of Los Angeles HIV Prevention Plan 2004-2008* is the Interventions section. In order for Los Angeles County to achieve its goal to reduce new HIV infections by 50% over five years, it is essential that the County help build and support interventions that have evidence of effectiveness and are well-grounded in behavioral theory. Thus, the Interventions section has been designed in a way to help HIV prevention providers to examine more thoughtfully their current and new programs and provide them with the tools to build better, more effective programs across Los Angeles County.

Evaluation is a high priority in Los Angeles County. It is a key element of the community planning process as well as critical for tracking the success of specific interventions being implemented. The *County of Los Angeles HIV Prevention Plan 2004-2008* discusses both of these important aspects of evaluation, as well as addresses the Centers for Disease Control and Preventions' new required program performance indicators. To assist community-based providers in their thought process around evaluation as a core element of program design, the CDC's program performance indicators are integrated into both the Interventions section as well as the Evaluation section of this plan.

In February 2004, the OAPP Director commented: *"HIV is 100% preventable. We have the evidence, but we need resources, vision, and political will."* The *County of Los Angeles HIV Prevention Plan 2004-2008* is now Los Angeles County's blueprint for achieving this laudable goal.

HIV Prevention Plan 2004-2008 Overview

How to Use This Plan

The Los Angeles County HIV Prevention Planning Committee (PPC) and the Los Angeles County Department of Health Services Office of AIDS Programs and Policy (OAPP) are jointly responsible for the development of the *County of Los Angeles HIV Prevention Plan 2004-2008*. The intended audience for the plan is broad and diverse. Although each section builds upon the other, each section may be read as a stand alone document. The seven major sections of the plan are outlined in the Table of Contents and briefly described below.

Overview of Community Planning

Now in its tenth year of HIV prevention community planning, the PPC and the Los Angeles County Commission on HIV Health Services (CHHS) are the community planning groups responsible for addressing Los Angeles County's continuum of HIV prevention and care services. The PPC, in collaboration with OAPP, is responsible for the assessment of community needs and the prioritization and allocation of resources to address gaps for HIV prevention. In 2003, the PPC launched the planning process required for the development and implementation of the *County of Los Angeles HIV Prevention Plan 2004-2008*, in accordance with the Centers for Disease Control and Prevention's (CDC) community planning guidance as well as its new national initiative *Advancing HIV Prevention: New Strategies for a Changing Epidemic*.

Epidemiologic Profile

The Los Angeles County Department of Health Services HIV Epidemiology Program is responsible for tracking trends in the epidemic and providing relevant data and analyses to the PPC and OAPP to aid in the prioritization and allocation of resources. The updated *HIV Epidemiologic Profile* presented here offers a broad overview of the HIV/AIDS epidemic in Los Angeles County, current trends, and detailed information on prioritized risk groups. The *HIV Epidemiologic Profile* displays key information for the County as a whole and by Service Planning Area (SPA), allowing community stakeholders to respond more effectively to local needs.

Community Assessment

Building upon the *HIV Epidemiologic Profile*, the *Community Assessment* takes a look at supplemental information related to HIV risk as well as critical qualitative information from selected target groups. Information regarding risk behavior and community-identified needs begins to create a portrait of the epidemic as well as HIV prevention needs in Los Angeles County. This section also identifies the currently available resources to address community needs. From the analysis of needs and resources, key gaps begin to emerge. Since the assessment of HIV prevention needs of Los Angeles County residents is an ongoing process, the PPC and OAPP will continue to update this section as new information is gathered and analyzed.

Prioritized Risk Groups

As stated earlier, the *County of Los Angeles HIV Prevention Plan 2004-2008* builds upon the work of the *HIV Prevention Plan 2000*. Information from the *HIV Epidemiologic Profile* and the *Community Assessment* strongly support the PPC's continued emphasis on HIV risk behavior as the foundation for targeting services to those individuals most at risk for HIV infection as well as for transmitting HIV. Thus, an updated version of the original behavioral risk group (BRG) model developed for the *HIV Prevention Plan 2000* is the basis for current priorities.

Interventions

Los Angeles County's overarching HIV prevention goal is *"to reduce new HIV infections by 50% over the next five years."* In order to reach this goal, the County must not only target services to prioritized risk groups at highest risk of being infected with or transmitting HIV, it must also identify those interventions, which have the highest likelihood of success. This section discusses the role of behavioral theory in the design of effective interventions, as well as a brief description of common behavioral theories. Providing "evidence" of success is also important in the design of effective interventions. Four sources of evidence include: (1) scientific theory, (2) evaluation of the same intervention, (3) evaluation of a similar intervention, and (4) informal theory based upon an organization's "practice wisdom."

Evaluation

Los Angeles County's evaluation plan includes three elements: (1) evaluating the community planning process, (2) evaluating the effectiveness of interventions, and (3) tracking the CDC program performance indicators. The CDC's program performance indicators provide the foundation for a common set of outcome measures that the PPC and OAPP will track across interventions being implemented by funded community based organizations (CBOs). This section also describes the County's HIV Information Resource System (HIRS), which provides a common infrastructure and format for data to be entered and tracked.

Geographic Snapshots

To better meet the health needs of its local communities, the Los Angeles County Children's Planning Council recommended that the County aggregate its 26 health districts into eight Service Planning Areas (SPAs) in 1993. The County Board of Supervisors approved this recommendation. In so doing, Los Angeles County, one of the nation's largest counties both in geography (4,084 square miles) and population (10.1 million as of January 2004) was divided into eight SPAs to create a more effective model for planning health services across this diverse region.

The Geographic Snapshots provide a one-page look at the County and each of its eight SPAs. The information presented includes selected sociodemographic information related to population, race/ethnicity, poverty, and transportation. Each profile also includes HIV/AIDS and related health information such as AIDS case data and sexually transmitted diseases, tuberculosis, and teen birth rates. This information sheds light on the tremendous regional variation within the County.

Overview of HIV Community Planning

The History of HIV Community Planning in Los Angeles County

Los Angeles County, California has been a pioneer in community planning since the beginning of the HIV/AIDS epidemic. Community engagement is a hallmark of the County's vision and approach in creating a comprehensive continuum of HIV prevention and care services to meet the needs of its diverse population. Through active participation of community members, including providers of HIV/AIDS services, persons living with HIV/AIDS, government representatives, faith communities, and others, Los Angeles County has created a responsive system of HIV prevention and care services targeting a subset of its 10.1 million residents (population as of January 2004), including an estimated 56,900 persons living with HIV/AIDS (PLWH/A).

Formal HIV/AIDS planning began in Los Angeles County in 1988 with the release of the *Comprehensive Service Plan*, prepared by Peat, Marwick & Company. In 1990, a group of community activists formed the County/Community Planning Council. Staff of HIV/AIDS community service providers, Los Angeles County staff, and others comprised the membership of this planning council. This council predated the Centers for Disease Control and Prevention's (CDC) 1993 national directive for locally-based community planning. The County/Community Planning Council collaborated extensively with the County's AIDS Program Office (now known as the Office of AIDS Programs and Policy) to prepare the first Los Angeles County HIV Strategic Plan. This plan guided both HIV prevention and care services for the three-year period from July 1990 through June 1993.

In early 1994, the Planning Council approved the 1993-1996 HIV Strategic Plan. The community planning process became more robust as the Planning Council obtained broader community input and participation through public hearings, focus groups, various subcommittees and task forces of the Planning Council, and the Department of Health Services HIV Epidemiology Program. At this time, the County also completed a full needs assessment regarding HIV education, counseling and testing, and the continuum of care services. With a continued emphasis on care services, HIV prevention comprised a relatively small portion of the overall document.

The Los Angeles County Board of Supervisors passed a County Ordinance in 1995, creating the Los Angeles County Commission on HIV Health Services (Commission). The Commission replaced the former Planning Council and remains the primary HIV/AIDS Care community planning group to date. To better address HIV prevention needs, the HIV Prevention Planning Committee (PPC) was established as a select subcommittee of the Commission. The purpose of the PPC was to serve as the CDC-required community planning group (CPG) with responsibility for making recommendations regarding targeted HIV risk groups and the full complement of prevention interventions in Los Angeles County.

Building upon the 1993-1996 HIV Strategic Plan, the PPC completed another needs assessment and an extensive reforecast to develop the County of Los Angeles HIV Prevention Plan Updates for the period July 1996 through June 1999. This plan continued to guide HIV prevention services and resource allocation in Los Angeles County through 1999. As the new millennium rapidly approached, the PPC embarked upon its most comprehensive community planning process ever in early 1999.

Los Angeles County's *HIV Prevention Plan 2000*, has guided HIV prevention planning, services, and resource allocation from 2000 to the present. This plan marked an end to the use of population-based target groups in Los Angeles County. Instead, the PPC adopted an approach that would better target those individuals most in need of services using behavior as the primary indicator of a person's risk for infection. The *HIV Prevention Plan 2000* identified six behavioral risk groups (BRGs) and three other priority populations, to which resources should be directed. The prioritized BRGs included both adults and youth; they were:

- Men who have sex with men (MSM)
- Men who have sex with men and women (MSM/W)
- Men who have sex with men and use injection drugs (MSM/IDU)
- Heterosexual males who use injection drugs (HM/IDU)
- Females who use injection drugs (F/IDU)
- Women at sexual risk (WSR)

The PPC prioritized three additional populations for services and resources:

- American Indians
- Transgenders
- People Living with HIV/AIDS

The PPC felt that although their new priorities were behaviorally based, they needed to ensure that American Indians and Transgenders, although small in number, did not fall through potential cracks as resources were allocated. Again the pioneer, Los Angeles County further recognized the need to prevent HIV transmission at the source of infection and prioritized services to meet the specific needs of persons living with HIV/AIDS. As one of the health jurisdictions piloting the CDC's *Prevention for Positives* demonstration project, Los Angeles County embraced this focus early. Finally, Los Angeles County's *HIV Prevention Plan 2000* raised awareness among HIV service providers regarding the importance of and need for designing HIV programs and interventions that were rooted in behavioral science, had an evidence base, and could be evaluated beyond simple process measures.

Beyond the content, the broad community involvement in the preparation, development, and implementation of the *HIV Prevention Plan 2000* was tremendous. Hundreds of community members and consumers from all arenas participated in community forums and focus groups, responded to surveys, and added their voice as active participants on the PPC and its numerous subcommittees. This highly participatory process became the benchmark for Los Angeles County's 2004-2008 HIV prevention community planning process.

A New Era of HIV Prevention and Community Planning in the United States

Los Angeles County entered its tenth year of HIV prevention community planning in 2003 with the intent of developing a new comprehensive HIV prevention plan. This coincided with dissemination of the Centers for Disease Control and Prevention (CDC) *HIV Prevention Community Planning Guidance* in July 2003. The CDC's guidance set forth national expectations and created clear linkages among community planning, the CDC's overarching national goal to reduce the number of new HIV infections by half, and the CDC's new *Advancing HIV Prevention (AHP) Initiative*.

CDC's HIV Prevention Community Planning Guidance

The CDC guidance outlines three primary goals for HIV community planning with eight implementation objectives [1]. Together, these goals and objectives provide the basic framework for local community planning groups to follow. In addition, the guidance includes required program performance indicators to gauge the progress and success of local community planning. In addition to creating an alignment between local community planning with national expectations, there must be internal agreement and consistency within the local community planning process itself. For Los Angeles County, this means that resources allocated must have a direct relationship with the priorities identified in the comprehensive HIV prevention plan as well as with the County's application to the CDC for federal funding.

The three community planning goals described in the CDC's community planning guidance are:

1. Community planning supports broad-based community participation in HIV prevention planning.

2. Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

3. Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

To support the evaluation of the above goals, the CDC has also outlined its required program performance indicators, which are:

1. Proportion of populations most at risk, as documented in the epidemiologic profile, that have at least one CPG member that reflects the perspective of each population.

2. Proportion of key attributes of an HIV prevention community planning process that CPG membership agreed have occurred.

3. Percent of prevention interventions/supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan.

4. Percent of health department-funded prevention interventions/supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.

The CDC's updated community planning guidance gives clear direction and expectation for local CPGs as they move into the future. In response to this direction, Los Angeles County has adopted a local version of the national overarching HIV prevention goal (i.e., to reduce new HIV infections in Los Angeles County by 50% over five years). In addition to the community planning guidance, the CDC embarked upon its own new direction through the unveiling of its *Advancing HIV Prevention Initiative* (AHP) in April 2003. This initiative further provides a strategic focus through which Los Angeles can enhance its current HIV prevention planning process.

■ CDC's *Advancing HIV Prevention: New Strategies for a Changing Epidemic*

The CDC's *Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic* marks a significant refocus of priorities for the CDC [2]. This initiative is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services for those diagnosed with HIV and their partners. AHP is based on available evidence that suggests the majority of new infections are caused by persons unaware of their HIV infection. An estimated one-quarter of those who are infected with HIV do not know they are infected. Thus, AHP emphasizes HIV testing, in both medical and non-medical settings, to identify infected persons who are not aware of their own infection and getting them into treatment and prevention services as early as possible.

Similarly, this pattern holds true in Los Angeles County. As seen in Table 1, there are an estimated 2,000 annual new HIV infections in the County. The Los Angeles County HIV Epidemiology Program estimates that approximately 55% are caused by HIV positive individuals who are unaware of their HIV infection and have yet to be diagnosed. Like the U.S., the need to identify high-risk individuals and get them tested and into care is vital for their own health as well as to reduce further transmission of HIV to others.

TABLE 1. Importance of Prevention and Care Linkage in Los Angeles County

Diagnosed PLWH/A	Undiagnosed PLWH/A	Total PLWH/A
42,700 (75%)	14,200 (25%)	56,900 (100%)
Estimated Contribution to New Infections	**Estimated Contribution to New Infections**	**Total New Infections**
900 (45%)	1,100 (55%)	2,000 (100%)

The AHP initiative is intended to complement, expand, and/or strengthen existing HIV prevention efforts; it consists of the following four HIV prevention strategies:

1. Incorporate HIV testing as a routine part of care in traditional medical settings;
2. Implement new models for diagnosing HIV infections outside medical settings;
3. Prevent new infections by working with persons diagnosed with HIV and their partners; and
4. Further decrease mother-to-child HIV transmission.

The CDC further defines the implementation of these strategies through seven activities:

1. Routinely recommend voluntary HIV testing as part of regular medical care services;
2. Offer rapid HIV testing in non-traditional settings;
3. Routinely and voluntarily test inmates in correctional facilities for HIV;
4. Offer HIV partner counseling and referral services (PCRS);

5. Offer prevention case management (PCM) services;

6. Offer HIV prevention services in medical care settings, and;

7. Achieve universal HIV testing of pregnant women.

Through this strategic change, AHP expands HIV prevention services to what the CDC envisions will achieve the greatest results. Because of the potential to substantially reduce HIV incidence, HIV community planning groups are now required to prioritize HIV-infected persons as the highest priority population for prevention services. As noted earlier, Los Angeles County has prioritized HIV-infected persons formally since its *HIV Prevention Plan 2000*. Thus, AHP serves to strengthen and validate a core element of Los Angeles County's current approach.

Los Angeles County HIV Prevention Community Planning: 2004-2008

In 2003, the PPC embarked on a five-year community planning process and began development of a comprehensive HIV Prevention Plan for Los Angeles County to guide HIV prevention efforts countywide. The purpose of the new plan was to expand on the vision introduced by the *Los Angeles County HIV Prevention Plan 2000*, which has guided HIV prevention services, resource allocation, and funding requests from 2000 to the present. As a result of significant changes in federal HIV prevention strategies introduced in 2003, the introduction of the CDC's new Community Planning Guidance, new HIV testing technologies, statewide legislation mandating HIV reporting, and OAPP preparing for a new HIV prevention competitive solicitation process, the timing was ripe to begin the development of a new comprehensive planning process.

■ PPC Mission, Vision, and Core Objectives

As the PPC began the planning for the new HIV prevention plan, they reaffirmed their mission, vision, and core objectives.

MISSION

To engage in an ongoing process to develop and update a comprehensive HIV prevention plan for the diverse population of Los Angeles County.

VISION

To identify and support methods and programs which are effective in preventing transmission of HIV, thus reducing the incidence of HIV infection in Los Angeles County.

CORE OBJECTIVES

1. Fostering the openness and participatory nature of the community planning process.

2. Ensuring that the Prevention Planning Committee reflects the diversity of the epidemic in Los Angeles County, and that expertise in epidemiology, behavioral and social science, health planning, and evaluation are included in the process.

3. Ensuring that priority HIV prevention needs are determined based on an epidemiological profile and a needs assessment.

4. Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost and cost effectiveness, theory, and community norms and values.

5. Fostering strong, logical linkages between the community planning process, application for funding, and allocation of CDC HIV prevention resources.

■ PPC Membership

As in past years, the PPC's membership (as of September 2004) is broadly diverse, reflecting the epidemic. Table 2 outlines the various demographic characteristics of the current PPC membership. The PPC maintains an open nomination process to solicit new members. Any interested community member may submit a membership application to OAPP at any time. Upon receipt, OAPP staff submit all applications to the PPC's Operations Subcommittee for review. Once reviewed, the Operations Subcommittee forwards recommendations to the PPC's Executive Committee, which then forwards its recommendations to the Director of OAPP for final endorsement.

TABLE 2. PPC Membership (as of September 2004)

	PPC Membership		LA County 2003	
	Number (22)	Percent %	Persons Living w/AIDS	
GENDER				
Male	15	68%	89%	
Female	5	23%	11%	
Transgender (Male to Female)	2	9%	Unknown	
ETHNICITY				
Latino/a	9	40%	38%	
African American	5	23%	22%	
Asian/Pacific Islander	3	14%	3%	
Native American/Alaskan	0	0%	1%	
White	5	23%	37%	
BEHAVIORAL RISK GROUP (BRG)				
Male –to-Male Sex (MSM)	10	45%	64%	
Male to Male or Female Sex (MSM/W)	3	14%	Not Reported	
Injection Drug Use (IDU)	2	9%	7%	
Male to Male Sex or IDU (MSM/IDU)	1	4%	6%	
Women at Sexual Risk	3	14%	7%	
No Reported Risk	3	14%	14%	
HIV STATUS				
HIV-Positive	5	23%	100%	
HIV-Negative	16	73%	N/A	
Undeclared / Unknown	1	4%	N/A	
AGE				
<24	3	14%	<13	<1%
			13 – 19	<1%
25 – 29	6	27%	20 – 29	4%
			30- 39	29%
>30	13	59%	40 – 49	43%
			50 – 59	18%
			60+	6%

The Executive Subcommittee, which is comprised of all other subcommittee chairs, acts as the nominating body that reviews PPC nominations and makes recommendations for membership to the PPC. With technical assistance from researchers and the Department of Health Services, the Executive Subcommittee reviews gaps in PPC membership and recommends nominees to fill the gaps. To ensure a clear and concise method for nominating and selecting new PPC members, the Executive Subcommittee follows the membership procedures outlined in the *PPC Policies and Procedures* manual.

The Executive Subcommittee ensures that outreach takes place throughout the year to recruit new PPC members. Recruitment efforts include encouraging all PPC members to distribute PPC fact sheets and membership applications at community meetings, including membership applications in all PPC meeting packets, and ensuring that targeted recruitment is taking place.
The PPC takes great care to ensure that the composition of its membership is reflective of the local epidemic in terms of representation from groups that are most affected by HIV/AIDS. To ensure that the local PPC reflects the demographic of the epidemic in Los Angeles County, the Executive Subcommittee of the PPC conducts regular reviews of the PPC's membership. PPC support staff administer annual member surveys and compare the membership profile with AIDS surveillance findings to review the extent to which membership reflects the epidemic in Los Angeles County.

Although Code Based-HIV reporting became effective July 1, 2002 in the State of California, presently there is a lack of reliable HIV incidence data. As a result, the PPC will continue to base its data on living AIDS cases until this new surveillance system provides sufficiently reliable data. OAPP and the PPC work closely with the Los Angeles County HIV Epidemiology Program to ensure that the best data available are used to establish data for membership representation.

■ PPC Subcommittees

The PPC creates standing and ad-hoc subcommittees as needed to accomplish its mission. Subcommittees report the progress of their work to the larger PPC membership at regular meetings. Each subcommittee strengthens its working partnership with OAPP and provides important feedback on a variety of programmatic and policy related issues. Standing subcommittees are not time-limited and provide the expertise necessary to complete the core objectives of the PPC. Each PPC member serves on at least one subcommittee, and members of the public are routinely invited and encouraged to join the subcommittees.

Currently, the PPC has four standing subcommittees that guide its work; they include:

1. Executive
2. Evaluation
3. Operations
4. Standards and Best Practices

For purposes of developing the *County of Los Angeles HIV Prevention Plan 2004-2008*, the Evaluation, Operations, and Standards and Best Practices subcommittees combined to form the Prevention Plan Ad-Hoc Subcommittee. Now that this task has been completed, the Prevention Plan Ad-hoc Subcommittee has dissolved, with participants rejoining their former subcommittee.

The following is a brief description of the PPC's current standing subcommittees:

Executive
The Executive Committee includes the PPC Co-Chairs and the Chairs of each standing subcommittee. This committee is responsible for setting the agenda for all PPC meetings and for ensuring that the PPC accomplishes its goals and objectives as stated in the comprehensive HIV prevention plan. Each year, this subcommittee reviews Los Angeles County's application for CDC prevention funding, prepared by OAPP. This review ensures that the application submitted is in concurrence with the HIV prevention plan. The Executive Subcommittee also guides the development of social marketing strategies and helps obtain community input in the content development process. Finally, the Executive Committee is responsible for addressing HIV/AIDS related prevention policy issues.

Evaluation
The Evaluation Subcommittee evaluates the HIV prevention application process, assists in developing subcontractor program reports, and utilizes data for resource prioritization and allocation. Annually, the Evaluation Committee surveys PPC members to assess their satisfaction with the community planning process.

Operations
The Operations Subcommittee maintains clear and consistent policies and procedures for efficient operation of the PPC. This subcommittee ensures that policies and procedures reflect current operations by monitoring membership needs, identifying logistical needs, and making revisions to the Policies & Procedures manual once per year if needed. The subcommittee acts as the nominating body that reviews PPC membership applications and forwards recommendations to the Executive Subcommittee and the OAPP Director. The Operations Subcommittee assures that new member orientations take place throughout the year as needed, reviews PPC member attendance, reviews gaps in the PPC membership, addresses gaps through their recommended nominees, and regularly reports to the PPC Co-Chairs regarding membership attendance and participation.

Standards and Best Practices
As the name implies, the Standards and Best Practices subcommittee provides recommendations related to minimum standards and best practices with HIV prevention programming, staffing, benchmarks, and planning. This subcommittee also identifies and prioritizes strategies that assist in the implementation of HIV prevention interventions that are consistent with the comprehensive HIV prevention plan.

■ The 2004-2008 Comprehensive HIV Prevention Planning Process

Early planning for the *County of Los Angeles HIV Prevention Plan 2004-2008* began in November 2002 when the PPC convened a community breakout session – *"Introduction to Community Planning*." At this meeting, PPC participants broke into six groups, with the explicit purpose of gathering community input regarding the process for developing a new HIV Prevention Plan. This first meeting provided invaluable feedback to the Executive Subcommittee, which met later that month to draft a proposed strategy to complete the prevention plan. In December 2002, the Executive Subcommittee presented the following goals:

1. Update the epidemiological profile.

2. Conduct a SPA-based needs assessment and utilize the Countywide Risk Assessment Survey data (CRAS) as the basis for the needs assessment.

3. Complete a comprehensive resource inventory.

4. Conduct an analysis of services and resource gaps.

5. Identify potential strategies and interventions.

6. Prioritize populations, interventions, and allocate resources.

7. Write the plan.

This strategy became the roadmap for the work to be completed over the next 18 months. As mentioned above, several of the standing PPC subcommittees joined together to form the Prevention Plan Ad-hoc Subcommittee. In this way, there was a single body responsible for ensuring that tasks were completed on time and work was able to move forward.

The Prevention Plan Ad-hoc Subcommittee decided to create four smaller workgroups in order to plan and conduct their work more efficiently. Each workgroup appointed a lead person to be responsible for ensuring the completion of all assignments. The following are the four Workgroups and their tasks:

1. Existing Behavioral Risk Group (BRG) Data Review - The existing Behavioral Risk Group (BRG) Data Review workgroup was responsible for reviewing the existing and secondary data on BRGs and interventions previously collected by the PPC's standing Evaluation Subcommittee. The workgroup also reviewed HIV-related risk behaviors of target populations. It was their responsibility to determine to what extent each population is engaging in specific high-risk behaviors and whether or not the existing model is responsive to prevention needs.

2. Focus Groups - The Focus Group workgroup collected consumer and community-based information and data through focus groups, community forums, interviews, etc. The Focus Groups workgroup elicited the following information:

    - Potential barriers to reach priority BRGs.
    - Potential barriers that may be experienced or perceived by members of the BRG when accessing or using prevention services.
    - Extent to which each priority high-risk group is participating in HIV prevention activities.
    - Extent to which each priority high-risk group is aware of HIV transmission modes.

3. Best Interventions by BRG - The Best Interventions by BRG workgroup identified science-based strategies and interventions that have been proven effective for each target population.

4. Resource Inventory - This workgroup identified currently available HIV prevention and related services that were accessible and appropriate by BRG. They also addressed issues related to the differing prevention needs and access issues of specific sub-populations.

To assist the work of the Prevention Plan Ad-Hoc Subcommittee, OAPP hired three consultants to assist with different aspects of the plan-development process. The first consultant helped to consolidate the work-to-date of the Subcommittee in order to prepare a written addendum for the HIV Prevention Plan 2000 to be submitted with OAPP's 2004 Cooperative Agreement with the CDC. The two other consultants assisted with data gathering related to the needs assessment and writing of the final HIV Prevention Plan.

HIV Epidemiologic Profile

Introduction

The Los Angeles County Department of Health Services HIV Epidemiology Program is responsible for compiling an HIV epidemiologic profile every 3 to 5 years. The profile presented here as part of the *County of Los Angeles HIV Prevention Plan 2004-2008* includes the major sections of the HIV Epidemiology Program's third edition of *An Epidemiologic Profile of HIV and AIDS in Los Angeles County, 2004*. The major sections are: (1) a general description of Los Angeles County with key information regarding selected sociodemographic characteristics, (2) trends in the HIV/AIDS epidemic, (3) geographic distribution of HIV/AIDS across the County, and (4) distribution of HIV/AIDS among priority populations. This is information will assist community-based organizations, planners, and policy-makers in the planning, implementation, and evaluation of programs and policies that involve HIV and AIDS care, prevention, education, and research in the County.

The epidemiologic profile is consistent with guidance from the Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration (HRSA). As in the *HIV Prevention Plan 2000*, it focuses on behavioral risk groups (BRGs) and other priority populations. Finally, the *Profile* emphasizes the presentation of information by Service Planning Area (SPA) to help planners and policy-makers address regional needs more effectively.

HIV reporting by non-name code became mandatory in the State of California in July 2002. However, the information on non-AIDS HIV-infected persons collected thus far is not complete, has not been validated, and so is not presented in this current HIV epidemiologic profile. In the absence of this information, the HIV Epidemiology Program has relied heavily on AIDS surveillance data, estimates of HIV prevalence, and data from HIV seroprevalence studies of high-risk populations conducted by the HIV Epidemiology Program, as well as data collected by other programs and academic institutions.

Description of Los Angeles County

To thoroughly understand the HIV/AIDS epidemic in Los Angeles County and the challenges around designing prevention services, it is important to understand the complexity of Los Angeles County's physical, demographic, and social environment.

■ Geography

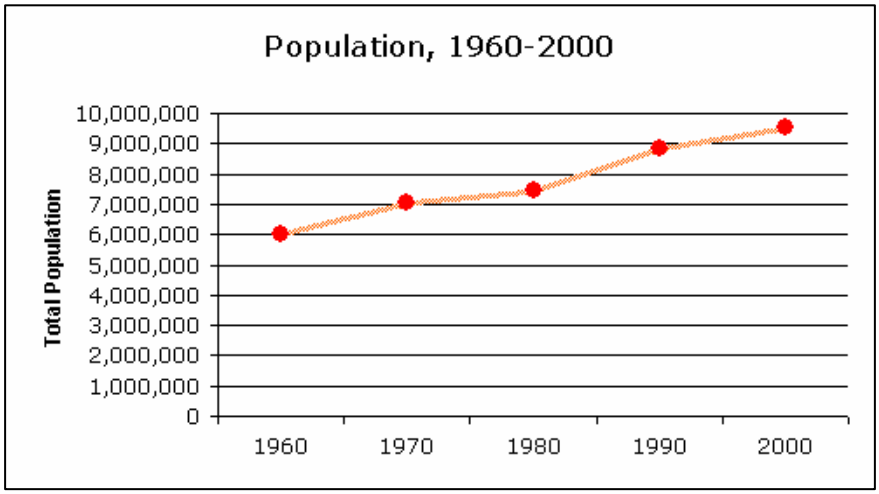
Established in 1850, Los Angeles County presently consists of 4,084 square miles, comprising approximately 3% of California's total land area. The County has 81 miles of ocean shoreline, mountain ranges with 10,000-foot peaks, densely populated valleys (up to 23,000 persons per square mile), and a sparsely populated desert (2,000 persons per square mile) [3].

■ Population

With over 10 million residents (as of January 2004), Los Angeles County is the most populous County in the U.S. In fact, it is more populous than 42 of the 50 States. The 2000 census reported

the population of Los Angeles County to be about 29% of California's total population. The County's population has increased 7.4% since the 1990 census (see Figure 1) [4]. The population has continued to grow from the 9.8 million residents reported in the 2000 census to its current size of 10.1 million. The City of Los Angeles is the largest of the County's 88 incorporated cities with a population of 3.7 million and representing 39% of all County residents. The City of Long Beach is next largest city with a population of 457,608, representing 5% of all County residents.

FIGURE 1. Los Angeles County Population From 1960-2000



Age/Gender Composition

As in past years, females accounted for slightly more of the County population (50.6%) in 2000 than did males (49.4%). As compared to the U.S., Los Angeles County has an excess of children and young adults, while the U.S. has an excess of adults aged 40 years and over. This trend indicates that Los Angeles County has a faster growing population than the U.S. Similarly, Los Angeles County had proportionately fewer residents aged 65 years and older (9.7%) than did the U.S. (12%), and had more children under the age of 18 years (28%) than did the U.S. (26%). In 2000, Los Angeles County's median age was 32 years, lower than that of the U.S., 35.3 years.

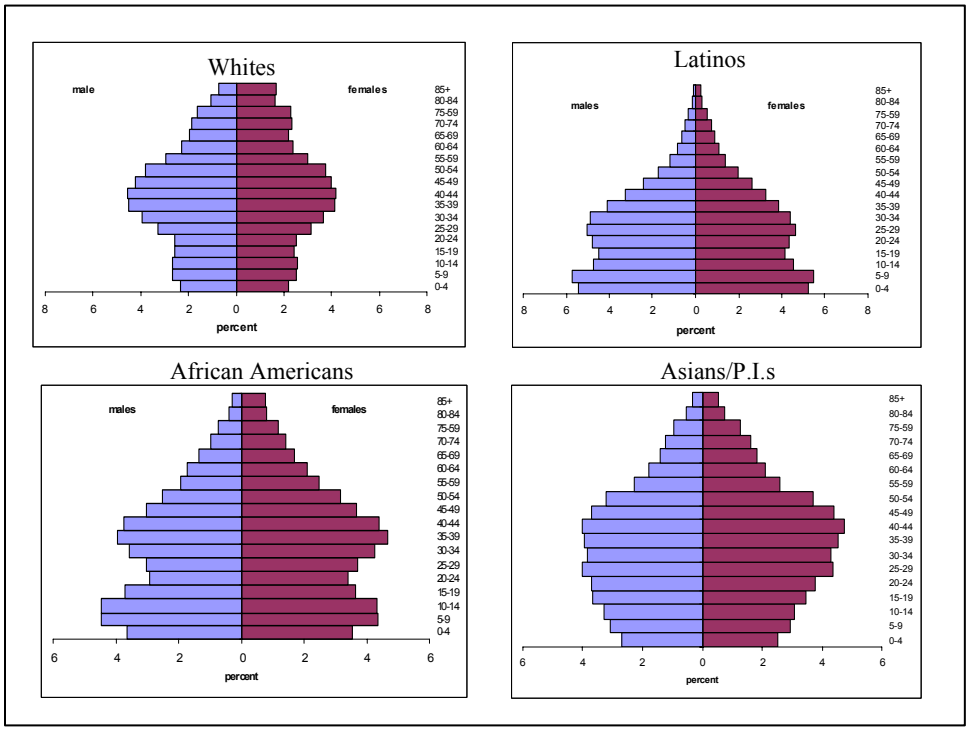
Age groups within the County vary greatly when examined by race/ethnicity. The race/ethnic-specific population pyramids vary greatly, ranging from a growing population of Latinos, with a broad base of children and young adults, to an apparently declining White population, with a higher proportion of older adults atop a narrower base of children and youth (Figure 2). Accordingly, the ratio of persons over 65 years to children under the age of 15 was highest for Whites (116:1), then Asians (60:1), African Americans (39:1), and lowest for Latinos (14:1). The median age of County residents in 2000 ranged from a low of 26 years for Latinos, to 28 years for American Indians, 33 years for African Americans, 35 years for Asians, to a high of 41 years for Whites [3].

Growth Trends

Births accounted for 59% of the County's population growth in 2000, while in migration from other states and immigration from other countries accounted for the other 41%. There were 98,000 births recorded in Los Angeles County in 2000 [3]. The birth rate (16 per 100,000

population in 2000) is slightly higher than that of California as a whole (15 per 100,000). County birth rates, however, have continued to decline since a peak of 23 per 1,000 in 1991 [5]. In 2001, Latina mothers delivered 63% of all births; Whites, 18%; Asian/Pacific Islanders, 10%; and African Americans, 8%. The infant death rate fell from 8 infant deaths per 1,000 births in 1990 to 5 in 2000. The proportion of births to teenagers (age under 20 years) was 10% in 2001. Births to women over 35 increased from 11% in 1990 to 17% in 2001 [3].

FIGURE 2. 2000 Census Population Pyramids by Gender, Age, and Race/Ethnicity for Los Angeles County



Recent Immigrants

Constant migration continues to drive the racial/ethnic diversity of Los Angeles County's population. Coming from 6 continents and nearly 100 countries, over 3.5 million County residents are foreign-born (36%), compared with 26% of Californians and 11% of Americans, according to the 2000 Census. In fact, Los Angeles is the nation's second largest port of entry for immigrants in the U.S. Nearly half (49%) of all Latino residents and 68% of Asians are foreign-born. More than half (54%) of the County's population speak another language besides English at home, while 28% state they do not speak English "very well [3]."

Racial Composition

Los Angeles is one of the most ethnically diverse counties in the nation. Los Angeles has been characterized by ethnic transition since the 1700's, shifting from Native American to Mexican to non-Latino White to today's multi-racial, multi-ethnic mix of people from all parts of the world. While Whites are the majority race/ethnic group in the United States as a whole, no racial or ethnic group constitutes a majority greater than 50% of the population in Los Angeles County [4].

Latinos, with 46% of the County's population, are projected to be a majority by 2010. Non-Latino Whites account for 32% of County residents, Asian/Pacific Islanders 13%, African Americans 9.4%, and American Indians 0.3%. Although American Indians represent less than 1% of the population, they constitute the largest urban concentration of American Indians in the U.S. Latinos represent the fastest growing population from 1990 to 2000, with a 28% increase.

These broad racial/ethnic categories mask an even greater diversity of the ethnic communities in Los Angeles County, composed of many nationalities with distinct cultures and languages. For example, as of 2000, countries of origin among the County's Latino residents include Mexico (72%), Central America (8.8%), South America (1.8%), Cuba (0.9%), Puerto Rico (0.9%), Dominican Republic (0.4%), while other Spanish and unspecified countries accounted for 15.2% [3]. Among Asian/Pacific Islanders (API), 97.7% are Asian and 2.3% Pacific Islander. Countries of origin include China (25%), the Philippines (22%), Korea (16%), Japan (9.6%), Vietnam (6.7%), India (5.2%), Taiwan (3.1%), Samoa (1.1%), and unspecified (11.3%) [3].

■ Industry and Employment

Over the past few years, the County has witnessed a shift in the labor force from manufacturing jobs to service industry jobs, which also implies a shift to lower wages and frequently to positions of lower pay with no health insurance benefits. In 2000, the leading industries in the County are Services with 33% of the labor force, followed by Retail Trade with 22%, and Manufacturing with 16%, and Government with 15% [6]. The seasonally adjusted unemployment rate in the County was up from a recent low of 5.0% in January 2001 to 6.7% in July 2003, compared with 6.6% in California and 6.2% in the U.S. [7]. By race/ethnicity, July 2003 unemployment rates varied from a high of 12% for African Americans, to 7.7% for Latinos to 6.1% for Whites.

■ Income and Poverty

Between 1990 and 2000, the median annual income for County residents, adjusted for inflation, declined 9%, from $46,067 to $42,189 [3]. Twenty-three percent of households were in the lowest income category—at or near poverty level—while 15% of County households made more than $100,000 per year. There was significant disparity in income among racial/ethnic groups, with Whites median annual income at $54,000, Asians at $48,000, American Indians at $36,000, Latinos at $34,000 and African Americans at $32,000 [3]. Los Angeles County has the highest proportion of residents living in poverty (18%) than any other major metropolitan area. In comparison, 14% of California's population and 12% of the U.S. population live in poverty. Among race/ethnic groups, 23-24% of the County's African American, Latino and American Indian residents were living in poverty, compared with 14% of Asians and 9% of Whites [3]. In 2000, about 1.7 million County residents received some sort of public assistance, half of whom received medical insurance coverage only [3].

■ Housing and Homelessness

Los Angeles County has the nation's 16th least affordable housing market. The housing vacancy rate is a very low 4.2% and only 48% of housing units are owner occupied compared to 57% in California or 66% in the U.S. [3]. Among County rented housing units, 23% were considered overcrowded in 2000, with more than one person per room (including the kitchen but excluding bathrooms). While there are some 18,500 beds available in over 300 homeless shelters in the County, there are an estimated 80,000 persons who are homeless on any given night in the

County and 254,000 homeless during the course of a year [8]. According to the 2000 U.S. Census, 375,000 LA County adults reported having been homeless in the past 5 years.

Health Insurance

According to the 2001 California Health Interview Survey—which interviews adults chosen from random telephone digit dialing—24% of adults and 12% of children in LAC did not have health care insurance [9]. Among contacted adults, Latinos had the highest proportion uninsured (38%), followed by Asians (21%), African Americans (15%), and Whites (13%). Among children of respondents to the 2002-2003 LA Health Survey, 10% were uninsured, including 14% of Latinos, 10% of Asian/Pacific Islanders, 4% of Whites, and 3% of African Americans. According to the County's *Key Indicators of Public Health*, 19% of adults and 7% of children in the County reported having no regular source of health care [10].

Infant Health

The vast majority of County women (86%) received prenatal care in their first trimester in 2001 and nearly all (96%) received care by the second trimester [3]. In every year since 1990, approximately 6-7% of women have given birth to low or very low birth weight babies [11]. Historically, African American women have had twice the rate of low birth weight babies than have other race/ethnicities. The infant mortality rate (deaths among infants less than 1 year of age) for Los Angeles County was down from 8.4 per 1,000 live births in 1990 to 4.9 per 1000 live births in 2000. In comparison, California's infant mortality rate was 5.2 per 1,000 live births in 2000; the *Healthy People: 2010* goal is 4.5 per 1,000.

Mortality and Cause of Death

In 2001, the overall crude death rate for Los Angeles County was 6.3 deaths per 1,000. Nearly two-thirds of all deaths in Los Angeles County were due to heart disease, cancer, or stroke, the leading causes of death in all racial/ethnic groups in the County and the U.S. [12, 13]. Between 1991 and 1999, the death rates for heart disease, cancer, and stroke decreased by 31%, 21%, and 23% respectively, while the death rate for diabetes increased 43%. A significant change from the earlier years is that AIDS is no longer a leading cause of death among Los Angeles County residents.

Education

The Los Angeles County Office of Education is the nation's largest regional education agency. In 2001-2002, there were 1.7 million students enrolled in 1,897 public schools in 94 school districts in the County [14]. Twenty-eight percent of all California students were enrolled in the County's public schools. The Los Angeles Unified School District is the largest district with 43% of all County public school students enrolled. Ten percent of all K-12 students were enrolled in private schools during the same time period. Latinos comprise 60% of all students in public schools, while Whites comprise 18%, African Americans 11%, Asians 8%, Filipinos 2%, Pacific Islanders 0.5%, and American Indians or Alaskan Natives 0.3%. Students in the County's schools speak 90 different languages. Of the high school Class of 2000, 62% of students graduated with their class—including 54% of African American students, 57% of American Indians, 93% of Asians, 74% of Pacific Islanders, 90% of Filipinos, 54% of Latinos, and 78% of Whites. Among the County's adult population over age 25 years, 30% did not graduate from high school. [15].

Incarcerated Persons

Incarceration of adults in Los Angeles County includes inmates of Federal, State, and County facilities. The two Federal correctional facilities had a daily census of a little more than 2,000 inmates [16]. One adult California Department of Correction facility houses over 4,500 inmates [17]. The daily inmate census for the nine jail facilities and the Inmate Reception Center of the Los Angeles County Sheriff's Department has recently dropped due to facility closures from an average of 19,500 in 2002 to just over 17,000 inmates in 2003 [18]. In 2002, 159,035 inmates were booked into the County jail system, of which 88% were male. Among males, 46% were Latino, 36% African American, 15% White, and 3% of other race/ethnicity. Among female inmates, 44% were African American, 29% Latino, 24% White, and 3% of other race/ethnicity. Historically, about 95% of the inmates released on probation from the County jail system remain in the County.

Mental Illness

Severe and persistent mental illness (SPMI) includes chronic schizophrenia, bipolar disorder, major depression, dementia, or other psychological conditions that may lead to persistent disability. It is estimated that around 2.6% of California adults suffer from SPMI and 5.4% from serious mental illness—which includes any mental illness diagnosis; meanwhile, the seriously and severely emotionally disturbed comprise 9% to 13% of children in California [19].

Los Angeles County represented 20% of mental health clients served statewide [20]. Approximately 2% of the entire County population (220,500 persons) was served by the Los Angeles County Department of Mental Health (DMH) in fiscal year 2002-2003 [21]. Slightly more than half (55%) of these clients were male and the majority (68%) were adults. The racial/ethnic distribution of DMH clients was as follows: 30% Latino, 27% White, 26% African American, 5.5% Asian, 0.5% American Indian, 1% other, and 10% unknown. Of these clients, 39% (86,000) were uninsured when accessing mental health services.

Epidemiologic Trends in HIV and AIDS in Los Angeles County

As of July 2004, a cumulative total of 48,510 persons with AIDS and 28,810 AIDS-related deaths were reported in Los Angeles County for a cumulative case-fatality rate of 59%. As of June 2004, Los Angeles County accounted for 5.5% of cumulative reported AIDS cases in the United States, 5.7% of U.S. AIDS deaths, and 5.1% of persons living with AIDS. There are now over 19,500 persons living with AIDS in Los Angeles County [22].

Comparison of AIDS Trends in Los Angeles County and the U.S.

While there are some similarities in AIDS trends in the U.S. and Los Angeles County—such as the dramatic decrease in reported AIDS cases and AIDS deaths from 1995 to 1998 (see Figures 3 and 4)—there are also some important differences—especially in the distribution of cases by demographics and risk exposure. Therefore, it is important to look at local data and trends when trying to understand the impact of the epidemic locally.

FIGURE 3

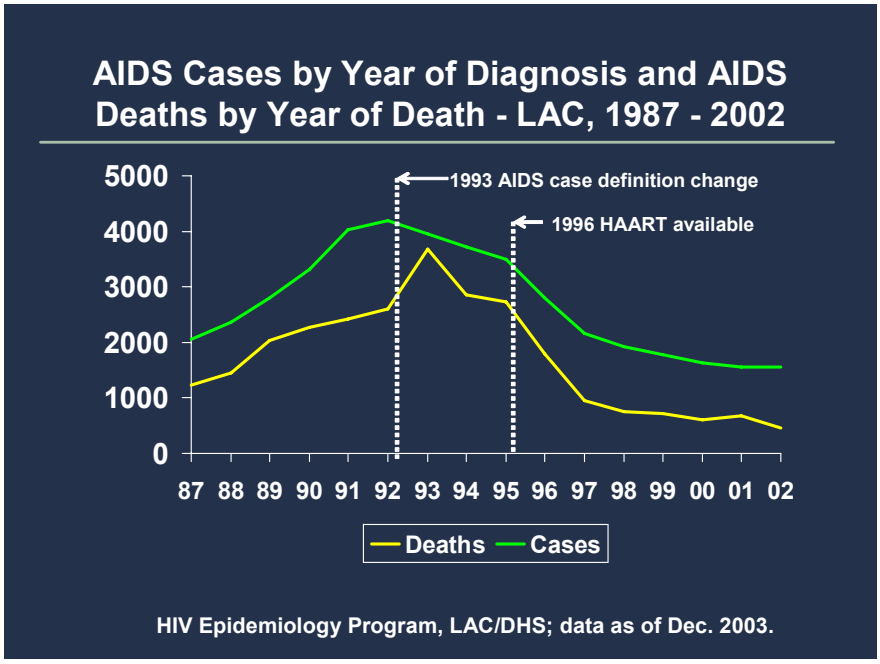
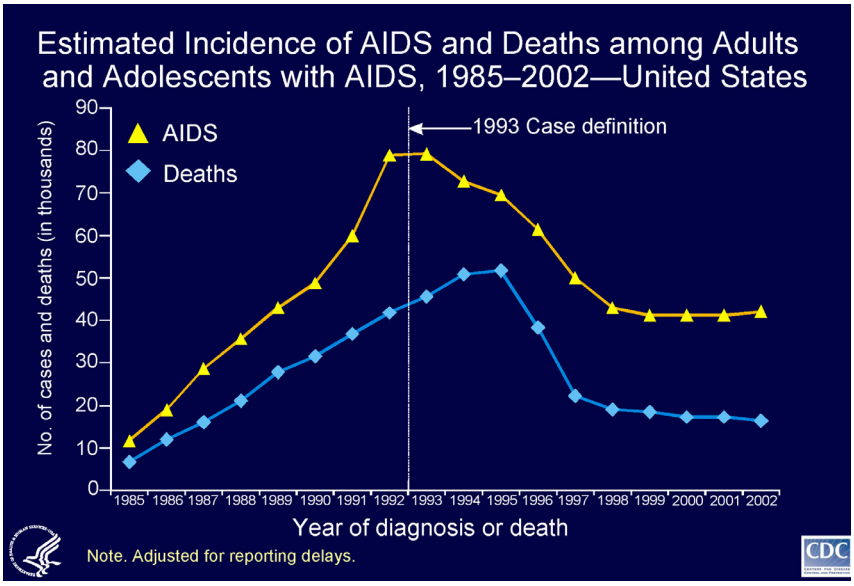


FIGURE 4



In both the U.S. and Los Angeles County, the number of AIDS cases diagnosed annually increased sharply, peaking in 1992-1993. After a few years of steady decline, a steeper decline was seen from 1996 to 1998 before leveling off from 1999 to 2002. Nationally, the CDC reported a 2.2% increase in annual diagnosed AIDS cases from 2001 to 2002, sparking concerns about the growing resistance of HIV to highly-active antiretroviral therapy (HAART). Unlike the U.S., Los Angeles County has yet to see a similar increase in annual AIDS cases.

Annual AIDS deaths have also shown nearly identical patterns in the U.S. and Los Angeles County, with steady increases seen up to 1995, followed by steep declines from 1996 to 1998 (when HAART was introduced), followed again by less steep declines thereafter. In 2001, the County saw its first increase in AIDS deaths since 1994-an increase of 1.1%.

With the decline in deaths outpacing the decline in new cases, the number of persons living with AIDS in the U.S. and Los Angeles County continues to increase (see Figures 5 and 6).

FIGURE 5

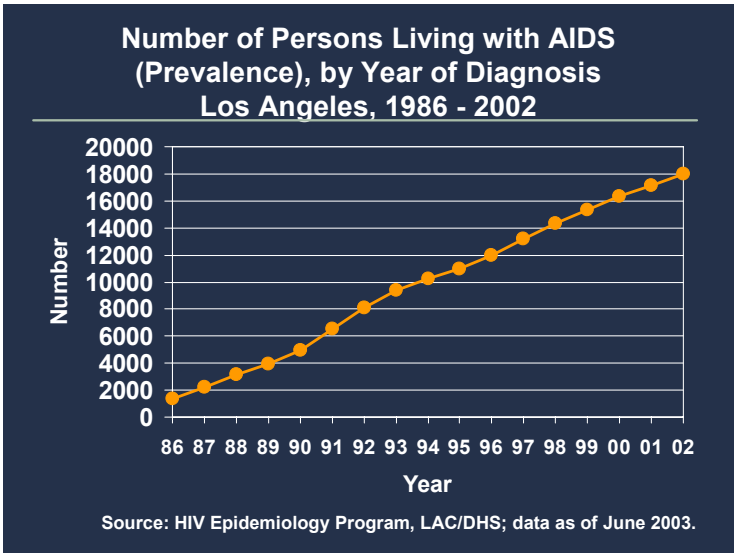
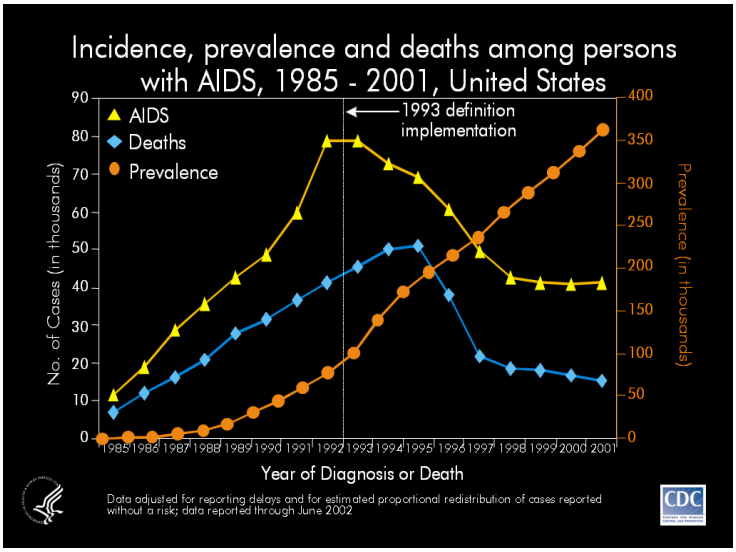


FIGURE 6



Gender

The percentage of males living with AIDS is much higher than for females. Men living with AIDS account for a higher proportion in Los Angeles County (89%) than they do nationally (78%). From 1993 to 2002, there has been a trend of increasing proportion of new AIDS that are

female; but this trend has been less marked for Los Angeles County than for the U.S. (see Figures 7 and 8). Males comprised 87% of newly reported AIDS cases in the County for 2001–2002 combined.

FIGURE 7

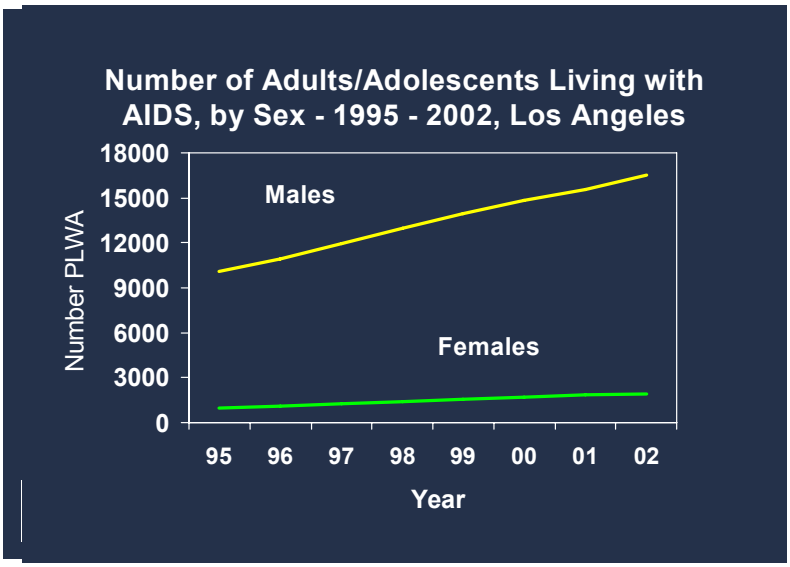
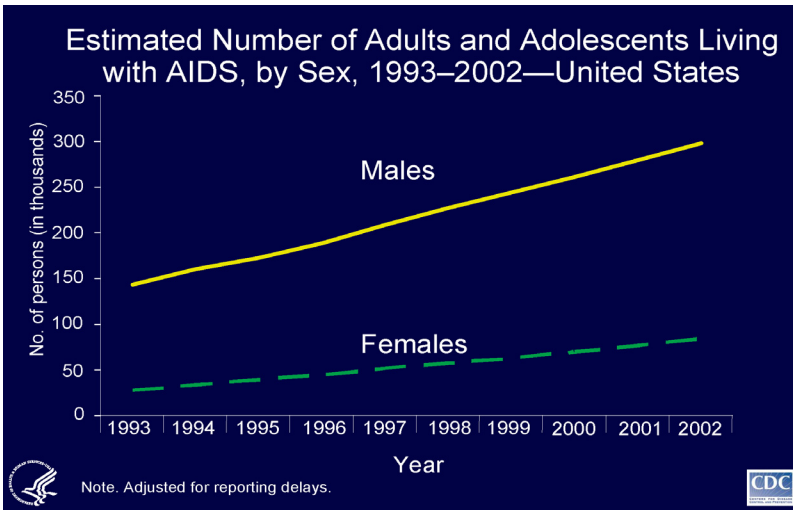


FIGURE 8



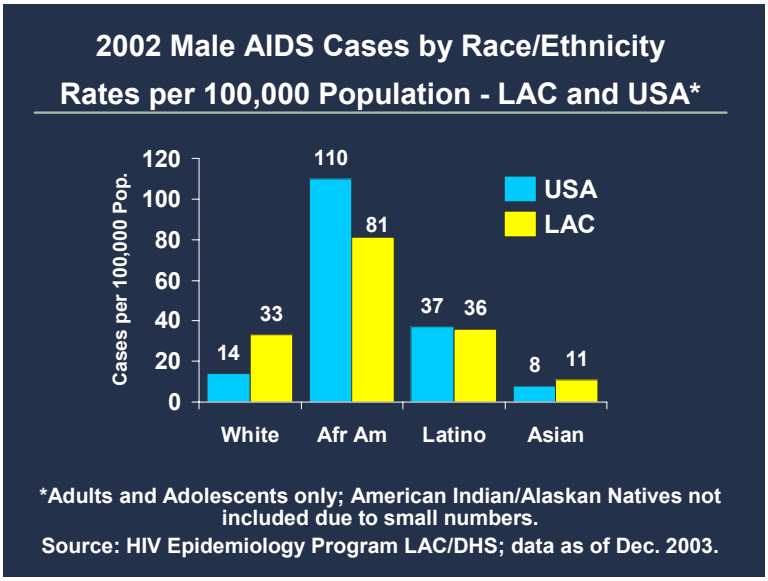
Race/Ethnicity

The racial/ethnic distribution of persons with AIDS differs markedly between Los Angeles County and the U.S. While Whites were the predominant group affected in both the U.S. and Los Angeles County in the 1980's and early 1990's, Latinos have become the predominant group in the County since 1997 and African Americans have become the predominant group in the U.S. since 1996.

In 2002, Latinos accounted for 43% of persons with AIDS diagnosed in Los Angeles County, but only 20% of U.S. cases. African Americans accounted for 22% of County cases, but half (50%) of all U.S. cases. Whites accounted for 30% of LAC cases and 28% of US cases, while other race/ethnicities such as Asian/Pacific Islanders and American Indian/Alaskan Natives accounted for less than 5% of County cases and only 2% of U.S. cases.

The percentage distribution of persons with AIDS is heavily influenced by underlying differences in the racial/ethnic population distributions of the U.S. compared to Los Angeles County, as seen in the previous section. For this reason, AIDS *rates* by race/ethnicity are a better indicator for measuring the relative impact of AIDS among these groups. For both the U.S. and Los Angeles County, the highest 2002 annual incident AIDS rates for men and women were seen among African Americans, while the lowest rates were seen in Asians. Rates of newly diagnosed AIDS cases were high for both U.S. and Los Angeles County African American males (110 and 81 cases per 100,000 population respectively) and similar for U.S. and Los Angeles County Latino males (37 versus 36 per 100,000), and for Asian males (8 versus 11 per 100,000). The rate of new cases for White males in the U.S. however, was half that of White males in Los Angeles County (14 versus 30 per 100,000) (see Figure 9).

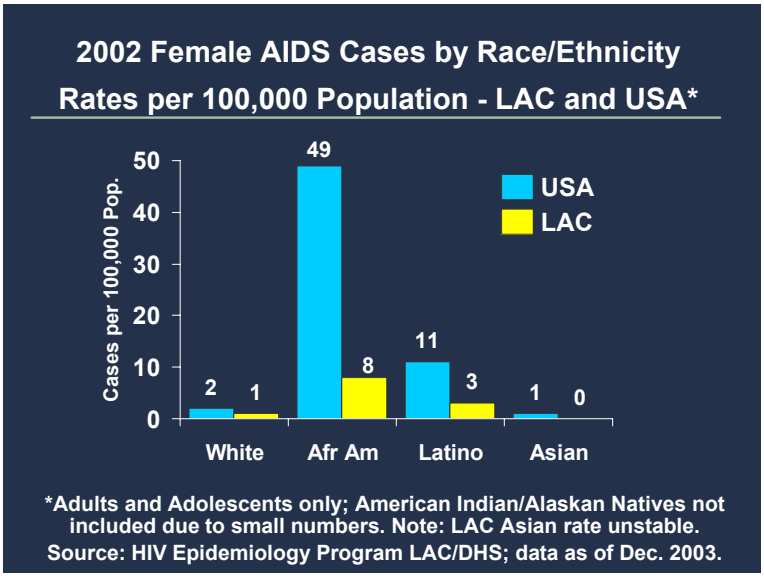
FIGURE 9



In a 1998 California Office of AIDS report entitled *A Spatial Study of AIDS Surveillance Data by Demographic Subgroups in California*, gender and race/ethnic-specific (White, Latino, and African American) AIDS rates were compared by County. Only among Latino males, did Los Angeles County have a statistically higher AIDS incidence rate (36 per 100,000) than did the State (28 per 100,000).

Among women, the U.S. and Los Angeles County rates for 2002 were similar for Whites and Asians; but among Latina females, U.S. rates were three times as high as Los Angeles County rates and among African American females U.S. rates were 6 times as high as Los Angeles County rates (see Figure 10).

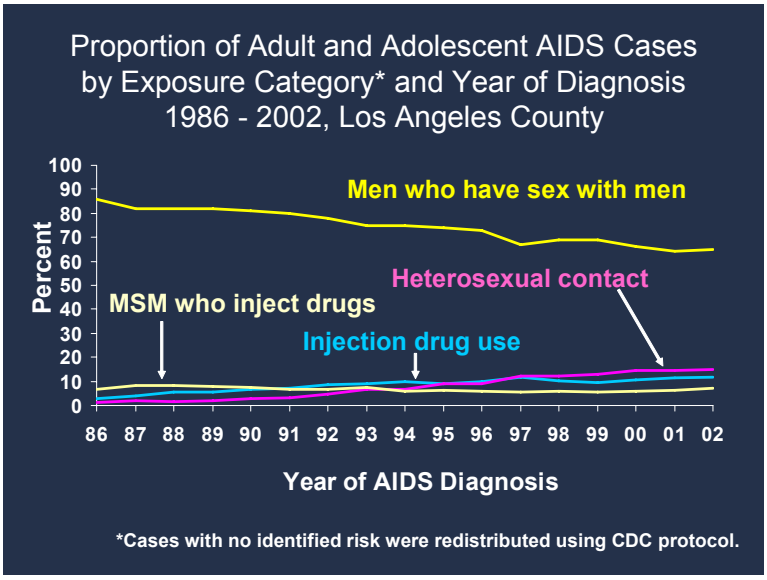
FIGURE 10



Mode of Exposure

Mode of exposure means how HIV is transmitted that is, through sexual contact, injecting drugs using an HIV-contaminated needle or syringe, from mother to child, or by receiving HIV-contaminated blood or blood products. The distribution of AIDS cases by modes of exposure differs greatly between Los Angeles County and other regions of the country. Los Angeles County has always had a higher proportion of cases attributed to male to male sexual behavior than the nation overall (see Figures 11 and 12).

FIGURE 11



From 1986 to 2002, the proportion of annual AIDS cases attributable to transmission by male to male sex decreased from 65% to 40% nationally, while Los Angeles County decreased from 85% to 65%. Conversely, cases attributable to heterosexual contact increased nationally from 3% in

1985 to 30% in 2002; while in Los Angeles County, the increase was from less than 1% in 1985 to 15% in 2002.

FIGURE 12

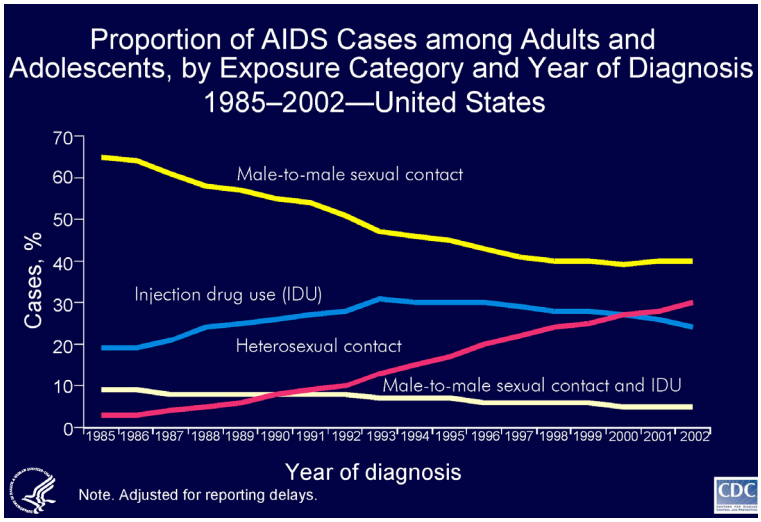
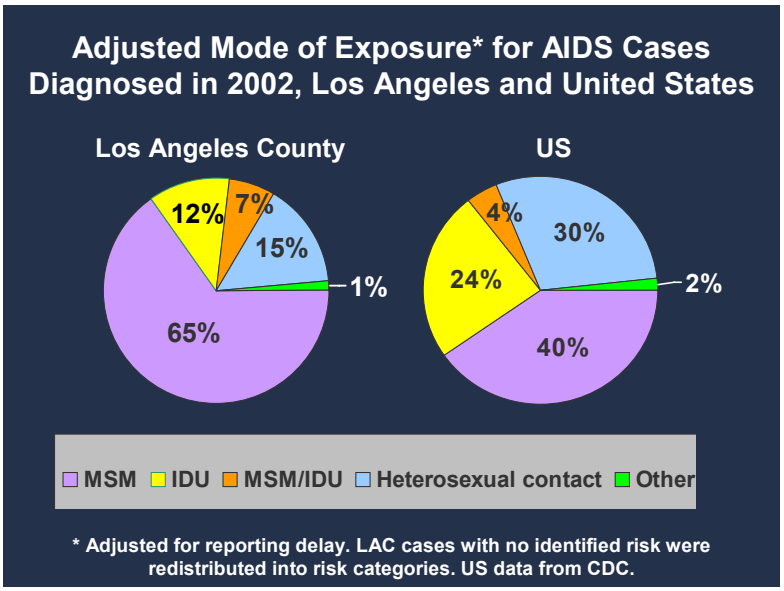


Figure 13 presents the distribution of newly diagnosed AIDS cases in 2002 by mode of exposure for both Los Angeles County and U.S. adults and adolescents. Men who have sex with men (MSM-- in purple) and MSM/IDU (MSM who also inject drugs, in orange), together accounted for 72% of the County's incident cases, but only 44% of national cases. Conversely, twice the proportion of U.S. cases reported HIV exposure through (non-MSM) injection drug use (24% versus 12%) or heterosexual contact (30% versus 15%) compared with Los Angeles County cases.

FIGURE 13



AIDS in Adolescents and Adults in Los Angeles County

Gender

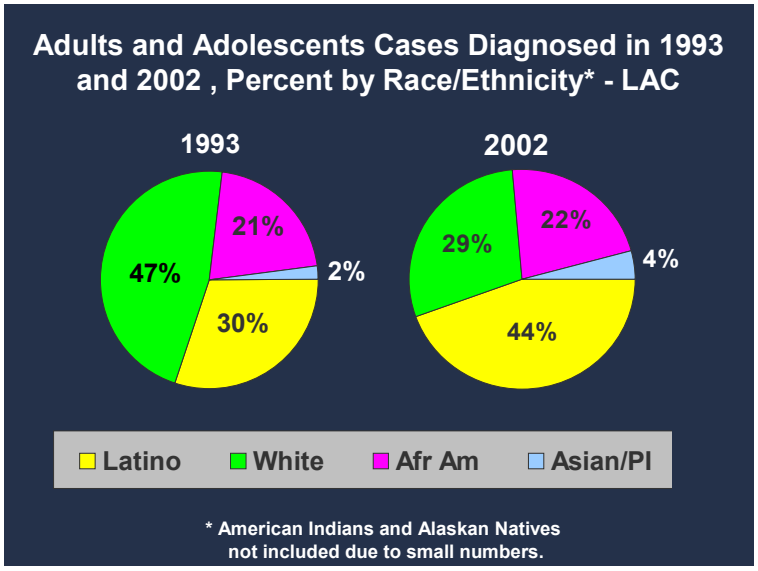
The number of male adolescent and adult AIDS cases diagnosed annually in Los Angeles County has decreased substantially from about 3,600 cases in 1993 to only 1,100 cases in 2002. Female AIDS cases have also decreased from a high in 1995 of 358 cases diagnosed to 168 cases for 2002. In 1993, males comprised 92% and females 8% of all adults and adolescent AIDS cases in Los Angeles County. The proportion of female cases rose to 13% in 2002.

Race/ethnicity

The annual number of diagnosed adult and adolescent AIDS cases decreased for all race/ethnicities in the last 10 years, most dramatically among Whites, whose annual total dropped from 1,845 cases in 1993 to only 378 cases in 2002. Latino cases also dropped sharply, from 1,179 in 1993 to 378 in 2002, while African American cases dropped from 847 to 256 cases in the same time period.

In 1993, Whites comprised 47% of adults and adolescents diagnosed with AIDS in Los Angeles County, Latinos 30%, African Americans 21%, and Asian/Pacific Islanders only 2% (see Figure 14). By 2002, however, Latinos comprised the largest number of diagnosed cases with 44%, followed by Whites at 29%, African Americans at 22%, and Asian/Pacific Islanders at 4%. Not shown in the figure due to small numbers, American Indians and Alaskan Natives comprised 0.5% of all County adults and adolescents living with AIDS in both 1993 and 2002.

FIGURE 14



While Whites once had, and Latinos now have, the highest number and proportion of cases, African Americans have had the highest rate of infection among all races/ethnicities in the County. African American adult and adolescent male annual AIDS rates, while steadily decreasing in the last 10 years, continue to be more than twice that of White and Latino males (see Figure 15). Similarly, among adult and adolescent females, African Americans have the highest rate of any racial/ethnic group, three times higher than Latina rates and seven times higher than Whites in 2001 (see Figure 16).

FIGURE 15

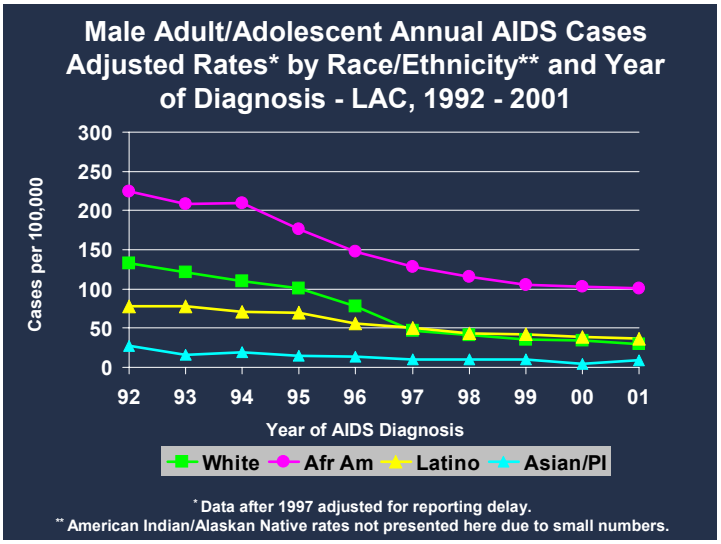
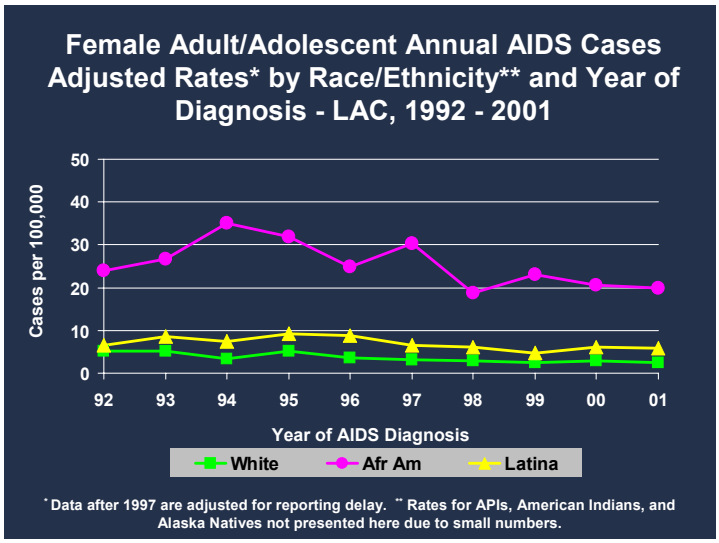


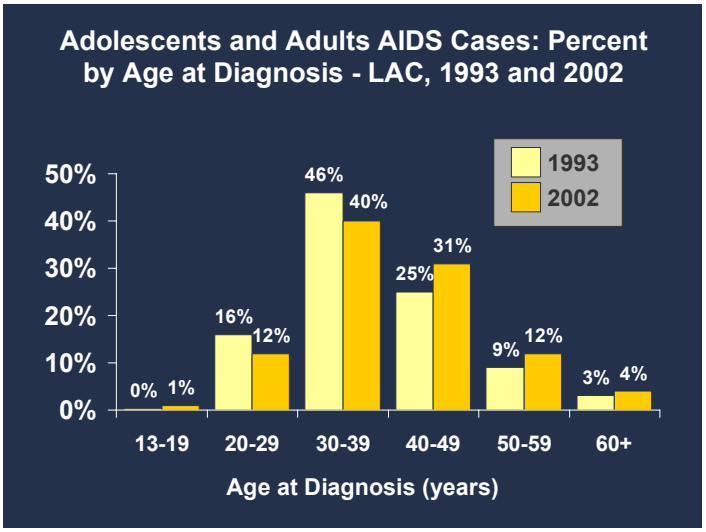
FIGURE 16



Age

Compared with 1993, there were proportionately fewer AIDS cases diagnosed in Los Angeles County in 2002 among younger age groups than among older age groups (see Figure 17). As a result, the median age at diagnosis rose from 33 years in 1981 to 39 years in 2001.

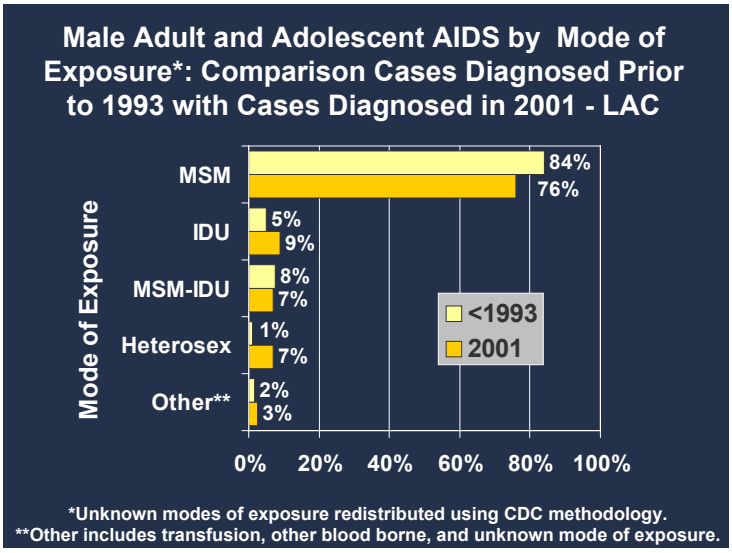
FIGURE 17



Mode of Exposure

While declining slightly, MSM (including MSM who inject drugs) continue to account for the vast majority of male adult and adolescent AIDS cases in Los Angeles County, with 92% of cases before 1993, but 83% of cases diagnosed in 2001 (see Figure 18). Injection drug use among heterosexuals has accounted for an increasing proportion of male cases, with 5% of cases prior to 1993, but 9% of cases diagnosed in 2001. Prior to 1993, heterosexual contact accounted for 1% of all male AIDS cases in the County. Among adult and adolescent males diagnosed with AIDS in 2001, 7% of cases reported heterosexual transmission as the mode of exposure.

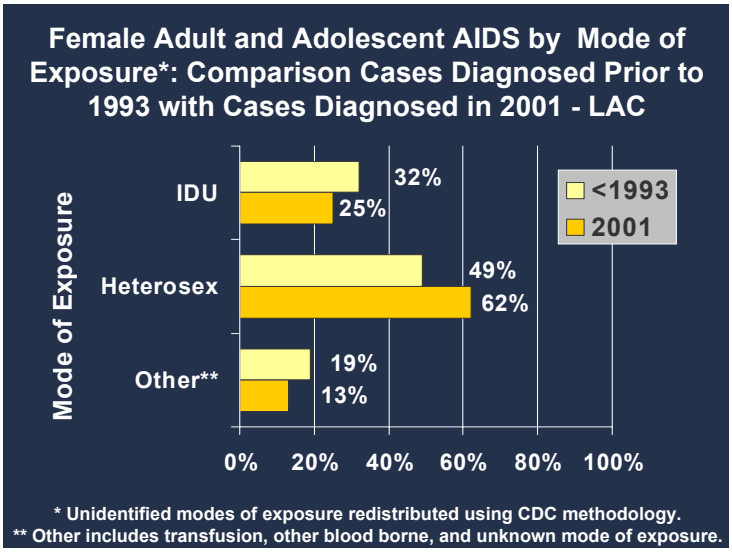
FIGURE 18



The proportion of female adults and adolescents in Los Angeles County who reported sexual contact as their mode of exposure to HIV rose from 49% among cases prior to 1993 to 62% among cases diagnosed in 2001 (see Figure 19). Conversely, injection drug use among female

cases has decreased from 32% prior to 1993 to 25% in 2001. Other modes of transmission among females – such as blood transfusion, hemophilia – dropped from 19% in 1993 to 13% in 2001.

FIGURE 19



HIV and AIDS in Children in Los Angeles County

As of June 2004, a cumulative total of 246 children 13 years of age or younger had been reported with AIDS in Los Angeles County. The number of children diagnosed with AIDS in the County declined from a peak of 28 in 1994, to 12 in 1996, 3 in 1998, 3 in 2002, and no new pediatric AIDS cases in 2003. The decrease in the number of children with AIDS in recent years is due to the effectiveness of providing antiretroviral treatment to HIV positive pregnant women as well as providing treatment to infected children [22].

A contributing factor to the decline in new pediatric AIDS cases is the increasing use of highly-active antiretroviral therapy (HAART) since 1995 in HIV-infected children who have not progressed to AIDS. Data from the Pediatric Spectrum of Disease study (see below) suggest that at their last medical contact, 79% of HIV infected children were receiving HAART.

The majority of children reported with AIDS have been exposed to HIV via perinatal (mother-to-child) transmission. Of the 246 cumulative children diagnosed with AIDS under age 13, 70% acquired HIV from their mothers; 26% were infected through a blood transfusion; and 3% had hemophilia or a coagulation disorder. In 2% of cases among children, no exposure category could be determined.

The racial/ethnic distribution for children with AIDS is similar to that of adult female cases. Overall, 17% of the 246 children diagnosed with AIDS in Los Angeles County were White, 35% African American, 46% Latino and 2% Asian/Pacific Islander.

As of December 2003, 55 of the 246 children who were under 13 when diagnosed with AIDS were still alive and in medical care in Los Angeles County. The average age of these children is now 12 years and 37% are 13 years of age or older. Although the number of children diagnosed with AIDS is small, prevention of secondary HIV transmission will be an issue as these

adolescents become sexually active and reach reproductive age. In addition, many will lose their family members to HIV and will continue to need supportive services.

Pediatric Spectrum of Disease Study

The Los Angeles County Pediatric Spectrum of Disease (PSD) study collected data on all children in the County who have been exposed to or infected with HIV, as well as those who have been diagnosed with AIDS from 1990 to 2004. Follow-up reviews were done every 6 months to document new symptoms, treatment regimens, immunologic status, and death. PSD data suggest that the widespread use of antiretroviral therapy in HIV-infected mothers and their newborns has been a major factor in the decline in perinatal HIV infection among the County's children.

PSD data show that in addition to the 55 children with an AIDS diagnosis, 107 children less than 13 years of age are currently living in Los Angeles County with HIV infection. Of the 162 cumulative children diagnosed with HIV or AIDS under age 13, 93% acquired HIV from their mothers, 4% were infected through a contaminated blood transfusion, and 2% had an unknown exposure.

HIV Testing in Pregnant Women

PSD data suggest that HIV-infected women who do not receive prenatal care are more likely to transmit HIV to their infants (28% vs. 7%) [23]. To maximize HIV prevention efforts, women must be identified as having HIV infection as early as possible during pregnancy and offered antiretroviral therapy. In 1998, PSD surveyed a sample of private obstetrical practices in Los Angeles County and found that while 96% of the practices were offering HIV testing to all pregnant women, only about half reported that 95-100% of their patients accepted the test. Implementation of mandatory prenatal HIV testing with an "opt out" clause has been shown to increase greatly HIV testing of pregnant women [24].

In 2003, California enacted an "opt out" prenatal testing law (California Health and Safety Code Sections 125085, 125090, 125105, and 125107) which mandates that all prenatal care providers make HIV testing a routine part of the blood panel for pregnant women. The new testing law is intended to increase the number of pregnant women tested for HIV during their prenatal care. The woman must sign a consent form and has a right to the refuse the test. The test must also be documented in the medical chart. Women presenting to labor and delivery with no documentation of a prenatal HIV test, must be HIV tested, again with her consent and right to refuse. The CDC recommended that a rapid HIV test be done in labor and delivery so that treatment can begin for the woman and her infant to prevent HIV transmission.

■ Persons Living with AIDS (PLWA)

As of June 30, 2004, there were 19,700 persons living with AIDS (PLWA) in Los Angeles County. This represents 35% of the 56,138 Californians living with AIDS and 5.1% of the 384,906 Americans living with AIDS. [Please note: the total number of PLWA will differ in the following figures according to the date the database was accessed to do each analysis.]

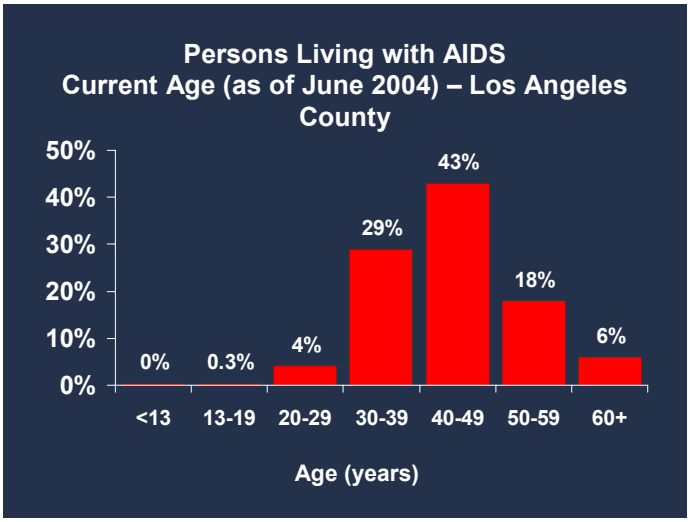
Gender

As discussed above, the number of persons living with AIDS in Los Angeles County has increased steadily since the beginning of the epidemic. This increase can be seen for both males and females, resulting in 17,533 or 89% males and 2,167 or 11% females living with AIDS in the County by June 30, 2004. In 2004, males represented 89% of all PLWA.

Age

Figure 20 shows the current age (as of June 2004) of persons living with AIDS in the County. Nearly two-thirds of PLWA were 40 years of age or older, the majority of whom were age 40 – 49 years. The median current age of PLWA in Los Angeles County is 42 years. Less than 1% of PLWA were under the age of 20 years and 5% were age 60 years and older.

FIGURE 20



Race/Ethnicity

As seen in Figure 21, 38% of persons living with AIDS in Los Angeles County are Latino, 37% White, 22% African American, and 3% Asian/Pacific Islander. About 0.5% of cases are American Indian/Alaskan Native. When viewed by gender (see Figure 22), these proportions vary slightly. Among female PLWA, 36% are African American, 19% White, 42% Latina, 2% Asian/Pacific Islander, and 1% American Indian/Native American.

FIGURE 21

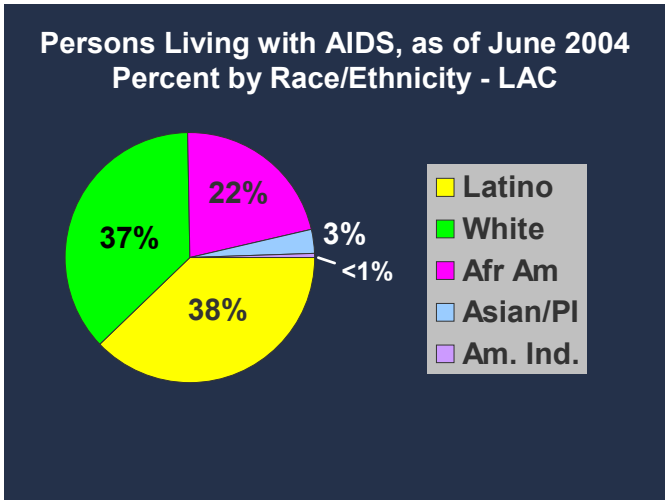
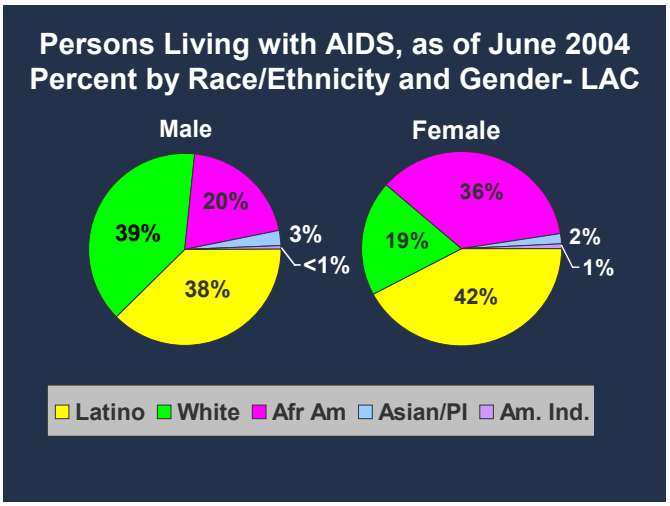


FIGURE 22

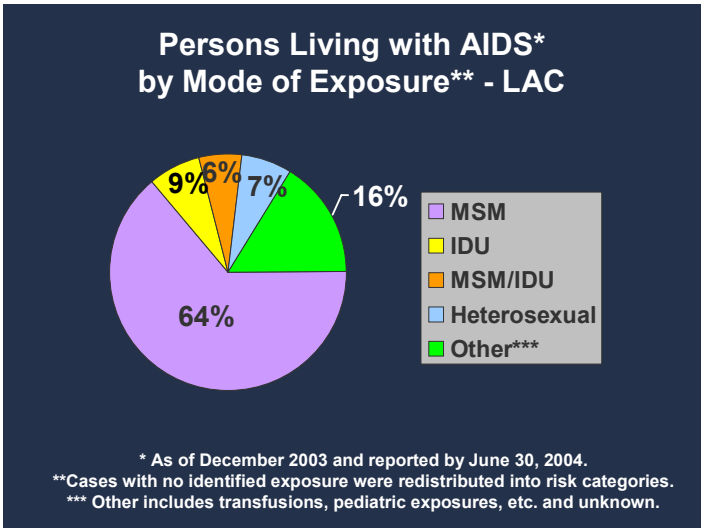


Among male PLWA, Latinos are the predominant group for the younger age groups (under 40 years old), while Whites predominate in the older age groups. Among female PLWA, Latinos again predominate in the younger age groups, but African Americans account for about 40% PLWA in females age 30-59 years.

Mode of Exposure

About 70% of PLWA are MSM, 6% of whom also inject drugs. Other reported modes of exposure include an additional 9% who report injection drug use, and 7% who report heterosexual contact (see Figure 23).

FIGURE 23



■ Persons Living With HIV Infection

In July 2002, the State of California mandated the reporting of persons infected with HIV using a non-name code. The regulation made it clear that both incident (new) and prevalent (existing)

cases of HIV were to be reported. This task was to be accomplished by requiring laboratories that tested for HIV antibodies to HIV or any part of the virus to report their results to the Los Angeles County HIV Epidemiology Program and for health care providers to report any of their as yet unreported cases identified by the laboratories. Since July 2002, over 12,000 non-AIDS HIV cases have been reported in the County and over 150,000 laboratory notifications have been received.

The number and distribution of HIV cases will not be available for analysis and publication until the non-name code has been validated and the system evaluated for completeness and accuracy. Until such time as these reported cases are available, the number of persons living with (non-AIDS) HIV must still be estimated.

CDC estimates 40,000 new HIV infections occur nationwide each year, of which about 5%, or 2,000, are estimated to occur in Los Angeles County. A range of estimates for persons living with HIV (including AIDS) has been generated using three methodologies: an updated version of estimates presented in the last *HIV Epidemiologic Profile*, an estimate based on the ratio of persons living with AIDS and HIV in jurisdictions similar to Los Angeles County who have been doing HIV surveillance for many years, and an estimate based on published CDC national estimates (see Table 3).

TABLE 3. Estimates of persons living with HIV and AIDS in Los Angeles County

Category	Based on 2000 CDC National Estimate	Updated 1999 Los Angeles County Estimates	Based on Living Cases HIV:AIDS	Average/ Midpoint Estimate	2004 Estimate
Persons living with AIDS	18,000	18,000	18,000	18,000	19,700
Persons living with HIV	19,000	23,000	27,000	23,000	23,000
Persons living with HIV/AIDS, aware	37,000	41,000	45,000	41,000	42,700
Persons living with HIV/AIDS, unaware	12,500	13,500	15,000	13,500	14,200
Persons living with HIV/AIDS, overall	49,500	54,500	60,000	54,500	56,900

In addition to the approximately 19,700 persons living with AIDS as of June 2004, there are an estimated 19,000 to 27,000 persons living with non-AIDS HIV. Added together, they represent the number of persons living with HIV and AIDS who are aware of their infection. Additionally, the CDC estimates that one of four persons living with HIV/AIDS are unaware of their status. With this in mind, an estimated 12,500 to 15,000 persons in Los Angeles County are living with HIV, but are unaware of their status. In total, there are an estimated 49,500 to 60,000 persons living with HIV in the County, whether or not they are aware of their HIV status.

HARS-Based Estimates of HIV and AIDS

Estimates of persons living with HIV and AIDS are presented in Table 4. HIV estimates were based on AIDS cases reported to the HIV/AIDS Reporting System (HARS), as well as from rates of new HIV infection data at publicly-funded testing sites. Estimates were distributed by gender, age groups, race/ethnicity, and CDC-defined modes of exposure including men having sex with men (MSM), injection drug use (IDU), MSM/IDU, heterosexual risk (male and female) and blood-borne risk (such as, hemophilia and blood transfusions).

While AIDS began as a disease mostly seen among Whites in the 1980s, it has transitioned in the 1990s to a disease predominantly affecting persons of color. Taken together, Latinos and African Americans now comprise 60% of persons living with AIDS, about 58% of all AIDS cases diagnosed in 2002-2003, and an estimated 67% of persons living with (non-AIDS) HIV in Los Angeles County. Whites comprise 37% of County residents living with AIDS, 31% of AIDS cases diagnosed in 2002-2003 and an estimated 28% of persons living with (non-AIDS) HIV. Of persons estimated to be living with HIV and AIDS, most are Latino (40%), followed by Whites (32%), African Americans (24%), Asian/Pacific Islanders (3%), and American Indian/Alaskan Natives (0.7%).

Unlike in other parts of the U.S., the HIV/AIDS epidemic in Los Angeles County remains largely a male phenomenon. Women in the County comprise 11% of persons living with AIDS, 12% of newly diagnosed AIDS cases in 2002-2003, and an estimated 15% of persons living with (non-AIDS) HIV. Among adults and adolescents in Los Angeles County, MSM and MSM/IDU together continue to be the predominant risk groups among persons living with AIDS (79%), among newly diagnosed AIDS cases (74%), and estimated persons living with (non-AIDS) HIV (78%). Heterosexual transmission was the exposure risk for 10% of persons living with AIDS and an estimated 11% of persons living with (non-AIDS) HIV**.**

HIV Incidence Studies

A goal of HIV surveillance is to detect recent infections, in order to identify who is acquiring HIV and how they are acquiring it. It is important to identify trends in recent infections, so that HIV prevention and testing efforts can be targeted more effectively. The ability to detect these recent cases has thus far been elusive. With the recent development of a new less sensitive HIV antibody laboratory test, known as the "Serologic Testing Algorithm for Recent HIV Sero-conversion" (STARHS), we can now determine whether or not persons with newly diagnosed HIV were likely to have been infected in the 6 to 12 months prior to their HIV test [25, 26].

In the near future, HIV Epidemiology Program's Seroepidemiology Unit will be measuring HIV incidence using STARHS in the Brothers y Hermanos Study, L.A. Men's Study, HIV Characterization Study, and HIV Incidence Surveillance.

STARHS has already been used for the following studies: the STD Clinic Study, Young Men's Surveys I and II, the Bathhouse Study, and Project One's Jail and Hotel studies. Some results from these studies follow.

TABLE 4. Newly Diagnosed Cases (Incidence) of AIDS for 2002-2003 and Estimated HIV/AIDS Prevalence (Number of Persons Living with HIV and AIDS in Los Angeles County Who are Aware of Their Disease.

Category	AIDS Incidence 2002-2003*		AIDS Prevalence*		Estimated (non-AIDS) HIV Prevalence**		Estimated Prevalence of HIV and AIDS	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Race/Ethnicity								
White	915	31%	7,288	37.3%	6,440	28.0%	13,700	32.2%
African American	646	22%	4,204	21.5%	5,830	25.4%	10,000	23.5%
Latino	1,267	43%	7,395	37.8%	9,750	42.4%	17,100	40.2%
Asian/PI	108	4%	500	2.6%	570	2.5%	1,100	2.6%
Am Indian/AN	13	<0.5%	99	0.5%	150	0.6%	300	0.7%
Multi-race	5	<0.5%	24	0.1%	120	0.5%	100	<0.5%
Not specified	1	<0.5%	38	0.2%	140	0.6%	200	0.5%
Gender								
Male	2,589	88%	17,463	89.3%	19,580	85.1%	37,000	87.0%
Female	366	12%	2,085	10.7%	3,420	14.9%	5,500	13.0%
Age (years)								
<13	3	<0.5%	79	0.4%	230	1.0%	300	0.7%
13 – 19	30	1.0%	156	0.8%	920	4.0%	1,100	2.6%
20 – 44	2,117	72%	15,643	80.0%	18,400	80.0%	34,000	80.0%
45+	805	27%	3,670	18.8%	3,450	15.0%	7,100	16.7%
Exposure Category, Adult/ Adolescent								
MSM	2,010	68%	14034	72.2%	15,560	68.3%	29,600	70.1%
IDU	276	9.3%	1692	8.7%	2,140	9.4%	3,800	9.0%
MSM-IDU	174	5.9%	1246	6.4%	1,350	5.9%	2,600	6.2%
Heterosexual	387	13%	2012	10.4%	3,000	13.1%	5,000	11.8%
Other Blood-borne	57	1.9%	298	1.5%	440	1.9%	700	1.7%
No Identified Risk***	41	1.4 %	149	0.8%	320	1.4%	500	1.2%
Sub-total, Adult	**2,945**	**100%**	**19,431**	**100%**	**22,800**	**100.0%**	**42,200**	**100%**
Exposure Category, Pediatric								
Maternal risk for HIV	7	70%	73	62.4%	105	62.4%	200	67%
Other Blood-borne	2	20%	36	30.8%	52	30.8%	100	33%
No Identified Risk	1	10%	8	6.8%	11	6.8%	---	---
Sub-total, Pediatric	**10**	**100%**	**117**	**62.4%**	**168**	**100%**	**300**	**100%**
TOTAL	**2,955**	**100%**	**19,548**	**100%**	**~23,000**	**100%**	**~42,500**	**100%**

* Data from HARS as of June 2004, except pediatric exposure numbers from December 2003.

** These estimates are based on a 1.2:1 ratio of living HIV to AIDS cases based on June 2004 AIDS data and do not include persons who are either undiagnosed or unaware of their infection.

*** Cases with no identified risk redistributed according to CDC protocol.

STD Clinic Study and Alternative Testing Site database

Stored blood from a study conducted at Los Angeles County's Sexually Transmitted Disease (STD) Clinics from 1993 to 1999 was tested using STARHS technology to estimate the level of recent infection in that study group.

HIV incidence was also estimated at State-funded "alternative testing sites" (ATS) among "repeat testers"—that is, those seeking testing who have a history of having a previous negative HIV test—using the ATS client database from 1995 to 2002.

Results from these two studies, distributed by gender and exposure mode, are presented in Table 5. Despite the differing methodologies, HIV incidence rates from the two studies appear comparable, with transgender women, MSM and MSM-IDU having the highest rates (3-6% per year), while men who have sex with women (MSW) and women had much lower rates (<0.5% per year). The HIV incidence rate for MSM at STD clinics (5.9% per year) was twice that for MSM at alternative testing sites (2.9% per year). This difference is perhaps not surprising, when one considers that persons attending STD clinic have most likely engaged in unprotected sexual intercourse, whereas the same may not be true of those testing at alternative testing sites.

TABLE 5. HIV incidence rate estimates by gender and exposure mode for Los Angeles County in STD Clinic Study (1993-1999) and Alternative Test Site data (1995-2002).

Exposure Group	STD Clinic Study, 1993-1999				Alternative Test Site, 1995-2002			
	No.[1] Recently Infected	Denominator[2]	Incidence Rate[3]	95% Confidence Limits	No.[4] Newly Infected	Denominator[5]	Incidence Rate[3]	95% Confidence Limits
MSM	48	2,100	5.9	(3.7, 9.2)	1,286	44,929	2.9	(2.7, 3.0)
MSM-IDU	3	139	4.7 [6]	(0.5, 19) [6]	64	1,707	3.8	(2.8, 4.7)
MSW-IDU	3	443	1.9 [6]	(0.3, 6.7) [6]	35	8,847	0.4	(0.3, 0.4)
MSW	40	29,750	0.4	(0.2, 0.6)	152	46,073	0.3	(0.3, 0.4)
Female IDU	0	264	-- [6]	-- [6]	18	6,114	0.3	(0.2, 0.5)
Females	20	19,394	0.3	(0.1, 0.5)	120	57,626	0.2	(0.2, 0.25)
Transgender Women	--	--	--	--	36	645	5.6	(3.8, 7.6)

[1] The number of recently infected persons in the STD Clinic Study was calculated based on those HIV-positive specimens that were available for STARHS testing (see Technical Notes).
[2] The denominator for the STD Clinic Study is the number of clients who tested negative for HIV plus those recently infected; it excludes non-recent HIV-infected persons (see Technical Notes).
[3] Incidence rate for both studies can be thought of as equivalent to the average number of individuals infected per 100 persons per year, over the study period (see Technical Notes).
[4] The number of new infections at Alternative Test Sites is the number of repeat testers who seroconverted since their previous self-reported negative HIV test; STARHS was not used.
[5] The denominator for Alternative Test Site data is the sum of all the time intervals between the two most recent HIV tests among clients who reported repeat HIV testing (see Technical Notes).
[6] Incidence rate and confidence limits based on zero observations are not definable and rates based on few observations are considered unreliable; therefore, making firm conclusions based on these rates is not advised (see Technical Notes).

Young Men's Survey I

Stored blood from a study conducted at public venues among young MSM, aged 15 – 22 years from 1994 to 1997, was tested using STARHS to find out the level of recent infection in that study group. Of 464 study subjects, 42 (8.3%) tested positive for HIV. Of the 32 positive specimens available for STARHS testing, 4 had evidence of recent infection. Therefore, the HIV incidence rate for this cohort was 2.4% per year (95%CL= 0.3%, 4.5%).

Young Men's Survey II

Stored blood from a study conducted from 1999 to 2000 at public venues among young MSM, aged 23 – 29 years, was tested using STARHS. Of 460 study subjects, 51 (11%) tested positive for HIV. Of the 45 HIV-positive specimens available for STARHS testing, 5 had evidence of recent infection. The HIV incidence for this cohort – presented as the percent of HIV-negative study participants who would have seroconverted if followed for exactly one year – was 2.9% per year (95%CL= 0.5%, 5.4%).

Los Angeles Bathhouse Study (HIV Incidence Study in Commercial Sex Venues)

There are approximately twelve bathhouses and sex clubs currently operating in Los Angeles County. The Bathhouse Study estimated the HIV incidence rate among MSM patronizing local bathhouses, who agreed to be interviewed and anonymously tested for HIV. Positive HIV tests were further evaluated for recent infection using STARHS. Of 914 subjects tested, 102 (11%) tested positive for HIV infection. Of the 40 HIV positive specimens available for STARHS testing, 11 (27.5%) had evidence of recent infection. The HIV incidence rate for study participants is 7.2% per year (95%CL= 4.5%, 9.8%). This rate is higher than that found during any other Los Angeles County study to date.

Project One: Jail Study of HIV Incidence

HIV Epidemiology Program conducted a study to assess new HIV infections in SPA 4 and SPA 6 residents recently incarcerated in Los Angeles County jails. Preliminary analysis found evidence of new HIV infections among 3 of 1,447 study participants, who had not previously tested positive for HIV. All 3 newly identified HIV-infected persons were women. The HIV incidence for this cohort is 0.9% per year (95%CL= 0.0%, 1.8%).

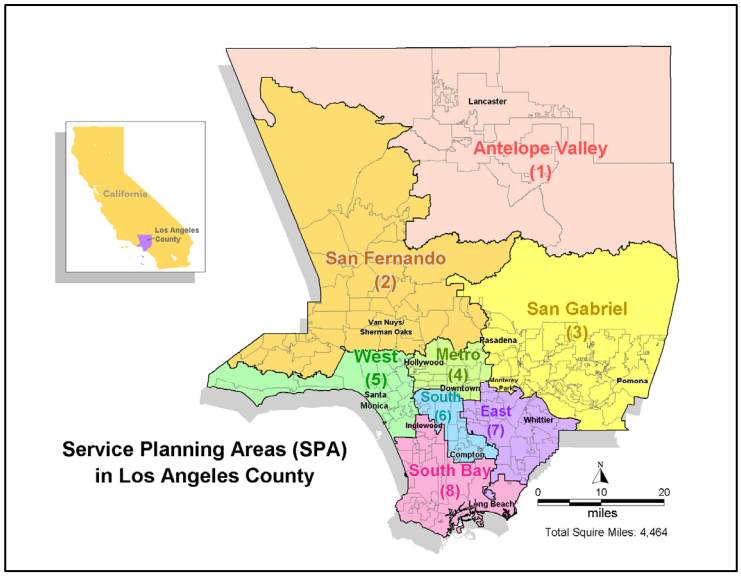
Project One: Low-income-hotel-based Study of HIV Incidence (Hotel Study)

The HIV Epidemiology Program (HEP) recently conducted a study of 1,098 skid row residents who lived in single occupancy hotel rooms or other low income housing and who identified themselves either as HIV-negative or of unknown HIV status. Most of the study participants (70%) were African American. Preliminary analysis found evidence of recent HIV infection in 3 of the participants who had not previously tested positive for HIV. All 3 recently infected persons were African American men. The HIV incidence for African American male study participants was 2.1% per year (95%CL= 0.0%, 4.4%).

Geographic Distribution of AIDS in Los Angeles County

In 1993, Los Angeles County aggregated its 26 health districts into eight Service Planning Areas or SPAs. SPAs were created by the Los Angeles County Children's Planning Council and approved by the County Board of Supervisors in 1993 to make public health service more responsive to local needs. The eight Service Planning Areas are: Antelope Valley, SPA 1; San Fernando Valley, SPA 2; San Gabriel Valley, SPA 3; Metro, SPA 4; West, SPA 5; South, SPA 6; East, SPA 7; and South Bay, SPA 8 (see Map 1).

Map 1: Service Planning Areas in Los Angeles County



Included at the end of the *County of Los Angeles HIV Prevention Plan 2004-2008* is the section, "Geographic Snapshots," which highlights key geographic and socio-demographic characteristics of the whole County as well as each SPA. These snapshots illustrate the tremendous variation between the SPAs. Just as the general population and other information varies, so is there variation in AIDS cases across SPAs as AIDS has not affected all areas of the County equally.

Table 6 shows the cumulative number of PLWA reported through June 2004 as well as number and rate per 100,000 population of new cases in 2003 and total PLWA in Los Angeles County by SPA reported through June 2004. SPA 4 (Metro) has the highest number (7,310) and rate (623 per 100,000) of PLWA among all SPAs. SPA 8 (South Bay) ranks second with 3,314 PLWA and a rate of 214 per 100,000. SPA 1 (Antelope Valley) has the lowest number (210) and rate (64 per 100,000) of PLWA in the County. Among new cases in 2003, SPA 4 (Metro) has the highest number (448) and SPA 2 (San Fernando) ranks second with 176 new cases. SPA 6 (South) has the third highest number (169) but second highest rate per 100,000 population (17 per 100,000).

TABLE 6. Cumulative Number of AIDS Cases, New AIDS Cases and Rate per 100,000 in 2002, and Number of Persons Living with AIDS and Rate per 100,000 by Service Planning Area, reported through June 2004.

Service Planning Area	Cumulative Number AIDS Cases	New Cases in 2003		PLWA as of December 2003	
		Number	Rate per 100,000	Number	Rate per 100,000
SPA 1: Antelope Valley	443	11	3	210	64
SPA 2: San Fernando	6,848	176	9	2,567	124
SPA 3: San Gabriel	3,501	96	5	1,321	73
SPA 4: Metro	**18,675**	**448**	**38**	**7,310**	**623**
SPA 5: West	2,762	69	11	1,004	158
SPA 6: South	4,662	169	**17**	1,894	192
SPA 7: East	2,769	83	6	1,221	92
SPA 8: South Bay	**7,453**	**246**	16	**3,314**	**214**
Total	**48,510**	**1,317**	**13**	**19,548**	**198**

Table 7 shows the racial/ethnic profile of PLWA for each SPA for AIDS cases reported as of December 2003. Among all SPAs, SPA 7 (East) has the highest proportion PLWA of a common race/ethnicity (74% are Latino). This is followed by SPA 5 (West) where 60% of PLWA are White. The majority of African American PLWA are in SPA 6 (South) and API PLWA in SPA 3 (San Gabriel). AI/AN are evenly spread across SPAs 5, 7, and 8 (1%).

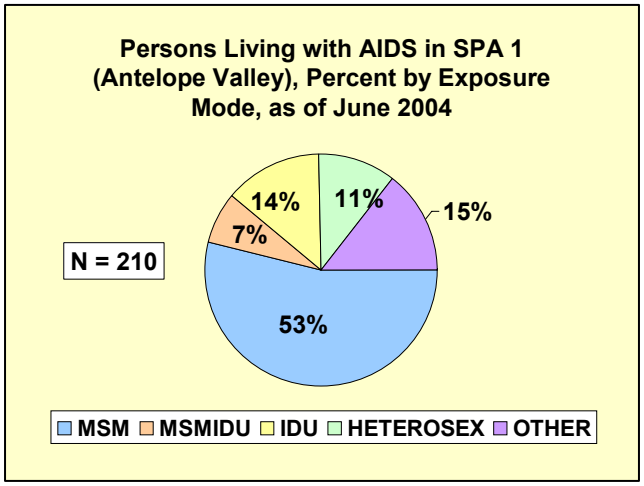
TABLE 7. Persons Living with AIDS by Service Planning Area, Percent by Race/Ethnicity as of June 2004.

Service Planning Area	Number	White	African American	Latino	API	AI/AN
SPA 1: Antelope Valley	210	44%	30%	24%	-	-
SPA 2: San Fernando	2,567	48%	11%	36%	3%	<1%
SPA 3: San Gabriel	1,321	25%	20%	49%	**6%**	<1%
SPA 4: Metro	**7,310**	42%	17%	37%	2%	**1%**
SPA 5: West	1,004	**59%**	15%	22%	3%	**1%**
SPA 6: South	1,894	5%	**56%**	39%	<1%	<1%
SPA 7: East	1,221	16%	7%	**74%**	2%	<1%
SPA 8: South Bay	3,314	42%	26%	28%	3%	**1%**

■ SPA 1: Antelope Valley

As of June 2004, there were a cumulative total of 443 persons reported with AIDS whose residence at the time of AIDS diagnosis was the Antelope Valley. Among the 443 total AIDS cases reported in this SPA, 210 (47%) are people living with AIDS (PLWA). Most PLWA in the Antelope Valley were men (85%) and aged 30-50 years of age (73%). In Antelope Valley, 44% of PLWA were White, 30% African American, and 24% Latino (Table 7). Two of every three PLWA was either MSM (53%) or MSM/IDU (7%) and, compared with other SPAs, SPA 1 had a relatively high proportion of cases with reported heterosexual IDU exposure (14%) (Figure 24).

FIGURE 24

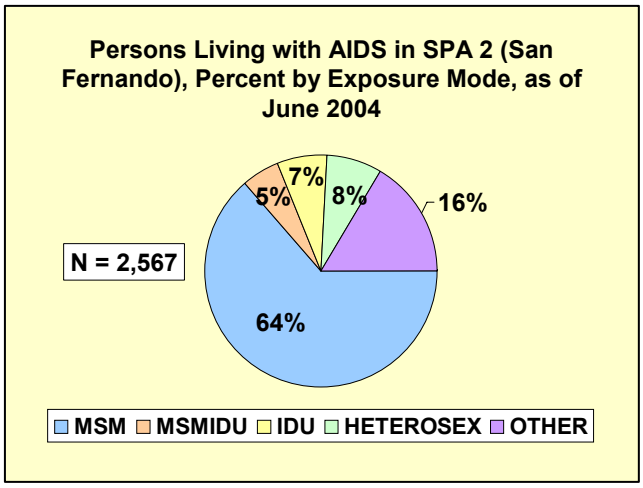


■ SPA 2: San Fernando Valley

A cumulative total of 6,848 persons with AIDS were reported in the San Fernando Valley as of June 2004. Among all cases, 2,567 (37%) were still living with AIDS, giving San Fernando Valley the third highest number of PLWA among SPAs, behind Metro and South Bay. As shown

in Table 7, most PLWA in SPA 2 were White or Latino (48% and 36%), and the most common mode of exposure to HIV reported was male-to-male sex (64%).

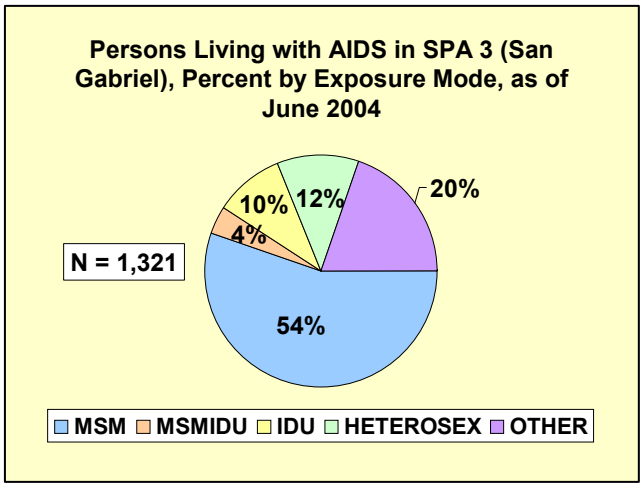
FIGURE 25



SPA 3: San Gabriel

The total number of persons reported with AIDS in the San Gabriel Valley as of June 2004 was 3,501. Of this number, 1,298 (37.7%) were living. In SPA 3, Latinos accounted for about half (49%) of the persons living with AIDS, followed by Whites (25%), Blacks (20%), and Asian/Pacific Islander (6%) (Table 7). In 2003, 19% of the persons diagnosed with AIDS in SPA 3 were female, 45% were age 30-39, and 9% were 50 years of age or older. Through June 2004, the majority of PLWA in SPA 3 PLWA reported MSM (65%) and MSM/IDU (4%) as the likely mode of transmission. By mode or exposure, heterosexual IDU accounted for 10% and male to female sex contact accounted for 12% of cases (Figure 26).

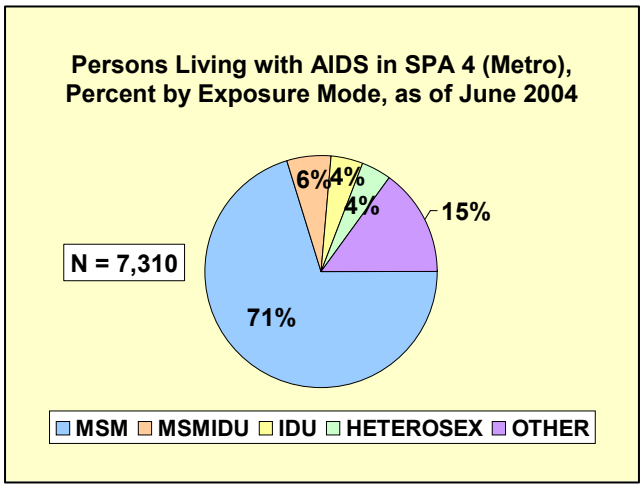
FIGURE 26



SPA 4: Metro

Since the beginning of the AIDS epidemic, SPA 4 (Metro) has been the SPA with the highest AIDS case rate in the County. It represents 38% of all cumulative AIDS cases (n=18,675). Among them, 7,310 (39%) were living as of June 2004. Of the 448 persons diagnosed with AIDS in SPA 4 in 2003 (Table 6), 91% were male, 39% were Latino, and 37% were White. African Americans in SPA 4 represented 17% of PLWA (Table 7); their AIDS case rate was highest for PLWA in SPA 4 among all races/ethnicities (1,759 per 100,000 population). MSM and MSM/IDU represented 77% of all PLWA in SPA 4 reported through June 2004 (Figure 27).

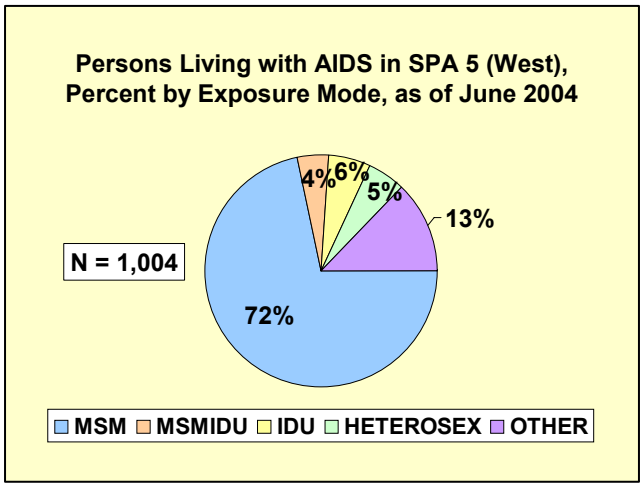
FIGURE 27



SPA 5: West

The West SPA reports 2,717 persons with AIDS since 1981. Among them, 971 (35.7%) were living as of December 2003. PLWA in SPA 5 were predominantly male (91%), age 30-59 (91%), and White (60%) (Table 6). MSM and MSM/IDU together accounted for 83% of the living AIDS cases, while 7% of PLWA were reported as heterosexual male or female IDU and 7% reported a risk for contracting HIV through heterosexual contact (Figure 28).

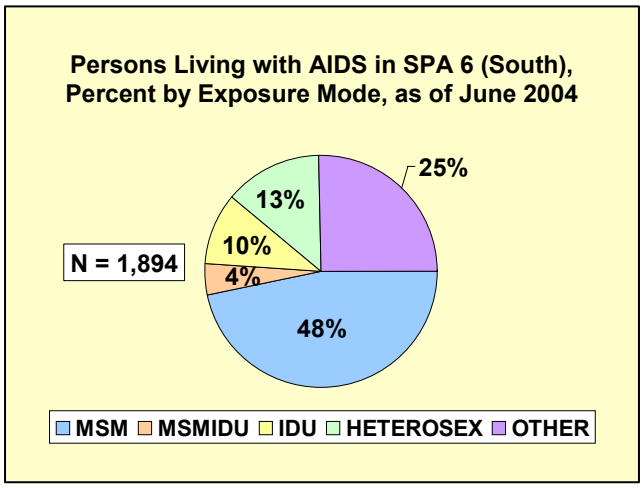
FIGURE 28



SPA 6: South

A cumulative total of 4,662 persons were reported with AIDS in the South SPA through June 2004. Among them, 1,894 (40.6%) were living as of June 2004. Among all SPAs, SPA 6 has the highest proportion of female (21%) PLWA. This compares with 11% female PLWA in the County overall. In 2003, 21% of South SPA residents diagnosed with AIDS were female. Among PLWA in the South SPA, 56% were African American and 39% Latino (Table 7). While male-to-male sexual contact and its MSM/IDU accounted for 52% of AIDS transmission in SPA 6, another 13% reported they were infected through heterosexual contact, and 10% were other injection drug users (Figure 29).

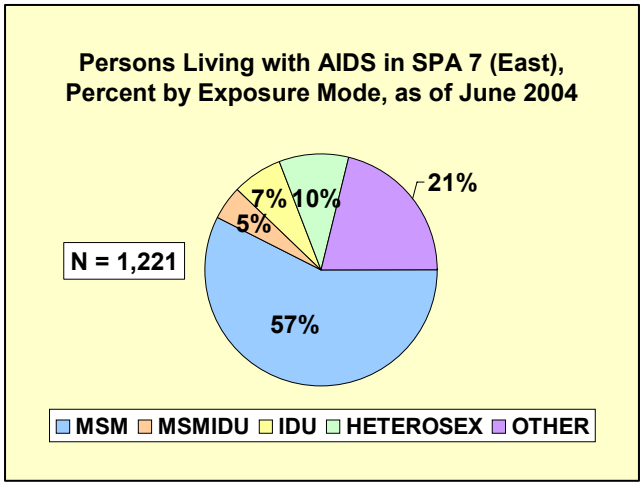
FIGURE 29



SPA 7: East

Through June 2004, there were 2,762 cumulative AIDS cases reported in the East SPA, of whom, 1,221 (44.2%) were PLWA. PLWA in SPA 7 were predominantly male (86%) and 7% were less than 30 years old. PLWA in SPA 7 were predominately Latino (74%), with only 16% White and 7% African American (Table 6). Approximately 62% of PLWA reported MSM or MSM/IDU as their exposure mode, 10% reported heterosexual exposure, and 7% IDU (Figure 30).

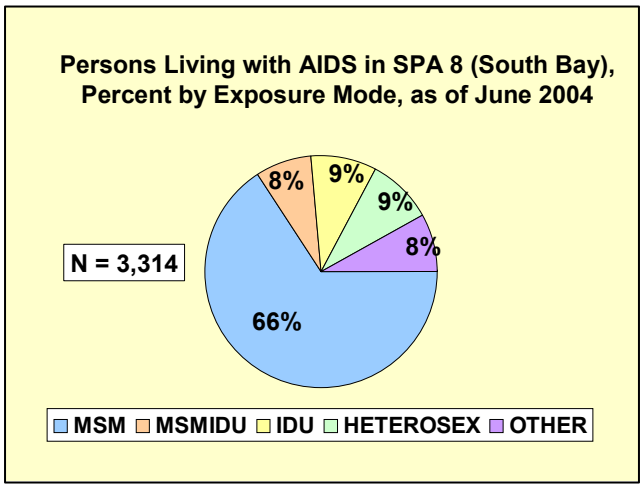
FIGURE 30



SPA 8: South Bay

The South Bay SPA has the second highest AIDS rate in Los Angeles County (Table 6). Through June 2004, the cumulative number of persons reported with AIDS in the South Bay SPA was 7,453. Among them, 3,314 (44.5%) were living. In 2003, males accounted for 87% of SPA 8 newly diagnosed AIDS cases. Among PLWA in SPA 8, 42% were White, 28% Latino, 26% African American, and 3% Asian/Pacific Islander (Table 7). Of new AIDS diagnoses for 2003, 42% were White while 32% were Latino. Among PLWA in SPA 8, 74% reported MSM or MSM/IDU, 9% reported other IDU, and 9% reported high-risk heterosexual contact as their exposure mode (Figure 31).

FIGURE 31



Behavioral Risk Groups & Priority Populations

In characterizing persons at risk for acquiring HIV, the PPC emphasizes behavioral risk groups (BRGs) in addition to non-BRG priority populations (see Priority Populations). The PPC defines seven mutually exclusive BRG categories as follows: men who have sex with men, or "MSM"; men who have sex with men and women, or "MSM/W"; men who have sex with men and inject drugs, or "MSM/IDU"; heterosexual male injection drug users, or "HM/IDU"; female injection drug users, or "F/IDU"; women at sexual risk, or "WSR" and their partners; and transgender persons, or "TGs", (which includes TG at sexual risk, TG injection drug users) and their partners. The PPC also prioritized services to Youth and persons living with HIV and AIDS (PLWH/A) across BRG categories.

For all BRGs, unprotected sexual intercourse and sharing contaminated injection drug paraphernalia place individuals at risk for HIV infection. Epidemiologic data and population estimates for each BRG are summarized in Table 8. There is no data on race/ethnicity for transgendered persons by time of this report. The last group addressed in this section is HIV and AIDS among Los Angeles County's American Indians and Alaskan Native (AI/AN) population, also identified to be of special interest by the PPC.

TABLE 8. Estimated persons living with HIV/AIDS in Los Angeles County (LAC) by Behavioral Risk Group* as of 12/31/2003.

BRG Race/ Ethnicity	Estimated Population for BRG	Estimated Number of PLWH/A in BRG	Proportion of PLWH/A In LAC	Estimated HIV Seroprevalence in Group*
MSM	**233,200**	**22300**	**53.2%**	**12.8%**
White	83,100	8800	21%	14.2%
African American	17,800	3900	9.2%	28.9%
Latino	100,900	8600	21%	11.4%
Asian/PI**	31,400	700	1.8%	3.1%
Other***	<100	300	0.6%	---
MSMW	**77,700**	**6100**	**14.4%**	**10.4%**
White	18,300	1600	3.8%	11.7%
African American	8,400	1500	3.6%	23.8%
Latino	39,300	2700	6.5%	9.3%
Asian/PI**	11,000	200	0.5%	2.5%
Other***	700	100	<0.5%	---
MSM/IDU	**19,800**	**2500**	**6.1%**	**17.1%**
White	6,700	1200	2.8%	23.1%
African American	2,500	600	1.4%	32.1%
Latino	8,900	700	1.6%	10.3%
Asian/PI**	1,400	<100	<0.5%	5.7%
Other***	300	<50	<0.5%	---
HMIDU	**88,100**	**2700**	**6.4%**	**4.1%**
White	30,500	600	1.4%	2.5%
African American	15,600	800	2.0%	7.2%
Latino	39,100	1200	2.8%	4.0%
Asian/PI**	1,400	<100	<0.5%	5.6%
Other***	1,500	<50	<0.5%	---
FIDU	**58,100**	**1300**	**3.0%**	**2.9%**
White	24,100	400	0.9%	2.0%
African American	9,800	500	1.3%	7.2%
Latino	22,200	300	0.8%	1.9%
Asian/PI**	500	<50	<0.5%	6.8%
Other***	1,500	<100	<0.5%	---
WSR	**267100**	**3100**	**7.3%**	**1.5%**
White	100,100	500	1.1%	0.6%
African American	33,600	1000	2.3%	3.8%
Latino	101,300	1500	3.6%	2.0%
Asian/PI**	29,200	100	<0.5%	0.3%
Other***	2,900	<50	<0.5%	---
TG ****	**10,000**	**1,400**	**3.3%**	**18%**
BRG Total	754,000	39,300	94%	6.9%*
Non-BRG	9,254,000	2,700	6.3%	0.04%*
LAC Total	10,008,000	42,000	100%	0.55%*

* Estimated seroprevalence in this column include those persons unaware of their HIV infection. ** PI represents persons of Pacific Islander ancestry.
*** Other race/ethnicity includes American Indians and Alaskan Natives (AI/AN), as well as persons of mixed or unknown ancestry. HIV estimates were not shown for AI/AN due to small numbers.
**** Race/ethnicity estimates not available for transgender persons.

■ Estimates of Persons in Behavioral Risk Groups Living with HIV and AIDS

The number and racial/ethnic distribution of prevalent and incident HIV and AIDS cases for the six BRGs were estimated by the HIV Epidemiology Program. BRG categories are mutually exclusive; so, aside from MSM/IDU, persons with multiple risk categories are only counted in one risk category. The methodologies employed by the HIV Epidemiology Program to arrive at

these estimates and group population estimates are outlined in the Technical Notes (see Appendix) including data sources, assumptions, and limitations.

In order to assess the impact of HIV and AIDS on each BRG, the population size of each BRG and their race/ethnicity breakdown were estimated using a variety of sources including the 2000 U.S. census, the 1999 Los Angeles Health Survey, the HIV/AIDS Reporting System (HARS), the State-funded Alternate Testing Site database, Alcohol and Drug Program Administration data, Sexually Transmitted Disease Clinic data, and information from epidemiological studies performed by the HIV Epidemiology Program.

Figure 32 shows the relative estimated population size of each BRG, while Figure 33 shows the number of PLWA as reported in HARS. While MSM and WSR have similarly large populations (over 200,000 persons each), MSM have over eight times the number of persons living with AIDS (10,461 vs. 1,235). Similarly, while female IDU have nearly three times the estimated population as MSM/IDU (58,100 vs. 19,800), they have less than half the number of persons living with AIDS (514 vs. 1,161).

FIGURE 32

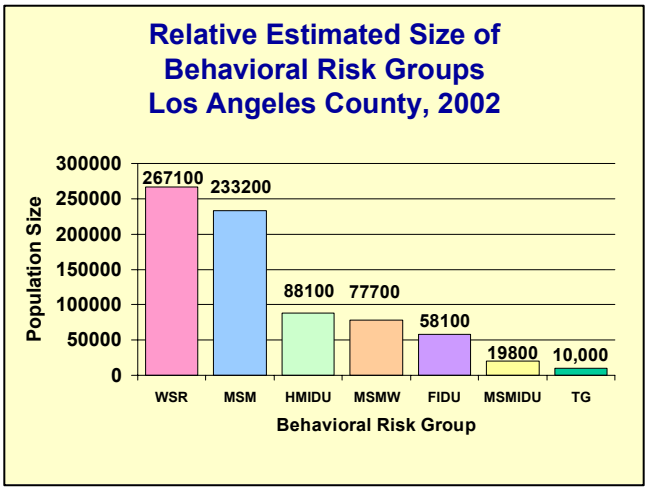


FIGURE 33

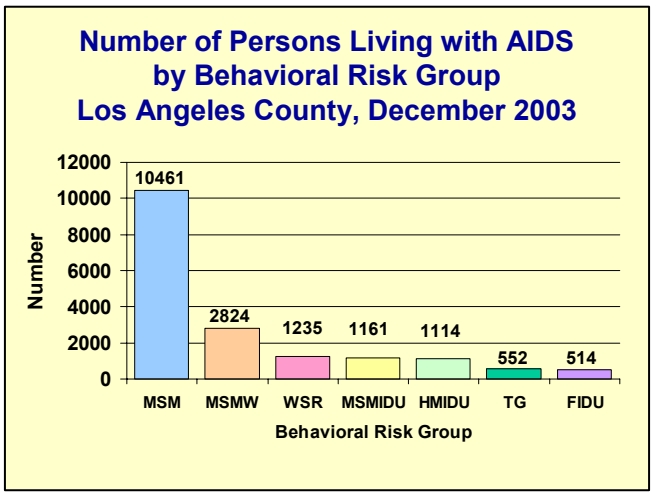


Figure 34 shows the estimated proportion of PLWH/A in Los Angeles County. Six percent of PLWH/A in the County do not fall within a known BRG. Figure 35 shows the estimated HIV seroprevalence - that is, the percent of each BRG estimated to be living with HIV. Relatively high seroprevalence is seen among transgender persons and the MSM BRGs.

FIGURE 34

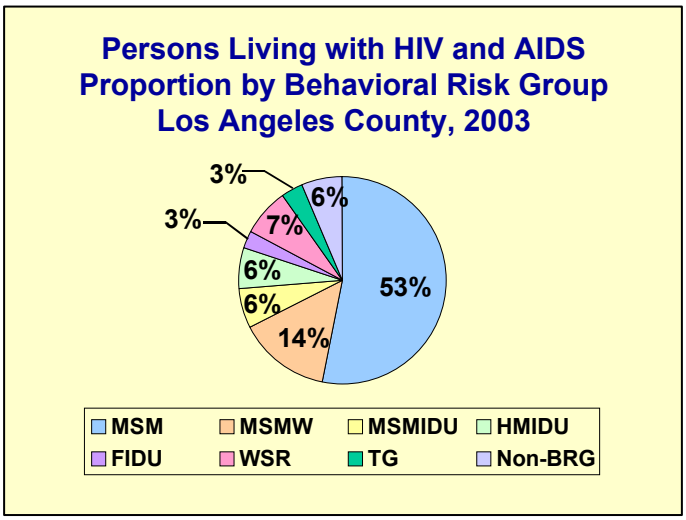
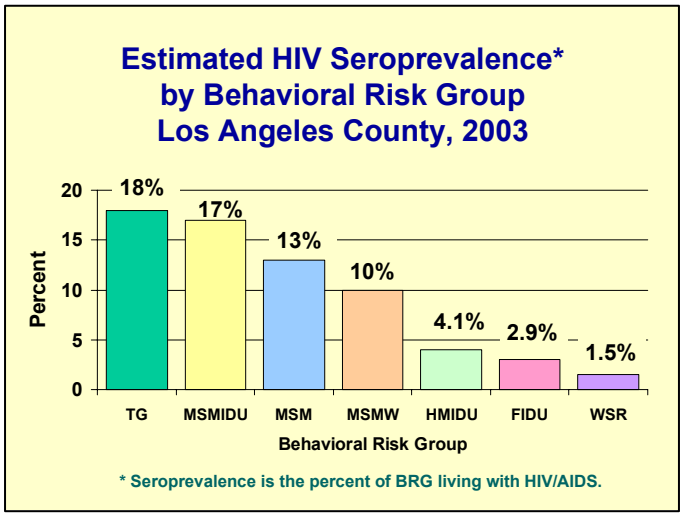


FIGURE 35



■ Estimated Rates of New HIV Infection by BRG

As of September 2004, 18 CBOs in Los Angeles County offer State-funded confidential and anonymous HIV testing. Figure 36 depicts the rates of seroconversion among repeat testers (testing positive following a previous negative HIV test) at these sites by BRG. The highest rate was seen among MSM/IDU, followed by MSM and MSM/W. As shown in Figure 37, among MSM and MSM/W, African Americans and Latinos had significantly higher seroconversion rates

than did White re-testers, while among WSR and F/IDU, African Americans had higher rates than did either Latinas or Whites.

FIGURE 36

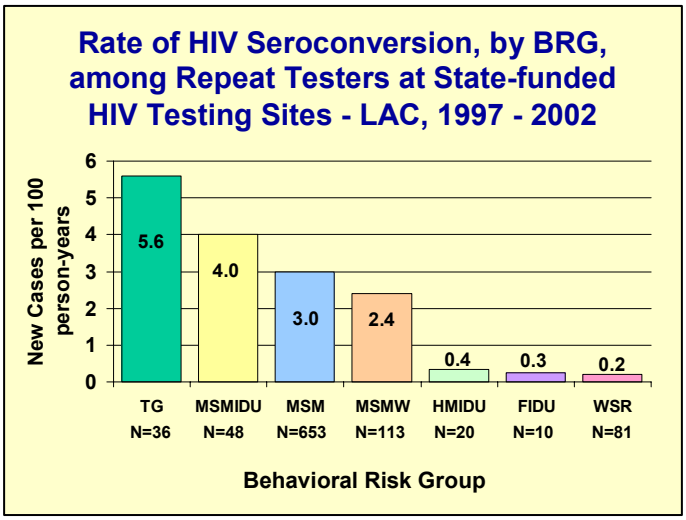
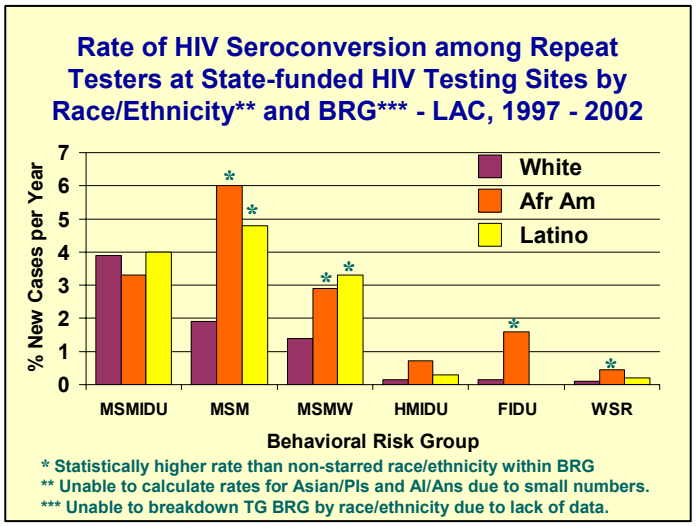


FIGURE 37



■ American Indians and Alaskan Natives

Of the approximately 30,000 American Indians and Alaskan Natives (AI/AN) living in Los Angeles County in 2002, the largest concentration live in SPA 2 (30%), followed by SPA 3 (18%), SPA 8 (17%), SPA 7 (15%), and SPA 4 (12%) (Figure 38). In contrast, of the 96 AI/AN estimated to be living with AIDS in the County, the greatest number reside in SPA 4 (39%), followed by SPA 8 (24%), and SPA 2 (13%) (Figure 39).

FIGURE 38

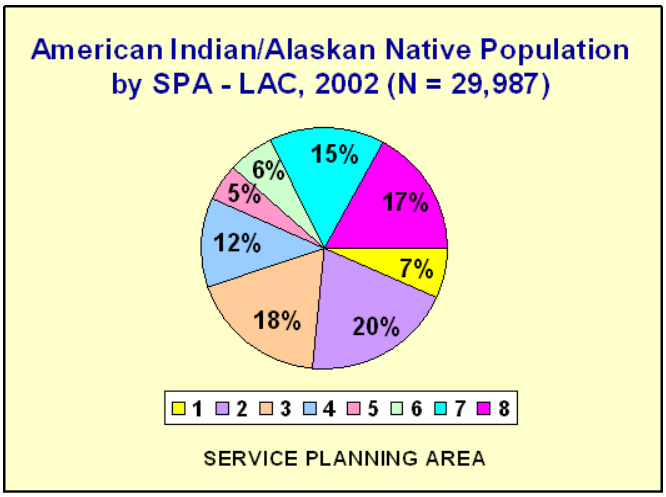
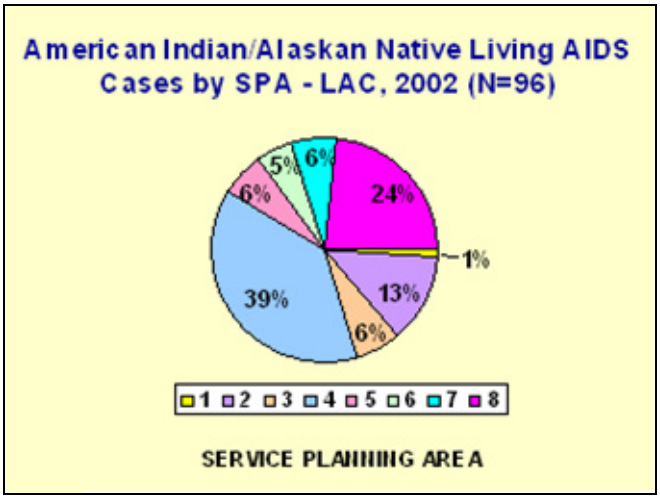


FIGURE 39



Nationally, and second only to African Americans, American Indians and Alaskan Natives (AI/AN) are diagnosed with AIDS at a higher rate than any other race/ethnicity [27]. In Los Angeles County, 3.4 out of every 1,000 AI/AN are living with AIDS, with the impact of the disease on this population second only to its impact on African Americans (Figure 40). Eighty-five percent (85%) of AI/AN AIDS cases were among men. Nearly three out of four AI/AN AIDS cases are among men who have sex with men (MSM), including those who also inject drugs (MSM-IDU; Figure 41). Together, IDU and MSM-IDU accounted for 20% of AI/AN cases.

FIGURE 40

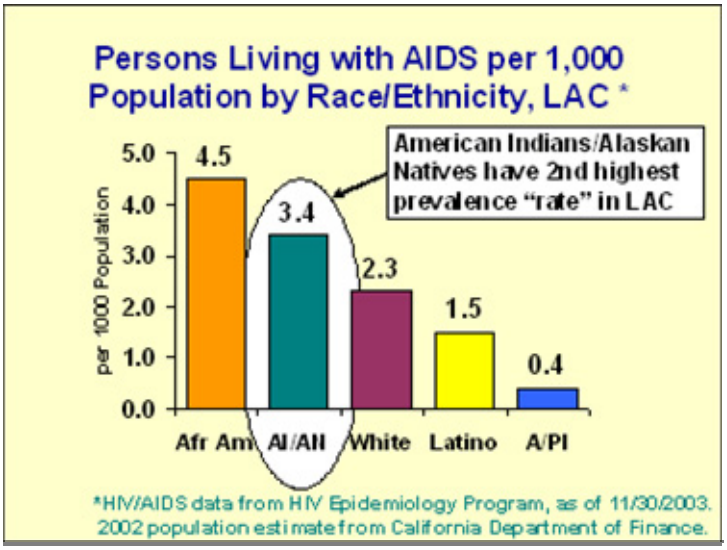
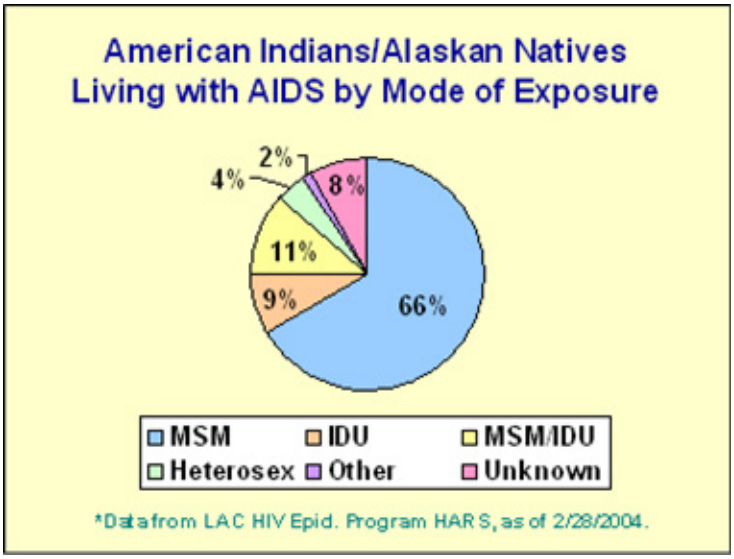


FIGURE 41



American Indian/Alaskan Native 2002 Validation Project

Because routine methods for ascertaining race/ethnicity information in the HIV/AIDS Reporting System (HARS) might lead to a pronounced underestimation of AI/AN living with AIDS due to racial misclassification, the HIV Epidemiology Program's core surveillance units undertook a study in conjunction with the U.S. Indian Health Service (IHS) and CDC to validate race/ethnic data using the IHS database, the LAC Vital Records mortality database, and the Office of AIDS Programs and Policy's Ryan White CARE Act client database.

In HARS, AI/AN cases were misclassified as follows: 67% as White, 22% as Latino, 5% as African-American, 3% as Asian, and 3% as unknown. AIDS cases reported at private facilities were significantly more likely to have AI/AN misclassification (68%) than were those reported at

public facilities (33%). After the correction of misclassified cases in HARS, the average annual AIDS rate for AI/AN increased 29% in HARS, from 2.1 to 2.7 per 1,000. When adjusted for misclassification based on all data sources, AI/AN cases increase even more to 3.1 per 1,000, a 48% increase. As of December 2003, the rate of AI/AN living with AIDS was 3.4 per 1,000.

■ Special Needs Populations

The Los Angeles County Commission on HIV Health Services (CHHS) has identified for 2004 eleven populations with special HIV care and service needs. These include: Transgender Persons; MSM of Color; White MSM; Homeless; Injection Drug Users; Recently Incarcerated; Non-injection Drug Users; Serious Mental Illness; Women of Child-bearing Age; Undocumented Youth (aged 13 – 24 years); and Undocumented Immigrants. Epidemiologic data are presented for each group and are summarized in Table 9. Unlike Behavioral Risk Groups, these special needs populations are not mutually exclusive. Therefore, some persons may fit into more than one category. Methods for estimating the size of the population for each group are presented in the Technical Notes.

TABLE 9. Summary of HIV and AIDS Estimates for Selected Populations, 2002.

Category	Estimated Population Size	Estimated No. Persons Living with AIDS	Estimated No. Persons Living with HIV & AIDS	Estimated HIV Seroprevalence (includes AIDS)*
Transgendered persons	10,000	552	1,700	17%
MSM of Color	222,000	8,300	23,000	10%
White MSM	108,000	6,100	10,300	9.5%
Homeless and Unstably Housed	236,000	3,300	8,300	3.5%
Injection Drug Users	166,000	2,800	6,100	3.7%
Recently Incarcerated	165,000	1,500	4,400	2.7%
Non-injection Drug Users	219,000	1,100	3,300	1.5%
Serious Mental Illness	343,000	1,100	3,200	0.9%
Women of Childbearing Age	2,449,000	1,500	4,900	0.2%
Youth, age 13-24 yrs	1,560,000	200	2,100	0.1%
Undocumented Immigrants	733,000	800	2,500	0.3%

* For estimated percent (%) of population infected with non-AIDS HIV only, subtract number in 2nd column from number in 3rd column, divide by population in 1st column, and multiply by 100.

Co-Morbid Communicable Diseases

■ Tuberculosis

Tuberculosis disease (TB) is one of 26 AIDS-defining opportunistic infections. HIV has been characterized as the most significant risk factor for progression of latent Mycobacterium tuberculosis infection to active TB [28]. While approximately 10% of persons infected with M. tuberculosis will develop active TB in their lifetimes, about 50% all persons compromised by HIV infection will develop active TB [29]. In addition, not only does infection with HIV increase

a person's susceptibility for M. tuberculosis infection and progression, TB has detrimental effects on the course of HIV disease as well; the risk of death in an HIV-infected person with TB is twice that of an HIV-infected person without TB, even with similar CD4 cell counts [30].

Statistics from the 2002 LAC Tuberculosis Control Program show a decreasing trend in the number of annual TB cases, from 1,299 in 1998 to 1,025 in 2002; among active TB cases who had an HIV test performed, a decreasing trend was also seen in the proportion who tested positive for HIV, from 15% in 1998 to 11% in 2002. TB cases during this 5-year period were predominantly male (62%), Latino (46%) or Asian (33%), and 45 years of age or older (53%). Asians were the most impacted race/ethnic group in 2002 with an active TB incidence rate of 30 new diagnoses for every 100,000 persons, followed by African Americans (12 per 100,000) and Latinos (11 per 100,000); Whites were the least impacted with 2.5 new diagnoses per 100,000 persons.

Compared with Whites, African American TB cases were twice as likely to be co-infected with HIV, while Asian TB cases were only 10% as likely to be co-infected (Table 10). Compared to male cases, female TB cases were only 20% as likely to be co-infected with HIV. The age group most likely to be co-infected with HIV was that of persons age 30 – 39 years, with 15 times the likelihood of infection compared with cases older than 60 years of age.

TABLE 10. Number, percent, and unadjusted odds ratios of HIV-TB co-infection among active tuberculosis (TB) cases, by demographic variables, Los Angeles County, 1998-2002.[1]

Demographic	Active TB Cases		TB-HIV Co-infection		Odds Ratio [2]
	Number	Percent	Number	Percent	
Gender [3]					
Male	3,471	62	394	78	Referent
Female	2,124	38	62	22	0.2 (0.2, 0.3)
Race/Ethnicity					
White	510	9.1	50	11	Referent
Asian	1,862	33	21	4.6	0.1 (0.1, 0.2)
Latino	2,570	46	270	59	1.1 (0.8, 1.5)
African American	653	12	115	25	2.0 (1.4, 2.9)
American Indian	10	0.2	--- 4	--- 4	--- 4
Age Group					
<13 years	270	4.8	2	0.4	0.4 (0.1, 1.8)
13-19 years	208	3.7	0	0.0	0.0 (0.0, 1.4)
20-29 years	786	14	49	11	3.9 (2.4, 6.5)
30-39 years	871	16	175	38	15 (9.7, 23)
40-49 years	1,028	18	144	32	9.7 (6.2, 15)
50-59 years	813	15	59	13	4.7 (2.9, 7.7)
60+ years	1,629	29	27	5.9	Referent
TOTAL	5,605	100	456	100	

1 Data provided by the Epidemiology Unit of the LAC TB Control Program excludes the cities of Pasadena and Long Beach.
2 Odds ratio followed by 95% confidence limits in parentheses. Statistically significant differences given in bold, non-significant differences in gray (see Technical Notes).
3 Total does not include 10 American Indian active TB cases.
4 Not enough information provided for analysis.

HIV/AIDS Reporting System (HARS)

Overall, 5.5% of AIDS cases reported in HARS also had TB. White AIDS cases had the lowest prevalence of TB (2.3%), while American Indians were 4.6 times, Latinos 3.9, Asians 3.6, and

Blacks 1.7 times more likely to have had TB than Whites (Table 11). Female AIDS cases had a 20% increased likelihood of having had active TB than did male cases (6.5% versus 5.4%). There was little difference in TB co-morbidity among age groups; only the 20-29 year old age group had a significantly higher likelihood of having TB than did AIDS cases aged 30-39 years (6.6% versus 5.3%). By mode of exposure, male AIDS cases who reported sex with men (MSM) as their exposure for HIV had the lowest prevalence of TB (4%), while those exposed to HIV through injection drug use (IDU) had 3 times the prevalence of active TB (12.4%) and MSM-IDU cases had twice the prevalence (9.3%) MSM cases. Lastly, foreign-born AIDS cases had more than twice the likelihood of having TB than did US-born cases (9.9% versus 4.4%).

TABLE 11. Number, percent, and unadjusted odds ratios of HIV-TB co-infection among AIDS cases, by demographic variables, Los Angeles County, 2002, as reported in HARS.[1]

Demographic	Total Number of Cumulative AIDS Cases	Number of AIDS Cases with TB	Percent with TB	Odds Ratio[2]
Gender				
Male	44,162	2,397	5.4	Referent
Female	3,782	245	6.5	1.2 (1.1, 1.4)
Race/Ethnicity				
White	22,622	531	2.3	Referent
Latino	14,187	1,208	8.5	3.9 (3.5, 4.3)
Asian/PI	1,021	82	8.0	3.6 (2.8, 4.7)
African American	9,778	794	8.1	1.7 (1.5, 1.9)
AI/AN	200	20	10	4.6 (2.8, 7.5)
Other	136	7	5.1	---
Age Group				
<13 years	246	4	1.6	---
13-19 years	225	15	6.7	1.3 (0.7, 2.2)
20-29 years	7,760	512	6.6	1.3 (1.1, 1.4)
30-39 years	21,281	1137	5.3	Referent
40-49 years	12,473	649	5.2	1.0 (0.9, 1.1)
50-59 years	4,428	241	5.4	1.0 (0.9, 1.2)
60+ years	1,531	84	5.5	1.0 (0.8, 1.3)
Exposure Mode				
MSM[3]	33,379	1,320	4.0	Referent
IDU[3]	3,363	418	12	3.5 (3.1, 3.9)
MSM-IDU	3,103	290	9.3	2.5 (2.2, 2.9)
Heterosexual	2,410	124	5.1	1.3 (1.1, 1.6)
Hemophilia	187	7	3.7	---
Transfusion	624	33	5.3	1.4 (0.9, 2.0)
Other	4,878	450	9.5	2.5 (2.2, 2.8)
Place of Birth				
US-born	31,917	1,408	4.4	Referent
Foreign-born	11,182	1,111	9.9	2.4 (2.2, 2.6)
TOTAL	47,944	2,642	5.5	

[1]HARS is the HIV/AIDS Reporting System of the LAC; reported as of February 29, 2004.
[2]Odds ratio followed by 95% confidence limits in parentheses. Statistically significant differences given in bold, non-significant differences in gray; "---" denotes inability to calculate valid confidence limits (see Technical Notes).
[3]MSM = men who have sex with men; IDU = injection drug use.

Sexually Transmitted Diseases

Many sexually transmitted diseases (STDs) can facilitate the transmission of HIV. Those that cause an open ulcer on the genitalia such as syphilis, herpes, and chancroid as well as those that do not—such as gonorrhea, chlamydia, and trichomoniasis decrease the protective mucosal/skin barrier and/or increase HIV viral shedding and thereby increase the odds of transmission by 2 to 5 fold [31]. Some STDs are indicators of unprotected sexual intercourse such as syphilis, gonorrhea, and chlamydia.

Finally, there are those diseases not thought of as STDs, that nonetheless may be transmitted between sexual partners; examples include "Hepatitis A" and shigellosis both spread via the fecal-oral route and Staphylococcus skin infections spread via skin-to-skin contact. The Los Angeles County Acute Communicable Disease Control Unit reports that there have been small outbreaks of, and increased risk for, these diseases among MSM in recent years.

In Los Angeles County, diseases reportable to the STD Program include syphilis, gonorrhea, and chlamydia. Unless otherwise noted, the following data have been abstracted and/or summarized from Los Angeles County's *Sexually Transmitted Disease Morbidity Report 1998-2002*.

Chlamydia

In Los Angeles County, the rate of chlamydial infections increased 40%, from 275 cases per 100,000 population in 1998 to 386 per 100,000 in 2002. The County's chlamydial rates for 2002 were 23% higher than the rate in California (313 per 100,000) and 30% higher than the U.S. rate (297 per 100,000) for the same year. The strongest predictions of Chlamydia risk include being a woman, young (age 15-24 years), African American, and living in SPA 6 (Table 12).

Gonorrhea

From 1998–2002, gonorrhea rates decreased slightly, from 132 to 125 per 100,000. For 2002, Los Angeles County gonorrhea rates were 49% higher than that for California (84 per 100,000) and 79% higher than the U.S. rate (70 per 100,000). In the County, gonorrhea case reports were predominant in men, youth (age 15-24 years), African Americans, and residents of SPA 6 (Table 12).

Syphilis

Recently, reported syphilis case rates in Los Angeles County have nearly quadrupled, from 1.0 per 100,000 in 1999 to 3.9 per 100,000 in 2002. Once lower than U.S. rates, the 2002 County syphilis rate was 63% higher than that of the U.S. and 30% higher than the California rate. Unlike chlamydia and gonorrhea, the highest syphilis rates were seen among adults aged 35-44 years, Whites, and residents of SPA 4 (Table 12).

In 2002, men had 19 times the rate of syphilis than did women (95 vs. 5 per 100,000). From 1998 to 2002, the syphilis rate in White men increased 17 fold, from 0.7 to nearly 12 per 100,000. This recent increase of early syphilis seen in Los Angeles County was first recognized in 2000 as an outbreak among MSM throughout Southern California (MMWR). This, in turn, prompted a multifaceted outbreak response lead by the Los Angeles County STD Program that included a media campaign ("Stop the Sores"), increasing provider awareness, community outreach, and studies targeting incarcerated transmission and Internet partner notification [32].

TABLE 12. Comparison of selected sexually transmitted diseases by demographic subgroup and Service Planning Area (SPA), Los Angeles County, 2002.[1]

Demographic	Chlamydia			Gonorrhea			Syphilis		
	No.	%	Rate[2]	No.	%	Rate[2]	No.	%	Rate[2]
Gender and Race/Ethnicity									
Male	9,949	28	218	4,366	56	96	346	95	7.6
White	763	7.7	78	646	15	63	168	49	12
African American	2,212	22	795	1,589	36	545	45	13	12
Latino	3,578	36	241	832	19	42	108	31	5.2
Asian/Pacific Isl.	294	3.0	74	82	1.9	20	13	3.8	2.3
Other[3]	33	0.3	---	14	0.3	---	<5	--	---
Female	25,691	72	547	3,420	44	73	18	4.9	0.4
White	1,461	5.7	148	227	6.6	21	<5	--	---
African American	4,569	18	1,436	1,507	44	435	11	61	2.4
Latina	10,587	41	723	733	21	46	6	33	0.3
Asian/Pacific Isl.	919	3.6	211	61	1.8	13	<5	--	---
Other[3]	105	0.4	---	28	0.8	---	<5	--	---
Age Group									
<15 years	446	1.2	21	86	1.1	3.9	1	0.3	0.0
15-19 years	9,729	27	1,397	1,620	21	233	6	1.6	0.9
20-24 years	11,709	33	1,785	1,971	25	300	29	8.0	4.4
25-29 years	6,488	18	943	1,308	17	190	41	11	6.0
30-34 years	3,483	9.8	464	963	12	128	70	19	9.3
35-44 years	2,725	7.6	191	1,292	17	90	150	41	11
45-54 years	669	1.9	58	386	4.9	34	57	16	5.0
55-64 years	105	0.3	15	62	0.8	8.7	6	1.6	0.8
60+ years	47	0.1	4.8	22	0.3	2.2	3	0.8	0.3
SPA									
Antelope Valley	888	2.5	273	257	3.3	79	<5	--	---
San Fernando	5,069	14	245	772	9.9	37	42	12	2.0
San Gabriel	4,216	12	254	571	7.3	35	14	3.8	0.8
Metro	5,468	15	466	1,471	19	125	206	57	18
West	1,187	3.3	187	340	4.4	53	27	7.4	4.2
South	8,482	24	858	2,416	31	244	25	6.9	2.5
East	4,770	13	358	531	6.8	40	20	5.5	1.5
South Bay	3,831	11	357	951	12	89	25	6.9	2.3
TOTAL[4]	35,688	--	386	7,800	--	84.3	364	--	3.9

[1] Data from Los Angeles County STD Program's *Sexually Transmitted Disease Morbidity Report, 1998-2002.*
[2] Rate = adjusted rate in cases per 100,000 population; rates based on <19 cases are unreliable.
[3] Includes data for race/ethnicity reported as "Other" and "Native American".
[4] Total category includes cases with unknown demographic information not otherwise shown.

Nevertheless, a decline in new syphilis cases has yet to be realized. In the STD Program's January 2004 issue of Early Syphilis Surveillance Summary, the number of reported early syphilis cases—that is, primary, secondary, and early latent cases—continued to rise, from 371 in 2002 to 398 cases in 2003. A similar trend was seen for California—with 1,797 early syphilis cases reported in 2002 and 1,991 cases for 2003 [33].

Of syphilis cases reported in Los Angeles County for 2003, 90% were male, three-quarters of cases were either White (41%) or Latino (36%), and 58% were aged 30–44 years. In 2000, only a third of cases were in MSM; by 2003, 65% of all cases were MSM, over half of which were also HIV-infected. Of MSM contracting syphilis in 2003, 67% reported having anonymous sex and only 25% reported use of a condom during sexual intercourse.

Public health implications of the recent early syphilis outbreak in Los Angeles County among MSM, half of whom are HIV-infected and half HIV-uninfected, are unclear. The rise in syphilis was not accompanied by a concomitant increase in new HIV cases at STD clinics during this period [MMWR]. Some believe that these men, many of whom are older, may be engaging in sexual intercourse exclusively with "seroconcordant partners" – that is, sex between two infected men or between two uninfected men [34].

■ Hepatitis C

Hepatitis C virus (HCV) infection is the most common bloodborne infection in the U.S., with an estimated 1.8% of all Americans infected [35]. HCV is predominantly transmitted through contact with contaminated blood and blood products. Persons at high risk for HCV include those receiving clotting factors made before 1989 and injection drug users (IDU). Those persons who received a blood transfusion or solid organ transplant prior to 1992 (hemodialysis patients, persons with undiagnosed liver problems, and infants born to infected mothers) are at intermediate risk [36]. While it has been shown that HCV is not easily transmitted through sexual intercourse [37, 38], sex may account for up to 15% of cases.

Once established, HCV is not cleared in 85% of infected persons and leads to chronic illness, such as cirrhosis, liver failure, and liver cancer, in 60–70% of those infected [39]. Unlike for hepatitis A and B viruses, there is currently no vaccine for HCV. Although recent advances have been made, HCV disease in persons co-infected with HIV is especially difficult to treat [40]. In one recent study, HIV-HCV co-infected patients were found to have a significantly higher proportion of depression and other psychiatric problems (70%) than did mono-infected persons (57%) [41].

HIV/AIDS Reporting System (HARS)

To estimate co-morbidity of HCV and AIDS in Los Angeles County, the HIV Epidemiology Program recently matched living AIDS cases in HARS with Los Angeles County-DHS Acute Communicable Disease Control Program's HCV database (see Technical Notes). Of the approximately 19,794 persons living with AIDS at the end of July 2004, 901 also had evidence of HCV infection (4.6%). Among the 10,634 non-AIDS cases reported to HARS by July 2004, 360 were also identified in the HCV Registry, for a co-morbidity of 3.4%.

These co-infection proportions are much lower than the 40% co-morbidity among HIV-infected persons reported in New York City [42] and lower than CDC's estimate that 25% of U.S. HIV-infected persons are co-infected with HCV [43]. By mode of exposure in HARS, IDUs have never accounted for more than 18% of Los Angeles County's AIDS cases; this is in contrast to the Northeastern U.S. where IDU was a reported mode of exposure for over 40% of AIDS cases [44]. Therefore, it is not surprising to see less HIV-HCV co-morbidity in Los Angeles County than in areas of the nation with higher IDU exposure risk. When analysis is limited to HIV and AIDS cases that reported injection drug use, however, HCV co-infection was estimated to be between 46–65% in Los Angeles County, which is similar to CDC's estimate nationally of 50–

90% co-infection among HIV-infected IDU [43]. Finally, preliminary findings from a recent local study of current and former IDUs in Los Angeles County found a typically low HIV seroprevalence (5.2%), a typically high HCV seroprevalence (70%), and a typically low HIV-HCV co-infection (2.6%) [45].

Satellite Testing Office for Research and Education (STORE)

In 1996, the HIV Epidemiology Program started a counseling and testing site in West Hollywood (the city in Los Angeles County with the highest AIDS rate). Before its closure in 2001, the Satellite Testing Office for Research and Education, or "STORE", screened over 1,000 clients for HCV, of whom 5% were positive for antibodies to HCV. Clients who tested positive for HIV had an equal likelihood of testing positive for HCV (5%) as those who tested negative for HIV (5%). Regardless of gender, race/ethnicity, or sexual orientation, IDUs were 20 times more likely to test positive for HCV (OR= 20; 95%CL= 11, 37), than non-IDUs with an HCV seroprevalence of 31% for IDU compared with only 2.2% for non-IDU clients.

Collaborative Injection Drug User Study (CIDUS III)

The Health Research Association of Los Angeles conducted the third Collaborative Injection Drug User Study in collaboration with the CDC and four other cities from 2002-2004. Injection drug users, age 15-30 years, were interviewed and tested for both HIV and hepatitis. Preliminary analysis found 27% of these young IDU participants from Los Angeles to be infected with HCV, 6.3% with HIV, and 1.8% to be co-infected with HIV and HCV; other participating cities New York, Baltimore, Seattle, and Chicago had similar low co-infection levels [46].

Community Assessment

Introduction

Assessing the needs of Los Angeles County residents in relation to HIV and AIDS is an ongoing process. One might suggest that to the degree residents engage in HIV risk behaviors, there is a need for HIV prevention and related services. However, estimating the extent of need can be challenging. As part of the development of the *HIV Prevention Plan 2004-2008*, the PPC examined HIV epidemiologic data as well as current sources of behavioral data to begin to assess the scope of HIV prevention needs in Los Angeles County. As in the past, the PPC also wanted to gather information directly from persons at risk. They accomplished this through several community forums and symposia, which targeted for the most part, individuals currently receiving HIV prevention services. However, unlike past efforts, the PPC wanted to gather information regarding HIV risk from individuals not accessing HIV prevention or related services. The PPC hoped that such an effort would reveal gaps in services, particularly related to those individuals who remain more hidden. OAPP and the PPC are currently engaged in the formidable task of gathering information from identified hard-to-reach populations as well as those individuals not receiving services.

The *Community Assessment* presented here expands upon the *HIV Epidemiologic Profile* presented in the previous section, which includes a general picture of Los Angeles County as well as key information regarding HIV epidemiologic trends and co-morbid communicable diseases (e.g., STDs, TB). The *Community Assessment* provides an overview of the two key sources of behavioral information – the *Countywide Risk Assessment Survey* (CRAS) and the *Supplement to HIV/AIDS Surveillance (SHAS) Project*. It then takes an in-depth look at the HIV risk behaviors of BRGs as well as other potentially at risk populations utilizing information from CRAS, SHAS, and other local studies. In so doing, a picture of need in Los Angeles County begins to emerge.

The present year marks significant change in the landscape of services and interventions being provided across Los Angeles County. The CDC re-solicited directly-funded programs under its AHP initiative and new programs funded through OAPP's CDC Cooperative Agreement will begin in January 2005. The *Community Assessment* begins to assess current HIV prevention and related resources available to meet the County's needs. As a work in process, OAPP and the PPC will update this assessment as additional information is gathered and analyzed.

In February 2004, the OAPP Director commented: *"HIV is 100% preventable. We have the evidence, but we need resources, vision, and political will."* The *Community Assessment* begins to map out what is needed to achieve this laudable goal.

Description of the Community Assessment Process

The PPC's 2004-2008 needs assessment process consisted of a four-pronged approach, including: (1) analysis of current HIV epidemiologic and related data; (2) analysis of key HIV risk behavior information available through CRAS, SHAS, and other local studies; (3) gathering of qualitative data through targeted focus groups; and (4) gathering of qualitative information from individuals at risk for HIV who are not receiving services. Much work has been completed in the first three areas and the fourth component remains a work in progress, to be completed in late 2004.

As a first component of the needs assessment process, much of the HIV epidemiologic and related information reviewed by the PPC has been presented in the *HIV Epidemiologic Profile.* Thus, the following brief descriptions discuss the three remaining components of the process.

■ Analysis of HIV Risk Behavior Information

Countywide Risk Assessment Survey

In response to a growing need for information to guide the County's needs assessment process, the PPC, in collaboration with OAPP, determined that a standardized instrument was necessary to assess sociodemographic characteristics, perceptions of risk, and behavioral risk of clients receiving HIV prevention services at County-funded agencies. As a result, the Countywide Risk Assessment Survey (CRAS) was developed and implemented in 1998 and subsequently in 1999, 2001, 2002, and 2003. In addition to behavioral data, CRAS also gathered demographic characteristics of participants. When CRAS was first designed, OAPP developed a sophisticated sampling methodology and weighting formula, which allowed OAPP to project the total number of clients being served.

For the past five years, CRAS has been implemented through OAPP in close collaboration with County-funded agencies. Staffs of these agencies complete the survey with their clients. CRAS consists of four parts:

- Part A assesses client demographic information including race/ethnicity, age, gender, educational level, sexual orientation, and place of birth;
- Part B examines drug, alcohol, and needle use;
- Part C assesses sexual risk behaviors including inconsistent condom use, sex with multiple partners, sex with HIV positive partners, and exchanging sex for money or drugs; and
- Part D examines utilization of HIV prevention and related services.

As with most tools, there are limitations to CRAS data. All information is collected by self-report and is subject to the biases associated with this type of data collection. Because many of the survey questions asked about events and behaviors presented six months prior to the interview, there could be recollection bias or the complete lack of memory of the events. In addition, due to different cultural responses to the survey and the sensitive nature of its contents, some respondents may not have been completely candid with their responses. To encourage accuracy, the CRAS surveys do not contain identifying information such as name, home address, or telephone number. The anonymity makes checking the accuracy of the reports impossible. CRAS contains information only on clients currently receiving HIV prevention services at County-funded health education/risk reduction and counseling and testing programs. CRAS participants may not have similar characteristics, perceptions, and behavioral patterns as individuals who are not receiving prevention services or services at non County-funded agencies but participants should be reflective of people accessing prevention services in the County [47].

Supplement to HIV/AIDS Surveillance Project

A second critical source of information regarding HIV risk behavior in Los Angeles County is the Supplement to HIV/AIDS Surveillance (SHAS) Project. The SHAS Project is a CDC-sponsored

interview study designed to obtain supplemental descriptive information on persons diagnosed with AIDS. The project began in 1990 and is conducted in Los Angeles County by the HIV Epidemiology Program. Persons with AIDS who are at least 18 years of age and reported to the Los Angeles Case Registry are eligible to participate in SHAS.

In Los Angeles County, SHAS is population-based and therefore is designed to represent all persons diagnosed with AIDS in the County. The SHAS study is the only population-based study of risk behaviors among persons diagnosed with AIDS in Los Angeles County [48].

SHAS data are used at the State and local levels to inform policy makers and others involved in HIV prevention and care. At the national level, these data are used to enhance HIV/AIDS surveillance information used for planning and allocation of resources. The information presented for the 2002 SHAS describes the demographic characteristics, sexual and drug using behaviors, HIV testing history, and health care utilization of Los Angeles SHAS participants who were interviewed from 1990 to 2002.

To participate, individuals are contacted through their providers at all sites that diagnose and report persons with AIDS. Trained interviewers administer a standardized questionnaire to participants within two years of their AIDS diagnosis, either as part of a routine visit to a medical facility or another mutually agreed upon location. The SHAS questionnaire, developed in consultation with the State and local SHAS project officers, CDC epidemiologists, and subject area consultants, includes information on demographics; sexual behaviors and STD history; drug and alcohol use; HIV testing and medical therapy; reproductive/gynecological history; and health and social services. With the increasing emphasis on prioritizing HIV positive persons for prevention services, it is essential to understand better their HIV risk behavior in order to design effective interventions to reduce transmission of HIV from this population.

■ Focus Group Data

Although both CRAS and SHAS have long provided Los Angeles County with needed information, direct conversation with individuals at risk for HIV has been a core component of Los Angeles County's needs assessment process. Historically, this conversation has taken place through several venues including community forums and focus groups. As in the past, the PPC convened several focus groups to inform the 2004-2008 needs assessment process. The PPC targeted selected BRGs, including WSR (youth), MSM (adult), MSM (youth), IDUs, and Transgenders and conducted a series of focus groups over several months. However, this focus group information is now dated, over two years old and were not the subject of analysis. As a result, the raw data, compiled from several focus groups that were conducted with staffs of CBOs serving these target populations, is included in the Appendix.

■ Individuals at Risk for HIV Who Are Not Receiving Services

Despite all of their information, the PPC and OAPP recognized early that core gaps in information regarding people not receiving HIV prevention services remained. This was particularly true of specific populations. To enhance the 2004-2008 needs assessment, the PPC and OAPP jointly determined the need to identify and target key populations from which to gather additional qualitative information regarding HIV prevention needs. These populations included: commercial sex workers, bath house and club patrons, MSM/W, and individuals across all BRGs who are not currently receiving services.

In early 2004, OAPP's Planning and Research Division began the process of identifying the best method for reaching their targeted groups as well as obtaining necessary approvals from the County's Institutional Review Board (IRB) to conduct the interviews and surveys. The OAPP project team, in collaboration with the PPC concluded that a blended approach using focus groups, on-site interviews, and internet assessments would yield positive results. These methods would work best if targeted to specific locations where potential participants could be recruited, including local bars, clubs, bath houses, cruising spots, as well as specific internet sites.

A short survey will track demographics, testing patterns, seropositivity, and risk behaviors in the sample. The survey provides an additional means of allowing representation regardless of focus group participation. By varying times, locations, recruitment strategies, and participation levels, this project will ultimately capture responses from a wide spectrum of the population.

Due to delays in obtaining IRB approval and other logistical challenges, this important data collection process is still underway and cannot be presented here. Once the data have been collected and analyzed, OAPP and the PPC will update this *Community Assessment* to incorporate key learnings regarding HIV prevention needs as identified by individuals not currently participating in HIV prevention programs. OAPP and the PPC anticipate that this data will provide valuable insight into how to access and target services better to these populations.

Los Angeles County: A Community at Risk

■ Findings from the 2003 CRAS and 2004 SHAS Projects

As discussed above, CRAS obtains behavioral data from current recipients of HIV prevention services, regardless of HIV status, and SHAS obtains similar data from PLWAs. Jointly, these surveys reveal disturbing information regarding the level of HIV risk behavior among Los Angeles County residents, particularly since survey participants are themselves recipients of HIV prevention services and/or HIV positive and living with AIDS.

In the following pages, three tables present key information regarding 2003 CRAS and 2004 SHAS participants. Table 13 details selected socio-demographic characteristics of participants. In general, 2003 CRAS and 2004 SHAS participants are reflective of the HIV/AIDS epidemic in Los Angeles County. In both surveys, females represent a higher proportion of participants (25%) than are living with AIDS [47, 48]. Tables 14 and 15 depict self-reported sexual and drug-using behaviors of participants overall and then by SPA.

High-Risk Behavior

Tables 14 and 15 outline the sexual and drug using risk behaviors of 2003 and 2004 SHAS participants. Although the variables for both the 2003 CRAS and the 2004 SHAS Project are not identical, they do provide some insight into the level of high-risk sexual and drug-using behavior of respondents. In general, the 2003 CRAS data reveal a high proportion of unprotected vaginal or anal sex among respondents. Both CRAS and SHAS respondents reported a significant amount of drug use and among those who had injected drugs, a significant proportion of sharing needles. In addition to the behaviors noted above, approximately 10.9% of 2003 CRAS respondents reported that they did not know the HIV serostatus of their main partner (if they reported having a main partner in the last six months) and 40.8% did not know the serostatus of their casual partner (if they reported having a casual partner). Of those respondents reporting that they had a casual partner 18.9% had a casual partner known to have injected drugs.

TABLE 13: Comparison of Selected Socio-Demographic Characteristics of 2003 CRAS and 2004 SHAS Participants

Characteristics	2003 CRAS (n=5,147)*	Through June 2004 SHAS (n=4,117)
Gender		
Male	71%	76%
Female	25%	24%
Transgender (male to female)	3.2%	Not available
Transgender (female to male)	0.1%	Not available
Transsexual (male to female)	0.3%	Not available
Race/Ethnicity		
Latino	45.0%	49%
White	20.4%	27%
African American	25.3%	20%
Asian	5.7%	2%
American Indian/Alaskan Native	2.5%	Not available
Native Hawaiian/Other Pacific Islander	<1.0%	Not available
Multiracial	<1.0%	Not available
Other/Unknown	0%	2%
Age		
<20	(13-24 yrs) 28.2%	<1%
20-29	(25-29 yrs) 15%	16%
30-39	(30-34 yrs) 16.9%	44%
40-49	(35-82 yrs) 40%	28%
50+	--	12%
HIV Exposure Category or BRG		
MSM	49.4%	47%
MSM/IDU	5.6%	17%
MSM/W	8.5%	Not available
IDU (male/female)	15.0%	6%
Heterosexual	(WSR) 21.5%	14%
Other/Unknown	0%	15%
Sexual Orientation		
Heterosexual	45.2%	50%
Homosexual	40.5%	36%
Bisexual	14.3%	12%
Other/refused/don't know	0%	2%
Level of Education		
Less than high school	n/a	36%
High school graduate	(of adults) 73.0%	24%
College	(of adults) 12.5%	40%

*This number is weighted so that each person who completed the survey has an equal "weight" to every other respondent.

TABLE 14. 2003 CRAS Participants and Elevated Sexual Risk

Characteristics	CRAS (n=5,147)
Inconsistently used condoms during vaginal or anal sex	75.0%
Used drugs or alcohol with their main or casual partners before, during, or after sex	63.1%
Got paid for sex with money, drugs, or something else they needed at least once in their life	22.1%
Reported getting paid for sex in the last six months	13.5%
Did not know the serostatus of their main partner (of those reporting a main partner in the last six months)	10.9%
Did not know the serostatus of at least one casual partner in the last six months (of those reporting a casual partner in the last six months)	40.8%
Had a casual partner who injected drugs (of those reporting a casual partner)	18.9%

TABLE 15. Sexual and Drug Using Behaviors of 1990-2004 SHAS Participants

Characteristics (9/2000-6/2004)	SHAS - Male		SHAS - Female	
Sexual Behaviors in the Past 12 Months	**N=683**	**%**	**N=162**	**%**
Had sexual intercourse	454	66%	102	63%
Of those who had intercourse: Had sex with males	320	70%	102	100%
# of male partners (1-4)	358	79%	102	100%
# of male partners (5-10)	46	10%	0	0%
# of male partners (over 10)	47	10%	0	0%
Of those who had intercourse: Had sex with females	151	33%	0	0%
Sexual Behavior during Last Intercourse				
Was high on drugs or alcohol	63	14%	11	11%
Had unprotected vaginal or anal sex with male	139	31%	35	34%
Had sex with and HIV positive partner	133	29%	36	35%
Alcohol and Drug Use (interviews from 1995-2000)				
Used alcohol in past 5 years	644	94%	127	78%
Used non-injection drugs in past year	464	68%	22	34%
Ever used injection drugs	122	18%	32	20%
Used injection drugs in past year	29	24%	8	25%
Shared needles in past year	3	10%	3	38%

HIV Risk Behavior by Service Planning Area

Information regarding an individual's residence is only available in the 2003 CRAS data. Table 16 provides HIV risk behavior of 2003 CRAS respondents for Los Angeles County in total and by SPA. SPA 1 respondents report the highest use of any substance (97.9%) and of crystal methamphetamines (39.7%) among all SPAs. SPA 2 respondents report the highest use of alcohol, injection drugs, use of drugs during sex, trading sex for money or drugs, and inconsistent condom use among females as compared to the rest of the County.

TABLE 16. Sexual and Drug Using Behaviors of 2003 CRAS Participants by SPA

	County	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
Substance Use									
Any substance	86.9%	**97.9%**	90.5%	81.6%	84.6%	87.5%	88.1%	82.7%	93.0%
Alcohol	71.8%	76.1%	**79.7%**	63.0%	75.3%	70.0%	66.5%	61.6%	72.6%
Marijuana	37.3%	46.2%	37.0%	31.8%	40.6%	33.2%	**49.3%**	22.1%	39.7%
Crystal Meth.	15.6%	**39.7%**	16.9%	15.1%	14.8%	6.4%	11.7%	16.6%	19.2%
Injection drugs	19.1%	19.7%	**28.3%**	19.3%	16.8%	25.0%	23.8%	9.9%	19.9%
Used drugs in relation to sex	63.1%	72.9%	**75.8%**	64.4%	54.9%	54.3%	68.2%	62.3%	65.2%
Ever traded sex	22.1%	21.0%	**28.0%**	24.3%	21.6%	21.5%	25.4%	12.8%	25.8%
Traded sex in last 6 mos.	14.5%	21.0%	**21.9%**	17.1%	12.6%	21.5%	15.7%	5.0%	15.9%
Sexual Behavior									
Had main partner	64.7%	76.7%	59.5%	**82.9%**	59.2%	74.3%	66.7%	49.9%	72.3%
Had casual partners	61.9%	52.5%	**70.5%**	49.4%	66.2%	40.9%	57.9%	56.7%	59.3%
Had HIV+ casual partner	5.3%	0.0%	6.8%	2.6%	5.6%	6.7%	3.1%	3.1%	**7.7%**
Had IDU casual partner	11.7%	**38.1%**	18.8%	9.5%	10.2%	12.3%	10.0%	3.4%	15.1%
Condom Use – Sometimes/Never									
Male	67.7%	**89.8%**	75.2%	70.8%	64.2%	58.7%	74.6%	60.2%	69.3%
Female	79.6%	74.2%	**89.4%**	78.6%	71.9%	48.6%	75.9%	82.8%	87.3%
Transgender	78.2%	n/a	81.8%	0.0%	78.8%	n/a	88.1%	**100%**	19.3%

First Learned of HIV+ Status and AIDS Diagnosis by Race/Ethnicity

In addition to behavioral characteristics, the 2004 SHAS Project collected information on the time between an individual's first HIV positive diagnosis and their AIDS diagnosis. This information has important implications for HIV testing programs and may suggest a need for improved targeting of services. The following table depicts this time difference for the interview period between 1997-2001and includes 819 participants.

As seen in Table 17 Latinos were more likely (44%) to receive an AIDS diagnosis within one month after testing for HIV than Whites (20%) or African Americans (33%). Another 28% of Latinos were diagnosed with AIDS within the first 12 months after testing HIV positive.

TABLE 17. Time between First Learned of HIV+ Status and AIDS Diagnosis (n=819), by Race/Ethnicity, SHAS Project, Los Angeles County, 2000-2004

	<1 mo.	1-12 mos.	13-36 mos.	37-60 mos.	>60 mos.
White	20%	15%	7%	9%	49%
African American	33%	20%	11%	8%	29%
Latino	44%	28%	12%	5%	11%

Additionally, approximately one-third of both male (n=2000) and female (n=710) 2004 SHAS respondents reported that they had an HIV negative test result prior to receiving their first HIV positive test result. Males reported that their primary reason for being tested was illness (55%) and only 14% were tested because they understood they were in a known risk group. For females, 45% reported that they were tested due to illness and only 3% were tested because they understood they were in a known risk group. Females were much more likely to be tested because of contact with a sex partner (18%) than males (8%).

■ Assessing HIV Prevention Needs Among Priority Populations

In 1999, as part of the work of the *HIV Prevention Plan 2000*, the PPC prioritized specific target populations based upon the behaviors that put individuals at risk of HIV infection. These behavioral risk group (BRG) categories became the starting place for the current PPC to assess HIV risk behaviors (e.g., unprotected sex or needle sharing behaviors).

When looking at condom use in relation to sexual risk, a higher percentage of inconsistent condom use during sex suggests a higher risk for HIV. Table 18 begins to examine 2003 CRAS data regarding condom use across BRGs. For every BRG except MSM, the proportion of inconsistent condom use is over 80% of the time during sex, and it is highest among HM/IDU.

TABLE 18. 2003 CRAS Respondents and Condom Use by Behavioral Risk Group

Behavioral Risk Group	Consistent	Inconsistent
Men who have sex with men (MSM)	37.9%	62.1%
Men who have sex with men and women (MSM/W)	12.6%	87.4%
Men who have sex with men and injection drug user (MSM/IDU)	19.5%	80.5%
Heterosexual male injection drug user (HM/IDU)	4.9%	95.1%
Female injection drug user (F/IDU)	12.9%	87.1%
Women at sexual risk (WSR)	19.8%	80.2%

Non-BRG-specific data from the 2003 CRAS suggest that there are several predictors of condom use including age, gender, sexual orientation, crystal methamphetamine use, injection drug use

(IDU), and homelessness. Participants over 25 years of age were more likely to use condoms consistently than those who were younger than 25. Females and transgenders were 1.5 times more likely to use condoms inconsistently than males. MSM were much more likely to use condoms consistently than MSM/W or heterosexual men. Further, participants who used crystal methamphetamine were more than 3 times more likely to use condoms inconsistently than those who did not use crystal methamphetamine. IDUs were more than 2.5 times more likely to use condoms inconsistently than non-IDUs. Homeless participants were 2.5 times more likely to use condoms inconsistently than those who reported having a place to stay.

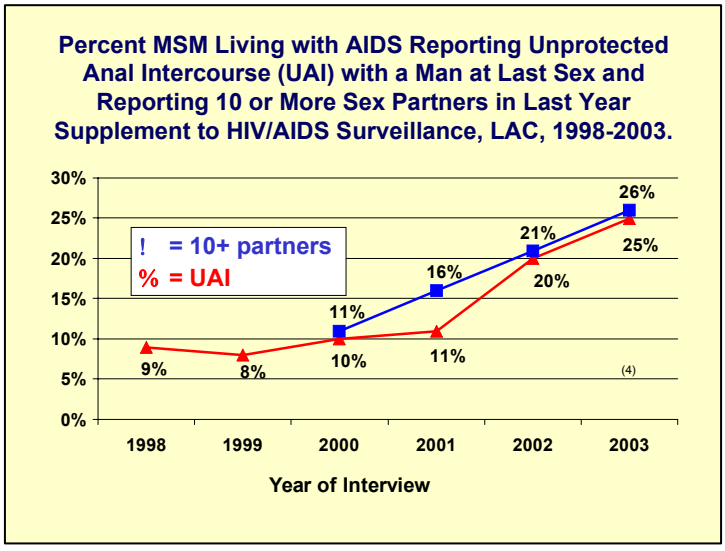
The above information is illustrative of information available by BRG. However, to assess HIV prevention needs and develop effective interventions targeting specific BRGs and other priority populations, it is necessary to examine the specific HIV risk behaviors in which individuals are engaging across BRGs. The following narrative provides an in depth look at HIV risk by BRG and priority population. Where available, information related to PLWH/A and youth are woven into the description of specific BRGs.

Men Who Have Sex With Men (MSM)

Of the estimated 233,200 men in Los Angeles County who have sex with men, but do not have sex with women or inject drugs, 43% are Latino, 36% White, 13% Asian, 8% African American, and 3% mixed or other race (Table 8, p. 45). Evidence in the scientific literature suggests that STDs, most notably syphilis, are on the rise among MSM, especially among HIV-infected MSM [2]. There is concern that the presence of STDs increases the transmissibility of HIV. Also, there is concern that HIV-infected men are having unprotected sexual intercourse with men, which then facilitates the transmission of HIV or the superinfection of men already infected with HIV.

In SHAS interviews from 2000 to 2003, MSM respondents living with AIDS were asked about both unprotected anal intercourse (UAI) and having 10 or more sexual partners in the last 12 months. As shown in Figure 42, the proportion of MSM in SHAS reporting UAI more than doubled from 11% in 2000 to 26% in 2003. Similarly, the number who reported having 10 or more sexual partners increased significantly from 11% in 2001 to 26% in 2003 [49].

FIGURE 42



Men Who Have Sex with Men Who Also Inject Drugs (MSM/IDU)

MSM injection drug users (MSM/IDU) comprise an estimated 19,800 (6%) of all men who have sex with men. Of the estimated MSM/IDU in Los Angeles County, 45% are Latino, 34% White, 13% African American, 6% Asian, and 1% mixed or other race. As this is the only BRG defined by more than one mode of exposure, it is not surprising that MSM/IDU have among the highest estimated HIV seroprevalence rates of any BRG and African American MSM/IDU have the highest seroprevalence of any socio-demographic group at 32% (Table 8).

As compared with other MSM, MSM/IDU engage in high-risk behaviors more frequently. One San Francisco study specifically targeting MSM/IDU in 2000 found both a very high seroprevalence (42%) and over one-third of respondents reported recent high-risk behaviors, such as unprotected anal sex and sharing needles [50]. Preliminary findings from another MSM/IDU specific San Francisco study suggest an HIV seroprevalence of 25%, with 67% of participants having engaged in exchange sex-that is, sex for money, food, lodging, drugs, or the like in the 6 months prior to interview [51].

Men Who Have Sex with Men and Women (MSM/W)

Overall, an estimated 77,700 men in Los Angeles County have sex with both men and women (MSM/W). Of the MSM/W, 50% are Latino, 24% White, 14% Asian, 11% African American, and 1% mixed or other race. As presented in the HIV risk behavior studies below, MSM/W were consistently less likely to engage in risky behavior than were MSM or MSM/IDU. Estimates of HIV seroprevalence and rates of new HIV infection were also markedly lower among MSM/W, compared with either MSM or MSM/IDU (Table 8).

Reported MSM/W behavior varies widely between race/ethnicities and between studies, and is highest among African American and Latino men [52]. In a recent study of HIV-infected heterosexual African American men conducted by the HIV Epidemiology Program, 31% of self-identified heterosexual cases and 16% of HIV-negative heterosexual neighborhood controls reported having anal sex with men; further, 46% of HIV-positive self-identified heterosexual respondents reported "infrequent condom use" when having anal sex with women [53]. In another recent study of Latino MSM conducted by the HIV Epidemiology Program, foreign-born Latinos were more likely than U.S.-born to be married (12% vs. 3.2%) and to have had sex with men and women (27% vs. 21%) [54]. A recent behavioral survey of Los Angeles MSM conducted by the HIV Epidemiology Program found a higher level of self-reported bisexual behavior among younger men, age 18-29 years (18%) than among men age 30 and over (11%) [55]. Finally, in the 2003 CRAS, more than 13% of self-identified heterosexual men reported having at least one male partner in the past six months.

Heterosexual Male Injection Drug Users (HM/IDU)

Of the estimated 88,100 heterosexual male injection drug users (HMIDU) in Los Angeles County, 44% are Latino, 35% White, 18% African American, 2% Asian, and 2% mixed race. Men who report injection drug use and report only sex with women comprise 6% of all PLWH/A in the County. HMIDU have the fifth highest seroprevalence among the seven BRGs (4.1%), yet African American HMIDU have an estimated 7% seroprevalence.

An HIV Epidemiology Program study conducted at Los Angeles County methadone treatment clinics found that, at least among male IDU, HIV infection was associated with the frequency of cleaning needles, frequency of injection, frequency of using unclean needles, number of people sharing a needle, and the frequency of needle sharing [56].

Female Injection Drug Users (FIDU)

Of the estimated 58,100 female injection drug users (FIDU) in Los Angeles County, 41% are White, 38% Latino, 17% African American, 1% Asian, and 3% mixed race and others (Table 8). Women who report injection drug use comprise about 3% of PLWH/A in Los Angeles County, and about one quarter of all women living with HIV and AIDS. While overall, HIV seroprevalence is relatively low in this BRG, African American FIDU have a higher estimated seroprevalence of 7%.

FIDU living with AIDS were more likely than any other BRG to have had an STD. In a recent local study of young injection drug users, FIDU reported more frequent needle sharing, more needle exchange use, and carrying clean syringes than did male IDU respondents [57]. A San Francisco study had similar findings, but also found FIDU to be more likely than males to report having been injected by a partner, having recent intercourse, and having a sexual partner who was also an IDU; in fact, the most significant risk factor for HIV infection among FIDU in this study was having an injection partner who was also a sexual partner [58]. A study of drug-using women-who-have-sex-with-women found that, in the 30 days prior to interview, over half of respondents had shared syringes and/or shared drug supplies and also had sexual intercourse with men, over 70% of which was unprotected [59].

Women at Sexual Risk (WSR)

The greatest challenge in estimating the relative impact of HIV and AIDS on women in this BRG is identifying which women are at risk. All agree that unprotected sex with multiple male sexual partners, a partner who also has sex with men, or an HIV-infected partner, puts a woman at risk for HIV. However, many women in Los Angeles County who reported being monogamous or married, have shown up in hospitals with AIDS, never suspecting that they were ever at risk for HIV. This scenario was especially prevalent among Latinas, as shown in the 2004 SHAS data discussed below.

Of the estimated 267,100 women at sexual risk (WSR) in Los Angeles County, 38% are Latino, 37% White, 13% African American, 11% Asian, and 1% mixed race and others (Table 8). Women who identified sexual intercourse with a man as their mode of exposure are estimated to comprise 7% of PLWH/A in the County. Rates of new infection for repeat testers at State-funded counseling and testing sites were similarly low for WSR and FIDU (0.2% and 0.3% per year, respectively). WSR have the lowest estimated seroprevalence of any BRG (1.5%). However, when distributed by race/ethnicity, African American and Latino women were estimated to have higher HIV seroprevalence than White or Asian women (see Table 8). One reason for this may be the higher degree of bisexual behavior reported by African American and Latino men.

In a recent study conducted at UCLA, HIV seropositivity in women was found to be associated with unemployment, less education, the number of sexual partners, the number of STDs, and a history of traumatic life experiences [60]. Young women who have older male sex partners have also been shown to be at risk for HIV [61].

In SHAS interviews from 2000 to 2003, WSR were less likely than FIDU to have engaged in unprotected receptive anal intercourse (2% vs. 8%, respectively), half as likely to ever have had an STD (34% vs. 64%), and much less likely to have had sex while high on alcohol or drugs (4% vs. 16%). Among non-injection drug using female respondents, Latinas were 4 times more likely than non-Latinas to have first tested positive for HIV while as an inpatient in the hospital and

twice as likely to have reported illness as the primary reason for being tested for HIV for the first time [62].

Transgenders at Sexual Risk and/or TG Injection Drug Users (TGs)

Historically, transgendered women (male-to-female) and transgendered men (female-to-male) have been ignored in population enumerations such as the U.S. Census and other population-based surveys. Although the HIV Epidemiology Program and the California Office of AIDS have been able to record male-to-female and female-to-male transgender as gender reporting options in HARS since July 2002, these data have yet to be evaluated for completeness and accuracy. For these reasons, the transgendered population and the impact of HIV and AIDS on this population must still be estimated.

The *2001 Consensus Meeting on HIV/AIDS Incidence and Prevalence* estimated the transgendered population in Los Angeles County to be around 10,000 persons [63]. In local studies, the HIV seroprevalence for transgendered women ranged from 7% to 22%, while in local State-funded HIV testing sites, transgendered men (female-to-male transgender) had a much lower seroprevalence (2%). Overall, 17% of transgendered persons in Los Angeles County are estimated to be HIV-infected, including those with AIDS (see Table 8).

Although relatively little objective HIV risk information is available on this population [64], recent studies indicate that transgendered women continue to be at high risk for HIV [65]. An incidence of new HIV infections of 5.6% per year was found among transgendered women who received repeat HIV testing at State-funded counseling and testing sites in Los Angeles higher than for any other socio-demographic group. By comparison, at HIV counseling and testing sites in San Francisco, an HIV seroconversion rate of 7.8% per year was found in transgendered women and a seroprevalence of 35% [66].

Recent HIV Epidemiology Program analysis of data from the *Los Angeles Transgender Health Study* – a collaborative study with the Van Ness Recovery House [67] – demonstrated significant differences in risk behaviors between transgendered women for whom sex work was their primary source of income in the prior 6 months and those for whom it was not. Transgendered women for whom sex work was their primary source of recent income were more likely to report having engaged in receptive anal intercourse (98% vs. 65%), having had more than 10 sex partners in the last 6 months (83% vs. 11%), having had sex while high on drugs or alcohol (74% vs. 33%), and having used street-bought syringes to inject hormones (84% vs. 57%) than transgendered women who do not report sex as their primary source of income (see Figure 43). Reported illicit drug use was infrequent among all study participants (less than 10%) and no difference was seen in sharing the needles and syringes used for injecting illicit drugs among groups based on source of income.

Table 20 illustrates the higher likelihood of being HIV-infected for older transgendered women whose primary source of income was sex work compared with other older transgendered women and younger study participants. As such, younger transgendered women whose primary source of income is sex work, and whose seroprevalence is relatively low, represent a subgroup who should be intensively targeted with HIV prevention messages and support services, because they are likely at very high risk of infection. Results from further analysis of this study will soon be published [68].

FIGURE 43

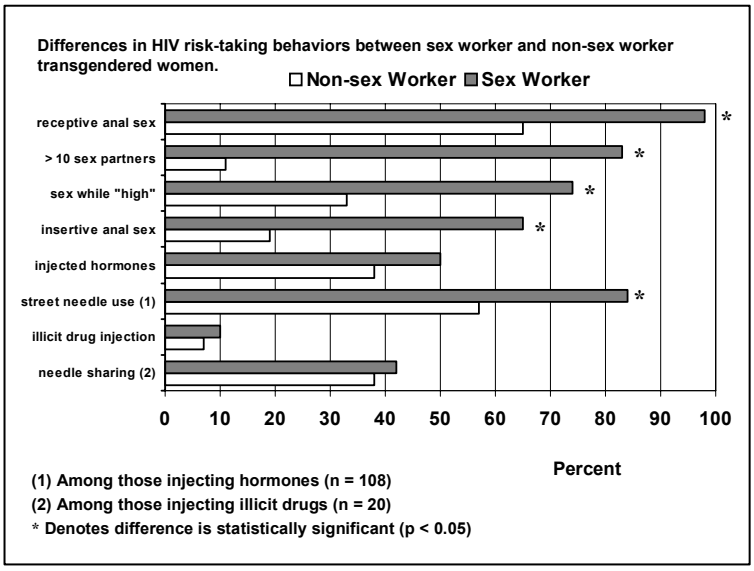


TABLE 19. Comparison of HIV seroprevalence among older and younger transgendered women by primary source of income—Los Angeles Transgender Health Study, 2001.

Older (≥30 years) transgendered women whose primary source of income is sex work: 48%	Younger (18-29 years) transgendered women whose primary source of income is sex work: 14%
Other older transgendered women: 22%	Other younger transgendered women: 13%

Community Resources to Address Needs

The largest share of resources in Los Angeles County that are directed to meeting the HIV prevention and related needs of residents comes from the CDC through its HIV Prevention Cooperative Agreement with OAPP and through its directly-funded programs, most of which are new as of 2003-2004. These funds support the cost of providing a broad spectrum of services along the HIV prevention continuum (see *Interventions* section). OAPP also receives State and local funds through the State of California Office of AIDS and Net County Cost, respectively. In addition to these resources, there are significant resources supporting HIV prevention and related activities from numerous sources, including among others: HRSA Ryan White CARE Act, Office of Minority Health, the City of Los Angeles, the City of West Hollywood, the City of Long Beach, the City of Pasadena, Substance Abuse and Mental Health Services Administration (through the Centers for Substance Abuse Prevention HIV set-aside funds), directly-funded initiatives through the California Office of AIDS, CDC, SAMHSA, private and corporate foundations, and through donations of individuals who recognize the need for continued efforts to prevent further transmission of HIV.

Rather than organize this information by funding source, the resources described in the following pages are presented by "categories" related to the type of activity that is currently being supported in Los Angeles County. For example, there are broadly defined categories such as "Capacity

Building" or "HIV Prevention Services" to guide the reader quickly to an area of interest. Discussed under these descriptions are specific types of programs being funded. Where known, information regarding SPA and target population is also provided. The resources presented below begin to fill in the landscape of HIV prevention as it relates to the needs described earlier.

■ AIDS Education & Training

The broad rubric of "AIDS education and training" refers here to the education and training available within Los Angeles County to meet the needs of health providers and other professional and paraprofessional staff of CBOs.

The Pacific AIDS Education and Training Center

The Pacific AIDS Education and Training Center (PAETC) provides HIV/AIDS-related training, education, and information services to health care providers. PAETC has 15 local sites in California, Arizona, Hawaii, and Nevada that provide services locally. PAETC is an affiliate of the University of California, San Francisco AIDS Research Institute. PAETC's mission is:

> *To provide health care professionals with the knowledge and skills necessary to care for HIV-infected patients in underserved and vulnerable populations; to increase the numbers of trained health care professionals working with HIV-infected patients; and to respond to the needs of high-risk populations and the changing face of the epidemic.*

There are three PAETC sites located within Los Angeles County:

1. USC AIDS Education & Training Center (SPA 4)
   Keck School of Medicine
   1420 San Pablo Street, PMB B205, Los Angeles, CA 90089-9049
   Phone: (323) 442-1846

2. UCLA AIDS Education & Training Center (SPA 5)
   Center for Health Promotion & Disease Prevention
   10833 LeConte Ave., CHS, Room 61-236, Los Angeles, CA 90095-1772
   Phone: (310) 794-7130

3. Drew University AIDS Education & Training Center (SPA 6)
   Charles R. Drew University of Medicine & Science
   1731 E. 120th Street, M.P. #11, Los Angeles, CA 90059
   Phone: (310) 668-4757

OAPP Educational and Skills Development

OAPP regularly offers targeted educational programs to improve the capacity of CBOs in the design, implementation, and evaluation of their HIV prevention programs. The following is a sample of core trainings currently offered:

1. Making the Connection – Developing a Comprehensive Curriculum – This 8-hour training includes an overview of the essential components of an effective HIV prevention curriculum. The training targets staff responsible for developing curricula, particularly new program directors and those who want to improve their skills.

2. Bridging Theory & Practice – Applying Behavioral Theory to HIV/STD Prevention – This interactive 2-day training provides an overview of behavioral science theory, and introduces a derived set of domains that summarizes the various personal, interpersonal, and structural influences on an individual's behavior choices. The training integrates behavioral science theory with intervention planning. It greatly benefits HIV/STD program designers, program directors, and grant writers.

3. Evaluation – Developed through a subcontract with AIDS Project Los Angeles and the Center for HIV Identification, Prevention, and Treatment Services, this 1-day workshop improves participants' understanding of the evaluation process, and provides them with tools to design and implement an effective evaluation of their current programs. During 2005-2008, OAPP will subcontract evaluation expertise to assist subcontracted CBOs with their ongoing training and technical assistance needs.

In addition to these focused trainings, OAPP offers individualized technical assistance directly to CBOs to assist with curriculum development, educational materials development, and other prevention intervention design and implementation needs.

OAPP HIV Test Counselor Training

OAPP offers in both English and Spanish *Basic I and Basic II - HIV Prevention Counseling and Skills Certification Training*. This seven-day training provides State of California and Los Angeles County certification for HIV Counselors. The training is split into Basic I, five-days, and Basic II, two-days. In Basic I, participants review elementary HIV knowledge, develop and practice strong client centered counseling skills, learn how to help clients assess HIV risks and work with clients to develop small, realistic steps towards reducing HIV risk.

New in 2005, OAPP will offer certification in reading the rapid HIV test and delivering preliminary HIV positive test results.

■ Capacity Building & Technical Assistance

There is a great deal of organizational and community-related capacity building being provided within Los Angeles County. Capacity building ranges from Board development to resource development to community coalition building. Because of the diversity in types of capacity building being supported within the County, the information presented here is discussed by primary funding source and are listed in alphabetical order.

California Office of AIDS

In 2003, the California Department of Health Services, Office of AIDS awarded AIDS Project Los Angeles a grant to provide training and technical assistance to California CBOs currently providing or desiring to provide prevention with positives (PwP) activities or programs targeting people of color. The purpose is to strengthen and build the capacity of CBOs in the areas of program planning, development, and evaluation. Program activities include a 2-day interactive training titled "Laying the Foundation" and one-on-one technical assistance. The training covers the fundamentals of program planning, development, and evaluation in regards to PwP.

CDC Capacity Building Initiative

In December 2003, the CDC solicited applications in response to *Program Announcement 04019:*

Capacity Building Assistance To Improve the Delivery and Effectiveness of Human Immunodeficiency Virus (HIV) Prevention Services for Racial/Ethnic Minority Populations. The purpose of this announcement was to identify national and regional non-governmental organizations to provide capacity building assistance (CBA) to CBOs and health departments providing HIV prevention services, and to HIV prevention community planning groups. This funding enables recipients of CBA to implement, improve, evaluate, and sustain the delivery of effective HIV prevention services for high-risk racial/ethnic minority populations of unknown or negative serostatus, including pregnant women, and people of color who are living with HIV/AIDS and their partners.

The CDC's CBA program includes the following four focus areas:

1. Strengthening Organizational Infrastructure for HIV Prevention: The goal is to improve the capacity of CBOs to strengthen and sustain organizational infrastructures that support the delivery of effective HIV prevention services and interventions for high-risk racial/ethnic minority individuals.

2. Strengthening Interventions for HIV Prevention: The goal is to improve the capacity of CBOs and Health Departments to implement, improve, and evaluate HIV prevention interventions for high-risk racial/ethnic minority individuals of unknown serostatus, including pregnant women, and people of color who are living with HIV/AIDS and their partners.

3. Strengthening Community Access to and Utilization of HIV Prevention Services: The goal is to improve the capacity of CBOs and other community stakeholders to implement strategies that will increase access to and utilization of HIV prevention and risk-reduction and avoidance services for racial/ethnic minority individuals.

4. Strengthening Community Planning for HIV Prevention: The goal is to improve the capacity of community planning groups (CPGs) and Health Departments to include HIV-infected and affected racial/ethnic minority participants in the community planning process, and increase parity, inclusion, and representation on CPGs.

Under this initiative, the CDC funded the Black AIDS Institute, a Los Angeles-based organization under the category *"Strengthening Community Access to and Utilization of HIV Prevention Service"* to provide national capacity building services to organizations working with at-risk African American communities. Recipients of these funds are charged to build inter-systems collaborations and public/private partnerships to change institutional policies in favor of HIV testing and referral services; influence community norms to reduce stigma against people living with HIV/AIDS; and increase access to and use of HIV testing and referral services.

Center for HIV Identification, Prevention, & Treatment Services

The Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) is a collaboration of researchers from UCLA, Charles Drew University of Medicine and Science, Friends Research Institute, and RAND working with the broader Los Angeles community toward a common goal: *to enhance our collective understanding of HIV research and to promote early detection, effective prevention, and treatment programs for HIV*. Funded by the National Institute of Mental Health, CHIPTS serves as a bridge among researchers, government, service providers, and people living with HIV in responding to the changes in the HIV epidemic and in shaping

sound public policy.
CHIPTS offers a range of services including consultation on the development of new research projects and assistance with obtaining funds for these initiatives. CHIPTS provides technical assistance in HIV program development and evaluation and sponsors an annual conference for developing researchers to present their work. In addition, CHIPTS hosts an annual policy forum for researchers, government officials, and the HIV community to discuss emerging HIV policy issues, as well as hosts a research colloquia series.

OAPP Capacity Building Initiative

OAPP provides capacity building and technical assistance to support HIV prevention and related services in several ways. First, OAPP has provided capacity building assistance to contracted CBOs for five years under its *Capacity Building Initiative*. Second, OAPP has delivered educational programs, designed to enhance the capacity of CBOs, as well as the PPC, to address skill and information gaps (discussed earlier under *AIDS Education and Training*). Lastly, OAPP has been committed to strengthening the capacity of local communities to better respond to the HIV/AIDS epidemic through the establishment of Service Provider Networks (SPNs) in specific geographic regions (see *OAPP – Community Coalition Capacity Building* listed below).

OAPP's Capacity Building Initiative is founded on the principle that services are frequently best provided by organizations and individuals indigenous to the community being served. As such, capacity building requires long-term, sustained efforts within these communities. Creating an "Environment of Improvement" is the cornerstone of OAPP's philosophy and approach. This environment consists of creating continuous improvement through the development of leadership, sustained professional relationships, and resources. OAPP's Capacity Building Initiative allows CBOs the opportunity to address immediate infrastructure needs such as technology, facility improvements, and fund development, as well as developing a long-term partner with whom they are able to address the systemic needs of their organization.

In 2004, OAPP solicited applications to support multi-year organizational infrastructure development in the following three areas:

1. Organizational Leadership – Activities that will strengthen the CBO's senior management staff and the Board of Directors' ability to lead and provide clear direction consistent with their respective responsibilities;

2. External Relations – Activities that involve external resources that will strengthen the CBO's ability to network better and involve important relevant community stakeholders for better service delivery; and

3. Internal Structure – Activities that will strengthen the CBO's ability to manage a multi-layered structure by integrating organizational support functions and systems.

OAPP works closely with CBOs to conduct an individualized organizational assessment and plan to address identified needs. This information helps OAPP to continually refine and improve its capacity building efforts to meet the needs of local communities and organizations.

OAPP – Community Coalition Capacity Building

Los Angeles County organizes health care services in each of eight geographic Service Planning Areas (SPAs). OAPP has created a number of formal community collaborations and networks, to

develop and strengthen the community infrastructure in Los Angeles County. Examples of such networks include Service Provider Networks (SPNs) in all eight SPAs, and two Community Development Initiatives (CDIs) targeting African Americans and Latinos.

1. Service Provider Networks - To plan and coordinate HIV/AIDS care services throughout the County, OAPP contracts with a lead agency in each SPA to coordinate a Service Provider Network (SPN). Each SPN is a formally organized group of providers, consumers, and community representatives that regularly convene in an effort to facilitate and improve the coordination of care and prevention services in their respective local area. The SPNs create a linked system of care that is client-centered in an effort to expedite service delivery across all SPAs. SPNs reduce duplication of efforts through formal, ongoing and mutual relationships that manage service delivery.

   The SPNs are currently developing comprehensive service and information technology inventories, standardizing intakes, and exploring options for using compatible systems for data management and cross communication. In addition, in late 2004, the SPNs will take on an increased focus on HIV prevention and related resources. This will ensure that there is a strong linkage and coordination between HIV prevention and care services.

2. Community Development Initiative - In 2003, OAPP developed two Community Development Initiatives (CDIs) serving both the African American and Latino communities. The CDIs are among a group of innovative responses to the increasing burden of HIV disease in communities of color. The largest number of AIDS cases diagnosed every year since 1997 in Los Angeles County has been among Latinos, and the most disproportionate impact of the HIV/AIDS epidemic is among African-Americans. The two CDIs provide the new leadership necessary to reinvigorate a public discussion of HIV/AIDS and to address the needs of those living with or at high risk for HIV infection in the targeted communities.

   Each lead agency is responsible for fostering vigorous and ongoing community involvement critical to creating an environment conducive to HIV prevention and awareness. The CDIs serve to create partnerships with leaders of civic organizations, elected officials, opinion leaders, and faith communities to mobilize community action to provide HIV prevention services, increase awareness of HIV, and generally expand the range of HIV prevention interventions.

Office of Minority Health

The Office of Minority Health (OMH) of the U.S. Department of Health and Human Services (HHS) administers the *Technical Assistance and Capacity Development Demonstration Grant Program for HIV/AIDS-Related Services in Minority Communities*. The OMH developed the program in 1999 as part of the Minority HIV/AIDS Initiative to address the HIV/AIDS epidemic in minority communities. The purpose of the program is to stimulate and foster the development of effective and durable service delivery capacity for HIV prevention and treatment among organizations closely linked with the minority populations impacted by HIV/AIDS. Specifically, the goals of the program are to: (1) provide administrative and programmatic technical assistance to enable minority-serving CBOs to enhance their delivery of necessary services; and (2) assist those minority-serving CBOs, through an ongoing mentoring relationship, in the development of

their capacity as fiscally viable and programmatically effective organizations thereby allowing them to successfully compete for federal and other resources. Currently, there are two programs in Los Angeles County receiving funds from this OMH initiative:

1. Los Angeles County OAPP (2002-2005) - The *Capacity Building Initiative for HIV/AIDS-Related Services in Minority Communities* targets organizations in Los Angeles County. Participating minority-serving CBOs include entities which are directly involved with OAPP programs, as well as emerging organizations seeking to provide HIV/AIDS related services. These organizations serve African American, Asian/Pacific Islander, Latino, and Native American communities.

2. Special Service for Groups (2003-2006) -The *Asian and Pacific Islander Community Development Project* seeks to increase the capacity and ability of Asian and Pacific Islander community based organizations (CBOs) in Los Angeles and Orange Counties to provide culturally appropriate HIV/AIDS prevention and treatment. Outreach, education, and training activities are conducted for small CBOs and Lesbian/Gay/Bisexual/Transgendered/Questioning (LGBTQ) focused organizations.

Office of Minority Health – Community Coalition Capacity Building

The *Minority Community Health Coalition Demonstration Program, HIV/AIDS* was developed in 1999 as part of the Minority HIV/AIDS Initiative to address the HIV/AIDS epidemic in minority communities. The purpose of the program is to improve the health status, relative to HIV/AIDS, of targeted minority populations through health promotion and education activities. This program is intended to demonstrate the effectiveness of community-based coalitions involving non-traditional partners in: (1) developing an integrated community-based response to the HIV/AIDS crisis through community dialogue and interaction; (2) addressing sociocultural, linguistic and other barriers to HIV/AIDS treatment to increase the number of individuals seeking and accepting services; and (3) developing and conducting HIV/AIDS education and outreach efforts for hard-to-reach populations. The OMH currently funds two CBOs in Los Angeles County:

1. Asian Youth Center – (2002-2005) - The primary goals of the *Asian and Pacific Islander Consortium for HIV/AIDS Prevention (API CHAP)* are to improve the educational understanding of HIV/AIDS and to increase access to HIV/AIDS prevention and treatment services through advocacy, coalition building, and culturally competent outreach and education activities targeting the diverse Asian and Pacific Islander (API) communities in Los Angeles. The Asian Youth Center collaborates with the Asian Pacific Health Care Venture, Korean Youth and Community Center, SHP/Lodestone Theater Ensemble, and South Asian Network in its efforts. The project works to provide culturally and linguistically appropriate HIV/AIDS services for the API communities, particularly API youth. The project also serves as a mobilizing force for the local council, which represents API ethnic communities and community-based organizations that address HIV/AIDS issues and services in the API communities.

2. Los Angeles Shanti Foundation, Inc. – (2002-2005) - The goal of the *Minority Community Health Coalition* is to increase the health status of African American and Latino women in Los Angeles County by increasing their educational level and understanding of HIV/AIDS, and improving access to HIV/AIDS prevention, testing,

and treatment services. Coalition members include the Los Angeles Shanti Foundation, LA Family AIDS Network, and Sunrise Community Counseling Center.

- **Early Intervention Services**

Historically, the Los Angeles County Commission on HIV Health Services has not allocated Ryan White CARE Act Title I funding for Early Intervention Services (EIS). This is due to the fact that there are significant other resources devoted to ensuring EIS services in Los Angeles County. Currently, there are a broad array of community-based primary care clinics offering directly-funded HIV Early Intervention Services (EIS) through Ryan White CARE Act Title III and the California Office of AIDS. As with the CDC's AHP initiative, one stated purpose of EIS is to identify high-risk individuals of unknown HIV serostatus, get them tested for HIV, and immediately link those individuals testing HIV positive into the HIV continuum of care and prevention services.

Ryan White CARE Act Title III: Early Intervention Services

The Title III Early Intervention Services (EIS) program funds comprehensive primary health care for individuals living with HIV disease. Title III services include, among others, risk-reduction counseling on prevention, antibody testing, medical evaluation, and clinical care, as well as case management to ensure access to services and continuity of care for HIV-infected clients. HRSA, which is responsible for administering Ryan White CARE Act funds, has an annual competitive solicitation process to identify new primary care programs in high-risk areas.

In Los Angeles County, HRSA funds 12 Title III EIS programs. Listed by SPA they include:

1. The Catalyst Foundation for AIDS Awareness and Care (SPA 1)
2. Northeast Valley Health Corporation/HIV/AIDS Programs (SPA 2)
3. Tarzana Treatment Centers, Inc. (SPA 2)
4. AltaMed Health Services (SPA 3)
5. LAGLSC/Goodman Special Care Clinic (SPA 4)
6. The Maternal Child and Adolescent Center for Infectious Diseases and Virology, USC Keck School of Medicine (SPA 4)
7. Venice Family Clinic (SPA 5)
8. LAC-Martin Luther King, Jr.-Drew Medical Center, The OASIS Clinic (SPA 6)
9. T.H.E. Clinic, Inc. (SPA 6)
10. Watts Health Foundation South L.A. Community AIDS Program (SPA 6)
11. El Proyecto Del Barrio (SPA 7)
12. Catholic Healthcare West/C.A.R.E. Program/St. Mary Medical Center (SPA 8)

State of California Office of AIDS (through OAPP)

The State of California provides funding for early intervention programs through OAPP. Similar to Title III programs, funds are used to identify HIV-infected individuals who do not yet know their HIV serostatus and link them early into the HIV continuum of care and prevention services.

1. Pasadena Public Health Department Andrew Escajeda Clinic (SPA 3)
2. AIDS Healthcare Foundation/Prototypes (SPA 4)
3. Hubert H. Humphrey Comprehensive Center (SPA 6)
4. AltaMed/Prototypes (SPA 7)
5. Long Beach Health Department (SPA 8)

HIV Epidemiology

The Los Angeles County Department of Health Services HIV Epidemiology Program is responsible for tracking and monitoring trends related to HIV counseling and testing, and HIV/AIDS incidence and prevalence. It strives to achieve its mission to:

> *Collect, analyze, and disseminate HIV/AIDS surveillance and epidemiologic study data essential for the planning, implementation, and evaluation of programs and policies involving HIV and AIDS care, prevention, education, and research in Los Angeles County.*

AIDS case surveillance is a core public health activity that has been the responsibility of the HIV Epidemiology Program since its inception. Non-AIDS HIV surveillance was mandated by California regulation starting in July 2002. These activities are supported by a grant from the California Office of AIDS and by federal funding through a cooperative agreement with the CDC. HIV and AIDS surveillance activities are divided among three units, Data Acquisition Unit, Data Analysis Unit, and Pediatric HIV/AIDS Infection Reporting (PHIR).

The following is a sampling of current epidemiological studies being conducted by the HIV Epidemiology Program (see Appendix). They include:

1. Supplement to HIV and AIDS Surveillance (SHAS) Project
2. The American Indian/Alaskan Native Validation Project
3. The Bathhouse Study
4. Finding and Characterizing Persons with Recent and Newly Diagnosed HIV Infection in Metro and South Service Planning Areas
5. Brothers y Hermanos
6. The Context of HIV Infection Project
7. The Los Angeles Men's Survey

In addition to the above studies, HIV Epidemiology Program staff are actively involved in publishing articles related to HIV/AIDS. Recent 2004 publications include:

1. Risk of mortality associated with viral hepatitis B and C in patients with HIV infection: A cohort study. In Press.
2. Changes in HIV Prevalence Among Public Sexually Transmitted Disease Clinic Attendees in the Western Region of the US (1989-1999).
3. Associations of Race/Ethnicity with HIV Prevalence and HIV-Related Behaviors among Young Men Who Have Sex With Men (MSM) in Seven U.S. Centers.
4. Comparing sexual behavioral patterns between two bathhouses: Implications for HIV prevention intervention policy. In Press.

5. Recent Increase In High-Risk Sexual Behaviors Among Sexually Active MSM Living With AIDS in Los Angeles County.

■ HIV Prevention and Related Services

CDC's Advancing HIV Prevention (AHP) Demonstration Projects

In the Fall of 2003, the CDC awarded $23 million over two years to nine health departments and 16 CBOs across the country to develop models and demonstrate efficacy for implementing four AHP strategies. Demonstration projects are designed to test the feasibility of the four strategies, which include (1) making HIV testing a routine part of medical care; (2) creating new models for diagnosing HIV infections outside medical settings; (3) preventing new infections by working with people diagnosed with HIV and their partners; and (4) further decreasing mother-to-child transmission by incorporating HIV testing in the routine battery of prenatal tests. Los Angeles County successfully received funding for four projects:

1. Los Angeles County Department of Health Services OAPP – OAPP received funding to support two different projects under this initiative. The first project involves routinely recommending HIV testing as part of regular medical care services and targets the general population seeking services in high volume, high prevalence medical settings.

   OAPP's second project is for HIV rapid testing to improve outcomes for partner counseling and referral services. The target population is partners of PLWH/A.

2. Bienestar Human Services, Inc. – Bienestar Human Services, Inc. received funding for two distinct demonstration projects. The first project is to conduct HIV rapid testing in non-clinical settings, targeting Latinos at high-risk for HIV infection.

   Bienestar's second project is to provide prevention case management services to HIV positive Latinos at risk for transmitting HIV.

CDC's HIV Prevention for Community-Based Organizations

In April 2004, the CDC announced the successful applicants of its *Program Announcement 04064: HIV Prevention Projects for Community-Based Organizations*, which represents the next step towards fully implementing AHP. The purpose of these 5-year projects is to: (1) decrease the number of persons at high risk for HIV; (2) increase the proportion of HIV-positive people who know they are infected and linked to appropriate care services; and (3) strengthen the capacity to monitor the epidemic, develop and implement interventions, and evaluate programs. This new funding replaces direct CDC funding under five previous initiatives. To maximize successful outcomes, the CDC only funded approved, evidence-based interventions, which could be adapted and/or tailored by the applicant. There are five Los Angeles County projects:

1. AIDS Healthcare Foundation (SPA 4) – AHF's project provides targeted outreach; HIV counseling, testing, and referral services targeting high risk MSM regardless of race/ethnicity.

2. AltaMed (SPAs 4, and 7) – AltaMed's project provides targeted outreach; Health Education/Risk Reduction (HE/RR) services and prevention case management

targeting Latino gay, bisexual and questioning men, including MSM; individuals living with HIV and their sex and injection drug using partners

3. Bienestar Human Services, Inc.(SPAs 2, 4, and 7) – Bienestar's project provides targeted outreach; the Many Men, Many Voices intervention; HIV counseling, testing, and referral services; and the Healthy Relationships intervention targeting Latino adult MSM and male-to-female Transgenders.

4. JWCH Institute (SPA 4 - Skid Row) – JWCH's project provides targeted outreach; the Community Promise intervention; and the Healthy Relationships intervention targeting very high risk homeless persons with special emphasis on African Americans, Latinos, MSM, and MSM/W.

5. Tarzana Treatment Center (SPA 2) – Tarzana's project provides targeted outreach and the Safety Counts intervention targeting active crack cocaine users and IDUs at very high risk for HIV infection.

City of Long Beach Health Department

The City of Long Beach is Los Angeles County's second largest city and has its own health department. The health department receives HIV prevention funding directly from the California Office of AIDS. Funds support social marketing, HIV prevention programs operated by the subcontracted agencies within the city, and an HIV transmission prevention project.

City of Los Angeles

In 1990, the AIDS Coordinator's Office spearheaded the development of the City of Los Angeles' first comprehensive AIDS Policy. The Policy served as a blueprint for the City's multi-pronged effort to combat HIV/AIDS. Today the AIDS Coordinator's Office, housed within the Department of Disability, continues to take a leading role in HIV/AIDS policy issues affecting the city's residents. Recently the AIDS Coordinator's Office worked with the Mayor's AIDS Leadership Council to create a white paper titled "HIV and AIDS in Los Angeles: 21st Century Challenges and Approaches," which was presented to the Los Angeles City Council in December 2003. The white paper summarizes key HIV/AIDS issues faced by the City today and outlines ways for Los Angeles to reinvigorate its HIV/AIDS policies.

The City of Los Angeles funds a broad array of HIV prevention interventions through approximately 19 subcontracted CBOs. In July 2003, the AIDS Coordinator's Office funded the purchase of the City of Los Angeles' first HIV/AIDS Mobile Education & Referral Unit.

City of Pasadena

The City of Pasadena also has its own public health department. The Pasadena Public Health Department receives direct funding from the California Office of AIDS to provide HIV prevention, AIDS surveillance and HIV reporting, and HIV counseling and testing services.

City of West Hollywood

Although small in size, the City of West Hollywood has the highest AIDS case rate in Los Angeles County. The City of West Hollywood has funded HIV prevention programs since the early years of this epidemic. It currently invests nearly one million dollars annually to prevention projects. In 2004, the City of West Hollywood began a new 2-year funding cycle and specific providers may change as a result of its solicitation process. The City also funds HIV counseling,

testing, and referral services.

OAPP

OAPP directly receives federal, State, and local funding to ensure that there is a full complement of HIV prevention and related services to meet the needs of Los Angeles County residents. OAPP competitively solicits the majority of funds to CBOs across the County. It is the responsibility of OAPP and the PPC to ensure that funds allocated are used for their intended purpose to address community needs. OAPP supports the following types of services:

1. Health Education/Risk Reduction (HE/RR), including outreach, individual-level interventions, group-level interventions, community-level interventions and health communication/public information targeted to high risk HIV-negative persons and HIV-positive persons. This category is intended to increase knowledge, awareness and skills to decrease the prevalence of HIV risk behaviors, to maintain and reinforce risk reduction behaviors and create community norms and values that support HIV risk reduction efforts, learning of one's HIV status and disclosure of HIV status, when appropriate. This category will secondarily serve as a vehicle to refer HIV at risk persons of unknown HIV status to available HIV counseling and testing services.

2. HIV Counseling and Testing (HCT), including risk assessment, rapid and non-rapid HIV-antibody testing, disclosure counseling, post-disclosure counseling, partner elicitation counseling and referral services targeted to persons of unknown HIV status. Funding under this category will emphasize confidential HIV testing services and support community-based, clinic-based and mobile unit-based counseling and testing services and multiple morbidity counseling, testing, screening, and vaccination services.

3. Partner Counseling and Referral Services (PCRS), to support the delivery of HIV counseling and rapid and non-rapid HIV testing of sexual and drug using partners of diagnosed HIV-positive persons by PCRS-trained and certified staff or agents of the Los Angeles County Department of Health Services.

4. Prevention Case Management (PCM), targeted to HIV-negative persons at high risk for HIV infection and HIV-positive persons at high risk for HIV transmission.

5. School-based Programs including the development and provision of an innovative HIV/AIDS training program that increases broad school-based support for HIV/AIDS education among school administration, teachers and medical staff, school boards, parent-teacher organizations and parents for comprehensive HIV education and prevention activities for students.

6. HIV Prevention Program Evaluation, Technical Assistance and Coordination, including SPA-based Behavioral Scientists, to assist local HIV prevention providers in the development of evidenced-based, behavior theory-based and behavioral risk group-specific interventions, to ensure collection of relevant program evaluation markers and to assist with program assessment and refinement efforts.

■ Integrated HIV and Substance Abuse Prevention

Substance Abuse and Mental Health Services Administration

In September 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced funding awards for its Targeted Capacity Expansion Initiatives for Substance Abuse Prevention (SAP) and HIV Prevention in Minority Communities: Services Grants (SP03-005). The 5-year prevention grants are designed to fund efforts by community-based organizations, faith communities, minority-serving colleges and universities, health care delivery organizations and others to provide effective, integrated substance abuse prevention and HIV services in high risk minority communities.

> Asian Pacific Family Center – This substance abuse prevention and HIV prevention project includes Life Skills Development and After School Group Activities for youth and bicultural parenting group sessions for parents. The target populations include Chinese and Korean immigrant high school age youth in the East San Gabriel Valley area of Los Angeles County and their parents.

■ Juvenile and Adult Criminal Justice, Correctional, and Parole Systems and Programs

As part of the national Corrections Demonstration Project, Los Angeles County has introduced a full complement of services for incarcerated persons living with HIV and persons at risk for HIV in the largest jail system in the country – the Los Angeles County Jail system managed by the Los Angeles Sheriff's Department (LASD). Services include transitional case management, treatment education, risk reduction counseling, HIV counseling and testing (HCT), and condom distribution. OAPP has developed a strong partnership with the Community Transition Unit of the LASD to ensure the consistent delivery of services, establish service standards across service categories and to expand the availability of critical HCT and HE/RR services.

Los Angeles County will continue to support both HCT and HE/RR services in several correctional settings. Los Angeles County has recently renewed HCT and HE/RR services in the LASD and will continue HE/RR services in the California Youth Authority. In addition, OAPP recently renewed a contract with the University of Southern California to deliver HE/RR services to incarcerated youth in the Los Angeles Juvenile Hall system, which are intended to, among other things, link individuals when appropriate to HCT.

Recently, in partnership with the City of Los Angeles-funded Palms Residential Facility and the LASD, OAPP has deployed Community Services Counselors to provide HCT to inmates being released from jail and their partners through a mobile unit. OAPP will work to offer this service consistent with demand, as well as introduce rapid testing as a testing option.

■ Perinatal Transmission Prevention

OAPP has been part of a California Department of Health Services Office of AIDS (OA) funded statewide HIV Perinatal Prevention Program since 2000. This project is part of the national perinatal demonstration projects funded by the CDC in 1999. This current HIV Perinatal Prevention project will continue with OA funding through June 30, 2004.

OAPP is collaborating with OA to develop a comprehensive set of HIV perinatal prevention activities for a number of counties in California, including Los Angeles, which will incorporate lessons learned from the current initiative and take program activities to the next level. Detailed

information on the proposed program activities will be described in the State of California application to the CDC.

■ Special Projects of National Significance (SPNS)

Los Angeles County currently has four SPNS projects funded through HRSA Ryan White CARE Act, which have important implications for HIV prevention:

1. UCLA School of Medicine – UCLA's *Outreach and Access to Care Project* will evaluate an existing intervention that provides HIV testing, counseling, and care services to the target population. During 2003-2005, UCLA will develop and implement a refined intervention featuring enhanced outreach and case-management, with the goal of improving access to care and health outcomes as a result of services provided. Drew University's Mobile HIV Outreach Program is a project partner.

   The target populations include commercial sex workers, runaway youth, the homeless, undocumented workers, gang members, teen parents, women of childbearing age, adult and adolescent MSM of color and transgendered/transsexual persons of color in the South Central, Hollywood, West Hollywood, East LA, and downtown neighborhoods of Los Angeles.

2. OAPP – OAPP's *HIV Prevention in Primary Care Settings Project* will study the effect of enhanced provider-based prevention services using motivational interviewing and loss-framed messages. Project goals include improving the patient-provider relationship, improving the ability of providers to implement prevention counseling, and reduce high-risk sexual behaviors. The project will be implemented by OAPP and its partners (Keck School of Medicine at the University of Southern California, Childrens Hospital Los Angeles, AltaMed Health Services, and Northeast Valley Health Corporation) during 2003-05.

   The target population is sexually active HIV-infected patients being seen at HIV-oriented primary care sites.

3. OAPP – OAPP's information technology project will allow Los Angeles County to better assess the impact of information technology (IT) utilized in the care of HIV infected patients. The initiative will assess the extent to which IT, applied in various HIV care settings, can contribute to measurable and sustainable improvements in the delivery, quality and cost-effectiveness of care for people living with HIV, especially among communities of color.

   The HIV/AIDS Interface Technology Systems (HITS) is designed to establish new computer interfaces with existing information systems that will improve client access to services. HITS will: (1) identify individuals who test HIV-positive but do not return for their results; (2) minimize delays between testing HIV-positive and entering an HIV system of care; and (3) improve local ability to appropriately screen patients for service eligibility.

   HITS is a component of OAPP's larger web-enabled HIV Information Resources System (HIRS). HIRS will enable OAPP and its providers to plan, operate, report,

and research HIV/AIDS related programs and services in Los Angeles County. To facilitate the disclosure of test results, HIRS will have an electronic reminder interface for use by counseling and testing staff. This electronic prompt, materialized through the HIV Status Follow-Up System (HSFUS) interface, will remind counselors to follow-up with HIV-positive clients who have not returned for their test results after a specified period of time. It will also prompt counselor follow-up with the newly diagnosed confidential client. This electronic link is expected to significantly strengthen the integration of counseling and testing and HIV medical care services in Los Angeles County.

4. OAPP – OAPP's newest SPNS project (September 2004) under the category *Outreach, Care, and Prevention to Engage HIV Seropositive Young MSM of Color Demonstration Models* is a collaboration between OAPP and the HIV Epidemiology Program. The demonstration project will use outreach to link HIV-positive young men of color (African American and Latino) who have sex with other men to primary health care and evaluate the effectiveness of an innovative integrated case management (ICM) model in their adherence to care and treatment as well as prevention and risk reduction. The ICM model consolidates the principles of psychosocial, medical, and prevention case management into one service delivery format. The integrated case managers will deliver the intervention on site at the participating clinics, AltaMed Health Services (for Latinos), and King-Drew Medical Center's Oasis Clinic (for African Americans).

■ Syringe Exchange / Harm Reduction

City of Los Angeles

To protect residents' health and safety, the City of Los Angeles sponsors syringe exchange programs (SEPs), allowing injection drug users to trade used needles for clean needles. Like other large cities worldwide, Los Angeles recognizes the important role syringe exchange plays in preventing the spread of HIV and other diseases and linking injection drug users with drug treatment programs, health care and other assistance.

Currently funded syringe exchange providers include:

1. Asian American Drug Abuse Program
2. Bienestar Human Services
3. Clean Needles Now
4. Common Ground
5. Homeless Health Care
6. Minority AIDS Project
7. Tarzana Treatment Centers

California Office of AIDS

OAPP received $100,000 for FY 04/05, 05/06, and 06/07 to do Peer-Based HIV Prevention among Injection Drug Users and Satellite Syringe Exchangers. The goal of the project is to reduce HIV and hepatitis risk among IDUs, formalize the harm reduction role of Secondary Syringe Exchangers (SSEs) as peer educators within the public health system, enhance street-based targeted prevention and evaluate the health effectiveness of the intervention.

IDUs that are trusted in the community by our project partners will be trained as Peer Educators and they will contact other IDUs and present HIV and HCV information. Each project partner (5 agencies) will select a Project Coordinator that will train and supervise all of the Peers at each site. OAPP plans to implement this new project in January 2005.

State of California

In September 2004, Governor Schwarzenegger signed Senate Bill (SB) 1159 (Vasconsellos, D, Santa Clara), that creates a disease prevention demonstration project. This project will allow individuals in California to purchase up to 10 hypodermic needles and syringes without a prescription from pharmacists who have registered with the local health department. The intent of this public health initiative is to reduce the spread of blood borne pathogens and infectious diseases such as HIV and hepatitis C through contaminated needles. SB 1159, which takes effect in January, will 'sunset' or expire [unless renewed by the Legislature] in 2010. At that time, health officials will report back to the state on the progress of risk reduction via this disease prevention demonstration project.

■ Research and Academic Partners

Los Angeles County is home to a significant amount of HIV prevention and related research. UCLA's Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) as well as the Santa Monica-based Rand Corporation conduct ongoing research in the areas of HIV prevention, substance abuse, sexually transmitted diseases, public policy, and more. The University of Southern California and the Charles Drew University of Medicine and Science also contribute to the wealth of research-related resources in the County. The following list identifies a selected portion of the research being conducted through CHIPTS and the RAND Corporation, which have implications for HIV prevention (see Appendix for selected abstracts).

California State University at Long Beach (CSULB)

CSULB has been a national leader in HIV prevention for nearly two decades through its Center for Behavioral Research and Services. CSULB's innovative research includes all races/ethnicities, multiple priority risk groups including MSM and IDUs, and multiple interventions. Among its many services, the Center for Behavioral Research and Services offers a 1-day workshop that acquaints participants with techniques for developing and distributing their own prevention materials that include role model stories. The workshop describes methods for involving members of the target population in the distribution of role-model stories and as community advocates for HIV prevention, including recruiting, motivating, and maintaining peer-advocate networks. The Center also designed and implemented the highly-acclaimed Long Beach AIDS Community Demonstration Project.

Center for HIV Identification, Prevention, and Treatment Services (CHIPTS)

The Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) is involved in a number of research activities, which have strong implications for HIV prevention and related services. The following briefly summarizes a sample of relevant research projects:

1. CLEAR (Choosing Life: Empowerment, Action, Results Intervention for Youth Living with HIV)

2. VIBE (Vaccine Interest and Benefit Evaluation)

3. Economic Evaluations for HIV Prevention Programs for Adolescents

4. Healthy Living Project: A Multi-Institutional Collaborative Research Project

5. Community Health Study

6. Making Decisions (MD) for Life

7. Technology Transfer and Transition of an Effective HIV Prevention with Runaway Youth

8. Youth LIGHT (Living in Good Health Together)

Charles R. Drew University of Medicine and Science

Charles R. Drew University of Science and Medicine was established to provide leadership, training, and service to the predominantly African American and Latino/a populations of southern Los Angeles County. The Drew Center for AIDS Research, Education and Services (CARES), along with the Spectrum Clinic, the Collaborative Alcohol Research Center, and the OASIS Clinic are all key partners in adding to the body of research in the County. A sample of current research includes:

1. Impact of Alcohol on High-Risk Sexual Behavior in Women Impacted by HIV/AIDS

2. Factors Affecting Adherence to Combination Antiretroviral Treatment Among HIV-Infected Alcohol Users

City of Los Angeles

The AIDS Coordinator's Office of the City of Los Angeles periodically commissions cutting-edge studies to determine the prevention and service needs of populations that are often overlooked or are unable to access HIV prevention programs because of stigma and cultural norms about sexuality. For example, past studies have evaluated:

1. The Relationship Between Crystal Methamphetamine Use and HIV Risk Behavior Among Gay and Bisexual Men.

2. The Incidence of Domestic Violence Against Women Living with HIV.

3. Risk Behaviors of Heterosexual Men Who Sometimes Have Sex with Other Men or Transgenders.

4. The Feasibility of Post-Exposure Prophylaxis for People with Recent Sexual or Intravenous Drug Use Exposure to HIV.

5. The Effectiveness of Prevention Messages Aimed at Women, Particularly African-American Women.

6. Prevention and Outreach Efforts to Men Who Frequent Bathhouses.

Los Angeles Unified School District

In 1985, the Los Angeles Board of Education approved the development of programs to prevent the spread of HIV/AIDS. Since 1987, the CDC has provided funds to develop age-appropriate lessons for students, to train teachers in strategies for preventing the spread of HIV/AIDS and other diseases that may be transmitted sexually (STDs), and for the prevention of teenage pregnancy. These funds help support the Los Angeles Unified School District's (LAUSD) HIV Prevention Unit. LAUSD is also involved in ongoing State and national research, including:

1. Youth Risk Behavior Study (YRBS): a CDC survey done every other year to learn what risky health behaviors students report. The survey allows one to compare LAUSD scores with national scores, 38 States, and 18 large school districts.

2. California Healthy Kids Survey (CHKS): a California survey done annually to learn the risky health behaviors students report. Allows one to compare LAUSD scores with other districts in California. Middle school and high school findings.

The RAND Corporation

For over 50 years, the RAND Corporation has provided decision-makers in the public and private sectors with objective analysis and effective solutions that address the challenges facing the nation and the world. RAND researchers and analysts are on the cutting edge of their fields and engaged with their clients to create knowledge, insight, information, options, and solutions that will be both effective and enduring.

> *The RAND Corporation is a nonprofit institution that helps improve policy and decision-making through research and analysis.*

RAND has conducted far-reaching HIV prevention and related research locally and nationally. A small sample includes:

1. HIV Prevention for Crystal Methamphetamine Users. (current project)

2. Partner-Oriented Drug Treatment and HIV Risk Reduction. (current project)

3. Sexual Relationships, Secondary Syringe Exchange, and Gender Differences in HIV Risk among Drug Injectors. (2004)

4. Substance Use and High-Risk Sex Among People with HIV: A Comparison Across Exposure Groups. (2003)

5. What is it About Needle and Syringe Programmes That Make Them Effective for Prevention HIV Transmission? (2003)

6. Substance Use and High-Risk Sex Among People with HIV: A Comparison Across Exposure Groups. (2003)

7. Maximizing the Benefit: HIV Prevention Planning Based on Cost-Effectiveness, A Practical Tool for Community Planning Groups and Health Departments. (2003)

8. Sex Without Disclosure of Positive HIV Serostatus in a US Probability Sample of Persons Receiving Medical Care for HIV Infection. (2003)

9. HIV Risk Behaviors and Their Correlates Among HIV-Positive Adults with Serious Mental Illness. (2003)
10. Prevalence and Predictors of HIV Testing Among a Probability Sample of Homeless Women in Los Angeles County. (2003)
11. Street Outreach for HIV Prevention: Effectiveness of a State-wide Program. (2003)
12. Asymptomatic Sexually Transmitted Diseases: The Case for Screening. (2003)
13. The Value of Screening for Sexually Transmitted Diseases in an HIV Clinic. (2003)
14. Patterns and Correlates of HIV Testing Among Sheltered and Low-Income Housing Women in Los Angeles County. (2003)
15. Preventing Perinatal Transmission of HIV. (2003)

University of Southern California (USC)

USC's Keck School of Medicine supplies the medical staff to Los Angeles County's first primary medical clinic ("5P21") at the Los Angeles County/University of Southern California Medical Center. The Medical School's Department of Preventive Medicine has conducted behavioral and prevention research in association with 5P21 for more than 16 years. Other important research is being conducted through the Maternal Child and Adolescent Center for Infectious Diseases and Virology. Recent USC studies include:

1. Brief Safer Sex Intervention for HIV Outpatient Clinics
2. Technology Translation and Transfer of Effective HIV Prevention Behavioral Interventions
3. HIV Counseling, Testing and Referral Services Targeting Persons at High-Risk of Infection in Los Angeles
4. Drug Use and HIV Infected Female Adolescent's Care Use
5. Implementation and Evaluation of Partnership for Health Safer- Sex Intervention at HIV Outpatient Clinics
6. Technical Translation and Transfer of Effective HIV Prevention Behavioral Interventions

Assessing Gaps

To assess gaps in the continuum of HIV prevention services, there needs to be a comprehensive knowledge of both the needs of the community and the resources available to address those needs. From this comparison gaps – where services are not meeting the needs of the community beyond available resources – generally emerge. The 2004-2008 planning process has coincided with significant changes in Los Angeles County making a thorough gaps analysis very challenging. The first key event was the resolicitation of HIV prevention support to directly-

funded programs by the CDC in early 2004 to ensure alignment with its new AHP initiative. Although these awards were announced in April 2004, programs began later in the year.

The second key event, making 2004 a year of tremendous transition for Los Angeles County, is OAPP's resolicitation of HIV prevention and related funds for services to begin in early 2005. This process will be finalized in late 2004. As a result, the new detailed landscape of HIV prevention and related services is currently not known.

To further complicate this analysis, a significant portion of the qualitative data collection for individuals not receiving services and other hard-to-reach populations is also still in process. Delays in IRB approval as well as other challenges delayed the beginning of this very important work. A cursory review of initial data suggests that this expanded community assessment process will yield vital information regarding needs of specific communities who have not previously participated in HIV prevention activities.

As a result of the convergence of these factors, the information presented here represents only a preliminary look at gaps in HIV prevention in Los Angeles County. As new information becomes available, a more comprehensive gaps analysis will be completed.

HIV Prevention Needs in Los Angeles County

When examining the data presented from the *HIV Epidemiologic Profile,* the 2003 CRAS, and the 2002 SHAS, a disturbing picture emerges.

1. Both the 2003 CRAS and the 2002 SHAS provide information on self-reported risk behavior of current recipients of HIV prevention services (CRAS) and PLWH/A (SHAS). By definition, these are all individuals who have some basic level of awareness and/or understanding of HIV and how it is transmitted. The findings from both surveys suggest that respondents, despite whatever basic knowledge they have, continue to engage in behaviors that place them at risk of infection or transmission. The epidemiological data reveals that across all BRGs and geographic regions, there continues to be new HIV infections.

2. Communities of color continue to be hardest hit by the HIV/AIDS epidemic in terms of overall impact on the population (African Americans and American Indians/ Alaskan Natives) and in absolute numbers (Latinos/as).

3. Communities of color which are hardest hit also have highest rates of poverty, unemployment, and lack of health insurance and access to services.

4. The tremendous racial/ethnic diversity and large recent immigrant population increases need for linguistically appropriate services that are culturally sensitive.

5. Although Transgenders represent a relatively small population across the County (estimated 10,000), there are high seroprevalence rates within this population. Focus group feedback stated that services targeting Transgenders were small in number.

6. In order to ensure the effectiveness of HIV prevention programming, evaluating programs and interventions is essential.

7. Staffs of agencies serving similar BRGs expressed a need to share information, learnings, and best practices with other agencies serving the same BRG.

8. There is a significant amount of research that is currently taking place in Los Angeles County. Much of the research centers around risk behavior and other relevant HIV prevention themes that could potentially be useful for community and program planning. The accessibility to the findings of that research is unclear.

9. Although much of the relevant research could inform community planning, the reciprocal relationship is unclear as to how community planning can better drive a community relevant research agenda in Los Angeles County.

Priority Populations

Introduction

The work of the PPC to prioritize populations at risk for HIV for 2004 to 2008 builds upon the work completed in 1999 for the *Los Angeles County HIV Prevention Plan 2000.* Based upon a comprehensive review of local HIV epidemiology in 1999, the PPC developed and adopted a behavioral risk group (BRG) model to guide the allocation of HIV prevention resources. This recommendation departed from the previous target population model that did not factor the behavioral HIV risk of targeted groups as significantly. The 1999 model also included key special populations that were small in size, but epidemiologic data and other research, identified these populations to be at risk of infection or transmission of HIV.

In 1999, the PPC endorsed six behavioral risk groups (BRGs) as the primary prioritized BRGs including both adults and youth; they were:

- Men who have sex with men (MSM)
- Men who have sex with men and women (MSM/W)
- Men who have sex with men and use injection drugs (MSM/IDU)
- Heterosexual males who use injection drugs (HM/IDU)
- Females who use injection drugs (F/IDU)
- Women at sexual risk (WSR)

The PPC prioritized three additional populations for services and resources:

- American Indians (AI)
- Transgenders (TG)
- People Living with HIV/AIDS (PLWH/A)

Although the PPC felt that their priorities needed to be behaviorally based, they wanted to ensure that the small populations of American Indians and Transgenders not fall through potential cracks as resources were allocated. The PPC did not know that their 1999 decision to prioritize services to PLWH/As would portend new priorities by the CDC in 2003.

Los Angeles County's *HIV Prevention Plan 2000* established a new model for targeting services. This model was based upon behavior versus population membership, recognizing that it is a person's behavior that places him or her at risk for HIV infection. With perinatal transmission virtually eliminated in the County, it made sense to prioritize resources targeting individuals within BRGs, who engaged in unprotected sexual and/or needle-sharing behaviors.

2004-2008 Prioritization Process

To refine the 1999 recommendations, the PPC reviewed numerous data sources to assess met and unmet HIV prevention needs, as well as to evaluate the appropriateness of the BRG model. The HIV Epidemiology Program provided data including current AIDS case data, estimates of HIV infection and surveillance, and HIV seroprevalence studies. The PPC chose to continue to rely on

estimates of HIV infection because data from HIV reporting in the State of California are still considered unreliable and incomplete. The PPC also reviewed HIV counseling and testing data provided by OAPP and behavioral data collected by local CBOs and universities.

In the PPC's data analysis, the HIV Epidemiology Program and OAPP Planning and Research Division staff presented key information to describe their methodology and assumptions for specific population estimates. Table 20 depicts the methodologies and assumptions that were employed:

TABLE 20. Methodology for Estimating Size of Specific Populations

Estimates	Methodology Used to Estimate Specific Populations
PLWH/A Estimates	The number and distribution of persons living with AIDS (PLWA), as well as persons diagnosed with AIDS in 2001, were obtained from HARS. The overall estimated number of persons living with HIV (PLWH) was determined by using a modified CDC formula. For every PLWA in LAC, it was estimated that another 1.2 persons are HIV-infected (non-AIDS). To estimate the total number of persons living with HIV and AIDS (PLWHA), these two numbers were added together with a third estimate, that of persons who are HIV-infected but unaware of their HIV status. Nationally, an estimated one out of every four PLWH are not aware of their status.
New HIV Infections	The number of newly diagnosed HIV infections estimated for Los Angeles County this year is based on the County comprising 5% of the national epidemic. With an estimated 40,000 newly diagnosed cases of HIV infection per year in the U.S., Los Angeles County is estimated to have 2,000 new cases annually.
Distribution of New HIV Infections	The distribution of newly diagnosed HIV infections is based on the proportion by BRG, race/ethnicity of persons testing positive at OAPP funded HCT sites, on HARS incident AIDS data, and on the estimated size of the BRG population. Overweighting F/IDU and WSR estimates from HARS data was done to compensate for the under representation of HCT data for the smallest BRGs.
BRG Estimates	The size of each BRG by race/ethnicity was estimated using a variety of sources, including, the 2000 U.S. census, the Los Angeles Health Survey, the HIV/AIDS Reporting System (HARS), OAPP's HIV counseling and testing database, Alcohol and Drug Program Administration data, Los Angeles County STD Clinic data, and epidemiological studies performed by the HIV Epidemiology Program. Surrogate definitions for specific BRGs were used. For example, OAPP defines women at high sexual risk as those who, in the last 2 years or since their last HIV test, engaged in anal sex with a male sex partner; engaged in "exchange" sex; had intercourse with a male IDU or MSM or HIV-infected male; had 2 or more male sex partners; had a history of an STD(s); or had sex under the influence of drugs (i.e., crack, amphetamines, cocaine, nitrites/ates, or ecstasy). The Los Angeles Health Survey defines WSR as that portion of women reporting more than one sex partner, plus 5% of women who reported only one sex partner in the previous 12 months. Thus, a combined proportion was applied to all women ages 15-64 years as determined by the 2000 U.S. census to obtain the estimate for the BRG.
Distribution of PLWH/A by BRG	For estimates of the distribution of PLWH by BRG and race/ethnicity, HARS incident AIDS cases for 2001 were used as a surrogate, as it is a better reflection of the emerging epidemic than that of PLWA. The limitation of this methodology is not knowing the exact relationship between the distribution of PLWH and that of newly diagnosed AIDS cases in HARS.

■ Additional Issues

In order to ensure a comprehensive reassessment of priority populations, the PPC's Ad Hoc Prevention Plan Subcommittee explored other key issues impacting priority setting and resource allocations, including:

1. How can Los Angeles County improve the model to allocate resources to ensure that racial/ethnic differences between SPAs are captured and that resources are distributed accordingly?

2. What is the best method to distribute resources across SPAs in Los Angeles County, given the fact that available data are based upon an individual's zip code of residence and not necessarily the location(s) where risk behavior takes place?

3. Does the 1999 recommendation to set-aside 25% of all BRG funds for youth still make sense based on the local epidemic?

4. Is the current mix of resource allocations that do not target people at risk of infection (i.e., *Evaluation, Capacity Building and Technical Assistance, Research and Data Collection*, and *PPC Support*) meaningful in today's funding climate?

5. What role do non-injection substance use and STD incidence and prevalence have when determining resource allocations?

6. Should incarcerated individuals be considered a separate priority population for distinct resource allocation?

7. What proportion of funds should target PLWH/A based upon the CDC's guidance that requests local jurisdictions to make HIV positive persons their number one priority?

2004-2008 Priority Populations

In March 2004, the PPC re-affirmed the 1999 decision to prioritize populations based upon HIV risk behavior (i.e., unprotected sexual intercourse and/or the sharing of injection drug paraphernalia) as the cornerstone of Los Angeles County's priority-setting process. The PPC also acknowledged that several risk co-factors play an important role in elevating HIV infection or transmission risk, including the use of crystal methamphetamine, the presence of ulcerative sexually transmitted diseases, and the number of sexual risk partners.

After a review of the available data, the PPC confirmed that the HIV epidemic in Los Angeles County has changed since the *Los Angeles County HIV Prevention Plan 2000*. They concluded that the updated estimates of HIV infections for Los Angeles County were sufficiently different from those in the previous plan to revise the priority populations as well as funding allocations. Thus, the PPC modified the BRG model to integrate Transgenders into the model. In addition, the PPC recommended that funding allocations targeting youth and HIV positive individuals also cross BRG categories rather than having set-aside allocations.

The seven prioritized BRGs for 2004-2008 include:

1. Men who have sex with men (MSM);
2. Men who have sex with men and women (MSM/W);
3. Men who have sex with men who are also injection drug users (MSM/IDU);
4. Heterosexual male injection drug users (HM/IDU);
5. Female injection drug users (F/IDU);

6. Women at sexual risk (WSR) and their partners; and
7. Transgenders at sexual risk/Transgender injection drug users (TSR/TIDU) and their partners.

Through examination of available data, the PPC identified two smaller populations at elevated risk for HIV infection. They are:

1. American Indians/Alaskan Natives; and
2. Incarcerated Population.

To ensure that services are targeted to these populations, the PPC recommended that dedicated resources be allocated to serve their needs.

■ Recommended Resource Allocations by Priority Population

Table 21 outline the recommended resource allocations by BRG:

TABLE 21. Recommended Funding Allocation by BRG and Minimum Percent of BRG Allocation Targeting HIV Positive Individuals and Youth

Behavioral Risk Group	Total Resource Allocation	Minimum Percent Targeting HIV+	Minimum Percent Targeting Youth
MSM	60%	20%	20%
MSM/W	10%	10%	15%
MSM/IDU	4%	20%	0%
HM/IDU	4%	0%	0%
F/IDU	2%	0%	0%
WSR and their partners	12%	10%	20%
TSR/TIDU and their partners	8%	20%	20%
Total	100%		

For purposes of making funding decisions, BRG categories are mutually exclusive. Persons at risk for HIV should be counted in only one BRG category.

The PPC also recommended that 1% of all HIV prevention funds directed to support HIV Education/Risk Reduction (HE/RR) and HIV counseling and testing programs that exclusively target American Indians/Alaskan Natives. In addition, the PPC recommended that 1.5% of HE/RR funds target the incarcerated population, ensuring that both of these small populations receive dedicated program resources.

Geographic Estimate of Need

The early years of the HIV/AIDS epidemic were characterized by a deep need for services in relatively distinct, often isolated communities, neighborhoods, and groups. The growth in the number of those in need of services was rapid, as was the commensurate rapid growth in services. Frequently, the growth in services was relatively unplanned.

In more recent years, the impact of the HIV/AIDS epidemic has spread throughout Los Angeles County, requiring a careful review of existing HIV prevention and care services. Thus, in order

to better understand and plan for HIV prevention needs and distribute resources across the County, OAPP developed the Geographic Estimate of Need (GEN) Model.

For HIV prevention and counseling and testing services, the GEN Model includes specific indicators, including some that indicate behavior associated with HIV risk or transmission. The six indicators are: living AIDS cases, recent AIDS cases, poverty, sexually transmitted disease incidence, substance abuse, and HIV counseling and testing results. OAPP associated weights to each of the six indicators based on the following criteria:

- The indicator is related to high-risk behavior
- The indicator is a co-factor of HIV transmission
- The data for the indicator are reliable, available and consistent County-wide

Figure 44 depicts the weights assigned to each of the six indicators.

FIGURE 44. Weighted Indicators Determining Geographic Estimate of Need for HIV Prevention

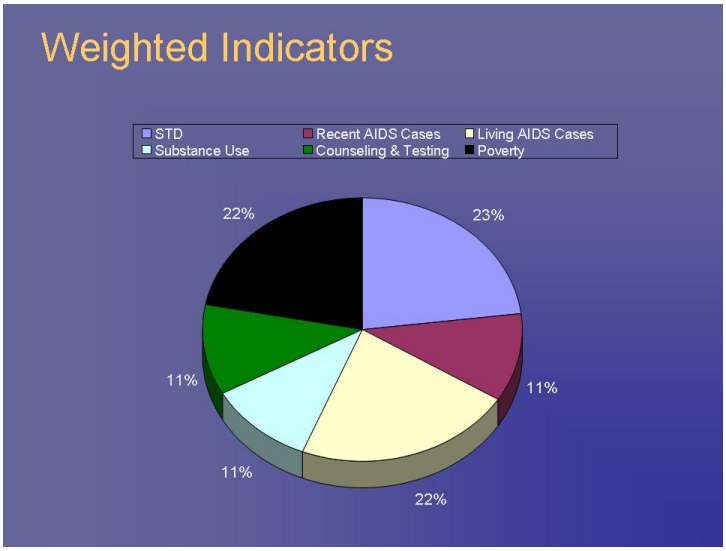


Figure 45 shows the variation across each of the County's eight SPAs when the weighted indictors for HIV prevention are applied to the SPA.

Recommended Resource Allocations by SPA and Race/Ethnicity

After reviewing the GEN Model, the PPC recommended that the model should guide funding decisions. They further recommended that in allocating resources by race/ethnicity, estimates of Recent AIDS Cases by race/ethnicity (a GEN indicator) within each SPA should guide funding decisions. Table 22 and Table 23 apply the GEN Model as recommended. Not surprising, SPA 4 (Metro) has the highest GEN value of 25.90%. The SPA 6 (South) ranks second with a value of 15.95%. Both SPA 2 (San Fernando) and SPA 8 (South Bay) are closely ranked to SPA 6. These four SPAs in aggregate comprise 71.44% of the County's total need for services. Figure 45 illustrates well the dramatic differences between each SPA.

FIGURE 45. Indicators of Need for HIV Prevention by Service Planning Area (SPA)

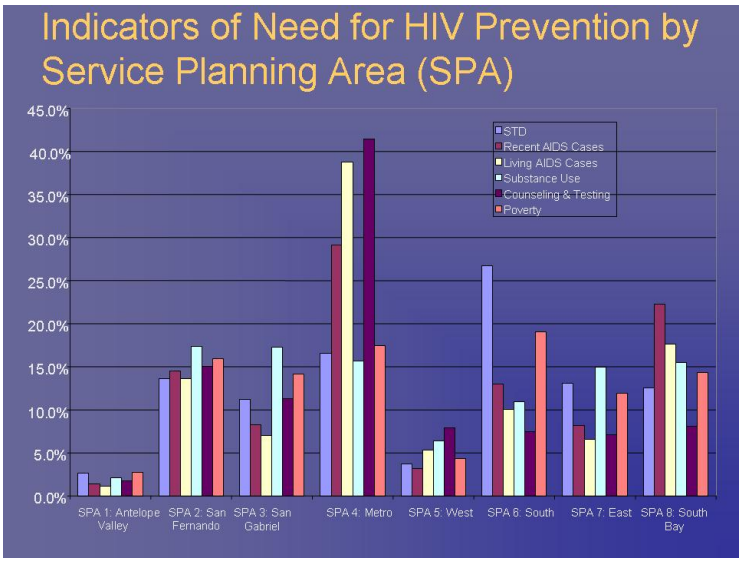


TABLE 22. Geographic Estimate of Need by Service Planning Area (SPA)

Service Planning Area	Geographic Estimate of Need
SPA 1: Antelope Valley	2.03%
SPA 2: San Fernando	14.78%
SPA 3: San Gabriel	11.28%
SPA 4: Metro	25.90%
SPA 5: West	4.89%
SPA 6: South	15.95%
SPA 7: East	10.36%
SPA 8: South Bay	14.81%

When examining need by race/ethnicity, the PPC directed that the GEN model be used to guide the targeting of services and distribution of resources. Table 23 depicts the results of applying the GEN model to each SPA by race/ethnicity. Need for services for African Americans is highest in SPAs 1 (Antelope Valley) and 6 (South). Need for services targeting Latinos is highest in SPAs 7 (East) and 3 (San Gabriel) with significant need in SPAs 2 (San Fernando), 4 (Metro), and 6 (South). Need for Whites is highest in SPAs 5 (West), 2 (San Fernando), and 8 (South Bay).

TABLE 23. Recent AIDS Cases by Service Planning Area (SPA) and by Race/Ethnicity

	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8
African American	**40.0%**	11.4%	16.0%	19.3%	27.8%	**52.2%**	8.3%	29.5%
Asian	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Latino	35.0%	**46.7%**	**60.6%**	**46.3%**	22.8%	43.9%	**77.9%**	33.5%
Native	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
White	25.0%	41.9%	23.4%	34.4%	**49.4%**	3.9%	13.7%	**37.1%**

Interventions

Introduction

In recent years, the CDC, researchers, behavioral scientists, and many others have conducted rigorous research to study and determine the effectiveness of a variety of HIV prevention interventions. Through extensive study, it has become increasingly clear that effective interventions are rooted in behavior change theory and have a strong evidence base. To foster the development of such interventions, the CDC encourages the adaptation and tailoring of evidence-based interventions. Several reference documents (e.g., CDC's Diffusion of Effective Behavioral Interventions) offer guidance to assist local health departments, community planning groups, and CBOs as they prioritize and develop effective interventions within their respective communities. In an effort to increase HIV prevention providers' understanding of behavior change theory and its role within the context of HIV prevention, OAPP offered formal training opportunities in behavioral theory and co-sponsored symposia featuring nationally-recognized HIV behavioral scientists. The information presented below continues this effort.

Behavioral Theories

There are numerous behavioral theories documented in the scientific literature, which can help inform the design of specific HIV prevention interventions. Some behavioral theories are based upon individual behavior modification approaches to behavior change and other theories address social networks and support systems, attempting to change behavior through influencing peer networks and community norms. The following list provides a brief description of selected behavioral theories, which are commonly-referenced in the literature. Where possible, examples of HIV prevention interventions that use each behavioral theory as its foundation are included [69, 70].

■ AIDS Risk Reduction Model

To change behavior the client must first identify and "label" the behavior as risky. Then the client must make a commitment to reduce the risky behavior and change his or her behavior. Factors influencing movement between these stages include fear/anxiety and social norms.

Example of HIV Prevention Interventions Using the AIDS Risk Reduction Model:

1. HIV Risk Reduction Among African American Homosexual and Bisexual Men
2. Prevention Case Management

■ Diffusion of Innovation or Social Diffusion Theory

Diffusion of Innovation describes how new ideas or behaviors are introduced and become accepted by a community. People in the same community adopt new behaviors at different rates and respond to different methods of intervention. The primary components of this theory include:

1. The target population perceives the innovation as new;
2. Channels of communication exist to disseminate the innovation;

3. There is sufficient time or process for the innovation to reach the target population; and
4. A social network exists that connects members of the target population.

Example of HIV Prevention Intervention Using Diffusion of Innovation:

1. Popular Opinion Leader
2. Mpowerment

■ Empowerment Theory

Empowerment Theory explains how groups of people change through a process of coming together to share experiences, understanding social influences, and collectively developing solutions to problems.

■ Harm Reduction

Harm Reduction accepts that while harmful behaviors exist, the main goal is to reduce their negative effects. Harm Reduction examines behaviors and attitudes of the client to offer ways to decrease the negative consequences of the targeted behavior.

Example of HIV Prevention Intervention Using Harm Reduction:

1. Syringe Exchange Programs
2. Holistic Harm Reduction

■ Health Belief Model

The Health Belief Model proposes that an individual's actions are based on four key beliefs:

1. People must believe they are personally susceptible to the disease to motivate behavior change ("perceived susceptibility");
3. An individual must perceive the serious nature of the illness ("perceived severity");
4. The person must believe that the behavior will have a benefit ("perceived efficacy"); and
5. The person must believe in his or her ability to overcome the barriers to the behavior.

Example of HIV Prevention Interventions Using the Health Belief Model:

- Mpowerment

■ Popular Education

Popular Education supports the belief that teachers and students both have strengths and should learn reciprocally from each other. Group discussions examine problems and develop solutions to personally empower people to change their environment, thereby influencing their subsequent actions.

■ Social Cognitive Theory

Social Cognitive Theory describes learning as a social process influenced by interactions with other people. In the Social Cognitive Theory, physical and social environments are influential in reinforcing and shaping the beliefs that determine behavior (reciprocal determinism). A change in any one of the theory's three components – behavior, physical, or social environments – will influence the remaining two. The concept of self-efficacy (i.e., the client's belief that he or she is capable of performing the new behavior in the proposed situation) is also an essential component of the theory.

Examples of HIV Prevention Interventions Using the Social Cognitive Theory:[*]

1. Real AIDS Prevention Project (RAPP)
2. SISTA
3. Healthy Relationships

■ Theory of Reasoned Action

In the Theory of Reasoned Action, a person's intention is the main influence on his or her behavior. Intention is defined as the combination of personal attitudes toward the behavior as well as the perceived opinions of peers, both heavily influenced by social norms.

Examples of HIV Prevention Interventions Using the Theory of Reasoned Action:[†]

1. Community PROMISE
2. VOICES/VOCES

■ Transtheoretical Model or Stages of Change

The transtheoretical model, often called the stages-of-change model, describes the stages people go through when changing behaviors. The five stages described by the model are:

1. Precontemplation - when the person has no intention to adopt (and may not even be thinking about adopting) the recommended protective behavior;

2. Contemplation - when the person has formed either an immediate or long-term intention to adopt the behavior but has not, as yet, begun to practice that behavior;

3. Preparation - when there is a firm intention to change in the immediate future, accompanied by some attempt to change the behavior;

4. Action - when the behavior is being consistently performed but for less than 6 months; and

5. Maintenance - the period beginning 6 months after behavior change has occurred and during which the person continues to work to prevent relapse.

[*] Source: CHIPTS, *Summary of Recommended HIV Interventions*.
[†] Source: CHIPTS, *Summary of Recommended HIV Interventions*.

The stages-of-change perspective is important because it recognizes that people are at different stages of readiness when it comes to using condoms or making other changes. Individuals at different stages may be receptive to different types of intervention messages. Clearly, a different strategy is necessary when one is dealing with someone who has no intention of changing his or her behavior than when one is dealing with someone who intends to change but has not been able to act upon that intention. Similarly, someone who is trying to change but has not been able to consistently perform the protective behavior requires a different message or strategy than someone who is consistently performing the behavior. The stages-of-change model suggests that rather than viewing behavior as an "all or nothing" phenomenon, it is important to view behavior change in terms of a sequence of steps and that interventions should be tailored to the stage that an individual is in.[‡]

Examples of HIV Prevention Intervention Using the Transtheoretical Model:

1. Community PROMISE
2. Real AIDS Prevention Project (RAPP)

Another resource that describes behavioral science theories and their application to health programs is *Theory at a Glance, A Guide for Health Promotion Practice*, National Institutes of Health (NIH), September 1997 (NIH publication number 97-3896).

Designing Effective HIV Prevention Interventions

Behavioral theory provides HIV program planners with a framework within which to develop the intervention, its activities, goals, and objectives. Behavioral theory can also help explain aspects of risk-taking behavior when working with a new target population. Thus, using behavioral theory to design HIV prevention interventions can improve the quality of programs, as well as save valuable time and resources. The behavioral theories discussed above represent a subset of possible theories, which HIV program developers can use to design interventions. The theories are not mutually exclusive and multiple theories can be used to guide effective programs.
In its *Procedural Guidance for Selected Strategies and Interventions for Community Based Organizations Funded Under Program Announcement 04064*, the CDC outlines and describes specific individual, group, and community-level interventions, which it has approved for adaptation, tailoring, and use with high-risk populations. These include Mpowerment, Safety Counts, Popular Opinion Leader, and Community PROMISE. These interventions have demonstrated a level of efficacy that the CDC deems appropriate for recommending to HIV prevention providers across the country.

■ Evidence Based Interventions

In each of the evidence-based interventions discussed earlier, behavioral science plays an important role. However, when developing HIV prevention interventions, there may be other evidence, which a CBO may offer to demonstrate the effectiveness of a particular intervention. This might include evidence based on successful:

1. Evaluation of the same intervention that has not been published in the scientific literature;

[‡] Description of Transtheoretical model available at: http://www.cdc.gov/hiv/projects/acdp/change.htm.

2. Evaluation of a similar intervention that has not been published in the scientific literature; and

3. Experience of an intervention based on the CBO's informal theory or "practice wisdom."

Professional and community experience are critical sources of important, practical information. As local providers develop HIV prevention interventions to meet the needs of their targeted risk group(s), these multiple sources of information play a key role in the design, implementation, and evaluation of the intervention. Whatever evidence base drives the program design, behavioral theory is an essential ingredient to program success.

The following narrative provides a brief description of the four different types of evidence, which may guide HIV prevention program design in Los Angeles County:

Evaluation of the Same Intervention

With this type of evidence, the intervention being developed is identical to one that has already been evaluated and shown to be effective. Congruence must exist between the proposed intervention and the evaluated intervention with regard to the population served, intervention setting, and core elements of the intervention. For two interventions to be considered the same, the intervention must use the same content, format, and method of delivering the intervention, and to deliver the same number and length of intervention sessions.

> *Example: A CBO designs a GLI for African American MSM who are in an urban setting. The intervention was previously conducted and evaluated in a different city, but with the same population. Core elements of the intervention will be replicated including using the same curriculum and materials, focusing on the same content, conducting the same number of group sessions, and utilizing peer educators who have been trained to deliver the intervention.*

Evaluation of a Similar Intervention

With this type of evidence, the intervention being developed is similar, though not identical, to an intervention that has already been evaluated. Although modifying a previously evaluated intervention may compromise its effectiveness, it may be necessary if available resources cannot support full implementation of the evaluated intervention or if the intervention needs to be adapted to be culturally appropriate for a different population and setting.

Generally, "evaluation of a similar intervention" means that there are differences between the proposed intervention and the previously evaluated intervention in one or more of the following areas: population served; intervention setting, content, and format; method of delivering the intervention; and the number and length of sessions. If differences are too significant between the proposed and the previously evaluated intervention, the prior evaluation may no longer provide sufficient evidence to support the proposed intervention.

> *Example: A CBO designs an ILI for rural heterosexual Latinas. A similar intervention with heterosexual African American women in a rural setting has been evaluated. The intervention plan explains how the risk assessment protocol and educational materials used in the evaluated intervention have been adapted to be culturally and linguistically appropriate for Latinas. The number and*

length of intervention sessions and the risk reduction skills addressed in each session remain the same.

Theory from the Scientific Literature

With this type of evidence, the intervention being developed is based on formal behavioral science theory, social science theory, or some other theory that is published in the scientific literature. The theory is divided into component parts (e.g., skills, self-efficacy) and corresponding intervention elements are then developed (e.g., activities to develop condom use skills and increase self-efficacy to use condoms). The intervention plan will explain how the theory is integrated into the content, format, and delivery of the intervention.

Example: A CBO designs a prevention case management intervention based on the Stages of Change theory. The intervention plan summarizes the theory, explains how it will be used to assess client readiness for behavior change, and describes how counseling strategies will be targeted to the client's stage. The plan also includes an example of a risk assessment tool based on the Stages of Change theory.

Informal Theory

With this type of evidence, the intervention being developed is based on a theory that is not described in conventional theoretical language and is not published in the scientific literature. The distinction between an informal and formal theory is subtle. Informal theory usually describes a contractor's "practice wisdom" (i.e., knowledge that comes from working with or being a member of a population) and is explained in lay terms. For example, the concept of "self-efficacy" from the behavioral science literature on Social Learning Theory may be stated as "confidence to use condoms" by someone not familiar with the formal language of behavioral science. Informal theory provides a logical explanation of why the population is at risk and then integrates this information into the content, format, and delivery of the intervention being designed to address that risk.

Example: A provider describes an informal theory by stating that some people are at risk for HIV because they lack confidence in their ability to use condoms, because they don't know how to talk about condom use with their sex partners, and because there are not enough positive role models in the community promoting condom use. The intervention plan describes a peer-led, individual-level counseling intervention focusing on condom use attitudes and skills, emphasizing the role of peer counselors as positive role models to promote the use of condoms.

Replicating Effective Interventions

In order to develop more effective HIV prevention programs that will create sustained behavior change, help individuals at risk for HIV to access HCT, and prevent transmission of HIV from HIV positive individuals, the PPC recommends that Los Angeles County incorporate the CDC's guidance regarding the implementation of evidence-based interventions into all future programming (CDC, 2003 Program Guidance for Program Announcement 04064).

Thus for CBOs that implement evidence-based interventions, or who propose to use locally implemented interventions that have been evaluated and shown to be effective, CBOs need to be

able to describe the intervention's core elements, key characteristics, and procedures as defined by the CDC (2003).

1. Core Elements are critical features of an intervention's intent and design and are thought to be responsible for its effectiveness and cannot be ignored, added to, or changed.

2. Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. They can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

3. Procedures describe the activities of the program and provide direction to agencies or organizations regarding its implementation.

Further, CBOs need to be able to describe the specific steps taken to adapt and tailor their intervention for the specified BRGs or target populations using the guidance provided by the CDC. The CDC definitions of adaptation and tailoring are:

1. Adaptation implies that the intervention is being delivered to a different population or in a different venue than the one in which efficacy was originally demonstrated. It involves changes in *who* receives the intervention and *where* it is delivered.

2. Tailoring is when an intervention or strategy is changed to deliver a new message (addressing condom use versus limiting the number of partners), at a new time (at a weekend retreat rather than over a series of weeks), or in a different manner (using verbal rather than written messages) than was originally described… It involves changes in *when* it is delivered, *what* is addressed, and *how* the message is conveyed.

In order to accomplish the work necessary to adapt or tailor interventions to best meet the needs of a given target population, the PPC encourages CBOs to access any available local resources for capacity building and technical assistance.

Types of Interventions

There are a wide variety of interventions that span the HIV continuum of prevention activities and include: outreach, individual level interventions, group level interventions, community level interventions, public health information, HIV counseling and testing, partner counseling and referral services, and prevention case management. The following narrative provides a brief description of each of these types of interventions.

■ Outreach

The primary purpose of outreach is recruitment of targeted individuals into more intensive services, such as HIV counseling and testing among others. Recruitment can be either internal within the organization or external, that is outside the organization. Internal recruitment is generally referred to as "inreach," whereby current clients or participants of an agency are recruited to participate in HIV prevention activities. When the agency looks for potential program participants outside the agency, this is generally referred to as "outreach."

In general, outreach is educational in nature and often conducted by peer or paraprofessional educators face-to-face with high-risk individuals in neighborhoods or other areas where the target population gathers. Sites may include streets, bars, parks, bathhouses, shooting galleries, etc. In addition to sharing information about HIV/AIDS, an outreach worker will distribute other promotional and educational materials, condoms, bleach, safer sex kits (e.g., condoms/latex barriers with instructions, lubricants), etc.

During outreach, the outreach worker often discusses other HIV/AIDS programs and services that are available through the agency he or she represents. The outreach worker emphasizes the potential benefit of these services for the individual. In order to identify those individuals most in need of services, the outreach worker may also ask a few questions to assess risk behavior(s). If the individual expresses interest in other services, the outreach worker collects the individual's contact information. At a later time, the outreach worker can set up an appointment for intake or a linked referral to another program or service.

Outreach is successful when it recruits an individual into a more intensive service, thereby achieving its primary purpose. Thus, tracking outreach is an important activity. Not only do outreach workers need to keep track of the numbers of individuals reached within the target population, they need to keep track of those individuals who are successfully linked to other services

Outreach Program Performance Indicator

One program performance indicator guides the evaluation of outreach activities. It is:

> The mean number of outreach encounters required to get one person to access any of the following services: HIV counseling and testing services, sexually transmitted disease screening or testing services, an individual level intervention services, a group level intervention service, or prevention case management.

■ Individual Level Interventions (ILI)

Individual level interventions (ILI) consist of health education and risk-reduction counseling provided to one individual at a time and either face-to-face or via the Internet. Individual level interventions (ILI) assist clients in making plans for individual behavior change, provide ongoing appraisals of the client's own behavior, and includes skills-building activities. These interventions also facilitate linkages to services in both clinic and community-based settings (e.g., substance abuse treatment settings, HIV counseling and testing services) and are intended to support behaviors and practices that prevent transmission of HIV.

1. **Risk-reduction counseling** consists of one-on-one counseling sessions that focus on understanding human behavior (i.e., why people do what they do), identifying the personal factors that affect actions (e.g., self-efficacy, social situations, and cultural norms), increasing knowledge, skills building, and behavior change (e.g., safer sex practices, proper condom/latex barrier use and demonstration, needle cleaning techniques). Trained program staff generally conducts counseling sessions.

2. **Internet risk-reduction counseling** consists of HIV risk reduction counseling activities conducted over the Internet. These activities often target gay, bisexual, and/or MSM and MSM/W populations. This type of intervention has a clear

engagement and screening process in order to determine client eligibility (e.g., risk group, zip code, etc.) and ability to document participant demographics as well as ongoing participation.

An ILI is successful when it helps an individual to change behavior that puts one at risk for HIV infection or at risk for transmitting HIV. Thus, to measure success, ensuring and documenting that individuals complete the required number of sessions is an important component of ILIs. This can be very challenging with some target populations, particularly those who may be more transient in nature or who wish to remain hidden. Another measure of success is the ability of an ILI to get a person to access other needed services, particularly HIV counseling and testing for those with unknown HIV serostatus and partner counseling and referral services for HIV positive individuals.

In the strictest sense, both outreach and prevention case management could be considered ILIs. However, although these interventions also target individuals, the PPC and OAPP define these interventions separately as distinct components of the broader continuum of HIV prevention services in Los Angeles County.

ILI Program Performance Indicators

There are two program performance indicators that guide the evaluation of ILI. These are:

1. Proportion of persons that completed the intended number of individual level intervention sessions.

2. Proportion of the intended number of the target population to be reached with the individual level intervention who were actually reached.

■ Group-Level Interventions (GLI)

As the name implies, group level interventions (GLIs) are health education risk-reduction counseling activities that shift the delivery of service from the individual to groups of varying size. GLIs may be peer or non-peer models, involving a wide range of skills-building, information, education, and support. In general, GLIs have multiple sessions and include a follow-up component. Like ILI, the purpose of GLI is to change to and sustain positive, health-promoting behaviors that reduce the risk of infection or transmission of HIV. They also seek to link participants to other needed services (e.g., HIV counseling and testing, prevention case management).

1. Group risk reduction counseling generally occurs in small group sessions that focus on behavior change activities (e.g., safer sex practices, proper condom/latex barrier use and demonstration, and needle cleaning techniques). Trained program staff conduct these sessions, which range from three to six sessions. Because behavior change occurs over time, sessions need to also occur over time.

   Group risk reduction counseling sessions follow a close-ended group model as opposed to an open-ended model. Close-ended groups are structured, have a defined lifespan, and have set membership limits. The closed group allows for important continuity, which fosters trust among members as they get to know each other over time. With a closed group model, the CBO is able to establish client-specific

outcome objectives that can be monitored over time (e.g., self-reported increased condom use with sexual partners at the end of four weeks of group attendance). Open-ended support group sessions that are less structured, informal, and are geared to risk reduction behavior maintenance are not conducive to this type of goal-setting. Closed end groups are usually finite and open-ended groups are usually ongoing.

2. Support group counseling sessions are informal groups that provide a supportive environment for participants to discuss openly the challenges and successes they have achieved in maintaining their newly acquired risk reduction behaviors. Support groups are usually open-ended with open enrollment. Potential members are able to "drop in" when they need to and thus avoid the wait for new groups to form. This type of group may appeal to individuals whose commitment to the group's process is initially limited. Due to their less structured, more fluid nature, support groups may be more appropriate to process evaluation (e.g., percentage of agency's clients attending a determined number of sessions). To be an effective intervention that supports sustained behavior change, participants attending multiple sessions will likely have a greater benefit.

   Although support group counseling sessions are less structured than group risk reduction counseling interventions, they are not psychotherapy groups. Very often support groups are facilitated by trained, self-identified members of the targeted risk group, population, or community (i.e., peer-based model). Trained professionals or paraprofessionals may also conduct these sessions.

3. Peer Health Education describes a role-model method of education in which trained, self-identified members of the target population provide HIV/AIDS education to their behavioral peers. Once Peer Health Educators are successfully trained (they are usually required to complete and pass an internal agency certification course), they have clearly defined roles and responsibilities. They do not replace the CBO's professional health educators, but they can augment the intervention team and enhance intervention efforts.

   Individuals who become Peer Health Educators often feel empowered as they help persons in their communities and social networks adopt healthy behaviors. This work strengthens and supports their own behavior change efforts. Peer Health Educators often serve as community change agents as they are able to sustain intervention efforts in the community long after professional educators are gone.

Like ILIs, GLIs are successful when they help small group participants create and sustain positive behavior change over time. Thus, tracking participation and attendance is a core element of the intervention. Whether groups are peer-led or professionally-led, CBOs need to develop rigorous tracking mechanisms to document participation. Follow-up is also a core element to be able to assess longer-term change. However, this can be particularly challenging to CBOs when trying to entice participants to come back for follow-up sessions.

GLI Program Performance Indicators

There are two program performance indicators that guide the evaluation of GLI. These are:

1. Proportion of persons that completed the intended number of group level intervention sessions.

2. Proportion of the intended number of the target population to be reached with the group level intervention who were actually reached.

■ Community-Level Interventions (CLI)

Community-level interventions (CLIs) seek to reduce risk conditions and promote healthy behaviors in the broader community as a whole, rather than by intervening with individuals or small groups. CLIs attempt to alter social norms, policies, and the environment. CLIs include community mobilization efforts, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

1. Community Mobilization - This is a process by which community citizens take an active role in defining, prioritizing, and addressing issues in their community. This process focuses on identifying and activating the skills and resources of residents and organizations while developing linkages and relationships within and beyond the community for the purpose of expanding the current scope and effectiveness of HIV/STD prevention.

    - OAPP funds the on-going Community Development Initiative discussed earlier to engage coalitions of community partners to advocate for services for PLWH/A and develop community networking resources. OAPP started the campaign in a broad attempt to reach the general audience, but over time has focused its efforts on targeted campaigns designed to reach specific persons at risk for or affected by HIV/AIDS. This has included the increasing support that OAPP provides to community partners at annual and special community events where large numbers of the target audience are present. This has enhanced OAPP's ability to focus resources where they will have the most effect and has improved collaboration with community partners. This continues OAPP progress to build the capacity of community partners and enhances the effectiveness of the Office in engaging community partners to stop the spread of HIV and AIDS.

2. Social Marketing Campaigns use modern marketing principles to affect knowledge, attitudes, behaviors, and beliefs regarding HIV/AIDS risk, associated behavior change and risk reduction, access to services, and treatment education. Social marketing is not simply advertising a service or hotline number but is action oriented. As required by OAPP's Materials Review Protocol, social marketing activities include a planning, development, and distribution phase.

3. Community-Wide Events

    a. Community Forums provide and elicit information to and from a community.

    b. Health Fairs/Community Events include special events such as street fairs, job fairs, health fairs, World AIDS Day activities, and local celebrations in communities that deliver public information to large numbers of people.

4. Structural Interventions remove barriers and incorporate facilitators of an individual's HIV prevention behaviors. These barriers or facilitators include physical, social, cultural, organizational, community, economic, legal, or policy circumstances or

actions that directly or indirectly affect an individual's ability to avoid exposure to HIV.

Structural interventions seek to modify the social, environmental, and political structures that influence the delivery of HIV prevention services. Structural interventions may impact legislation, technology, and health care standards, among others, to improve the delivery and/or effectiveness of HIV prevention efforts.

Structural interventions may include, but are not limited to: (1) integrating HIV/AIDS services into faith-based activities, (2) mandating HIV-antibody testing for specific offenders, (3) modifying a standard of care to include mandatory offering of HIV-antibody testing to pregnant women, or (4) establishing standards and regulations for the operation of commercial sex venues.

Measuring the success of CLIs offers unique challenges as large-scale impact or change may not be evident for years. Thus, although long-term outcome-oriented evaluation is needed to measure the success of CLI, in the immediate-term, process measures lend themselves to CLI. CBOs may be able to utilize more outcome-oriented measures for specific CLIs, such as structural interventions that produce concrete outcomes (e.g., legislative changes).

- **Health Communications / Public Information (HC/PI)**

Health communications/public information (HC/PI) efforts deliver HIV/AIDS prevention messages through one or more channels. Their purpose is to target specific audiences to build general support for safer behavior, personal risk-reduction efforts, and/or inform persons at risk for infection or transmission how to obtain specific services. HC/PI interventions do not include a skills building component.

Group Presentations are the most common form of HC/PI activity. These information-only, "one-shot" education interventions (e.g., HIV 101 class) may target small or large groups. Group presentations differ from group risk reduction counseling in that group presentations lack a skills building component.

- **HIV Counseling and Testing (HCT)**

Over the past two years, the technology for HIV counseling and testing (HCT) has improved so that community-based providers (where available) now have a choice to offer individuals two different HIV testing technologies: Non-Rapid HCT and Rapid Testing. Both Non-Rapid HCT and Rapid Testing can be provided either confidentially or anonymously. However, Rapid Testing allows the individual being tested to receive his or her HIV test results within a half hour or so of being tested.

Non-Rapid HCT

HIV counseling and testing (HCT) is a voluntary, client-centered interaction process through which an individual seeks to learn his or her HIV status. During this process, the individual receives basic HIV/AIDS information, an explanation of testing procedures and test results, a review of strategies to prevent HIV infection or transmission, information and offering of partner counseling and referral services, and the delivery of client-centered, linked referrals. Referrals

are made as appropriate to the needs of the individual whether that person is newly diagnosed HIV positive or HIV negative.

1. Risk Assessment Counseling Session is a one-on-one, client-centered discussion that encourages the client to review his or her personal risk for acquiring HIV.

2. HIV Test must be a Food and Drug Administration-approved HIV-antibody test to determine the presence of HIV antibodies.

3. Disclosure Counseling Session occurs after the test results have returned from the laboratory. Within the context of a client-centered discussion, the HCT counselor informs the client of his or her HIV-antibody test results. The HCT counselor integrates the test result in a meaningful discussion based on the individual's reported risk factors and consistent with his or her risk reduction efforts. This session reinforces the issues and topics discussed in a risk reduction counseling session.

4. Post-Disclosure Counseling Session occurs after the disclosure session and provides the opportunity for clients to receive additional counseling, information, and linked referrals.

5. Linked Referrals direct individuals being tested for HIV to a specific service as indicated by his or her individual assessment (e.g., group-level HE/RR program, PCM, substance abuse treatment, medical care). The HCT counselor provides written information regarding the referral, which may include but not be limited to: date, client's name, agency referred to, reason for referral, and the name of the individual making the referral. The distinguishing characteristic of a linked referral is that verification is obtained regarding the client's access to the referred service(s).

Rapid HCT

Although a small number of HCT providers in Los Angeles County have been providing rapid HIV testing using OraQuick testing devices since the end of 2003, broad-scale implementation of rapid HIV testing at OAPP-contracted agencies began in June 2004. These sites consist mostly of clinic-based venues and mobile testing units. OAPP has also supported the delivery of rapid HIV testing in eight drug treatment centers and one court testing site.

Since June 2004, community-based agencies have reported overwhelming community acceptance of rapid testing and have seen a distinctly high rate of HIV infection (3.49%). OAPP anticipates that all of the current rapid HIV testing providers listed will continue to implement this new testing technology into 2005 as part of either contracted HCT services or as part of the implementation of Rapid HIV testing through the national Advancing HIV Prevention demonstration project through CDC-direct funding to health department or CBOs.

Los Angeles County is likely to see a dramatic increase in the number of rapid HIV tests provided beginning the second quarter of 2005. In 2005, the projected number of HIV tests in Los Angeles County will be over 66,500. Rapid HIV testing is new to the community and the availability of this service is just beginning to be widely promoted. As such, Los Angles County expects that a minimum of 16,600 rapid HIV tests will be conducted using OraQuick devices.
Also in CY2005, OAPP will work with Los Angeles County Department of Health Services Public Health partners and Commercial Sex Venue (CSV) owners to support the delivery of rapid

HIV testing in CSVs. Based on local research, the provision of rapid HIV testing in these venues ensures that resources and efforts are directed to high prevalence geographic areas and high-risk populations. The expansion of rapid HIV testing services in these venues will be guided by the following steps:

1. Site identified as high volume, high prevalence setting
2. Site expresses interest in implementing Rapid HIV Testing
3. Resources are identified to support Rapid HIV Testing in new venue
4. Site is inspected to ensure that requirements for providing Rapid HIV testing are in place and that the Quality Assurance plan can be met
5. OAPP provides implementation guidelines and technical assistance
6. Rapid HIV Testing staff is identified, trained and certified
7. Rapid HIV Testing services begin

HCT Program Performance Indicators

There are three program performance indicators associated with HIV counseling and testing, whether it is non-rapid testing or rapid testing. These indicators are:

1. Percent of newly identified, confirmed HIV-positive test results among all tests reported by CDC-funded HIV counseling, testing, and referral sites.
2. Percent of newly identified, confirmed HIV-positive test results returned to clients.
3. Percent of facilities reporting a prevalence of new HIV-positive tests equal to or greater than the jurisdiction's target as specified in the first indicator immediately above.

■ Partner Counseling and Referral Services (PCRS)

Partner Counseling and Referral Services (PCRS) refers to a systematic approach to notifying sexual and needle-sharing partners of HIV-infected persons of their possible exposure to HIV. The purpose of this notification is to encourage partners of HIV positive individuals to be tested for HIV so that they can learn their HIV status, provide them with information to avoid infection, or if infected, prevent HIV transmission to others. PCRS helps partners gain timely access to individualized counseling, HIV testing, medical evaluation, treatment, and other HIV and related prevention services. There are two primary components of PCRS:

1. Partner Elicitation is the process of eliciting or obtaining names of sexual and/or needle-sharing partners of an HIV-positive individual. Due to the very sensitive nature of PCRS, CBO staff must be well trained in order to conduct partner elicitation.
2. Partner Notification involves informing an HIV-positive individual's sexual or needle sharing partner of his or her possible exposure to HIV. Partner notification is

traditionally a function of the health department and its staff or agents must be certified in order to deliver Partner Notification services.

PCRS is successful when a sex or needle sharing partner who is notified of a possible exposure to HIV gets tested for HIV.

PCRS Program Performance Indicators

There are three program performance indicators that guide the evaluation of Partner Counseling and Referral Services. These indicators are:

1. Percent of contacts with unknown or negative serostatus who receive an HIV test after PCRS notification.

2. Percent of contacts with newly identified, confirmed HIV-positive test among contacts who are tested.

3. Percent of all contacts with a known, confirmed HIV-positive test among all contacts.

■ Prevention Case Management (PCM)

Prevention case management (PCM) is an individual, client-centered HIV prevention intervention with the goal of promoting the adoption of HIV risk reduction behaviors by individuals with multiple, complex problems, and HIV risk reduction needs. PCM is a hybrid of individual HIV risk-reduction counseling and traditional, psychosocial case management. PCM provides intensive, ongoing, and individualized prevention counseling, support, and service coordination or brokerage.

The CDC offers clear guidance regarding the core elements of PCM. Prominent among the core elements is the assessment of HIV risk behaviors and other psychosocial and health service needs in order to provide risk reduction counseling and to assure psychosocial and medical referrals (e.g., housing, drug treatment, and other health and social services) for HIV positive and high-risk negative persons. PCM provides intensive, individualized support and prevention counseling to help high-risk individuals remain HIV-negative, or to reduce the risk of HIV transmission by HIV-positive persons.

Prevention Case Management Indicators

There are two program performance indicators that guide the evaluation of prevention case management services. These indicators are:

1. Proportion of persons that completed the intended number of prevention case management sessions.

2. Proportion of the intended number of the target population to be reached with prevention case management who were actually reached.

■ Selecting the Appropriate Intervention

To assist CBOs in selecting appropriate interventions by risk group, the PPC recommends that Los Angeles County CBOs review the table developed by CHIPTS, entitled *"Summary of*

Intervention Recommendations for the County of Los Angeles HIV Prevention Plan" The information contained within has been developed to share current best practices around HIV interventions while, at the same time, acknowledging that CBOs have considerable experience in the development and implementation of locally-successful interventions, which may have evidence of effectiveness that falls outside the scientific literature. The table provides a rich starting point from which CBOs can benefit.

Recommendations

Prevention Model

In summary, the PPC recommends the following types of HIV prevention interventions and other critical services to reach Los Angeles County's priority risk groups and improve the County's response to the HIV epidemic:

1. Health Education Risk Reduction (HE/RR) – including GLI, ILI, PCM, etc.
2. HIV Counseling and Testing (HCT) – including Alternative Test Sites (ATS) and Mobile Testing Units (MTU), etc.
3. Partner Counseling and Referral Services
4. Multiple Morbidity Screening – including screening for HIV, STDs, TB, Hepatitis, Substance Use, etc.
5. Social Marketing
6. Capacity Building / Technical Assistance
7. Evaluation / Training
8. Service Directories / Client Advocacy
9. Syringe Exchange
10. Structural Interventions – including Faith-based and School-based Interventions

Allocations by Type of Prevention Service

The PPC recommends the following resource allocation model outlined in Table 24.

TABLE 24. Recommended Resource Allocations by Type of Prevention Service

Service Description	Recommended % Allocation
1.0 Health Education/Risk Reduction (HE/RR)	
1.1 HE/RR by BRG	58.0%
1.2 Corrections HE/RR	1.5%
sub-total	59.5%
2.0 HIV Counseling and Testing	
2.1 HCT by BRG	12.5%
2.2 Mobile Testing by BRG (to encompass Multiple Morbidity Screening)	7.8%
2.3 Partner Counseling (Contractual)	0.4%
2.4 Partner Counseling and Referral Services (PCRS)	1.2%
sub-total	21.9%
3.0 Set Asides	
3.1 Evaluation / Training	4.0%
3.2 Capacity Building / Technical Assistance	4.9%
3.3 PPC Support	1.5%
Sub-total	10.4%
4.0 Other Special Initiatives	
4.1 Directory / Client Advocacy	0.5%
4.2 Faith-Based HIV Prevention	1.5%
4.3 Social Marketing	2.7%
4.4 Networks	1.5%
4.5 School Based Prevention (Structural Interventions)	2.0%
sub-total	8.2%
TOTAL	**100%**

Evaluation

Introduction

Since the writing of the *HIV Prevention Plan 2000*, the CDC released an updated guidance on the evaluation of HIV prevention programs in June 2001. Although, the CDC itself is updating the evaluation guidance to reflect changes made clear through its *Advancing HIV Prevention Initiative*, the 2001 guidance continues to provide structure for evaluation across health jurisdictions. OAPP is responsible for developing and implementing the County's evaluation plan in accordance with CDC guidelines. The evaluation plan presented here represents the County's current framework for evaluation. The PPC acknowledges that, as a result of the anticipated new CDC evaluation guidance, the information presented and details will likely change prior to the end of 2008.

Los Angeles County utilizes an integrated approach to evaluation, which is consistent with the CDC's most current evaluation guidance. Central to the County's evaluation effort is its overarching goal to reduce new HIV infections within Los Angeles County by 50% over five years. To achieve this goal, three evaluation components are essential: (1) evaluating the community planning process, (2) evaluating HIV prevention interventions and related programs subcontracted through OAPP, and (3) tracking the CDC required program performance indicators.

Community Planning

Evaluation of the community planning process is a core responsibility of the PPC and OAPP. Several key objectives, which are also reflected in the CDC's program performance indicators (discussed below), provide the framework for evaluating the community planning process.

1. Objective A - Implement an open recruitment process (outreach, nomination, and selection) for PPC membership.

2. Objective B - Ensure that the PPC membership is representative of the populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from governmental and non-governmental agencies.

3. Objective C - Foster a community planning process that encourages inclusion and parity among community planning members.

4. Objective D - Carry out logical, evidence-based processes to determine the highest priority, population-specific prevention needs in the jurisdiction during the development of the most recent HIV Prevention Plan.

5. Objective E - Ensure that priority target populations are based on an epidemiologic profile and a community services assessment during the development of the most recent HIV Prevention Plan.

6. Objective F - Ensure that prevention activities for identified priority populations are based on behavioral and social science, outcome effectiveness and/or have been adequately tested with intended consumers for cultural appropriateness, relevance, and acceptability during the development of the most recent HIV Prevention Plan.

7. Objective G - Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the health department application for federal HIV prevention funding during the development of the most recent HIV Prevention Plan.

8. Objective H - Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions/services delivered during the development of the most recent HIV Prevention Plan.

At least annually, OAPP and the PPC assess their progress in achieving the above objectives. This helps to ensure congruence between HIV prevention activities and identified priorities.

The PPC Evaluation Subcommittee and OAPP employ a variety of methods to evaluate the community planning process. These include, but are not limited to: demographic assessment of PPC members, community forums, formal surveys, etc. For example, in November 2002 during a general PPC meeting, the PPC invited key community stakeholders to participate in a community forum to discuss the planning process and other relevant issues. Fifty-nine stakeholders participated. Each group discussed one of four questions.

1. What is your perception of the role and responsibility of the PPC?

2. What would you like to have in order to get a better understanding of the epidemic in Los Angeles County as it relates to HIV and other factors?

3. How would you suggest the PPC more effectively gather community input during the prevention planning process?

4. What do you believe the community's role is in the prevention planning process?

Overall, community stakeholders who participated had a clear understanding of the role of the PPC, as well as their needs. Among the needs expressed was a desire for capacity building around evaluation as well as improved epidemiologic information around prioritized risk groups. Participants also identified creative ways to gather community input through targeted email, street outreach to reach individuals not engaged in HIV prevention, and through public service announcements. Finally, participants clearly identified an ongoing and future role for the community in the HIV prevention planning process.

Annually, the PPC distributes a survey to all PPC members and co-chairs to assess the representation, parity and inclusiveness of the planning process. The last survey was in September 2003, with a 100% response rate. In addition to collecting demographic information, the survey also asked members to assess the responsiveness of the PPC with regard to the eight community planning objectives listed above. Overwhelmingly, PPC members stated that the PPC had achieved each of the eight objectives.

HIV Prevention Interventions and Related Services

Los Angeles County has long evaluated HIV prevention and related programs. Historically, this has been conducted through OAPP's contract monitoring process with CBOs, which assesses the attainment of contractually stated goals and objectives. For the most part, this type of evaluation emphasizes process objectives, such as numbers of participants, types of services, etc. This has also included limited outcome evaluation around change in self-reported HIV risk behaviors over time during follow-up activities.

■ Capacity Building: Laying the Foundation for Evaluation

Since the *HIV Prevention Plan 2000,* Los Angeles County has taken great strides in improving the capacity of CBOs around evaluation in order to build a foundation for a more comprehensive, system-wide approach. In July 2001, OAPP subcontracted with AIDS Project Los Angeles (APLA) and CHIPTS to build evaluation capacity for HIV/AIDS service providers, the PPC, and select OAPP staff in order to improve HIV prevention and care services to people living with HIV/AIDS in Los Angeles County. The program was conducted in three phases: (1) needs assessment, (2) curriculum development for training, and (3) evaluation training. The needs assessment identified an overall low capacity among all target groups to perform evaluation activities. Conversely, it also identified an overwhelmingly high interest in evaluation training. To date, APLA and CHIPTS have delivered evaluation training to approximately 185 participants representing CBOs, OAPP staff and PPC members.

Capacity building takes time and sustained effort. During the 2004-2008 planning cycle, OAPP and the PPC will build upon this solid foundation and strive to:

1. Continue offering basic evaluation training to targeted groups;

2. Deliver advanced level training to increase knowledge and skills in specific areas of program evaluation;

3. Provide ongoing program evaluation-related technical assistance and capacity building to CBOs; and

4. Focus efforts on measuring core program performance indicators across all contracted CBOs.

■ Assessing Effectiveness

Successfully preventing new HIV infections is the ultimate measure of effectiveness for an HIV prevention intervention. However, until recently, there has not been a systematic approach to assess this indicator. As discussed, evaluation of HIV prevention programs has consisted primarily of measuring process objectives and limited outcome objectives, none in a systematic way. Los Angeles County has relied on AIDS case data, HIV counseling and testing data, and specific HIV surveillance studies to provide a surrogate for outcome monitoring. Through the introduction of the CDC program performance indicators, a systematic and common approach to assessing program effectiveness is now available.

Los Angeles County's Program Performance Indicators

As part of its ongoing effort to monitor success in achieving its goal to reduce new HIV infections by 50%, Los Angeles County has integrated the CDC's program performance indicators into its evaluation activities. This began with the establishment of Countywide baseline measures, including one- and five-year performance targets. With the release of its new HIV prevention request for proposal (RFP) in June 2004, OAPP took this a step further and requested that respondents integrate the program performance indicators into their applications for HIV prevention services beginning January 1, 2005.

The program performance indicators are a positive step forward in outcome monitoring. They represent a systematic and strategic effort to measure the success of a broad array of programs and services. The following tables present Los Angeles County's program performance indicators by evaluation category as of December 2004.

HIV Community Planning

Program Performance Indicator	BASELINE 2003	1 YEAR 2004 (Target)	2005 (Target)	5 YEAR 2008
1. Proportion of populations most at risk, as documented in the epidemiologic profile, that have at least one community planning group (CPG) member that reflects the perspective of each population.	83%	80%	80%	100%
2. Proportion of CPG membership that agrees that key attributes of an HIV prevention planning process have occurred.	94%	95%	95%	100%
3. Proportion of prevention interventions and supporting activities in the health department CDC funding application specified as a priority in the Comprehensive HIV prevention Plan.	100%	100%	100%	100%
4. Proportion of health department-funded prevention interventions and supporting activities that correspond to priorities specified in the Comprehensive HIV Prevention Plan.	100%	100%	100%	100%

Newly Diagnosed HIV Infections

Program Performance Indicator	BASELINE 2003	1 YEAR 2004 (Target)	2005 (Target)	5 YEAR 2008
1. Number of newly diagnosed HIV infections.	1043	1,123	1,203	1,443
2. Number of newly diagnosed HIV infections, 13-24 years of age.	153	168	180	216

HIV Testing

Program Performance Indicator	BASELINE 2003	1 YEAR 2004 (Target)	2005 (Target)	5 YEAR 2008
1. Percent of newly identified, confirmed HIV-positive test results among all tests reported by CDC funded HIV counseling, testing and referral sites.	1.45%	1.56%	1.67%	2.00%
2. Percent of newly identified, confirmed HIV-positive test results returned to clients.	78%	81.4%	84.8%	95%
3. Percent of facilities reporting a prevalence of HIV-positive tests equal to or greater than the jurisdiction's target as specified in the first indicator immediately above.	39.5%	41.6%	43.7%	50%

Partner Counseling and Referral Services

Program Performance Indicator	BASELINE 2003	1 YEAR 2004 (Target)	2005 (Target)	5 YEAR 2008
1. Percent of contacts with unknown or negative serostatus who receive an HIV test after PCRS notification.	60.6%	50%	60.6%	80%
2. Percent of contacts with a newly identified, confirmed HIV-positive test among contacts who are tested.	9%	17%	17%	17%
3. Percent of contacts with a known, confirmed HIV-positive test among all contacts.	23%	23%	27%	39%

Prevention Case Management

Program Performance Indicator	BASELINE 2003	1 YEAR 2004 (Target)	2005 (Target)	5 YEAR 2008
1. Of those enrolled in PCM, proportion of HIV-infected persons that completed the intended number of sessions for PCM.	45%	50%	60%	80%
2. Percent of HIV-infected persons who, after a specific period of participation in PCM, report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status.	40%	50%	60%	75%

HIV Prevention Interventions & Outreach

Program Performance Indicator	BASELINE 2003	1 YEAR 2004 (Target)	2005 (Target)	5 YEAR 2008
1. Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level intervention (ILI), group level intervention (GLI), and PCM.	ILI - 66%	80%	82.5%	90%
	GLI - 72%	80%	82.5%	90%
	PCM- 43%	75%	77.5%	90%
2. Proportion of the intended number of the target populations to be reached with any of the following specific interventions (ILI, or GLI, or PCM) who were actually reached.	73%	80%	82.5%	90%
3. The mean number of outreach encounters required to get one person to access any of the following services: HCT, STD screening and testing, ILI, GLI or PCM.	3.84	3.39	3.04	2.00

Perinatal Transmission

Program Performance Indicator	BASELINE 2003	1 YEAR 2004 (Target)	2005 (Target)	5 YEAR 2008
1. Proportion of women who receive an HIV test during pregnancy.	0.9%	1.0%	TBD	95%
2. Proportion of HIV infected pregnant women who receive appropriate interventions to prevent perinatal transmission.	85%	86%	87%	90%
3. Proportion of HIV infected pregnant women whose infants are perinatally infected.	14%	9%	5%	2%

Evaluation

Program Performance Indicator	BASELINE 2003	1 YEAR 2004 (Target)	2005 (Target)	5 YEAR 2008
1. Proportion of providers reporting representative process monitoring data to the health department in compliance with the CDC program announcement.	28%	15%	47%	94%

Capacity Building

Program Performance Indicator	BASELINE 2003	1 YEAR 2004 (Target)	2005 (Target)	5 YEAR 2008
1. Proportion of providers who have received at least one health department-supported capacity building assistance episode, specifically in the form of trainings/ workshops in the design, implementation, and evaluation of science-based HIV prevention interventions.	83%	90%	94%	100%

Geographic Snapshots

Introduction

Established in 1850, Los Angeles County is one of California's original 27 counties. It is bordered on the east by Orange and San Bernardino Counties, on the north by Kern County, on the west by Ventura County, and on the south by the Pacific Ocean. Los Angeles County also includes the islands of San Clemente and Santa Catalina. Geographically, Los Angeles County is one of the nation's largest counties spanning 4,084 square miles, an area some 800 square miles larger than the combined area of the States of Delaware and Rhode Island.

In addition to its geographic size, Los Angeles has the largest population of any County in the United States. Its population is exceeded by only eight States, including California. Approximately 28 percent of the State's residents live in Los Angeles County. There are 88 incorporated cities within the County, each with its own city council. All of the cities, in varying degrees, contract with the County to provide municipal services, including health services.

The Board of Supervisors is the governing body for Los Angeles County. Five supervisors are elected to four-year terms by voters within their respective districts. As a subdivision of the State, the County is charged with providing numerous services that affect the lives of all residents. Traditional mandatory services include law enforcement, property assessment, tax collection, public health protection, public social services and relief to indigents.

More than 65 percent of the County is unincorporated. For the 1 million people living in those areas, the Board of Supervisors is their "city council" and County departments provide their municipal services. The 2004-2005 County budget is approximately $17.314 billion. Twenty-three percent of the revenue comes from the State, 28% from the federal government, 19% from property taxes, and 30% from other sources. The largest percentage -27% - of the budget goes to pay for social services, while 20% is spent on public protection and 25% on health services.

■ Service Planning Areas (SPAs)[§]

In 1993, the Children's Planning Council recommended that Los Angeles County aggregate its 26 health districts into eight Service Planning Areas or SPAs. The County Board of Supervisors approved this recommendation to make public health services more responsive to local needs. The following eight SPAs were developed:

1. SPA 1: Antelope Valley;
2. SPA 2: San Fernando Valley;
3. SPA 3: San Gabriel Valley;
4. SPA 4: Metro;
5. SPA 5: West;
6. SPA 6: South;
7. SPA 7: East; and
8. SPA 8: South Bay.

[§] The source information for all data listed on each of the nine geographic snapshots are noted once on the Los Angeles County snapshot with citations in the Appendix.

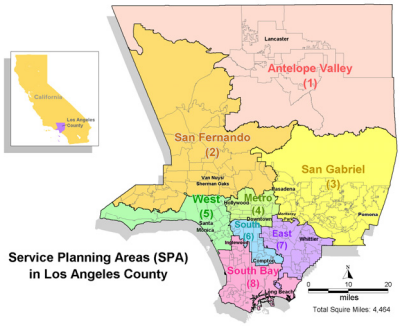
Los Angeles County, California

Facts At A Glance:

Population (2000): 9,519,338
Square Miles: 4,084
Population Density: 2,331 / square mile

County Board of Supervisors:

District 1: Gloria Molina
District 2: Yvonne B. Burke
District 3: Zev Yaroslavsky
District 4: Don Knabe
District 5: Michael D. Antonovich



SOCIO-DEMOGRAPHIC PROFILE [72]

Race/Ethnicity	
Total Population	9,519,338
African American	9.5%
American Indian	0.3%
Asian/Pacific Islander	12.0%
Latino	44.6%
White	31.1%
Other/Multi-racial	2.5%

Age	
0-3 years	6.1%
4-5 years	3.3%
6-9 years	6.8%
10-14 years	7.6%
15-17 years	4.3%
18-24 years	10.3%
25-34 years	16.6%
35-64 years	35.3%
65 years and over	9.7%

Immigration & Language	
Foreign-born Naturalized Citizen	13.8%
Not a US Citizen	22.5%
Spanish Monolingual	13.8%
Asian Language Monolingual	3.1%
Other Language Monolingual	1.2%

Poverty	
Persons below 100% Poverty	17.9%
Persons below 200% Poverty	39.9%

Adult Education	
Less than a 9th grade education	16.2%
9th-12th grade (no diploma)	13.8%
High school graduate/equivalent	18.8%

Transportation	
No vehicle available	12.6%
Public Transportation to work	6.8%
Walking / bicycle / other to work	4.6%

PERSONS LIVING WITH AIDS & OTHER HEALTH INDICATORS

PLWA *(as of 6/30/04)* [22]	***Number***	***Rate***
County Total	19,548	193

Race/Ethnicity	***Percent***	***Rate***
White	37%	238
African American	22%	437
Latino	38%	164
API	3%	39
AI/AN	1%	320

Exposure Category	***Percent***	***Rate***
MSM	64%	n/a
MSM/IDU	6%	n/a
IDU (non-MSM)	7%	n/a
Heterosexual	7%	n/a
Other	16%	n/a

Teen Births *(2001 rate per 1000 live births)* [10]	
15-19 yrs	44.4

STDs *(2002 rate per 100,000)* [73]	
Primary & Secondary Syphilis	3.9
Early Latent Syphilis	3.8
Late & Late Latent Syphilis	9.7
Gonorrhea	84.3
Chlamydia	385.7

Tuberculosis *(2002 rate per 100,000)* [10]	
Incidence of Tuberculosis	11.1

Alcohol & Drug Use *(2001 data)* [10]	
Rate of drug-related adult deaths	9.6
Percent of adults who binge drink	17.1%

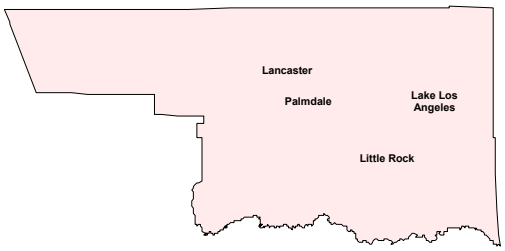
SPA 1: Antelope Valley

Facts At A Glance:

Population (2000): 305,400
Square Miles: 1,504.2
Population Density: 200 / square mile

Supervisorial District:

District 5: Michael D. Antonovich



SOCIO-DEMOGRAPHIC PROFILE

Race/Ethnicity	
Total Population	305,400
African American	12.8%
American Indian	0.6%
Asian/Pacific Islander	3.4%
Latino	29.1%
White	51.2%
Other/Multi-racial	3.0%

Age	
0-3 years	6.3%
4-5 years	3.7%
6-9 years	8.3%
10-14 years	10.3%
15-17 years	5.7%
18-24 years	8.6%
25-34 years	12.3%
35-64 years	37.1%
65 years and over	7.7%

Immigration & Language	
Foreign-born Naturalized Citizen	6.7%
Not a US Citizen	8.6%
Spanish Monolingual	4.2%
Asian Language Monolingual	0.4%
Other Language Monolingual	0.3%

Poverty	
Persons below 100% Poverty	15.7%
Persons below 200% Poverty	34.9%

Adult Education	
Less than a 9th grade education	7.7%
9th-12th grade (no diploma)	15.5%
High school graduate/equivalent	25.7%

Transportation	
No vehicle available	7.8%
Public Transportation to work	2.1%
Walking / bicycle / other to work	2.4%

PERSONS LIVING WITH AIDS & OTHER HEALTH INDICATORS

PLWA *(as of 6/30/04)*	***Number***	***Rate***
Lancaster	78	61
Palmdale	71	58
SPA 1 Total	210	64

Race/Ethnicity	***Percent***	***Rate***
White	44%	58
African American	30%	127
Latino	24%	49
API	-	-
AI/AN	-	-

Exposure Category	***Percent***	***Rate***
MSM	53%	n/a
MSM/IDU	7%	n/a
IDU (non-MSM)	13%	n/a
Heterosexual	10%	n/a
Other	14%	n/a

Teen Births *(2001 rate per 1000 live births)*	
15-19 yrs	52

STDs *(2002 rate per 100,000)*	
Primary & Secondary Syphilis	0.6
Early Latent Syphilis	1.5
Late & Late Latent Syphilis	1.5
Gonorrhea	78.9
Chlamydia	272.7

Tuberculosis *(2002 rate per 100,000)*	
Incidence of Tuberculosis	4.6

Alcohol & Drug Use *(2001 data)*	
Rate of drug-related adult deaths	9.8
Percent of adults who binge drink	15.8%

SPA 2: San Fernando

Facts At A Glance:

Population (2000): 1,981,961
Square Miles: 1,206.1
Population Density: 1,644 / square mile

Supervisorial Districts:

District 3: Zev Yaroslavsky
District 5: Michael D. Antonovich

SOCIO-DEMOGRAPHIC PROFILE

Race/Ethnicity	
Total Population	1,981,961
African American	3.5%
American Indian	0.3%
Asian/Pacific Islander	9.2%
Latino	35.8%
White	47.7%
Other/Multi-racial	3.6%

Age	
0-3 years	5.8%
4-5 years	3.1%
6-9 years	6.4%
10-14 years	7.2%
15-17 years	4.1%
18-24 years	9.2%
25-34 years	16.2%
35-64 years	37.8%
65 years and over	10.2%

Immigration & Language	
Foreign-born Naturalized Citizen	15.3%
Not a US Citizen	21.3%
Spanish Monolingual	10.7%
Asian Language Monolingual	1.6%
Other Language Monolingual	0.5%

Poverty	
Persons below 100% Poverty	13.7%
Persons below 200% Poverty	32.6%

Adult Education	
Less than a 9th grade education	12.5%
9th-12th grade (no diploma)	11.6%
High school graduate/equivalent	18.7%

Transportation	
No vehicle available	8.7%
Public Transportation to work	4.7%
Walking / bicycle / other to work	3.7%

PERSONS LIVING WITH AIDS & OTHER HEALTH INDICATORS

PLWA *(as of 6/30/04)*	***Number***	***Rate***
Studio City	230	433
North Hollywood	441	340
SPA 2 Total	2,567	124

Race/Ethnicity	***Percent***	***Rate***
White	48%	124
African American	11%	372
Latino	36%	121
API	3%	37
AI/AN	<1%	202

Exposure Category	***Percent***	***Rate***
MSM	64%	n/a
MSM/IDU	5%	n/a
IDU (non-MSM)	7%	n/a
Heterosexual	8%	n/a
Other	16%	n/a

Teen Births *(2001 rate per 1000 live births)*	
15-19 yrs	41

STDs *(2002 rate per 100,000)*	
Primary & Secondary Syphilis	2.0
Early Latent Syphilis	2.4
Late & Late Latent Syphilis	7.0
Gonorrhea	37.4
Chlamydia	245.4

Tuberculosis *(2002 rate per 100,000)*	
Incidence of Tuberculosis	8.2

Alcohol & Drug Use *(2001 data)*	
Rate of drug-related adult deaths	7.6
Percent of adults who binge drink	16.2%

SPA 3: San Gabriel

Facts At A Glance:

Population (2000): 1,734,254
Square Miles: 680.6
Population Density: 2,542 / square mile

Supervisorial Districts:

District 1: Gloria Molina
District 4: Don Knabe
District 5: Michael D. Antonovich

SOCIO-DEMOGRAPHIC PROFILE

Race/Ethnicity	
Total Population	1,734,254
African American	4.7%
American Indian	0.3%
Asian/Pacific Islander	22.7%
Latino	43.6%
White	26.6%
Other/Multi-racial	2.2%

Age	
0-3 years	5.8%
4-5 years	3.2%
6-9 years	6.6%
10-14 years	7.9%
15-17 years	4.6%
18-24 years	10.2%
25-34 years	15.1%
35-64 years	36.4%
65 years and over	10.4%

Immigration & Language	
Foreign-born Naturalized Citizen	17.0%
Not a US Citizen	20.4%
Spanish Monolingual	10.5%
Asian Language Monolingual	7.2%
Other Language Monolingual	0.4%

Poverty	
Persons below 100% Poverty	14.0%
Persons below 200% Poverty	34.2%

Adult Education	
Less than a 9th grade education	14.6%
9th-12th grade (no diploma)	13.1%
High school graduate/equivalent	19.2%

Transportation	
No vehicle available	8.2%
Public Transportation to work	3.9%
Walking / bicycle / other to work	4.5%

PERSONS LIVING WITH AIDS & OTHER HEALTH INDICATORS

PLWA *(as of 6/30/04)*	***Number***	***Rate***
Pasadena	219	161
Pomona	179	117
SPA 3 Total	1,321	73

Race/Ethnicity	***Percent***	***Rate***
White	25%	72
African American	20%	304
Latino	49%	81
API	6%	16
AI/AN	<1%	111

Exposure Category	***Percent***	***Rate***
MSM	55%	n/a
MSM/IDU	4%	n/a
IDU (non-MSM)	10%	n/a
Heterosexual	12%	n/a
Other	19%	n/a

Teen Births *(2001 rate per 1000 live births)*	
15-19 yrs	43

STDs *(2002 rate per 100,000)*	
Primary & Secondary Syphilis	0.8
Early Latent Syphilis	0.8
Late & Late Latent Syphilis	4.7
Gonorrhea	34.5
Chlamydia	254.4

Tuberculosis *(2002 rate per 100,000)*	
Incidence of Tuberculosis	11.7

Alcohol & Drug Use *(2001 data)*	
Rate of drug-related adult deaths	6.6
Percent of adults who binge drink	14.9%

SPA 4: Metro

Facts At A Glance:

Population (2000): 1,144,083
Square Miles: 106.5
Population Density: 10,680 / square mile

Supervisorial Districts:

District 1: Gloria Molina
District 2: Yvonne B. Burke
District 3: Zev Yaroslavsky

SOCIO-DEMOGRAPHIC PROFILE

Race/Ethnicity	
Total Population	1,144,083
African American	5.9%
American Indian	0.3%
Asian/Pacific Islander	15.4%
Latino	54.2%
White	21.9%
Other/Multi-racial	2.3%

Age	
0-3 years	5.8%
4-5 years	3.0%
6-9 years	5.9%
10-14 years	6.1%
15-17 years	3.5%
18-24 years	10.9%
25-34 years	20.7%
35-64 years	34.4%
65 years and over	9.6%

Immigration & Language	
Foreign-born Naturalized Citizen	16.2%
Not a US Citizen	35.0%
Spanish Monolingual	21.0%
Asian Language Monolingual	5.5%
Other Language Monolingual	2.4%

Poverty	
Persons below 100% Poverty	26.2%
Persons below 200% Poverty	54.7%

Adult Education	
Less than a 9th grade education	23.8%
9th-12th grade (no diploma)	15.2%
High school graduate/equivalent	16.7%

Transportation	
No vehicle available	25.1%
Public Transportation to work	17.9%
Walking / bicycle / other to work	6.3%

PERSONS LIVING WITH AIDS & OTHER HEALTH INDICATORS

PLWA *(as of 6/30/04)*	***Number***	***Rate***
Hollywood	2,121	898
West Hollywood	995	2,695
SPA 4 Total	7,310	623

Race/Ethnicity	***Percent***	***Rate***
White	42%	1138
African American	17%	1759
Latino	37%	428
API	2%	93
AI/AN	1%	1039

Exposure Category	***Percent***	***Rate***
MSM	70%	n/a
MSM/IDU	6%	n/a
IDU (non-MSM)	4%	n/a
Heterosexual	4%	n/a
Other	16%	n/a

Teen Births *(2001 rate per 1000 live births)*	
15-19 yrs	51

STDs *(2002 rate per 100,000)*	
Primary & Secondary Syphilis	17.5
Early Latent Syphilis	15.7
Late & Late Latent Syphilis	26.7
Gonorrhea	125.3
Chlamydia	465.7

Tuberculosis *(2002 rate per 100,000)*	
Incidence of Tuberculosis	21.2

Alcohol & Drug Use *(2001 data)*	
Rate of drug-related adult deaths	10.4
Percent of adults who binge drink	19.8%

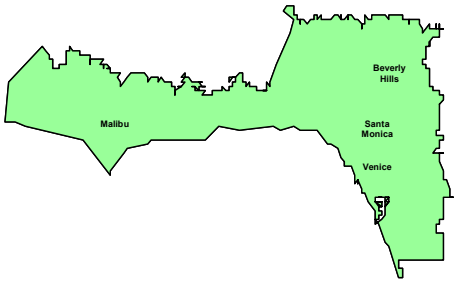
SPA 5: West

Facts At A Glance:

Population (2000): 613,191
Square Miles: 223.9
Population Density: 2,775 / square mile

Supervisorial Districts:

District 2: Yvonne B. Burke
District 3: Zev Yaroslavsky
District 4: Don Knabe



SOCIO-DEMOGRAPHIC PROFILE

Race/Ethnicity	
Total Population	613,191
African American	6.4%
American Indian	0.2%
Asian/Pacific Islander	10.8%
Latino	16.0%
White	62.7%
Other/Multi-racial	6.5%

Age	
0-3 years	3.9%
4-5 years	1.9%
6-9 years	3.9%
10-14 years	4.4%
15-17 years	2.5%
18-24 years	11.0%
25-34 years	19.5%
35-64 years	39.8%
65 years and over	13.1%

Immigration & Language	
Foreign-born Naturalized Citizen	13.5%
Not a US Citizen	14.7%
Spanish Monolingual	3.5%
Asian Language Monolingual	1.1%
Other Language Monolingual	1.5%

Poverty	
Persons below 100% Poverty	12.1%
Persons below 200% Poverty	23.9%

Adult Education	
Less than a 9th grade education	4.7%
9th-12th grade (no diploma)	5.6%
High school graduate/equivalent	12.2%

Transportation	
No vehicle available	8.0%
Public Transportation to work	4.7%
Walking / bicycle / other to work	6.8%

PERSONS LIVING WITH AIDS & OTHER HEALTH INDICATORS

PLWA (as of 6/30/04)	*Number*	*Rate*
Santa Monica	170	193
Venice	135	353
SPA 5 Total	1004	158

Race/Ethnicity	*Percent*	*Rate*
White	59%	145
African American	15%	338
Latino	22%	211
API	3%	36
AI/AN	1%	469

Exposure Category	*Percent*	*Rate*
MSM	72%	n/a
MSM/IDU	4%	n/a
IDU (non-MSM)	6%	n/a
Heterosexual	5%	n/a
Other	13%	n/a

Teen Births (2001 rate per 1000 live births)	
15-19 yrs	20

STDs (2002 rate per 100,000)	
Primary & Secondary Syphilis	4.2
Early Latent Syphilis	2.2
Late & Late Latent Syphilis	3.1
Gonorrhea	53.4
Chlamydia	186.5

Tuberculosis (2002 rate per 100,000)	
Incidence of Tuberculosis	5.0

Alcohol & Drug Use (2001 data)	
Rate of drug-related adult deaths	8.5
Percent of adults who binge drink	18.5%

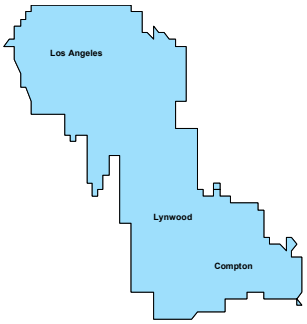
SPA 6: South

Facts At A Glance:

Population (2000): 955,054
Square Miles: 87.2
Population Density: 11,581 / square mile

Supervisorial Districts:

District 1: Gloria Molina
District 2: Yvonne B. Burke
District 4: Don Knabe



SOCIO-DEMOGRAPHIC PROFILE

Race/Ethnicity	
Total Population	955,054
African American	34.7%
American Indian	0.2%
Asian/Pacific Islander	1.6%
Latino	59.7%
White	2.6%
Other/Multi-racial	1.2%

Age	
0-3 years	7.8%
4-5 years	4.4%
6-9 years	8.8%
10-14 years	9.6%
15-17 years	5.1%
18-24 years	12.6%
25-34 years	15.9%
35-64 years	28.6%
65 years and over	7.2%

Immigration & Language	
Foreign-born Naturalized Citizen	8.3%
Not a US Citizen	28.2%
Spanish Monolingual	26.2%
Asian Language Monolingual	0.4%
Other Language Monolingual	0.1%

Poverty	
Persons below 100% Poverty	32.1%
Persons below 200% Poverty	62.7%

Adult Education	
Less than a 9th grade education	30.5%
9th-12th grade (no diploma)	22.2%
High school graduate/equivalent	19.2%

Transportation	
No vehicle available	22.9%
Public Transportation to work	14.1%
Walking / bicycle / other to work	5.9%

PERSONS LIVING WITH AIDS & OTHER HEALTH INDICATORS

PLWA *(as of 6/30/04)*	***Number***	***Rate***
Crenshaw	210	294
West Adams-Exposition	291	227
SPA 6 Total	1,894	192

Race/Ethnicity	***Percent***	***Rate***
White	5%	356
African American	56%	319
Latino	39%	120
API	<1%	30
AI/AN	<1%	281

Exposure Category	***Percent***	***Rate***
MSM	47%	n/a
MSM/IDU	4%	n/a
IDU (non-MSM)	10%	n/a
Heterosexual	13%	n/a
Other	16%	n/a

Teen Births *(2001 rate per 1000 live births)*	
15-19 yrs	83

STDs *(2002 rate per 100,000)*	
Primary & Secondary Syphilis	2.5
Early Latent Syphilis	3.8
Late & Late Latent Syphilis	17.8
Gonorrhea	244.4
Chlamydia	858.0

Tuberculosis *(2002 rate per 100,000)*	
Incidence of Tuberculosis	12.4

Alcohol & Drug Use *(2001 data)*	
Rate of drug-related adult deaths	11.2
Percent of adults who binge drink	16.1%

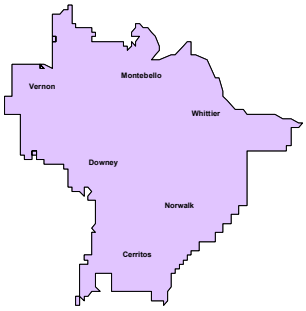
SPA 7: East

Facts At A Glance:

Population (2000): 1,285,210
Square Miles: 155.1
Population Density: 8,199 / square mile

Supervisorial Districts:

District 1: Gloria Molina
District 4: Don Knabe



SOCIO-DEMOGRAPHIC PROFILE

Race/Ethnicity	
Total Population	1,285,210
African American	2.7%
American Indian	0.3%
Asian/Pacific Islander	8.1%
Latino	68.2%
White	19.3%
Other/Multi-racial	1.9%

Age	
0-3 years	6.9%
4-5 years	3.7%
6-9 years	7.7%
10-14 years	8.5%
15-17 years	4.8%
18-24 years	10.9%
25-34 years	16.2%
35-64 years	32.1%
65 years and over	9.0%

Immigration & Language	
Foreign-born Naturalized Citizen	13.8%
Not a US Citizen	23.9%
Spanish Monolingual	20.2%
Asian Language Monolingual	1.8%
Other Language Monolingual	0.4%

Poverty	
Persons below 100% Poverty	16.0%
Persons below 200% Poverty	41.1%

Adult Education	
Less than a 9th grade education	22.0%
9th-12th grade (no diploma)	17.9%
High school graduate/equivalent	22.3%

Transportation	
No vehicle available	10.9%
Public Transportation to work	5.5%
Walking / bicycle / other to work	4.4%

PERSONS LIVING WITH AIDS & OTHER HEALTH INDICATORS

PLWA *(as of 6/30/04)*	***Number***	***Rate***
Belvedere Gardens	91	135
Huntington Park	103	163
SPA 7 Total	1,221	92

Race/Ethnicity	***Percent***	***Rate***
White	16%	80
African American	7%	212
Latino	74%	97
API	2%	25
AI/AN	1%	131

Exposure Category	***Percent***	***Rate***
MSM	57%	n/a
MSM/IDU	5%	n/a
IDU (non-MSM)	7%	n/a
Heterosexual	10%	n/a
Other	16%	n/a

Teen Births *(2001 rate per 1000 live births)*	
15-19 yrs	57

STDs *(2002 rate per 100,000)*	
Primary & Secondary Syphilis	1.5
Early Latent Syphilis	1.6
Late & Late Latent Syphilis	5.7
Gonorrhea	39.9
Chlamydia	358.3

Tuberculosis *(2002 rate per 100,000)*	
Incidence of Tuberculosis	8.9

Alcohol & Drug Use *(2001 data)*	
Rate of drug-related adult deaths	10.6
Percent of adults who binge drink	19.1%

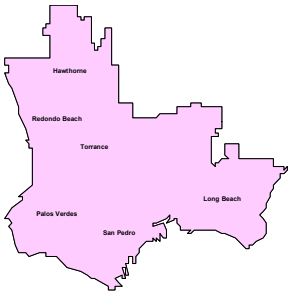
SPA 8: South Bay

Facts At A Glance:

Population (2000): 1,500,185
Square Miles: 205.6
Population Density: 7,130 / square mile

Supervisorial Districts:

District 2: Yvonne B. Burke
District 4: Don Knabe



SOCIO-DEMOGRAPHIC PROFILE

Race/Ethnicity	
Total Population	1,500,185
African American	15.9%
American Indian	0.3%
Asian/Pacific Islander	13.4%
Latino	34.9%
White	32.7%
Other/Multi-racial	2.9%

Age	
0-3 years	6.2%
4-5 years	3.4%
6-9 years	6.9%
10-14 years	7.6%
15-17 years	4.1%
18-24 years	9.4%
25-34 years	16.5%
35-64 years	36.3%
65 years and over	9.7%

Immigration & Language	
Foreign-born Naturalized Citizen	11.2%
Not a US Citizen	17.8%
Spanish Monolingual	10.3%
Asian Language Monolingual	2.6%
Other Language Monolingual	0.4%

Poverty	
Persons below 100% Poverty	17.1%
Persons below 200% Poverty	37.1%

Adult Education	
Less than a 9th grade education	12.3%
9th-12th grade (no diploma)	12.6%
High school graduate/equivalent	19.3%

Transportation	
No vehicle available	11.4%
Public Transportation to work	4.8%
Walking / bicycle / other to work	4.0%

PERSONS LIVING WITH AIDS & OTHER HEALTH INDICATORS

PLWA *(as of 6/30/04)*	***Number***	***Rate***
Inglewood	228	198
Long Beach	2,116	444
SPA 8 Total	3,314	214

Race/Ethnicity	***Percent***	***Rate***
White	42%	282
African American	26%	333
Latino	28%	165
API	3%	41
AI/AN	1%	353

Exposure Category	***Percent***	***Rate***
MSM	66%	n/a
MSM/IDU	8%	n/a
IDU (non-MSM)	9%	n/a
Heterosexual	9%	n/a
Other	8%	n/a

Teen Births *(2001 rate per 1000 live births)*	
15-19 yrs	57

STDs *(2002 rate per 100,000)*	
Primary & Secondary Syphilis	2.3
Early Latent Syphilis	2.3
Late & Latent Syphilis	6.5
Gonorrhea	88.5
Chlamydia	356.7

Tuberculosis *(2002 rate per 100,000)*	
Incidence of Tuberculosis	10.3

Alcohol & Drug Use *(2001 data)*	
Rate of drug-related adult deaths	10.1
Percent of adults who binge drink	17.3%