

# WHITE PAPER

## HIV AND AIDS, CITY OF LOS ANGELES: 21st Century Challenges and Approaches ASSESSMENT AND UPDATE



**December 2014**

**Author:**

**Aaron Celious, Ph.D.**  
[celious@maroonsociety.com](mailto:celious@maroonsociety.com)  
[www.maroonsociety.com](http://www.maroonsociety.com)

**maroonsociety**  
research strategy solutions

# Executive Summary

Since 2003, the average rate of HIV diagnosis has dropped 19%, HIV-related mortality is down 59%, and the rate at which people with HIV transmit the virus has declined 48% in the City of Los Angeles. HIV medication can now reduce the presence of HIV to nearly undetectable levels in the body, which significantly reduces the possibility of HIV transmission; and, biomedical interventions, specifically Pre-Exposure prophylaxis and Post-Exposure prophylaxis have demonstrated promising evidence of interrupting seroconversion after HIV exposure. These game-changing accomplishments may give casual observers the impression that the fight against HIV/AIDS is over. However, before declaring *mission accomplished* it should be noted that there are more people living with HIV in the City of Los Angeles (City) now than in any previous era. Growth in the size of the HIV positive population increases the statistical probability of HIV transmission; and, although HIV medication is more effective, just over half of the people living with HIV adhere to their antiretroviral regimen, which translates to missed health benefits for almost 45% of HIV positive individuals who are not adherent to antiretroviral therapy (ART) and lost prevention benefits to the community.

---

In the City, 85% of people living with HIV are gay or bisexual men and nearly 85% of all new HIV diagnoses over the past ten years, were among gay and bisexual men. As such, the key to preventing new HIV infections depends on our ability to provide adequate programs to address the needs of gay and bisexual men. Between 2003-2012, gay/bisexual men experienced a 19% reduction in the average rate of HIV diagnosis, which resulted chiefly because White men in every age group had fewer HIV infections. However, during the same period, 20-29 year old gay/bisexual Blacks, Asian/Others and Latinos experienced escalating average HIV diagnosis rates, ranging from 20% to 68%. The AIDS Coordinator's Office endeavors to prevent new HIV infections among all people in the City by reinforcing co-factors that increase access to health care and adherence to ART. The strategy to achieve this goal has four tactics: (1) link high priority groups to primary health care with access to biomedical interventions, (2) support health facilities to adopt routine opt-out HIV testing policies, (3) help people living with HIV adhere to their antiretroviral therapy regimen, and (4) hold bi-annual or quarterly forums to disseminate relevant information and engage the community for feedback.

## KEY FINDINGS

1. The statistical probability of acquiring HIV is higher today than in any previous period.
2. Medication is able to stop HIV from becoming AIDS but only 55% of people with HIV adhere to an antiretroviral regimen that suppresses their viral load.
3. The most promising prevention options are community viral load reduction and targeted biomedical interventions.

# Acknowledgements

The AIDS Coordinator's Office and the research team from Maroon Society would like to acknowledge the support and generous contributions made by the individuals listed below.

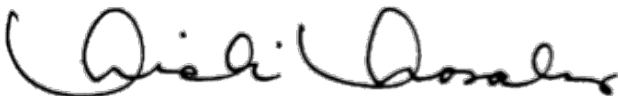
Aaron Fox	Michael Johnson
Amy Ragsdale	Miguel Martinez
Angelica Skouras	Milton Smith
Bradley Land	Nathaniel Celious
Brenda Wiewel	Oscar De La O
Carrie Broadus	Patricia E. Ortega
Cindy Davis	Patricia M. Villasenor
Craig Vincent-Jones	Philip Curtis
Dahlia Ferlito	Richard Zaldivar
Daisy Bonilla	R. Khari Brown
Doane Liu	Rose Veniegas
Douglas Frye	Sara Train
Drian Juarez	Shane Jenkins
Efren Chacon	Shoshanna Scholar
Emmett McOsker	Stephen David Simon
Erik Sanjurjo	Suzette Flynn
Gina Blades	Terry Goddard
Jeff Bailey	Terry Smith
Jeffrey King	Tony Mills
John Fabian	Tonya Jessie
Kevin James	Tony Weathersby
Karen Buchanan	Uyen Kao
Kyle Baker	Yunyin "Virginia" Hu

# AIDS Coordinator's Statement

Over the nearly eleven years following the release of the ACO's first white paper on HIV/AIDS strategy, Los Angeles' communities have witnessed a rapidly changing HIV/AIDS landscape. The National HIV/AIDS Strategy, the Affordable Care Act, advances in HIV treatment, the treatment as prevention movement, and biomedical prevention, have changed the national and local discourse on HIV prevention and care. This is an era of hyper polarization in politics and budget shortfalls, which means now, more than ever, we must work together to address the myriad of obstacles facing the City's most vulnerable populations. We can no longer be content with business as usual. The science, understanding and practice behind our work continue to advance and we need to be prepared to embrace the changes and capture the opportunities quickly to keep up and adapt.

Through the convening of experts drawn from Los Angeles' diverse HIV/AIDS community stakeholders, this document attempts to capture a detailed and accurate portrayal of HIV/AIDS within the City, while at the same time acknowledging that in order to succeed we must work collaboratively with local, regional and national partners. The intended audience for this document includes researchers, consumers, AIDS Service Organization staff, government officials, and other stakeholders. The aim of the white paper is not only to ascertain statistics on the local epidemic, but also provoke critical thinking to creatively find solutions for stemming HIV/AIDS in the City of Los Angeles. The challenge before us is not solely to implement the recommendations herein, but to do so in a creative, community focused and efficient manner.

As the City AIDS Coordinator, my ultimate responsibility is to work with the community to ensure the goals set forth in the white paper are achieved. I stand firm in my commitment to identifying and supporting innovative ways to curb the proliferation of HIV/AIDS, while improving the quality of life for those living with HIV/AIDS in the City.



Ricky Rosales  
AIDS Coordinator  
City of Los Angeles  
Department on Disability

# TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY</b> .....	<b>I</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>II</b>
<b>AIDS COORDINATOR'S STATEMENT</b> .....	<b>III</b>
<b>INTRODUCTION</b> .....	<b>1</b>
2014 WHITE PAPER GOALS .....	1
BACKGROUND .....	2
METHODS OF EVALUATION AND WHITE PAPER DEVELOPMENT .....	3
PREVENT CITY FROM REACHING 1% HIV PREVALENCE THRESHOLD .....	3
<b>EVALUATION OF PROGRESS</b> .....	<b>4</b>
ACO PROGRAMMATIC ACHIEVEMENTS: 2003 - 2012.....	4
<i>HIV Prevention</i> .....	5
<i>Reducing Stigma and Discrimination</i> .....	7
<i>Housing and Support Services</i> .....	8
EPIDEMIOLOGIC ACHIEVEMENTS: 2003 - 2012 .....	9
<i>Average HIV Diagnosis Rate by Race</i> .....	9
<i>Average HIV Diagnosis Rate by Transmission Mode</i> .....	10
<i>Average HIV Diagnosis Rate–Race, Gender, Gay/Bisexual</i> .....	10
<i>HIV Transmission Rate</i> .....	11
<i>Average HIV Mortality Rate</i> .....	12
<i>Proportion of People Living with HIV</i> .....	13
<b>CHARACTERISTICS OF HIV: 2012</b> .....	<b>14</b>
POPULATION CHARACTERISTICS .....	15
HIV CHARACTERISTICS IN HIGH PRIORITY GROUPS .....	15
1. <i>HIV Positive People</i> .....	15
2. <i>Gay and Bisexual Men</i> .....	19
4. <i>Youth (20-29 Years)</i> .....	24
5. <i>Transgender Persons</i> .....	24
6. <i>Persons who share injection paraphernalia</i> .....	26
<b>NEW RESPONSES TO THE EPIDEMIC</b> .....	<b>27</b>
EXPAND ROUTINE OPT-OUT HIV TESTING.....	29
SUPPORT ADHERENCE TO ANTIRETROVIRAL THERAPY .....	30
HOLD FORUMS FOR INFORMATION DISSEMINATION .....	31
<b>CONCLUSION</b> .....	<b>32</b>
<b>GLOSSARY OF TERMS</b> .....	<b>33</b>

<b>APPENDIX A – NEW STRATEGY ANALYSIS .....</b>	<b>35</b>
LINKING HIGH PRIORITY GROUPS TO HEALTH CARE .....	36
HIGH PRIORITY GROUPS .....	37
<i>HIV positive gay/bisexual men – 20-59 years old</i> .....	38
<i>HIV negative gay/bisexual men – 20-39 years old</i> .....	38
<i>Injection drug users</i> .....	39
<i>Heterosexual women</i> .....	39
<i>Transgender women</i> .....	39
EXPANDING ROUTINE OPT-OUT HIV TESTS .....	40
SUPPORT ANTIRETROVIRAL THERAPY ADHERENCE .....	40
FORUMS FOR INFORMATION EXCHANGE WITH COMMUNITY .....	41
<i>Viral load suppression and serodiscordant couples</i> .....	41
<i>PrEP and PEP education</i> .....	41
<i>Condom fatigue among HIV positive and negative men</i> .....	41
<i>Transmission modes</i> .....	42
<i>Co-morbidity reduction</i> .....	42
PREVENTION RESEARCH.....	42
SYRINGE EXCHANGE.....	42
HOPWA .....	43
COLLABORATE WITH LOS ANGELES COUNTY .....	43
<b>APPENDIX B – ADDITIONAL TABLES .....</b>	<b>44</b>
<b>APPENDIX C – COMMUNITY RECOMMENDATIONS.....</b>	<b>61</b>
<b>APPENDIX D – METHODS.....</b>	<b>64</b>
<b>REFERENCES .....</b>	<b>67</b>

## List of Tables

Table 1: Average HIV Diagnosis Rate by Race .....	9
Table 2: Average HIV Diagnosis Rate by Transmission Mode.....	10
Table 3: Average HIV Diagnosis Rate by Race, Gender, Gay/Bisexual Male .....	10
Table 4: Transmission Rate by Race - 2002 vs. 2012 .....	11
Table 5: HIV Transmission Rate by Exposure Mode - 2002 vs. 2012 .....	11
Table 6: Average HIV Mortality Rate - 1992-2002, 2002-2012 .....	12
Table 7: Rate of People Living with HIV - 2002 vs. 2012.....	13
Table 8: City of L.A. Population - 2000-2010 .....	15
Table 9: People Living with HIV - 2012, and New HIV Diagnoses - 2012 .....	17
Table 10: Estimated Gay/Bisexual Male Population and HIV Seroprevalence - 2012.....	19
Table 11: MSM HIV Diagnoses in a single year - 2002 vs. 2012.....	21
Table 12: Average HIV Diagnosis Rate - 1992-2002 vs. 2002-2012 .....	24
Table 13: People living with HIV from IDU - 2012 .....	26
Table 14: Recent HIV Diagnoses from IDU - 2009-2012 .....	26
Table 15: Key Populations, Priority Subpopulations, and Populations of Interest .....	36
Table 16: High Priority Groups for HIV Prevention and Support Services .....	37
Table 17: Population Estimates for City of Los Angeles - 2000 and 2010 .....	45
Table 18: Population Estimate of Gay and Bisexual Men in the City of Los Angeles .....	46
Table 19: People Living with HIV by Race and Age - 2012.....	47
Table 20: People Living with HIV by Transmission Mode - 2012 .....	48
Table 21: Gay and Bisexual Men Living with HIV - 2002 and 2012 .....	49
Table 22: 20-29 Year Olds Living with HIV by Transmission Mode - 2012.....	50
Table 23: Projection of People Living with HIV and HIV Seroprevalence by 2022 .....	51
Table 24: HIV Diagnoses (single year) and HIV Transmission Rate - 2002 vs. 2012 .....	52

Table 25: Average HIV Diagnosis Rate by Race and Gender -.....	53
Table 26: Average HIV Diagnosis Rate by Age, Race, Gender - 2012 .....	54
Table 27: Average HIV Diagnosis Rate by Transmission Mode, Race, Gender - 2012 .....	55
Table 28: Average HIV Diagnosis Rate by MSM and MSM/IDU, Race, Age - .....	56
Table 29: Average HIV Diagnosis Rate by Females, Race, Age - 2012 .....	57
Table 30: Average HIV Diagnosis Rate by Age - 1993-2002 vs. 2003-2012 .....	58
Table 31: Recent HIV Diagnoses by IDU, Age - 2002-2005 vs. 2009-2012.....	58
Table 32: Recent HIV Diagnosis Rate by Transmission Mode - Females: 2002-05 vs. 2009-12..	59
Table 33: Recent HIV Diagnosis Rate by Transmission Mode - 2002-2005 vs. 2009-2012.....	59
Table 34: Recent HIV Diagnosis Rate by MSM and MSM/IDU, Race, Age .....	60
Table 35: Community Recommended Prevention Target .....	62
Table 36: Community Recommendation for Prevention Strategy .....	62
Table 37: Community Recommendation to Increase Access to Health Care and Treatment....	63
Table 38: Community Recommendations to Reduce HIV-Related Disparity .....	63



## List of Figures

Figure 1: Living Less than 10 Years after Diagnosis vs. More than 10 Years After Diagnosis.....	2
Figure 2: People Living with HIV and Percent of Population Living with HIV by Year End .....	3
Figure 3: People Living with HIV - Gay/Bisexual Men and Females.....	15
Figure 4: People Living with HIV by Race, Gender, Gay/Bisexual Men - 2012 .....	16
Figure 5: HIV Seroprevalence Rate (per 100) by Race, Gender, Gay/Bisexual Men - 2012 .....	16
Figure 6: People Living with HIV by Transmission Mode - 2012, .....	17
Figure 7: Rate of People Living with HIV by Age - 2002 vs. 2012 .....	18
Figure 8: Rate of Recent HIV Diagnoses by Age - 2002-2005 vs. 2009-2012 .....	18
Figure 9: Recent HIV Diagnoses from MSM Transmission - 2012 - Top 10 Cities of PLWH .....	20
Figure 10: Rate of Recent HIV Diagnoses by MSM Transmission - 2002-2005 vs. 2009-2012....	20
Figure 11: Recent HIV Diagnoses by MSM and MSM/IDU for 20-29 Year Olds - 2009-2012 .....	21
Figure 12: HIV Seroprevalence for Gay/Bisexual Men - 2012 .....	22
Figure 13: Women Living with HIV - 2012, and Recently Diagnosed with HIV - 2009-2012 .....	23
Figure 14: Rate of Recent HIV Diagnoses by Women - 2002-2005 vs. 2009-2012.....	23
Figure 15: Number of HIV Diagnoses among Transgender Persons - 1992-2012 vs. 2003-2012 ...	24
Figure 16: Transgender Women Living with HIV- LA County - 2012 .....	25
Figure 17: People Living with HIV Exposed from Intravenous Drug Use - 2012 .....	26
Figure 18: Average HIV Concentration by Transmission Mode and Transgender Women .....	36
Figure 19: HIV Impact Score for HIV Positive Gay/Bisexual Men - 20-59 years old - 2012 .....	38
Figure 20: HIV Impact Score for 20-29 and 30-39 year old Men - MSM exposure- 2009-2012 ...	38
Figure 21: HIV Impact Score for Females exposed from Heterosexual Contact - 2009-2012 .....	39
Figure 22: Los Angeles County Testing Linkage to Care Plus Treatment Cascade - 2011 <sup>10</sup> .....	40

# Introduction

## 2014 White Paper Goals

The City of Los Angeles AIDS Coordinator's Office (ACO) commissioned this white paper to:

- (1) Evaluate progress made achieving the goals established in the 2003 white paper
- (2) Characterize the current HIV/AIDS epidemic in Los Angeles, and
- (3) Recommend a new strategy to respond to the HIV/AIDS epidemic in Los Angeles.

The new ACO strategy is intended to be a locally relevant version of the National HIV/AIDS Strategy (NHAS) with ambitious achievable goals. The NHAS expects that:

**The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.<sup>1</sup>**

The NHAS indicates this outcome can be achieved if communities reduce new HIV infections, increase access to health care and treatment and, reduce HIV-related disparity. These tactics are interrelated such that providing access to health care and reducing HIV-related disparity is likely to result in fewer HIV transmissions/infections. Given the mandate to develop ambitious achievable goals, it is recommended that the ACO focus on reducing HIV infections by supporting and developing programs that:

- (1) Link high priority groups to health care with access to biomedical interventions,**
- (2) Expand routine opt-out HIV testing,**
- (3) Help people living with HIV adhere to their antiretroviral therapy regimen, and**
- (4) Hold regular forums for information dissemination and community feedback**

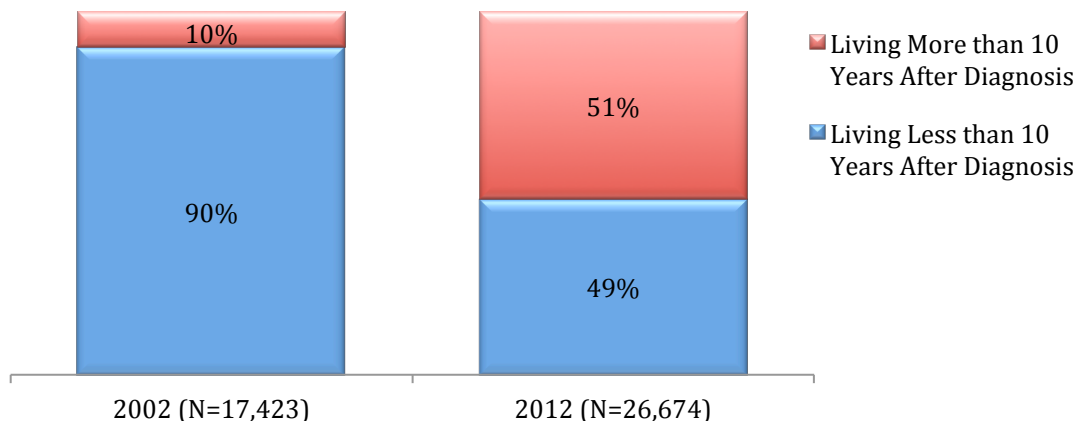
The NHAS urges local municipalities to focus on communities where HIV is highly concentrated. In the City of Los Angeles, that community is primarily gay/bisexual men. Gay/bisexual men comprise 85% of people living with HIV, 84.5% of all reported HIV diagnosis between 2003-2012, and 89% of new HIV infections in 2012. It is estimated that the seroprevalence of gay/bisexual men in the City is 18.2%, which is higher than every other group, including transgender women (Table 10 on page 19). The insistence that gay/bisexual men remain a focal point of prevention efforts in the City is meant to reinforce the ACO's commitment to achieve ambitious Citywide HIV prevention goals. Other communities that will continue to be served include cisgender women, transgender women, intravenous drug users, homeless people, undocumented immigrants and all HIV positive people.

## Background

### *AIDS Leadership Council motivated by HIV infections and mortalities*

In 1989, Mayor Tom Bradley created the City of Los Angeles AIDS Coordinator's Office (ACO) to develop comprehensive HIV policies to reinforce the City's commitment to combat AIDS through a long-range, multipronged approach.<sup>2</sup> City policies were critical to provide support and protection for people living with HIV who faced social stigma, discrimination, poverty, homelessness, lack of medical treatment, an almost certain AIDS diagnosis, and a median of 1.7 years before HIV-related death.<sup>3</sup> During the thirteen years following the creation of the ACO, the HIV/AIDS landscape improved dramatically. The Ryan White Comprehensive AIDS Resources Emergency Act provided health care benefits for uninsured or underinsured people living with HIV,<sup>4</sup> Housing Opportunities for People with AIDS (HOPWA) formed to offer housing for people living with HIV/AIDS,<sup>5</sup> and combination antiretroviral therapy (ART) was introduced, curtailing the progression of HIV to AIDS and averting thousands of HIV related mortalities.<sup>6</sup> Despite these major achievements, by the end of 2002, only 10% of people living with HIV had survived more than ten years after their initial diagnosis (Figure 1), and HIV diagnoses were increasingly found among gay and bisexual men of color.

**Figure 1: Living Less than 10 Years after Diagnosis vs. More than 10 Years After Diagnosis**



Confronted with the sustained public health threat of HIV, Mayor Hahn assembled the AIDS Leadership Council to assess the needs of the community and produce a strategy for the ACO to respond to the HIV/AIDS epidemic. Council members included stakeholders from AIDS service organizations, researchers, policy makers and City officials who collectively identified gaps in HIV/AIDS-related services throughout the City and produced three broad goals:

- (1) Prevent new HIV infections,
- (2) Reduce stigma and discrimination associated with HIV/AIDS, and
- (3) Increase access to housing and support services for people living with HIV/AIDS.

## Methods of Evaluation and White Paper Development

This report was developed over nine months and four-phases of research and engagement with the HIV/AIDS community. This community includes People Living with HIV/AIDS, consumers of other services, government administrators, policy makers, researchers and health and social service providers in Los Angeles. The research and engagement phases:

**Phase 1: 20-year analysis of epidemiologic HIV data in the City of Los Angeles**

**Phase 2: 25 in-depth interviews with HIV community stakeholders**

**Phase 3: 50 web-based surveys of community stakeholders**

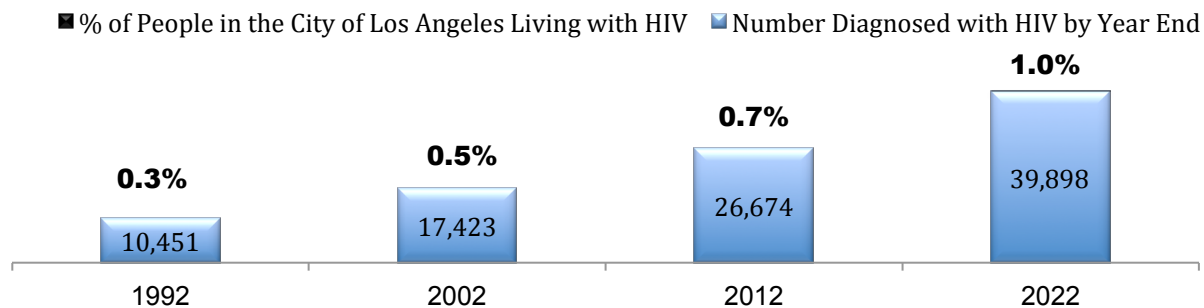
**Phase 4: Roundtable community discussion**

More details about the methods are provided in Appendix D page 64

## Prevent City from reaching 1% HIV prevalence threshold

Over the past decade, the ACO has accomplished the goals established in the 2003 white paper. This achievement is the result of collaboration with community stakeholders and tremendous technological advances in medicine and HIV screening including: ART is more effective now than ever before, biomedical interventions, PEP and PrEP, show capacity to prevent seroconversion after HIV exposure, and stigma and discrimination continue to wane as public awareness about HIV increases. However, the need to be vigilant about HIV prevention and support services is as important today as it has ever been. Forecasts indicate the number of people living with HIV will increase from 26,674 in 2012 to 39,898 in 2022 if HIV transmission trends continue. Figure 2 shows the number and percent of people living with HIV in the City over the past twenty years and forecasts up to the year 2022.<sup>a</sup> By 2022, 1% of the population in the City of Los Angeles will be living with an HIV diagnoses if this trend continues. When 1% of the population has HIV, the World Health Organization defines that as an epidemic.<sup>7</sup> The ACO and HIV prevention community should do everything in their power to prevent this threshold from being reached for three reasons: (1) a larger HIV positive population corresponds to an increase in the statistical probability of acquiring HIV, (2) capacity to prevent this threshold from being reached exists, and (3) the ACO is a national leader who may demonstrate how size, scope and targeted prevention can achieve results. **This is an ambitious goal that the community can achieve with collective coordinated effort.**

**Figure 2: People Living with HIV and Percent of Population Living with HIV by Year End**



<sup>a</sup>See Table 23 on page 51 for projection calculations.

# Evaluation of progress

The evaluation of progress made achieving the 2003 white paper goals is divided between programmatic and epidemiologic achievements. Programmatic achievements relate specifically to the ACO's activities. Epidemiologic achievements relate to HIV surveillance data, which show improvements resulting from a combination of efforts by the ACO, Los Angeles County Department of Public Health, County Commission on HIV, Housing Opportunities for Persons with AIDS, community based organizations, health providers, improved HIV medications and screening technology, and efforts of people living with HIV/AIDS to reduce transmissions.

## Snapshot of ACO Programmatic Progress

1. Coordinated with Los Angeles County
2. Funded programs not funded by the Federal Government
3. Advocated for underrepresented communities
4. Collaborated with community based organizations
5. Supported exploration of new prevention interventions

## ACO Programmatic Achievements: 2003 - 2012

There was general consensus among the community that the ACO has excelled and remained relevant by filling gaps in the local response to the HIV/AIDS epidemic through efforts to:

- (1) Fund programs targeting communities not prioritized by the Federal Government
- (2) Support pilot prevention programs via ACO Technical Assistance Grants,
- (3) Develop research insight through the ACO's AIDS Prevention Research program,
- (4) Advocate for PLWH by supporting cutting edge interventions and legislative reform,
- (5) Identify co-factors of HIV, and
- (6) Promote harm reduction as a philosophy for AIDS service organizations.<sup>b</sup>

The following offers an evaluation of the ACO's programmatic achievements in the areas of Prevention, Stigma and Discrimination and Housing and Support Services.

<sup>b</sup> Co-factors of HIV are variables that may contribute to a person's risk for acquiring HIV including homelessness, substance use, depression, inadequate healthcare, and low self-esteem. Harm reduction is a philosophy that purports to allow people to access services without meeting specific criteria (e.g., being sober is not a criteria for housing services).

## HIV Prevention

In 2003, the ACO was charged with five prevention goals: (1) coordinate with the County to avoid duplication of efforts, (2) support programs and communities that the Federal Government does not fund, (3) advocate for groups for whom funding is limited or absent, (4) engage the community to create a broad-based prevention network through increased collaboration and (5) continue to seek out new prevention interventions.

### *ACO met and surpassed all five programmatic prevention goals*

#### *1. Coordinate with the County*

The ACO coordinated and collaborated with the County to avoid duplication of services and provide a more comprehensive response to the epidemic. This included:

1. Participating in the County's HIV Prevention Planning Committee
2. Co-Chairing the County's Commission on HIV
3. Collaborating with the County on a testing initiative for Veterans on Skid Row
4. Advising the Office of Public Health on starting a Syringe Exchange Program
5. Supporting the City/County Commercial Sex Venue Ordinance
6. Funding Routine Opt-Out HIV Testing at nine health provider locations

#### *2. Fund programs not supported by the Federal Government &*

#### *3. Advocate for underfunded communities*

The ACO supported communities and programs not funded by the Federal Government. The intended communities included transgender women, gay men and other men who have sex with men, female partners of MSM, sex workers and drug users. The ACO served these communities and expanded this target to include Native Americans and youth. The most notable programs funded by the ACO, which are not supported by the Federal Government, were and continue to be, syringe exchange programs. ACO support for syringe exchange programs demonstrates the ACO's commitment to provide HIV prevention resources to all people; and, as expressed in the next section, the sharp decline in HIV transmission by intravenous drug use (IDU) demonstrates the significance of this support.

The ACO supported the following programs:

1. Syringe exchange programs
2. Transgender Service Provider Network by Children's Hospital LA
3. Latina Women at Sexual Risk through the East Los Angeles Women's Center
4. Sex workers via *Red Umbrella* a collaboration of SWOP and Women Alive
5. Incarcerated women and Female Partners of MSM by the Center for Health Justice
6. Native Americans via *The Red Circle Project* of APLA
7. Runaway & Homeless Youth with the LA Gay & Lesbian Center

#### ***4. Engage community to build Prevention Network***

The ACO collaborated with AIDS service organizations, local government agencies and law enforcement officers to develop and fortify a broad-based HIV prevention network. These collaborations were a mixture of advocacy, education and community building. Specific activities included:

1. Collaborate with the Department of Neighborhood Empowerment
2. Solicit LAPD to support Syringe Exchange/Collection programs
3. Reach out to City Council members for support and collaboration
4. Participate on LAUSD HIV Materials Review Board
5. Think Tanks at UCLA Center for HIV Identification Prevention & Treatment Services
6. Support Pacific Regional Housing and HIV/AIDS Research Summit
7. Support International Community Dialogues on Microbicides/ PrEP/Women of Color
8. Host Disability Forum on HIV Testing
9. Host Disability and HIV/AIDS Forum for Increased Health Provider Capacity
10. Recognize World AIDS Day

#### ***5. Seek new prevention interventions***

The ACO sponsored the development of new prevention interventions through their AIDS Prevention Research program. These projects explored new trends in HIV transmission and opportunities for targeted prevention in the following areas:

1. Post-Exposure Prophylaxis as a Bio-behavioral Prevention Intervention
2. Transmission Risk from Heterosexual Identified Men who have Sex with Men
3. Attitudes about HIV and HIV Risk Behaviors among Gang members
4. Awareness, Attitudes and Beliefs about HIV among Neighborhood Councils
5. Grindr Study: Potential to disseminate prevention messages on social media apps
6. Opportunities to implement Routine Opt-Out HIV Testing in Clinics and Hospitals
7. Transgender Inclusive Policies and Practices for Businesses in Los Angeles



## Reducing Stigma and Discrimination

The ACO endeavored to reduce stigma and discrimination by focusing on four objectives: (1) execute a multipronged approach of educational material development and distribution, community outreach, counseling, prevention interventions and enhanced legal services, (2) update City employee education and training, (3) educate City contractors on HIV/AIDS and (4) update City AIDS workplace policies.

### *ACO achieved most programmatic Stigma and Discrimination goals*

#### *Multipronged Approach*

The ACO's multipronged approach to combat stigma and discrimination included a combination of community outreach and education activities to support a deeper understanding of HIV/AIDS risks, prevention, screening and treatment options. The ACO's activities included:

1. Partnership with the Black Treatment Advocacy Network for PEP, PrEP education
2. Billboard Campaigns – HIV is a Human Disease
3. PSA HIV Testing Campaign targeting Women, Latinos and African Americans
4. Coping with Hope – Mental health needs of people living with HIV/AIDS
5. Advocate reform of California HIV Testing Informed Consent Laws, lower testing barrier
6. Fund Routine Opt-Out HIV Testing to normalize HIV tests as a standard of care<sup>c</sup>

#### *City Employee education, training & Workplace policy updates*

The ACO successfully updated the City's HIV and AIDS Discrimination in City Employment Policy. This update was published in English and Spanish; and, it is part of the curriculum for newly hired City employees. The update serves as a written document and a template for the City's training sessions for all employees, which were halted during the budget crisis.

#### *Educate City contractors*

The ACO did not implement a mechanism to educate City contractors on HIV/AIDS. Actualizing this goal appears to require reform in at least four areas:

1. City contract procurement,
2. Contract management,
3. Legislative reform and
4. Law enforcement.

---

<sup>c</sup> Routine opt-out HIV testing is included in this section, given that it normalizes HIV as an illness that can be screened for and treated within a primary health care environment. This helps accomplish the goal of reducing stigma of HIV by normalizing HIV as any other illness that can be managed with proper treatment.



## Housing and Support Services

The 2003 white paper outlined 8 goals to improve Housing and Support Services for PLWH:

1. Hire a Housing Opportunities for Persons with AIDS (HOPWA) Coordinator
2. Develop mechanisms to coordinate housing and supportive services for PLWH
3. Enhance the opportunities for community oversight of the HOPWA Program
4. Find ways to spend the full allocation of HOPWA funds more effectively
5. Incorporate strategic plans from needs assessments to guide use of HOPWA funds
6. Seek and access funds to provide housing for undocumented immigrants living with AIDS
7. Identify an appropriate department for HOPWA
8. Direct the HOPWA Coordinator to ensure Section 8 units are in communities with access to medical, community, and other support networks

### *Programmatic Housing and Support Services Goals Still Out of Reach*

The housing and support goals developed in 2003 were reasonable. However, clarity about who was responsible for carrying out and monitoring activities related to achieving them was missing from the 2003 white paper. In the past decade, the ACO has had limited involvement with HOPWA and the aforementioned goals remain a work in progress. Part of the lapse in collaboration may be attributed to gaps in leadership within the Los Angeles Housing Department, the City Department that previously administered HOPWA. For instance, there have been two HOPWA coordinators in the past ten years; and, there does not appear to be an official with the role of HOPWA Coordinator in the current Los Angeles Housing and Community Investment department – the new City department that manages HOPWA funds for the entire County of Los Angeles. Another explanation for the lapse in collaboration may be attributed to the absence of a mechanism to reinforce partnership. Historically, HOPWA has operated without much community oversight; and, ACO involvement has been restricted to participation in the Los Angeles Countywide HOPWA Advisory Committee (LACHAC).

During interviews, some community stakeholders expressed the perception that HOPWA client needs may be going unmet as a result of three factors: (a) lack of HOPWA oversight by an external entity, (b) failed collaboration, and (c) lack sufficient knowledge about people living with HIV among HOPWA administrators. The accuracy of these inferences remains untested. As the size of the population living with HIV expands and ages, the need for coordinated housing and support services for people living with HIV will increase;<sup>8</sup> and, a greater level of expertise on matters related to HIV may benefit the administration of HOPWA programs for people living with HIV.

**The ACO and HOPWA missed an opportunity to collaborate over the past decade. This pattern of missed collaboration will likely continue until the Mayor, City Council or HUD develops a formal relationship between the ACO and HOPWA. Without an explicit mandate, HOPWA administration has no incentive to rely on the ACO for insight. This will keep the ACO's programmatic housing and support services goals out of reach.**

## Epidemiologic Achievements: 2003 - 2012

### Community collaboration yields measurable prevention gains

Collaboration between the ACO, County, AIDS service organizations, health providers and consumers, helped curb new HIV infections, increase the life expectancy

of people living with HIV and dramatically reduce HIV related mortalities over the past decade. The AIDS Leadership Council established a goal to reduce new HIV infections. During the ten years following the 2003 white paper, the average HIV diagnosis rate dropped 19%. The HIV transmission rate was nearly cut in half, and HIV related mortalities dipped 59%. To better characterize these epidemiologic shifts, the HIV surveillance data is shown by race, transmission mode, and then a combination of race, gender and gay/bisexual men.<sup>d</sup>

#### Snapshot of Citywide Epidemiologic Progress

1. 19% decline in Average HIV diagnosis rate
2. 48% reduction in HIV transmission rate
3. 59% decline in Average HIV mortality rate
4. 49% increase in proportion of PLWH

### Average HIV Diagnosis Rate by Race

The majority of people acquiring HIV are Latino, White and Black. **Table 1** shows the number of diagnoses during the past twenty years and the average HIV diagnosis rate during each ten-year period. Citywide, the average HIV diagnosis rate declined 19% comparing 2003-2012 with 1993-2002. This translates into 258 fewer HIV diagnoses per year over the past decade. Latinos, Whites and Blacks experienced declines from -4% (Black) to -34% (White) during this period. Asian/P.I., Others and Native Americans had increases in average HIV diagnosis rate between 6% (Others) to 37% (Native Americans). To put these increases in context, it is important to look at the number of HIV diagnoses for each group. Asian/P.I. had 108 more HIV diagnoses in the past decade than in the decade prior (1993-2002) and, Native Americans and Others had an almost equal number HIV diagnoses across the two decades.

Table 1: Average HIV Diagnosis Rate by Race

	1993-2002			2003-2012			Rate Change
	N	%	Avg. Rate	N	%	Avg. Rate	%
<b>Total</b>	<b>15,385</b>	<b>100</b>	<b>41.6</b>	<b>12,806</b>	<b>100</b>	<b>33.8</b>	<b>-19</b>
Latino	5,945	39	34.6	5,669	44	30.8	-11
White	5,175	34	47.1	3,402	27	31.3	-34
Black	3,663	24	91.1	3,029	24	87.2	-4
Asian/P.I.	310	2	8.4	418	3	9.8	17
Other	216	1	22.4	211	2	23.9	6
Native American	76	0.5	85.4	77	1	116.9	37

<sup>d</sup> The Department of Public Health combined gay/bisexual Asian/P.I., Native Americans and Others into a single group for HIV diagnosis rate, as a result of their small number of cases.

## Average HIV Diagnosis Rate by Transmission Mode

The average HIV diagnosis rates shrank across all transmission modes during the past decade. Gay and bisexual men, who accounted for most HIV diagnoses during the past two decades, had sizable declines in average HIV diagnosis rate. Combined, MSM and MSM/IDU had 1,552 fewer HIV

Table 2: Average HIV Diagnosis Rate by Transmission Mode

	1993-2002			2003-2012			Rate Change
	N	%	Avg. Rate	N	%	Avg. Rate	%
<b>Total</b>	<b>15,385</b>	<b>100</b>	<b>41.6</b>	<b>12,806</b>	<b>100</b>	<b>33.8</b>	<b>-19</b>
MSM	11,271	73	975.9	10,181	80	819.3	-16
MSM/IDU	1,101	7	95.3	639	5	51.4	-46
IDU	1,232	8	3.3	593	5	1.6	-53
Heterosexual	1,632	11	4.4	1,353	11	3.6	-19
Hemo/Transf.	56	0	0.2	10	0	0.0	-83
Other	93	1	0.3	30	0	0.1	-69

diagnoses from 2003-2012 vs. 1993-2002. This decline is larger than all HIV diagnoses for heterosexual exposures during the same period (i.e., second highest HIV transmission mode). Separately, HIV exposure dropped 16% for MSM and 46% for MSM/IDU. The average HIV diagnosis rate fell 19% for heterosexual exposure and 53% for intravenous drug use (IDU). The reduction in IDU exposure can be attributed to effective syringe exchange programs in the City. Since 2004, ACO funded syringe exchange programs have served 125,239 clients.

## Average HIV Diagnosis Rate—Race, Gender, Gay/Bisexual

Table 3 shows Citywide declines in average HIV rate were largely the result of the 35% reduction in HIV diagnoses for White gay/bisexual men. They had 1,572 fewer HIV diagnoses in 2003-2012 vs. 1993-2002. Gay and bisexual Latinos had more HIV diagnoses from 2003-2012 than 1992-2003 but because these increases were smaller than their

Table 3: Average HIV Diagnosis Rate by Race, Gender, Gay/Bisexual Male

	1993-2002			2003-2012			Rate Change
	N	%	Avg. Rate	N	%	Avg. Rate	%
<b>Total</b>	<b>15,385</b>	<b>100</b>	<b>41.6</b>	<b>12,806</b>	<b>100</b>	<b>33.8</b>	<b>-19%</b>
White Gay/Bisexual	4,730	31	1,155.9	3,158	25	754.7	-35%
Latino Gay/Bisexual	4,652	30	972.6	4,766	37	875.4	-10%
Black Gay/Bisexual	2,484	16	2,175.2	2,283	18	2,088.6	-4%
Latina Female	723	5	8.6	664	5	7.3	-15%
Black Female	717	5	33.3	556	4	30.4	-9%
Latino Male	570	4	6.9	239	2	2.7	-60%
Asian/Other Gay/Bisexual	504	3	328.8	613	5	359.4	9%
Black Male	462	3	26.3	190	1	12.4	-53%
White Female	229	1	4.2	171	1	3.2	-24%
White Male	216	1	4.2	73	1	1.4	-66%
Asian/Other Female	62	0.4	2.5	64	0.5	2.3	-8%
Asian/Other Male	36	0.2	1.7	29	0.2	1.3	-24%

population increases, their average HIV diagnosis rate declined 10%. The key piece of information from Table 3 is that there is

variability in how HIV prevention gains were experienced by race, gender, and sexual orientation. For instance, Asian/Other males and females both had average HIV rate declines, whereas Asian/Other gay/bisexual men recorded the only average HIV rate increases in the City. Then again, these men accounted for 5% of all HIV diagnoses during the past decade while their gay/bisexual White, Latino and Black counterparts had 80% of all HIV diagnoses.

## HIV Transmission Rate

The HIV transmission rate dropped 48% from 2002 to 2012. Transmission rate is a metric of how many times a person living with HIV during a specific period may have transmitted HIV to others.<sup>f</sup> As a metric, HIV transmission rate may reflect the steps

PLWH are taking to avoid transmitting HIV to others. This includes initiating antiretroviral therapy (ART), adhering to ART, and using condoms and sterile needles, as applicable. As Table 4 and Table 5 illustrate, there were steep declines in the HIV transmission rate across every race and exposure mode from 2002 to 2012. The National HIV/AIDS Strategy set the goal to reduce the HIV transmission rate to 3.5 persons infected per 100 people with HIV by 2015.<sup>1</sup> All modes, except for MSM, are below the target transmission rate as of the end of 2012. If the transmission rate for MSM exposure can decline from 4.3 to 3.7, the citywide transmission rate would be at 3.5. Taking 2012 as a baseline for HIV diagnoses, this equates to reducing the number of HIV diagnoses in a given year from 1,062 to 930, a reduction of 132 annual diagnoses.

**Table 4: Transmission Rate by Race - 2002 vs. 2012**

	2002			2012			Rate Change
	N	%	Rate	N	%	Rate	%
<b>Total</b>	1,345	100	7.7	1,062	100	4.0	-48
Latino	559	42	8.9	492	46	4.6	-49
White	407	30	6.2	260	25	3.0	-52
Black	324	24	8.4	239	23	4.1	-51
Asian/P.I.	31	2	8.6	47	4	6.4	-25
Native American	5	0	5.3	5	0.5	3.5	-33
Other	19	1	7.6	19	2	4.9	-36

**Table 5: HIV Transmission Rate by Exposure Mode - 2002 vs. 2012**

	2002			2012			Rate Change
	N	%	Rate	N	%	Rate	%
<b>Total</b>	1,345	100	7.7	1,062	100	4.0	-48
MSM	961	71.4	7.4	903	85	4.3	-41
MSM/IDU	114	8.5	7.5	40	3.8	2.2	-70
IDU	94	7	8.2	35	3.3	2.7	-67
Heterosexual	168	12.5	10.7	83	7.8	3.2	-70
Hemo/Transf.	4	0.3	6.0	0	0	0.0	-100
Other	3	0.2	2.3	2	0.2	1.3	-43

<sup>e</sup> HIV transmission rate is the number of HIV diagnoses in one year divided by the total number of persons living with HIV at the end of that year.

<sup>f</sup> If the transmission rate is high, it means people living with HIV have transmitted HIV to more people; and, if the rate is lower, PLWH transmitted HIV to fewer people.

## Average HIV Mortality Rate

The average HIV mortality rate plummeted 59% over the past decade. Declines were sharpest for males at 62%, versus reductions for females at 23%. Given the comparatively lower average HIV mortality rate for Females (2.5), it is expected that declines will be slower for females until the gender/sex gap closes. Every racial group and gender/sex witnessed reductions in their average HIV mortality rate. White men had the greatest rate reductions, followed closely by Latino and Asian/Other men.<sup>8</sup> White women experienced a small dip in average HIV mortality rate, which is less notable than their second lowest rate among all groups (1.8). For White women to have larger reductions would require an almost complete elimination of HIV related mortalities for White women.

Table 6: Average HIV Mortality Rate - 1992-2002, 2002-2012

	1992-2002			2002-2012			Rate Change
	N	%	Avg. Rate	N	%	Avg. Rate	%
<b>Total Pop</b>							
Total	8,413	100	22.8	3,555	100	9.4	-59
Female	606	7	3.3	482	14	2.5	-23
Male	7,807	93	42.4	3,073	86	16.3	-62
<b>White</b>							
Total	3,778	100	34.4	1,217	100	11.2	-67
Female	116	3	2.1	97	8	1.8	-14
Male	3,662	97	66.4	1,120	92	20.3	-69
<b>Latino</b>							
Total	2,357	100	13.7	1,107	100	6.0	-56
Female	199	8	2.4	141	13	1.6	-34
Male	2,158	92	24.6	966	87	10.4	-58
<b>Black</b>							
Total	1,969	100	49.0	1,081	100	31.1	-36
Female	269	14	12.5	228	21	12.5	0.3
Male	1,700	86	91.0	853	79	51.9	-43
<b>Asian/Other</b>							
Total	309	100	6.5	150	100	2.9	-56
Female	22	7	0.9	16	11	0.6	-35
Male	287	93	12.6	134	89	5.5	-56

Black men experienced a sizeable decline in average HIV mortality rate (43%). Alternatively, Black women had almost no change (0.3%). Among women, Black women have maintained the highest average HIV mortality rate since the beginning of the epidemic and Black men have had the highest rate of all people since 2002. The disproportionate rate of Black deaths may be attributed to later stage HIV diagnoses, failure to get linked to care and adhere to HIV treatment that may suppresses viral load and help avert HIV related death.<sup>9</sup> In Los Angeles County, as of 2011, Blacks had the lowest linkage to care percent of all ethnic groups (74.1%) (Figure 22, page 40). When linked to care, 54.1% of Blacks were retained in care and 46.4% were virally suppressed.<sup>10</sup> To reduce HIV mortality, it is essential to support interventions that meet the needs of all people, especially Black women and gay/bisexual men. This can be achieved with the new goals of the ACO to identify people with HIV, link them to primary health care and help them attain and maintain viral load suppression.

<sup>8</sup> Asian/Other includes Asian/P.I., Native American and Others, per the County's reporting.

## Proportion of People Living with HIV

Between 2002-2012, the proportion of people diagnosed with HIV in the City grew 49% to 703.3 PLWH per 100,000 residents. Although it may seem counterintuitive to count an expansion of people diagnosed with HIV as an accomplishment, it is viewed as a success for three reasons: (1) it indicates more people living with HIV are being identified through HIV screening, which is the first step toward linking a person to treatment and getting them virally suppressed (2), the 49% increase is less than the 57% increase in the previous decade, 1992-2002 (Table 23, page 51) and, (3) it demonstrates that PLWH are living longer. These conclusions are supported by the (a) 59% drop in the average HIV mortality rate since 2002 (Table 6, page 12) (b) composition shift among PLWH from a community where only 10% had lived over ten years past their initial diagnosis in 2002, to 51% having lived ten years past their initial diagnosis by 2012 (Figure 1, page. 2) and (c) a greater percent of HIV positive people aware of their serostatus, demonstrated by the decrease in the percent of unaware HIV positive people from 2002 (estimated 20%) to 2012 (estimated 15.8%).<sup>11</sup>

As previously mentioned, a larger population of people living with HIV increases the statistical probability of HIV transmission. For this reason alone, there is a growing need to identify PLWH and link them to antiretroviral treatment to reduce community viral load. Table 7 demonstrates that the proportion of PLWH has increased for all racial groups and expanded across all modes of HIV transmission, except for hemophilia.

Table 7: Rate of People Living with HIV - 2002 vs. 2012

	2002			2012			Rate Change
	N	%	Proportion	N	%	Proportion	%
<b>Total</b>	17,423	100	471.6	26,674	100	703.3	+49
Latino	6,247	36	363.4	10,809	41	587.8	+62
White	6,612	38	601.5	8,797	33	809.4	+35
Black	3,860	22	960.2	5,808	22	1,671.9	+74
Asian/P.I.	360	2	97.5	731	3	172.2	+77
Native American	95	1	1,067.8	142	1	2,155.1	+102
Other	249	1	258.5	387	1	437.7	+69
<b>Modes</b>							
MSM	12,974	74	11,233.1	20,810	78	16,745.5	+49
MSM/IDU	1,527	9	1,322.1	1,799	7	1,447.6	+9
IDU	1,148	7	31.1	1,288	5	34.0	+9
Heterosexual	1,575	9	42.6	2,566	10	67.7	+59
Hemophilia	67	0.4	1.8	58	0.2	1.5	-16
Other	132	1	3.6	154	1	4.1	+14
Female	1,790	10	96.6	2,763	10	145.1	+50
Male	15,633	90	848.8	23,911	90	1,265.8	+49



# Characteristics of HIV: 2012

In 1981, five of the first cases of Pneumocystis Pneumonia, later designated as AIDS, were discovered in Los Angeles.<sup>12</sup> Since then, an estimated 47,623 people have been diagnosed with HIV and 20,465 have

died of AIDS. Today, the City of Los Angeles has 26,674 people diagnosed with HIV and an estimated 5,000 more who are living with HIV and unaware of their serostatus. Three significant characteristics of the HIV epidemic have not changed since 1992:

## Snapshot of HIV in City of Los Angeles

1. 85% of people living with HIV are gay/bisexual men
2. HIV is expanding among 20-29 year old gay/bisexual Black and Latino men
3. HIV positive community over 50 years old is growing

- (1) Male-to-male sexual contact is the primary mode of exposure;
- (2) Gay/bisexual Latino men make up the majority of new HIV diagnoses; and,
- (3) Gay/bisexual Black men have the highest rate of people living with HIV, average HIV diagnosis rate and average HIV mortality rate in the City of Los Angeles.<sup>h</sup>

Over the past decade, new characteristics of the HIV epidemic have emerged, including:

- (1) People living with HIV are more likely to be over 40 years old. 74% of persons living with HIV in the City are over 40 years old, of which 39% are 50 years and older;<sup>i</sup>
- (2) HIV diagnoses are emerging for 20-29 year old gay/bisexual Black and Latino men.

The HIV epidemic in the City has other features that persist. For instance, Native Americans have the highest rate of people living with HIV and average HIV diagnosis rate; however, they have the smallest number of persons living with HIV (N=142) and recently diagnosed with HIV of any racial group (77 cases from 2003-2012). Latina and Black women make up 84% of new HIV diagnoses among women and 82% of all women living with HIV. Transgender women with HIV are primarily Latina and Black (82%); and, HIV heavily impacts homeless people.

This section describes the current HIV epidemic in the City with surveillance data, reporting percentages and rates. Percent shows the impact each group has on the City's HIV epidemic. Rate shows relative impact that HIV has on each group. For instance, women make up 10% of all people living with HIV; and, the rate of women living with HIV of 145.1 per 100,000. HIV data is reported for high priority groups defined by the LA County HIV/Prevention Planning Committee Comprehensive HIV Planning Task Force (Table 15 on page 36) and include:

1. HIV Positive
2. MSM (Gay and Bisexual Men)
3. Women
4. Youth (20-29 years)
5. Transgender Persons
6. Persons who share injection paraphernalia

<sup>h</sup> This is compared to groups with the largest number of people living with HIV or diagnosed with HIV. Mortality reports do not record sexual orientation. Yet, we conclude that these mortalities are among gay/bisexual men since 70% of Black men with HIV have been gay/bisexual since the 1980s.

<sup>i</sup> PLWH, 40 years and older, experienced rate increases from 31%-258% since 2002 (Figure 7, page Figure 7).

## Population Characteristics

Los Angeles grew 2.6% over the past decade, maintaining its position as the second largest City in the U.S. with approximately 3.8 million residents. The majority are Latino (48.5%), White (28.7%), Asian/Pacific Islander (11.2%) and Black (9.2%). Native Americans make up 0.2% of the City. During the past decade, Blacks experienced an exodus of 54,606 from the City. Native Americans lost 25.9% of their population. Conversely, the number of Asian/P.I. and Latinos grew over the past decade 14.9% and 7%, respectively. Understanding population size and shifts helps clarify the impact that HIV has on groups.<sup>j</sup>

Table 8: City of L.A. Population - 2000-2010

Population	2000 (N=3,694,820)	2010 (N=3,792,621)	Change
	%	%	%
<b>Total</b>	100	100	2.6
Female	50.2	50.2	-
Male	49.8	49.8	-
<b>Race</b>	%	%	%
Latino	46.5	48.5	7.0
White	29.7	28.7	-1.1
Black	10.9	9.2	-13.6
Asian/P.I.	10.0	11.2	14.9
Native American	0.2	0.2	-25.9
Other	2.6	2.3	-8.2

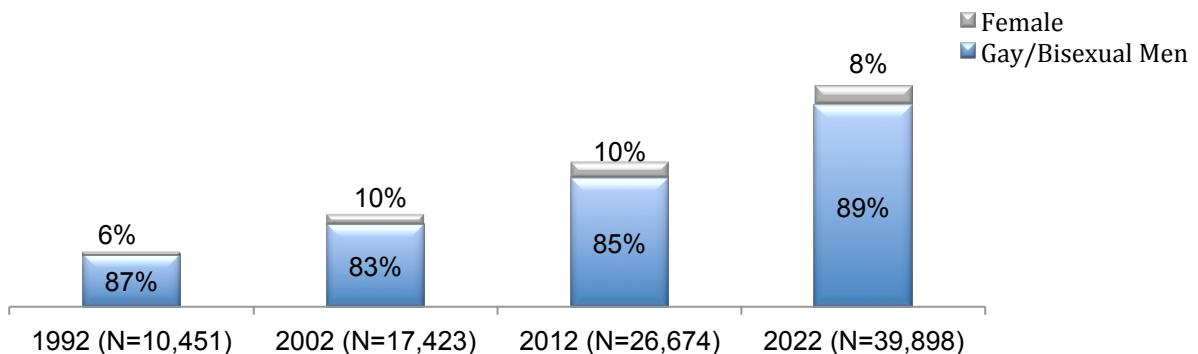
## HIV Characteristics in High Priority Groups

### I. HIV Positive People

#### *Most people living with HIV in L.A. are gay or bisexual men*

As of December 31, 2012, there are 26,674 people diagnosed with HIV in the City of Los Angeles. The majority is male (90%) and primarily gay or bisexual (85%). This pattern has remained consistent over the past three decades. If it continues, by 2022, there will be approximately 39,898 people diagnosed with HIV in the City, 89% will be gay or bisexual men. Figure 3 shows the percent of all people living with HIV who are gay or bisexual men or females by the end of 1992, 2002, 2012, and the projected percentages and number for 2022.<sup>k</sup>

Figure 3: People Living with HIV - Gay/Bisexual Men and Females



<sup>j</sup> Population data used to calculate percent and rate (N/100,000) is available in Table 17, page 45.

<sup>k</sup> Projections for 2022 were calculated based on transmission trends for males and females separately from 1992-2012. See Table 23 on page 51 for calculations.



Figure 4 lists the number of people living with HIV and demonstrates that the majority are gay/bisexual Latinos, Whites, and Blacks.<sup>1,m</sup> Figure 5 shows the HIV seroprevalence rate, which is the number of persons with HIV per 100 people in each group. The U.S. Census does not count gay/bisexual men. As such, the population for gay/bisexual men in the City (N=124,272) is an estimate, based on calculations established by the Florida Department of Health Bureau of HIV/AIDS (see Gay and Bisexual men, page 19 for more details).<sup>13</sup> Native American gay/bisexual men have the highest HIV seroprevalence rate of any group (51.3), followed by gay/bisexual men who are Black (39.6), White (19.6) and Latino (16.5). Figure 5 demonstrates the enormous gulf between how gay/bisexual men are impacted by HIV compared to all other groups, specifically heterosexual males and females.

Figure 4: People Living with HIV by Race, Gender, Gay/Bisexual Men - 2012

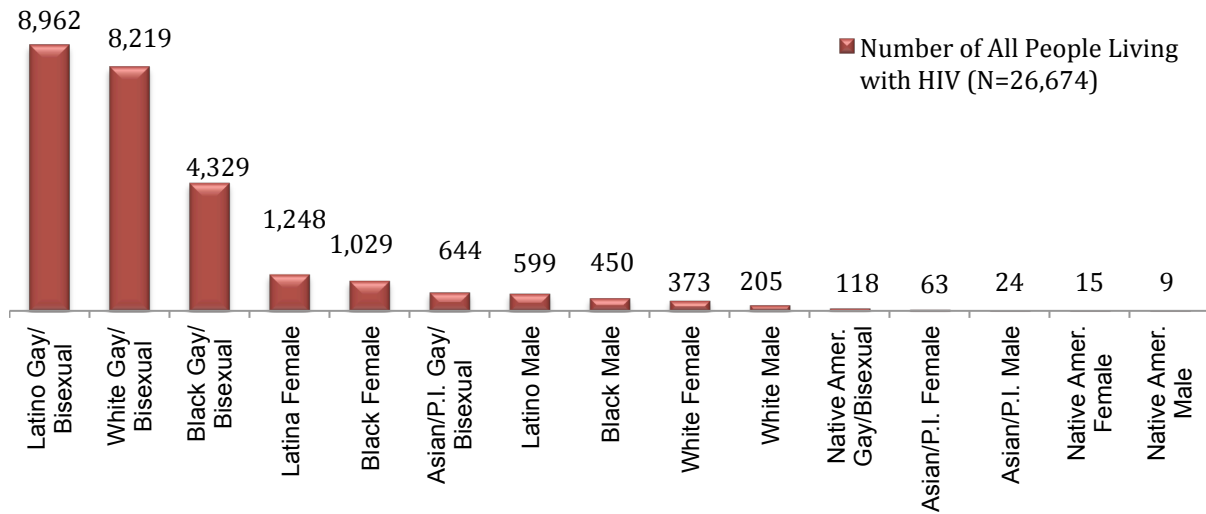
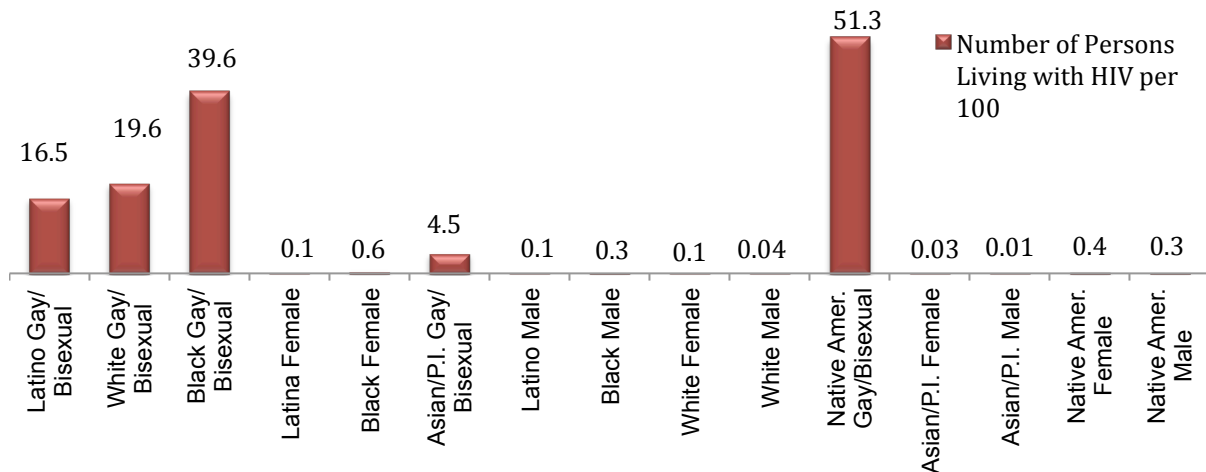


Figure 5: HIV Seroprevalence Rate (per 100) by Race, Gender, Gay/Bisexual Men - 2012



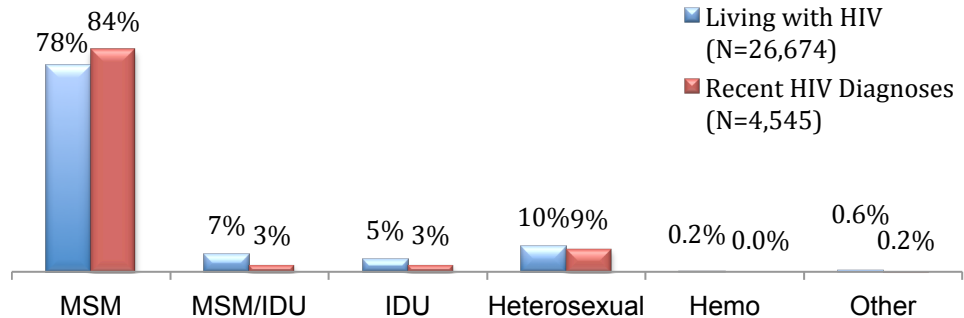
<sup>1</sup> Throughout this section, efforts were made to include HIV surveillance data about transgender people. However, the small size of the population, coupled by limits on data gathered, restricts reporting capabilities.

<sup>m</sup> “Others” were omitted from Figure 4 and Figure 5. See Table 19, page 47 for “Others” HIV rate per 100,000.

### Sexual contact remains the primary mode of HIV exposure

Figure 6 illustrates the mode of HIV exposure for people living with HIV as of 2012 and recent HIV diagnoses from 2009-2012 (N=4,545). Sex is the primary mode of exposure for people living with HIV (88%), followed by intravenous drug use (12%). The

Figure 6: People Living with HIV by Transmission Mode - 2012, and Recent HIV Diagnoses by Transmission Mode - 2009-2012



percent of recent HIV diagnoses from sexual contact (93%) is growing, even though the actual number of infections and average rate of HIV diagnoses have declined for heterosexual and male-to-male sexual contact since 2003 (Table 2, page 10). This is because average HIV diagnosis rates have declined more precipitously for non-sex related transmission modes. For instance, the average HIV diagnosis rate for MSM/IDU and IDU dropped 46% and 53%, respectively, since 2003. Alternatively, the average HIV diagnosis rate for MSM and Heterosexual contact declined 16% and 19%, respectively (Table 2, page 10). Table 9 reveals a greater percent of men living with HIV (89%), were exposed via sexual contact than women (75%); and, a larger percent of women (21%) than men (11%) were exposed to HIV from IDU.

### HIV diagnosis is increasingly synonymous with MSM exposure

Male-to-male sexual contact (MSM) remains the leading mode of HIV transmission in the City. In 2012, 85% of HIV diagnoses were from MSM, compared to 2002, where 71% of HIV diagnoses were from MSM (Table 2 page 9). HIV diagnoses among gay and bisexual men will become more concentrated, as long as HIV diagnoses decline for other transmission modes faster than declines for MSM. Even though HIV diagnoses are declining from MSM exposure, there should be a concerted effort to make sure reductions from MSM keep pace with declines of other exposure modes to avoid a future where HIV diagnosis is synonymous with gay/bisexual men.

Table 9: People Living with HIV - 2012, and New HIV Diagnoses - 2012

	People Living with HIV			HIV Diagnoses in 2012		
	Total	Female	Male	Total	Female	Male
	N=26,674	N=2,763	N=23,911	N=1,062	N=92	N=970
	%	%	%	%	%	%
<b>Total</b>	100	100	100	100	100	100
MSM	78		87	85	0	93
MSM/IDU	6.7		8	4	0	4
IDU	4.8	21	3	3	16	2
Heterosexual	9.6	75	2	8	83	1
Hemo/Transf.	0.2	0.8	0.1	0	0	0
Other	0.6	2.5	0.4	0	1	0

This scenario is problematic, as it would undoubtedly increase stigma associated with gay men and PLWH, which could undue prevention gains made to date.

### HIV positive community is getting older

People living with HIV are getting older. Figure 7 shows the rate of people living with HIV by age in 2002 and 2012. The major shift in age took place among people over 50 years old. In 2002, people 50 years and older represented 19% of PLWH. In 2012, they represent 39%; and, the rate increase was 123% for 50-59 year olds and 258% for people 60 years and older. The shift toward an older HIV positive community is the result of sharp declines in HIV related mortalities (Table 6 on page 12) rather than an increase in new HIV diagnoses in older cohorts.

### Recent HIV diagnoses among younger people

The major change in recent HIV diagnoses took place among 20-29 year olds. Figure 8 illustrates that the rate of recent HIV diagnoses increased 31% for 20-29 year olds, comparing 2009-2012 with 2002-2005. HIV diagnosis rates shrank for all cohorts above 29 years old during the same period. The next sections demonstrate that gay/bisexual Latino and Black 20-29 year old men account for 76% of the new HIV diagnoses among 20-29 year olds.

Figure 7: Rate of People Living with HIV by Age - 2002 vs. 2012

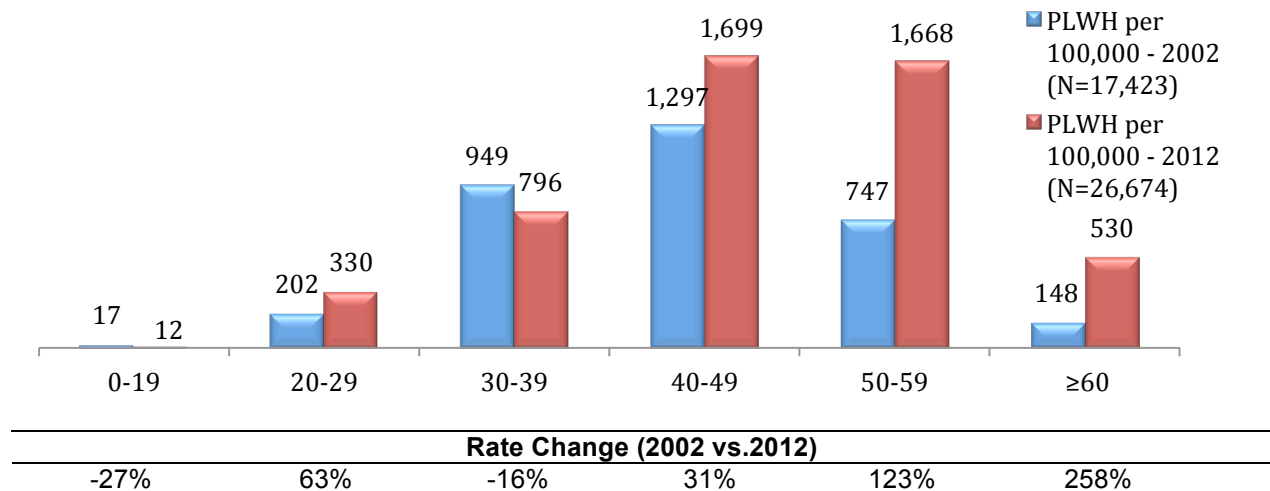
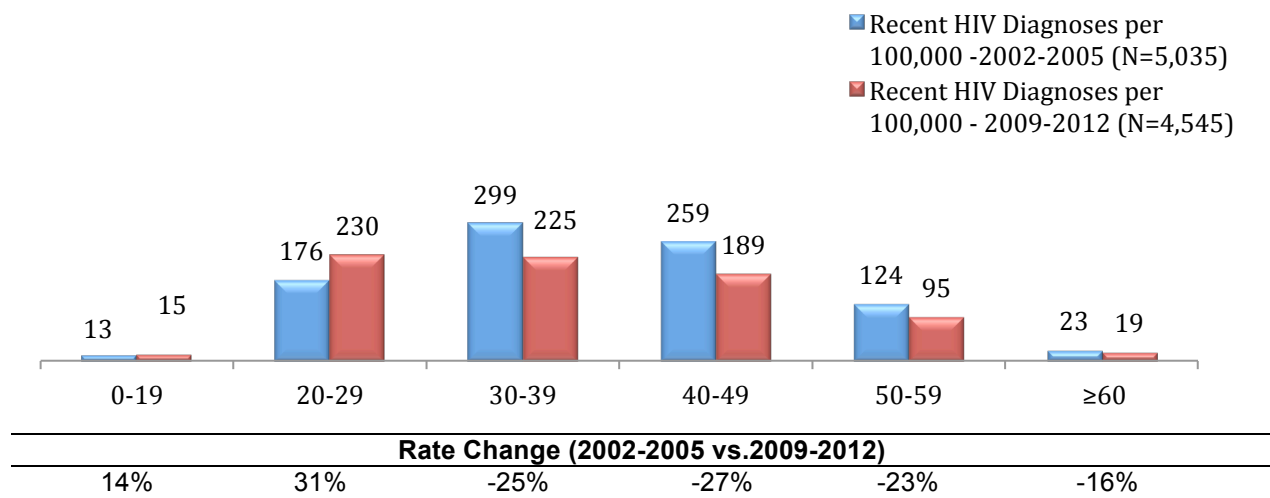


Figure 8: Rate of Recent HIV Diagnoses by Age - 2002-2005 vs. 2009-2012



## 2. Gay and Bisexual Men

### *Gay/Bisexual men face an alarming impact from HIV in the City*

There are 23,911 men living with HIV in the City of Los Angeles, 94.6% are gay or bisexual (Table 20, page 48). It is evident that HIV has a tremendous impact on gay and bisexual men. However, the full extent of its impact is difficult to measure, given that there is not a verified estimate for the population size of gay and bisexual men. The CDC estimates that approximately 3.9% of all males are gay or bisexual.<sup>14</sup> When looking at an urban setting like Los Angeles, others suggest that gay and bisexual men may comprise up to 9% of the population of men over 18 years old.<sup>13</sup> We used the 9% approximation to estimate the size of the gay/bisexual male population in the City of Los Angeles, as of 2010. The calculation is based on the 2010 census data for men, 20 years and older, in the City of Los Angeles. Based on this estimate, there are approximately 124,272 gay or bisexual men in the City with an overall HIV seroprevalence of 18.2%.<sup>n</sup> This means that approximately 2 out of every 10 gay/bisexual men in the City is living with HIV. This estimated HIV seroprevalence is higher than the seroprevalence for homeless (3%) and transgender women (15.1%),<sup>29</sup> respectively.

Table 10 lists the estimated HIV seroprevalence rate for gay/bisexual men. These estimates are understandably disturbing. Although the size of the population of gay/bisexual men is an estimate, the numbers for *gay/bisexual men living with HIV* are based on the numbers of HIV positive cases reported to the Los Angeles County Department of Public Health.<sup>o</sup> The burden of HIV, demonstrated by HIV seroprevalence rate, is highest for gay and bisexual Native American (51.3%) and Black men (39.6%).

**Table 10: Estimated Gay/Bisexual Male Population and HIV Seroprevalence - 2012**

	Estimated Population	Gay/Bisexual Men Living with HIV	Gay/Bisexual Male HIV Seroprevalence
<b>Total</b>	124,272	22,609	18.2%
Latino	54,441	8,962	16.5%
White	41,844	8,219	19.6%
Black	10,931	4,328	39.6%
Asian/P.I.	14,384	644	4.5%
Native American	230	118	51.3%

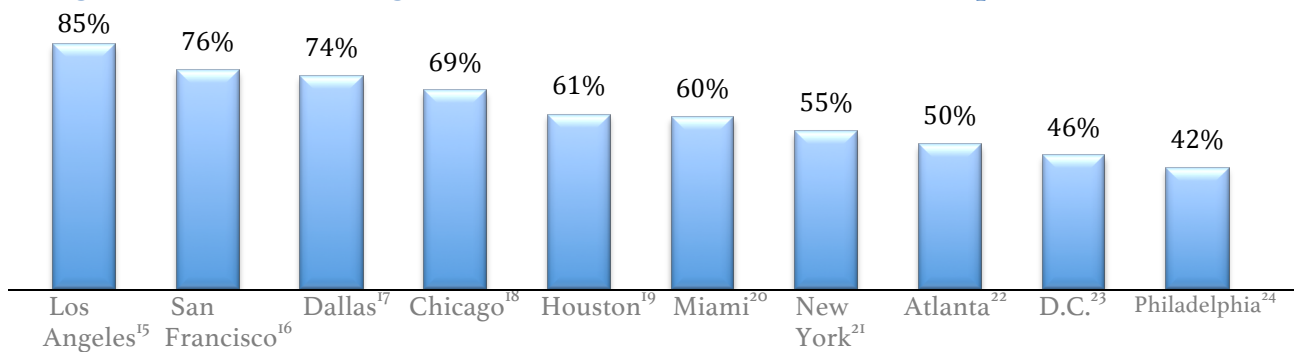
<sup>n</sup> See Table 18, page 46 for more discussion of how the gay/bisexual male population estimate was calculated.

<sup>o</sup> It is unlikely that the combined percent of gay and bisexual men in the City exceeds 9% by more than a few percentage points. For instance, if 14% of all men, 20 years and older, were gay/bisexual, then their HIV seroprevalence would be 12% rather than 18%, which is still an extremely high HIV seroprevalence.

### Gay men in LA have the highest % of HIV infections in the U.S.

The concentration of HIV among gay and bisexual men is larger in Los Angeles than anywhere else in the United States;<sup>p</sup> and, male-to-male sexual exposure accounts for a greater percent of recent HIV diagnoses in Los Angeles than in any of the top 10 City/Metropolitan areas with the largest numbers of people living with HIV. Figure 9 illustrates recent HIV diagnoses by MSM exposure in 2012. This figure highlights a unique need for HIV prevention and support services to address gay/bisexual men that other cities may not need. For instance, New York has the largest number of people living with HIV and recent HIV diagnoses; however, only 55% of diagnoses are from male-to-male exposure, compared to 85% in L.A.<sup>q</sup>

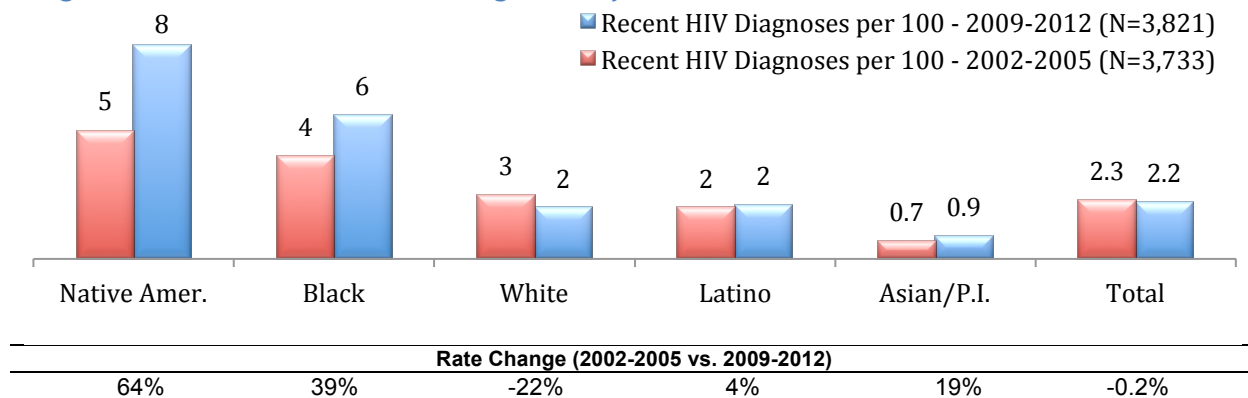
Figure 9: Recent HIV Diagnoses from MSM Transmission - 2012 - Top 10 Cities of PLWH<sup>r</sup>



### HIV diagnoses for MSM exposure differs by race

The average HIV diagnosis rate for male-to-male sexual exposure declined 16% comparing decades 2003-2012 and 1993-2002 (Table 2, page 10). However, in comparing the HIV diagnosis rate for MSM from the end of the last decade (2009-2012) to the beginning (2002-2005) there was almost no change (-0.2%). Figure 10 illustrates HIV diagnoses per 100 gay/bisexual men by MSM exposure. Figure 10 lists the rate change between these two periods. As can be seen, the MSM HIV diagnosis rate declined 22% for White men and increased for all other men.

Figure 10: Rate of Recent HIV Diagnoses by MSM Transmission - 2002-2005 vs. 2009-2012



<sup>p</sup> This comparison is for men living with HIV, exposed from male-to-male sexual contact as of 2012.

<sup>q</sup> New York has a much larger percent of new infections among heterosexuals (19.6%).

<sup>r</sup> This table assembles HIV surveillance data from health departments in each jurisdiction listed for 2012. Data for Chicago, Houston and Atlanta is from 2011.

### HIV diagnoses are declining for White gay/bisexual men

Table II reinforces this pattern of fewer HIV diagnoses by MSM exposure for White men and increasing or unchanged HIV diagnoses by MSM exposure for all other men. Comparing 2012 vs. 2002 indicates a 33.8% decline in HIV diagnosis rate by MSM exposure for White

Table II: MSM HIV Diagnoses in a single year - 2002 vs. 2012

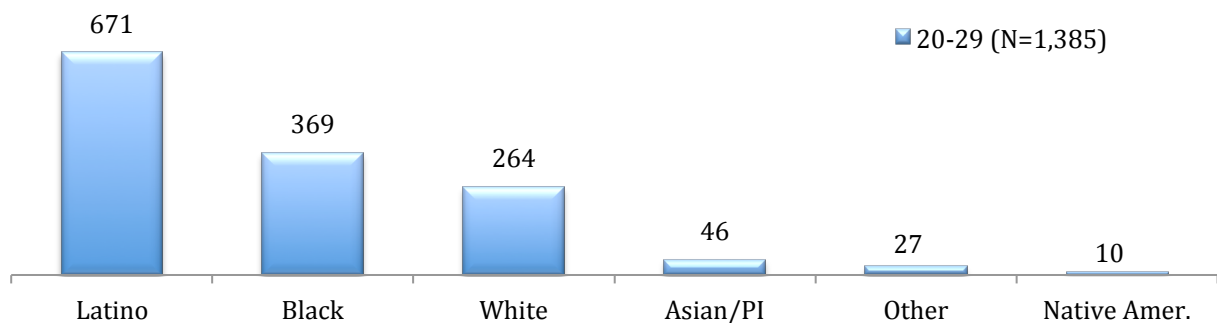
	2002			2012			Rate Change
	N	%	Rate	N	%	Rate	%
<b>Total</b>	948	100	0.8	887	100	0.7	-13.0
Latino	405	42	0.8	427	47	0.8	-7.4
White	337	35	0.8	228	25	0.5	-33.8
Black	179	19	1.6	182	20	1.7	6.2
Asian/P.I.	24	2	0.2	45	5	0.3	58.5
Native American	3	0	1.1	5	1	2.2	105.7
Other	14	1	0.5	16	2	0.7	35.0

men. Regardless of the metric used – ten year comparison of average HIV diagnosis rate (Table 3, page 10), a comparison of HIV diagnoses during the past decade, last four years vs. the first four years (Figure 10, page 20), or a year-to-year comparison in Table II – the story remains the same: White gay and bisexual men are experiencing declining HIV diagnoses by MSM and men of other racial groups are not. These data are provocative. Prevention efforts afforded by White gay/bisexual men successfully reversed the trajectory of their HIV diagnosis trends over the past decade. Conversely, prevention efforts targeted at non-white gay/bisexual men had a minimal and inconsistent impact on their HIV diagnoses in the same period. This prevention stalemate between 2002-2012 is especially concerning considering that prevention resources were supposed to be more plentiful and medical therapies more efficacious than in any previous period. New research should explore how non-white men can realize the HIV prevention benefits afforded by their White counterparts.

### Younger gay and bisexual men are driving new HIV infections

Although the composition of gay/bisexual men with HIV is becoming older (Table 21, page 49), people diagnosed with HIV are increasingly younger. For instance, gay or bisexual men, 13-19 and 20-29 years old, have had recent HIV diagnosis rate increases since 2005, 40% and 45%, respectively (Table 34, page 60) and, a combined average HIV diagnosis rate increase of 17% since 2003 (Table 28, page 56). Latinos (48%) and Blacks (27%) comprise 76% of recent HIV diagnoses among 20-29 year olds (Figure II), as well as 75% of all HIV diagnoses among 20-29 year olds from 2003 to 2012 (Table 28, page 56).

Figure II: Recent HIV Diagnoses by MSM and MSM/IDU for 20-29 Year Olds - 2009-2012



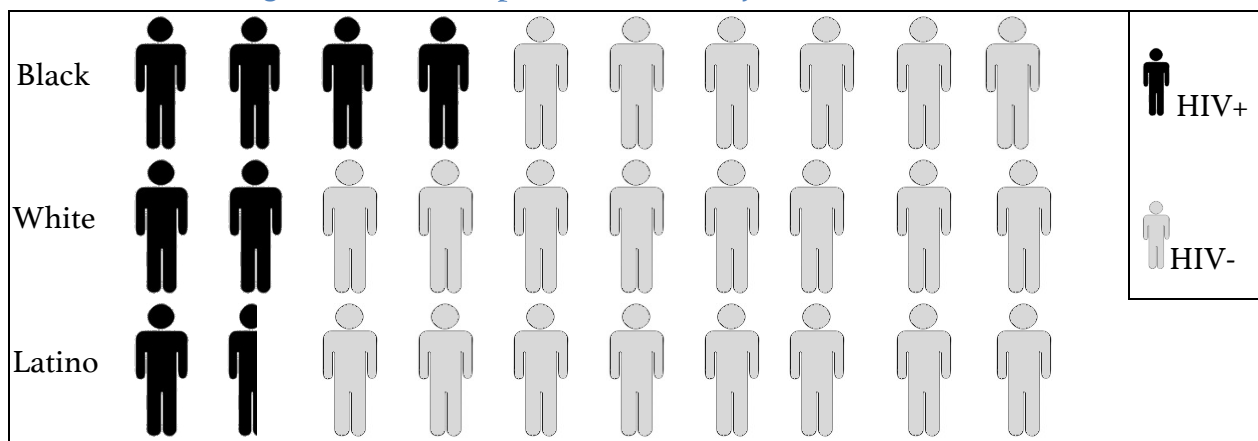


***Gay/bisexual Black men are disproportionately impacted by HIV***

Gay and bisexual Black men experience the heaviest impact of HIV among all races and genders, when considering the rate of Black men living with HIV, recently diagnosed with HIV or succumbing to HIV related death. Black men represent 8.8% of all gay/bisexual men in the City; yet, among gay and bisexual men, they make up 19% of men living with HIV (Table 21, page 49), 22% of recent HIV diagnoses (Table 34, page 60); and, among all men, 27.8% of HIV related mortalities since 2002 (Table 6, page 12).<sup>5</sup> The CDC suggests that gay/bisexual Black men may be at an elevated risk for HIV infection as a result of (1) limited access and use of health care, (2) lower income and educational attainment, (3) higher rates of unemployment and incarceration, and (4) sexual partnering with Black men who have higher HIV seroprevalence, which creates a greater statistical risk of HIV exposure.<sup>26</sup>

These hypotheses are all plausible. The fact that gay/bisexual Black men have a higher HIV seroprevalence than other men is likely the primary reason that Black men will continue to have high HIV diagnosis rates. In the City, it is estimated that 4 out of 10 gay/bisexual Black men are living with HIV. Research suggests that gay/bisexual Black men are more likely to have sexual partners of the same race.<sup>27</sup> If gay/bisexual White and Latino men also couple within their race, then the potential to acquire HIV for Black men is two times higher than Whites and 2.4 times higher than Latinos. Figure 12 shows HIV risk variance resulting from an HIV seroprevalence gap between Black, White and Latino men.

Figure 12: HIV Seroprevalence for Gay/Bisexual Men - 2012



***Gay/bisexual Native American men, high HIV rates with low numbers***

HIV also disproportionately impacts gay and bisexual Native American men. The population of Native American men is small (n=3,324) and the estimated number of gay or bisexual Native American men is even smaller (N=230). At least 118 of these men are living with HIV (n=118) and between 2009-2012, gay/bisexual Native American men had 26 new HIV diagnoses (Table 34, page 60). This means over half of all gay/bisexual Native American men are living with HIV. Without an immediate and coordinated commitment to preventing HIV for this group, being a Native American gay/bisexual man will soon be synonymous with being HIV positive.

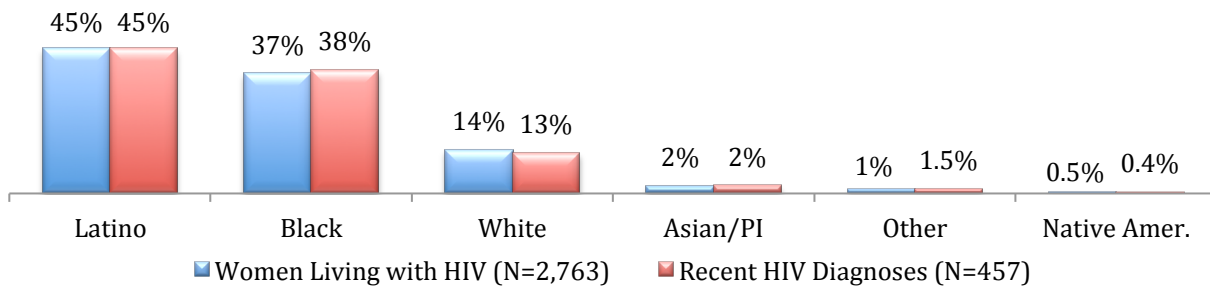
<sup>5</sup> Black men face a public health crisis when it comes to the most prolific sexually transmitted infections. In 2012, Black men had the highest rate of Chlamydia, Gonorrhea and Syphilis in Los Angeles County<sup>20</sup>

### 3. Women

#### *Latinas and Blacks make up the majority of women impacted by HIV*

Average HIV diagnosis rates declined 18% for women, 2003-2012 (Table 25, page 53). As of 2012, there are 2,763 HIV positive women in the City. Figure 13 shows a consistent trend between the percent of women living with HIV and recently diagnosed with HIV. As Figure 13 reveals, women living with HIV and recently diagnosed with HIV are primarily Latina or Black, 82.4% and 83%, respectively. Among women, Blacks have the heaviest HIV burden.<sup>†</sup> Black women represent 9.6% of all women in the City; yet, they make up 37% of all women living with HIV, 38% of recent HIV diagnoses (Figure 13) and 47% of HIV related mortalities since 2002 (Table 6, page 12). Since HIV diagnoses are declining for all women, racial disparity may be best confronted with more racially equitable support for women living with HIV.

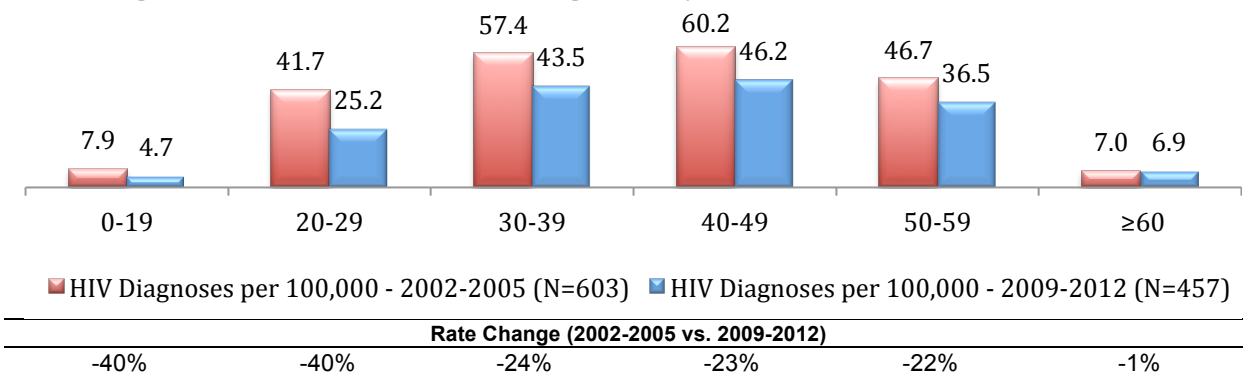
**Figure 13: Women Living with HIV - 2012, and Recently Diagnosed with HIV - 2009-2012**



#### *Sex is the primary mode of HIV exposure for women*

75% of women living with HIV were exposed from sexual contact with men and 21% from intravenous drug use (Table 20, page 48). This pattern of HIV exposure is consistent for recent HIV diagnoses – Heterosexual (83%), IDU (17%) (Table 32, page 59). There have been no major shifts related to the age of women recently diagnosed with HIV over the past decade. Figure 14 shows that 76% of recent HIV diagnoses occurred among women age 20-49 at the beginning of last decade (2002-2005) and by the end of the decade (2009-2012), 71% of recent HIV diagnoses were found among the same age groups (20-49 year olds). 69% of women living with HIV are 40 years and older (Table 19, page 47).

**Figure 14: Rate of Recent HIV Diagnoses by Women - 2002-2005 vs. 2009-2012**



<sup>†</sup> Native American women appear disproportionately impacted by HIV; yet, caution should be used interpreting these data, given their small number of women living with HIV (n=118) and recently diagnosed with HIV (n=28).



## 4. Youth (20-29 Years)

### *Gay/bisexual Latinos & Blacks lead 20-29 year-olds in HIV diagnoses*

20-29 year olds are the only age group that experienced HIV diagnosis rate increases since 2003 (Table 12). The majority of these HIV diagnoses were among gay/bisexual men (85.6%), of which 75% are Latino and Black (Table 28, page 56).<sup>u</sup> Although Latinos make up the majority of HIV positive youth and HIV diagnoses, 2003-2012, 20-29 year old Black males have a higher average HIV diagnosis rate (3,783.9) than Latinos (1,109.6) (Table 28, page 56); thus, the disease burden is 3.4 times greater for Black youth than Latino youth. Overall, Black and Latino gay/bisexual youth have the greatest need for HIV prevention services in LA.

Table 12: Average HIV Diagnosis Rate - 1992-2002 vs. 2002-2012

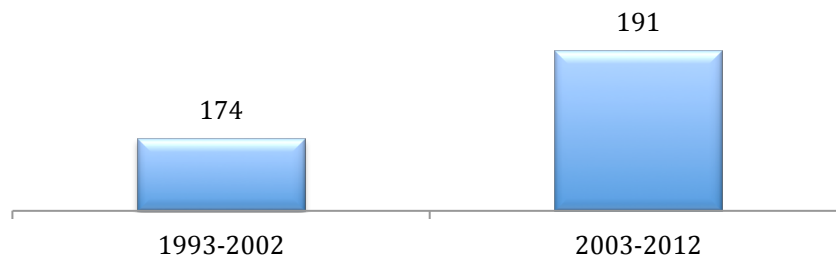
	1993-2002			2003-2012			Rate Change
	N	%	Average Rate	N	%	Average Rate	%
<b>Total</b>	15,385	100	41.6	12,806	100	33.8	-19
0-29	3,725	24	21.5	3,965	31	24.2	12
30-39	6,575	43	102.0	4,167	33	69.4	-32
40-49	3,553	23	69.9	3,164	25	58.7	-16
50+	1,532	10	18.9	1,510	12	14.9	-21

## 5. Transgender Persons

*“Transgender is an umbrella term covering anyone whose gender identity or expression does not conform to society’s expectations for, or stereotypes about, people assigned a particular sex.”* US. Department of Labor<sup>28</sup>

Los Angeles County estimates that 15.1% of transgender women in LA County are living with HIV.<sup>29</sup> Excluding gay/bisexual men, this HIV seroprevalence is extremely high compared to all other people in the City. For instance, 15.1% is higher than the HIV seroprevalence of the general population (0.7%), cisgender women<sup>v</sup> (0.15%) and men only (1.3%) (Table 23, page 51). The average HIV diagnosis rate declined 19% Citywide since 2003 (Table 12); yet, among transgender women, it is estimated that HIV diagnoses increased 9.8% since 2003 (Figure 15).

Figure 15: Number of HIV Diagnoses among Transgender Persons - 1992-2012 vs. 2003-2012

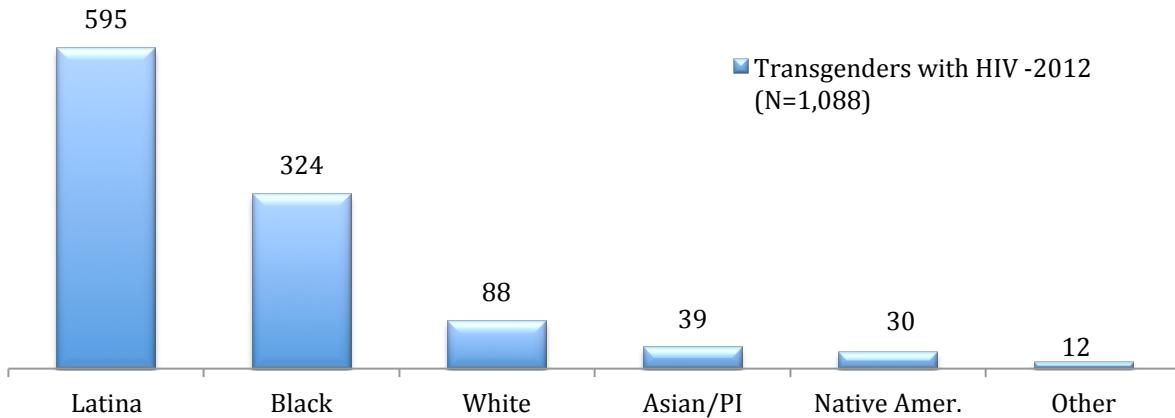


<sup>u</sup> Total HIV diagnoses for 20-29 year olds since 2003 is 3,965 (Table 30, page 58).

<sup>v</sup> Cisgender woman is a woman whose gender conforms to the sex to which she was assigned at birth.

HIV surveillance data shows racial parallels for transgender women and cisgender women – Latinas and Blacks make up the majority of cisgender and transgender women living with and diagnosed with HIV. Figure 16 profiles transgender women living with HIV and shows that 85% are either Latina (55%) or Black (30%).

Figure 16: Transgender Women Living with HIV- LA County - 2012



### ***Discrimination and high HIV seroprevalence for transgender women***

Transgender people often confront discrimination in non-occupational and occupational settings. In non-occupational settings this discrimination can range from mild annoyance to life threatening. In occupational settings, it can be the primary cause for being terminated from a job or not hired in the first place. In a recent national survey, 90% of transgender participants reported experiencing harassment, mistreatment or discrimination on the job.<sup>30</sup> In 2012, the California Department of Fair Employment and Housing received 338 employment complaints for *Gender Identity or Gender Expression* and 6,169 reports of *sex harassment*.<sup>31</sup> If we assume that transgender people filed the *gender expression* complaints and cisgender women filed the *sex harassment* complaints, it means 0.91% of employed transgender people filed complaints and 0.09% of cisgender women filed complaints.<sup>w</sup>

This means that transgender persons were 11 times more likely to file discrimination complaints than cisgender women – a potential sign of elevated levels of employment discrimination. Although untested by research, discrimination may explain why transgender women are more likely to report having engaged in sex work (11%) than are cisgender women (1%).<sup>32,30</sup> The increased participation in sex work, coupled with economic insecurity, potential substance use and housing instability, places transgender women at a greater risk for acquiring HIV than most groups in the City. One solution currently being explored by the ACO is to measure how job training in a variety of employment sectors may help transgender women avoid a path toward sex work; and, as a result, lower their risk for acquiring HIV.

<sup>w</sup> This relies on the UCLA William's Institute estimate that transgender people represent 0.1% of the population in California (N= 37,254, as of 2010 Census). In 2012, there were 7,171,915 employed women in California.

## 6. Persons who share injection paraphernalia

### *Most people infected with HIV from IDU are men*

Over the past decade, HIV rates from IDU declined for all age groups (Table 31, page 58). In fact, HIV diagnoses from IDU had the greatest percent reduction of all modes from 2003-2012 (Table 2, page 10). By the end of 2012, 11.6% people living with HIV in the City were exposed from injection drug use (Table 9, page 17), 81% were men, 58% gay/bisexual men, and 19% women (Figure 17). Figure 17 reveals that most people living with HIV from IDU are White (33%), Latino (32%) or Black (30%); and, 83% are over 40 years old (Table 13). Conversely, those recently diagnosed with HIV from IDU are more likely to be under 40 years old (Table 14).

Table 13: People living with HIV from IDU - 2012

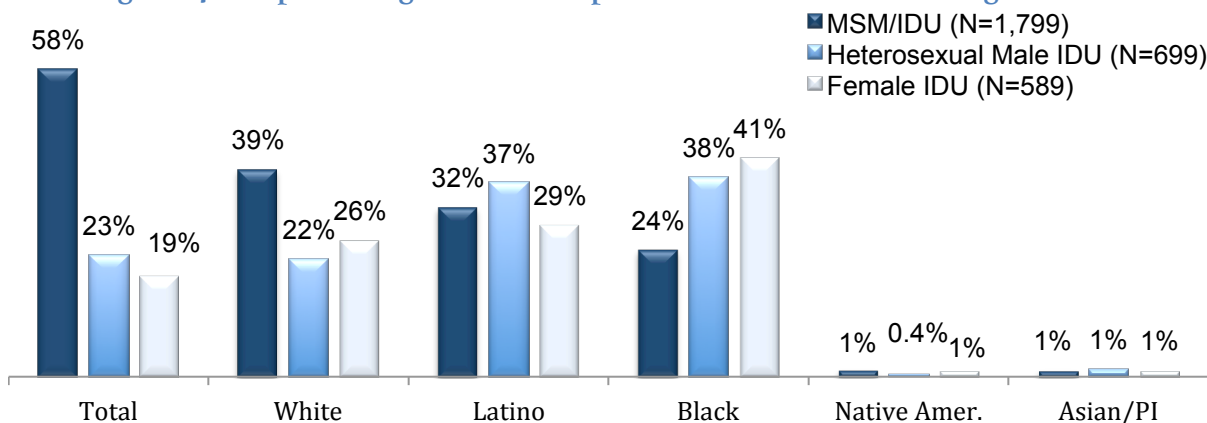
Total	Female (N=589)	Male (N=2,498)	Total (N=3,086)
–	19.1%	80.9%	100%
13-19	0.0%	0.04%	0.03%
20-29	4.7%	4.3%	4.4%
30-39	13.7%	14.5%	14.4%
40-49	33.5%	36.0%	35.5%
50-59	33.9%	33.9%	33.9%
60+	14.1%	11.2%	11.8%

Table 14: Recent HIV Diagnoses from IDU - 2009-2012

Total	Female (N=77)	Male (N=221)	Total (N=298)
–	25.8%	74.2%	100%
13-19	5.2%	3.2%	3.7%
20-29	14.3%	29.9%	25.8%
30-39	19.5%	33.0%	29.5%
40-49	35.1%	22.6%	25.8%
50-59	19.5%	9.0%	11.7%
60+	6.5%	2.3%	3.4%

Figure 17 shows the racial distribution of people living with HIV exposed from IDU.<sup>x</sup> Black women and men are disproportionately impacted. For example, Black females make up 9.6% of all females in the City; yet, they account for 41% of women living with HIV exposed from IDU. In addition, 8.7% of all males in the City are Black. However, Black men represent 24% of HIV diagnoses from MSM/IDU and 38% of HIV diagnoses from heterosexual male IDU.

Figure 17: People Living with HIV Exposed from Intravenous Drug Use - 2012



<sup>x</sup> White (N=1,011), Latino (N=999), black (N=938), Asian/P.I. (N=39), Native American (N=33) and Other (N=67).

# New Responses to the Epidemic

In 2003, the Mayor's AIDS Leadership Council established three goals for the ACO – reduce new HIV infections, reduce stigma and discrimination, and provide greater housing and support services for people living with HIV. In the ten years following the 2003 white paper, HIV diagnoses have fallen 19%, there is anecdotal evidence that HIV-related stigma is waning, possibly as a result of public awareness that HIV is no longer a death sentence, and housing and support services, via HOPWA, continue to expand. HIV surveillance data demonstrates that, while gains have been made preventing new HIV infections Citywide, HIV diagnoses have increased for 20-29 year-old gay/bisexual men of almost every racial group. For people living with HIV, the coming years will usher in a first of its kind – an aging HIV positive community of seniors. These are just two of the many groups in the City who have divergent and sometimes overlapping HIV prevention and support needs.

The ACO's mandate is to represent and advocate for all persons living with HIV and people at risk of acquiring HIV. If the ACO's budget were greater, determining where and how to focus its resources would be less of a challenge. However, the ACO budget is limited. Currently, a large portion of the budget is spent on syringe exchange programs. Based on the previous sections, it is clear that HIV diagnoses from IDU represent a small fraction of all recent HIV diagnoses (6%) (Figure 6, page 17). However, the impact that syringe exchange programs have had reducing new HIV infections from 13% in the beginning of the last decade to 6% by the end of the decade is substantial.<sup>7</sup> It is important that the ACO maintains and builds upon the real prevention gains it has made reducing HIV diagnoses from IDU. It is also imperative that the ACO find ways to remain relevant to the community and serve its evolving needs.

The ACO's greatest opportunity to integrate the recommendations of this white paper is to maintain and expand its annual budget for AIDS prevention research and technical assistance training grant funding to develop and support programs that:

- (1) **Link high priority groups to health care with access to biomedical interventions,**
- (2) **Expand routine opt-out HIV testing,**
- (3) **Help people living with HIV adhere to their ART regimen, and**
- (4) **Hold regular forums for information dissemination and community feedback.**

These four initiatives will contribute to the National HIV/AIDS Strategy to reduce HIV infections, increase access to health care and treatment and, reduce HIV-related disparity. Executing these goals will improve the support and services network available to people living with HIV and people at a heightened risk of acquiring HIV. The expected result is better service delivery, reduced viral load, and fewer HIV transmissions. A secondary result is the ACO will fortify its national leadership role, demonstrating how to adapt to the changing landscape of HIV prevention and support services with ambitious achievable goals.

---

<sup>7</sup> HIV diagnoses by IDU are combined for MSM/IDU and IDU. Data is available in Table 33, page 59

## Link high priority groups to health care

Over the past decade, HIV prevention funding has shifted away from behavioral programs toward medical, treatment as prevention, programs. This new prevention paradigm asserts that there is a greater opportunity to prevent HIV by reducing viral load in people living with HIV than by teaching people preventive measures to remain HIV negative. This new paradigm is shifting government funding away from traditional behavioral prevention programs (condoms, self-esteem, safer sex education, etc.) toward treatment as prevention (i.e., health providers who can provide HIV positive people antiretroviral medication and “high risk” HIV negative people biomedical interventions). The ACO can support this shift by developing programs that link high priority groups to primary health providers.

## Anticipated results

Linkage to primary health care is expected to reduce HIV infections by raising a person’s awareness about their HIV status and increasing their access to preventive medication. People linked to primary care are more likely to know their HIV status. This means people living with HIV who were previously unaware can, upon being made aware, initiate ART and other activities to avoid HIV transmission; and, people who are HIV negative can discuss prevention options with their provider, including access to biomedical HIV prevention options like PrEP and PEP, which may help them avoid acquiring HIV.

## Steps to be taken

1. Identify or develop a program that links high priority groups to health providers,
2. Secure funding for linkage program to ensure its sustainability, and
3. Monitor program for success.

## Target: High priority groups<sup>z</sup>

1. Gay/bisexual Latino and Black men – 18-29 years old,
2. Gay/bisexual men – 30-59 years old,
3. Cisgender Latina and Black women,
4. Transgender women, and
5. Health providers that serve high priority groups.

## Epidemiologic Goal

Currently, the HIV transmission rate in the City is 4 per 100 persons living with HIV. By the end of 2017, the goal is to lower the Citywide HIV transmission rate to 3.5. This goal can be accomplished by reducing the transmission rate for MSM exposure from 4.3 to 3.7. Based on 2012 figures, this equates to reducing the total number of Citywide HIV diagnoses in a given year from 1,062 to 930; and, for MSM exposure, it means reducing annual diagnoses by 14.7%.

---

<sup>z</sup> A description of high priority groups is found in Appendix A, page 36.

## Expand routine opt-out HIV testing

A growing number of public health professionals contend that finding ways to implement routine opt-out HIV testing policies in Community Health Centers (CHC) is critical to curbing the proliferation of HIV in the U.S.<sup>33,34</sup> The CDC estimates that, nationwide, 15.8% of people living with HIV are unaware of their serostatus.<sup>11</sup> It is unclear who makes up the 15.8%, which makes it challenging to target these *HIV positive unaware*. We know that HIV is emerging among younger gay/bisexual Latino and Black men in the City of Los Angeles; and, 64% of all CHC patients are racial minorities.<sup>35</sup> As such, expanding HIV tests in CHC may offer an opportunity to target communities in which HIV is emerging. The ACO can support routine opt-out HIV test expansion by developing a training program that offers an accessible way for CHC to train staff on routine opt-out HIV test administration and cost reimbursement.<sup>36</sup>

## Anticipated results

Expanding routine opt-out HIV testing in CHC that serve high priority populations will help identify people who are *HIV positive unaware*. Test expansion will make receiving an HIV test a standard of care; thus, reducing the stigma associated with requesting an HIV test and increasing the HIV literacy of health providers. This should facilitate more open discussions between providers and patients about HIV risk factors and prevention options.<sup>aa</sup>

## Steps to be taken

1. Identify Community Health Centers that serve high priority populations,
2. Develop training to implement routine opt-out HIV testing, and
3. Secure funding for routine opt-out HIV test training and implementation.

## Target: Health providers

1. CHC that serve high priority groups.

## Epidemiologic Goal

At present, the ACO funds routine opt-out HIV testing programs at nine primary health centers. The ACO should leverage the knowledge gained by these health centers to establish a training and integration manual for implementing routine opt-out HIV testing. ACO funding presently used to reimburse these nine clinics for HIV tests should be repurposed toward efforts to expand routine opt-out HIV testing at more CHC. By the end of 2017, the goal is to increase the number of people aware of their HIV status from approximately 85% to 90%. Increasing the number of clinical settings where routine opt-out HIV tests are offered will help accomplish this goal. Today, there are nine health centers receiving funding to provide routine opt-out HIV tests. By 2017, the goal is to have eighteen health centers offer routine opt-out HIV testing, based on the ACO training and implementation initiative.

---

<sup>aa</sup> More description of routine opt-out HIV testing is found in Appendix A, page 40.



## Support adherence to antiretroviral therapy

There is mounting evidence that viral load suppression may reduce the risk of HIV transmission up to 99%.<sup>37</sup> This statistic should inspire hope that new HIV infections can become an uncommon occurrence in the not too distant future. Barriers to ART adherence include anything that prevents a person from accessing and taking medication regularly: housing instability, economic insecurity, untreated mental health needs, substance abuse and health care access.<sup>1</sup> Barriers can also be based on knowledge gaps such as where and how to fill prescriptions, how to enroll in a primary care plan, and knowing ART should be taken, even if HIV symptoms are not present. The ACO can support adherence to ART by offering information about low cost and free services available to people living with HIV and people at a heightened risk of acquiring HIV. Information can be made available through an updated ACO website and pamphlets distributed to health providers serving high priority populations.

### Anticipated results

Medication adherence is expected to increase, provided that the underlying factors that promote medication adherence are provided to people living with HIV. Medication adherence promotes the health and wellbeing of persons living with HIV and reduces their ability to transmit HIV to others. The ACO can help increase medication adherence by being a trusted source of information, bridging the gap between service providers and consumers.<sup>bb</sup>

### Steps to be taken

1. Identify available low-cost and free support services for PLWH,
2. Include information about support services on the ACO website (<http://lacityaids.org>),<sup>cc</sup>
3. Produce a pamphlet with information about support services, and
4. Monitor web traffic to the ACO website and monitor pamphlets distributed by providers.

### Target: Health providers and Consumers

1. CHC that serve high priority groups,
2. Emergency Department at LAC+USC Medical Center, MLK, Jr. Outpatient Center, and
3. ACO website visitors.

### Epidemiologic Goal

The goal is to close the gap between those linked to care and virally suppressed. Figure 22, page 40 shows that almost every racial group has a 20-percentage point gap between those linked to care and those virally suppressed.<sup>dd</sup> The NHAS expects to increase the number of people who are virally suppressed by 20% (from 2010-2015). Locally, this means increasing the total percent of people who are virally suppressed from 57% to 68% by the end of 2017.

---

<sup>bb</sup> More description of antiretroviral adherence and viral suppression is found in Appendix A, page 40.

<sup>cc</sup> AIDS Action Committee of Massachusetts has a website with relevant categories (<http://www.aac.org/get-info/>) and AVERTing HIV and AIDS has a website that is information dense and user friendly (<http://www.avert.org>)

<sup>dd</sup> HIV Viral Load Suppression is defined as having one or more VL tests performed in 2011 with a result indicating fewer than 200 copies of virus per milliliter of blood plasma.

## Hold forums for information dissemination

The resounding message from interviews with the community and round table discussion was a desire to have more public dialogue about issues relevant to the HIV/AIDS community and opportunities for information dissemination between service providers, and with consumers (Table 36, page 62). This includes conversations about biomedical interventions like PrEP and PEP, questions about roles and responsibilities of social media *hookup* applications and websites, given the belief that these applications/websites facilitate increased unprotected sexual encounters, healthy practices for HIV serodiscordant couples, concerns about HIV positive men regressing into unsafe sex practices, and facts about viral load suppression.<sup>ee</sup> The ACO, by holding community forums, can fortify its leadership position as a community advocate and conduit between policymakers, service providers, researchers and consumers.

### Anticipated results

Holding semiannual or quarterly forums with community stakeholders is expected to increase linkages between potentially isolated organizations, improve communication between stakeholders and facilitate collaboration. This should translate into better coordination of prevention and support services, which is measured by improved utilization of resources, less overlap of services to the same geographic target and, potential innovation. Prevention research and insight generated via the ACO's annual HIV/AIDS prevention research program is not always widely distributed to consumers and service providers. Forums may provide a venue to distribute ACO research findings and offer an opportunity for community feedback.

### Steps to be taken

1. Identify a location to hold forums,
2. Develop topics for discussion with community input, and
3. Partner with sponsoring organizations to help cover costs, and expand community reach.

### Target: Health providers and Consumers

1. HIV/AIDS community stakeholders,
2. Related service providers – housing, substance abuse, mental health, and
3. Consumers of HIV/AIDS services.

### Program Goal

The goal is to solidify the network of HIV/AIDS service providers and reduce the distance between consumers and service providers. A more cohesive and communicative HIV/AIDS services provider community means the ACO will have a better sense of emerging community needs and resources to address the needs. This will help the ACO shape new questions for its annual HIV/AIDS prevention research and technical assistance grant program. In addition, it will provide more community oversight and coordination with the County.

---

<sup>ee</sup> Potential topics of interest for ACO community forums are found in Appendix A, page 41.



# Conclusion

This White paper outlines practical strategies that the AIDS Coordinator's Office can execute to reduce new HIV infections, increase access to health care and treatment for people living with HIV, and reduce HIV-related disparity; thus, contributing to the three goals of the National HIV/AIDS Strategy. The core findings from this research and evaluation demonstrate that although the statistical probability of acquiring HIV is greater today than in any previous period, the community is better equipped to interrupt the spread of new HIV infections with more potent antiretroviral therapy. The AIDS Coordinator's role has traditionally been to fill unmet gaps in the local response to the HIV/AIDS epidemic. This requires an ongoing finger on the pulse of the community to understand its needs and steady engagement with the County to identify resources to serve those needs.

It is recommended that the ACO collaborate with the County to:

- (1) Link high priority groups to primary health care**
- (2) Expand routine opt-out HIV testing,**
- (3) Help people living with HIV adhere to their ART regimen, and**
- (4) Hold regular forums for information dissemination and community feedback.**

This approach focuses and builds upon the ACO's strengths – understanding how to target hard to reach groups and serve them with appropriate community based service providers.

The recommended approach solidifies the ACO's leadership position, allows it to adapt to the changing landscape of health care, and offer more comprehensive support to people living with HIV and people at a heightened risk of acquiring HIV. It is anticipated that these initiatives will foster greater linkages between the ACO and community stakeholders, increasing the ACO's ability to monitor progress and shift direction in order to achieve the ambitious yet practical goals outlined in this white paper. In the coming years, it is projected that the efforts of the ACO, in collaboration with community partners, will reduce new HIV infections, expand the percent of people who know their HIV status, increase the percent of people living with HIV who are virally suppressed, and improve the collective knowledge about innovative and effective HIV prevention and support techniques.

# Glossary of Terms

## HIV SURVEILLANCE DATA RELATED TERMS:

<b>Seroprevalence</b>	The proportion of a population that has a particular illness. If there are 20,000 people with the flu in a population of 1 million people, the seroprevalence of flu is 2%.
<b>Rate</b>	The number of reported cases of an illness in a given population per 100,000, at a specific time period.
<b>Diagnosis</b>	Clinical verification of an illness through medical examination.
<b>Infection</b>	The acquisition an illness, regardless of a diagnosis. To avoid redundancy, “infection” is also used to described diagnoses even though HIV data reported do not include all the infections.
<b>Exposure</b>	The mode by which an uninfected person acquires an illness.
<b>Transmission</b>	The passage of an illness from one person to another person.
<b>Mode</b>	The manner in which an illness can be transmitted. The Department of Public Health records 5 transmission modes for HIV: (1) MSM, (2) IDU (3) MSM/IDU, (4) Heterosexual contact, (5) Hemophilia/Transfusion, and (5) Other/undetermined.
<b>MSM</b>	Men who have Sex with Men.
<b>IDU</b>	Injection Drug Use.
<b>MSM/IDU</b>	Men who have Sex with Men, likely exposed to HIV from IDU.
<b>Heterosexual contact</b>	Sexual intercourse between a woman and man.
<b>Hemo/Transf.</b>	Hemophilia/Transfusion
<b>Other</b>	HIV infections with an unspecific mode of transmission.
<b>ART</b>	Acronym for Antiretroviral Therapy. The medication regimen used by people with HIV to suppress their viral load.
<b>PrEP</b>	Acronym for Pre-exposure Prophylaxis – an approach to HIV prevention where a person takes medication with behavioral modifications to reduce risk of acquiring HIV
<b>PEP</b>	Acronym for Post-exposure Prophylaxis – antiretroviral medication taken immediately after exposure to HIV to reduce the risk of seroconversion (becoming HIV positive).

## DEMOGRAPHIC RELATED TERMS:

<b>Race</b>	Categories used in HIV surveillance data to record information. Categories include: White, Black, Hispanic, Asian/P.I. (Pacific Islander), Native American, and Other.
<b>Latino/a</b>	Refers to Hispanics; and, even though Latino is an ethnic group that includes a variety of racial groups, Latino is treated like a racial group, based on how data is collected by the County.
<b>Other</b>	Includes people who either did not report their race or whose race may have included two racial groups.
<b>Gay</b>	Refers to homosexual men. This term is used in favor of MSM to acknowledge the distinction between an HIV transmission mode and a term of individual identity.
<b>Bisexual</b>	A person who is sexually attracted to both women and men.
<b>Gay/Bisexual</b>	Abbreviation for gay or bisexual. It refers frequently to gay or bisexual men in the context of combining the HIV surveillance categories of MSM and MSM/IDU.
<b>Transgender Person</b>	A person whose gender identity does not conform to the sex to which they were assigned at birth.
<b>Cisgender</b>	A person whose gender conforms to the sex to which they were assigned at birth.
<b>People living with HIV (PLWH)</b>	The number of people living with an HIV or AIDS diagnosis. It also includes HIV positive people infected without a diagnosis.
<b>HIV</b>	An acronym for Human Immunodeficiency Virus
<b>AIDS</b>	An acronym for Acquired Immune Deficiency Syndrome. A person with HIV is diagnosed with AIDS when their CD4 count falls below 200 cells /mm <sup>3</sup>
<b>Viral Load (VL)</b>	Amount of HIV (copies of genetic material) in a person's blood.
<b>Viral Suppression</b>	The act of reducing viral load. An undetectable viral load is considered to be 40-75 copies in a person's blood.
<b>CD4 / T-cells</b>	Cells of the immune system that fight infection. A person without infection has a CD4 count between 500-1,000 cells/ mm <sup>3</sup>

# Appendix A – New Strategy Analysis

## Linking high priority groups to health care

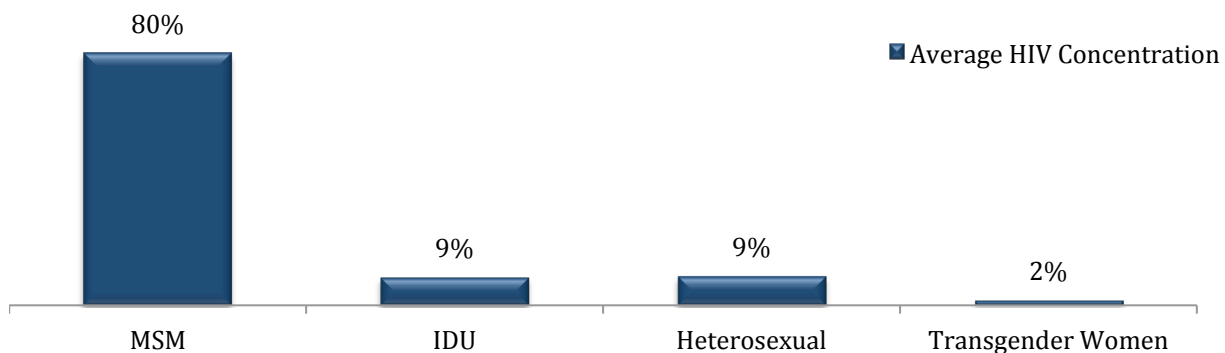
The NHAS recommends local municipalities focus HIV prevention and support on communities where HIV is heavily concentrated. Los Angeles County identified six high populations with a high concentration of HIV – HIV Positive, MSM, Women, Youth (13-24 years), Transgender Persons, and Persons who share injection paraphernalia (Table 15)<sup>38</sup>

**Table 15: Key Populations, Priority Subpopulations, and Populations of Interest**

Key Populations	Priority Subpopulations
1. HIV Positive 2. MSM 3. Women 4. Youth (13-24 years) 5. Transgender Persons 6. Persons who share injection paraphernalia (SIP)	<ul style="list-style-type: none"> <li>• HIV Positive – undiagnosed &amp; not in care; sexual and/or needle sharing partners</li> <li>• Black and Latino MSM</li> <li>• Black Women and Latinas</li> <li>• Young MSM (YMSM)</li> <li>• Transgender Persons – Native American &amp; Others</li> </ul>
Populations of Interest	
<ul style="list-style-type: none"> <li>• Homeless</li> <li>• Incarcerated / Post-incarcerated</li> <li>• Undocumented</li> <li>• Mentally ill</li> </ul>	<ul style="list-style-type: none"> <li>• Sex workers / sex for exchange</li> <li>• Persons with sensory impairments (i.e., partially sighted/blind, hearing impaired/deaf)</li> <li>• Asian/Pacific Islanders</li> <li>• Aging Persons (50 years and older)</li> </ul>

The ACO acknowledges these populations and continues to collaborate with the County in its planning to ensure ACO activities contribute to the larger priorities of the County. Figure 18 shows groups with the heaviest concentration of HIV. *HIV concentration* is an average taken of people living with HIV and recently diagnosed with HIV by exposure mode. Transgender women were included given their critical need for HIV prevention services.<sup>ff</sup>

**Figure 18: Average HIV Concentration by Transmission Mode and Transgender Women**



<sup>ff</sup> Data for transgender women living with HIV in the City and diagnosed with HIV for 2009-2012 were not available. As such, this data was calculated by estimating that 39% of transgender women with HIV in the County live in the City of LA (420 of 1,088). 39% was used because 39% of the County's population lives in the City of LA. HIV diagnoses from 2009-2012 were derived by taking the number of transgender women diagnosed with HIV from 2002-2012 and multiplying it by .40 (76 of 191). 0.40 was used because 2009-2012 is four years and 4 years out of 10 years is 0.40.

## High Priority Groups

85% of HIV positive people in the City are gay/bisexual men; and, Youth with HIV and people recently diagnosed with HIV are primarily gay/bisexual males (84%). As such, gay/bisexual men are the highest priority group for HIV prevention and support services in the City. Table 16 lists high priority groups in order of the HIV impact score of each racial group. This score approximates the impact of HIV by accounting for the number of people diagnosed with HIV and the recent HIV diagnosis rate for each racial group.<sup>88</sup> This approach was taken to best estimate racial group needs.

**Table 16: High Priority Groups for HIV Prevention and Support Services**

HIGH PRIORITY GROUP	TARGET 1	TARGET 2
<b>1. HIV Positive Gay/Bisexual Men</b>	<b>20-59 Years Old</b>	
	1. Black	
	2. Latino	
	3. White	
	4. Native American	
	5. Asian/P.I.	
<b>2. HIV Negative Gay/Bisexual Men</b>	<b>13-29 Years Old</b>	<b>30-39 Years Old</b>
	1. Black	1. Latino
	2. Latino	2. Black
	3. White	3. White
	4. Native American	4. Native American
	5. Asian/P.I.	5. Asian/P.I.
<b>3. Injection Drug Users</b>	<b>20-49 Years Old</b>	
	1. Gay/Bisexual Men	
	2. Women	
	3. Heterosexual Men	
<b>4. Heterosexual Women</b>	<b>20-59 Years Old</b>	
	1. Black	
	2. Latina	
	3. White	
	4. Native American	
	5. Asian/P.I.	
<b>5. Transgender Women</b>	<b>15-64 Years Old</b>	
	1. Latina	
	2. Black	
	3. White	
	4. Native American	
	5. Asian/P.I.	

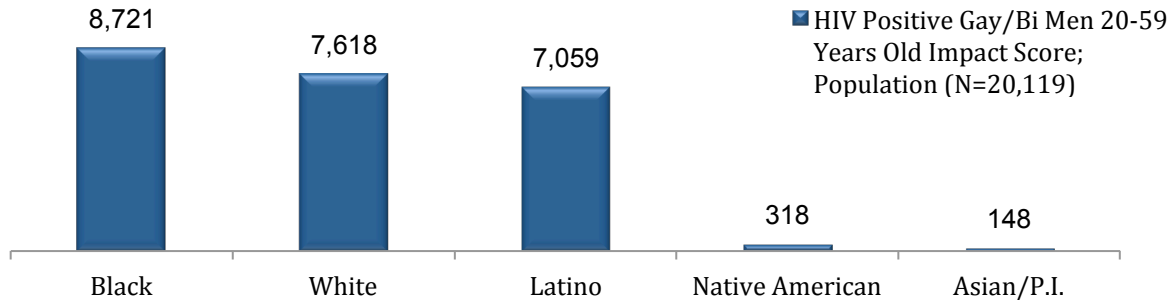
See Table 35, page 62 in Appendix C for community recommended targets for Prevention.

<sup>88</sup> The HIV impact score is calculated by multiplying the racial group's percent of cumulative HIV infections from 2009-2012 with the corresponding HIV diagnosis rate.

## HIV positive gay/bisexual men – 20-59 years old

Most recent HIV diagnoses are among 20-29 year old gay/bisexual men (35%) Table 34, page 60; and, most people living with HIV are 30-59 year old gay/bisexual men (81%) (Table 21, page 49). As such, 20-59 year-old gay/bisexual men are the primary focus of prevention efforts targeted at HIV positive people in the City. Together, they comprise 75% of all 26,674 people diagnosed with HIV in the City. HIV positive gay/bisexual men 20-59 years old should receive services that support viral load suppression. Allocation of support may be prioritized according to the HIV impact score for each racial group found in Figure 19.

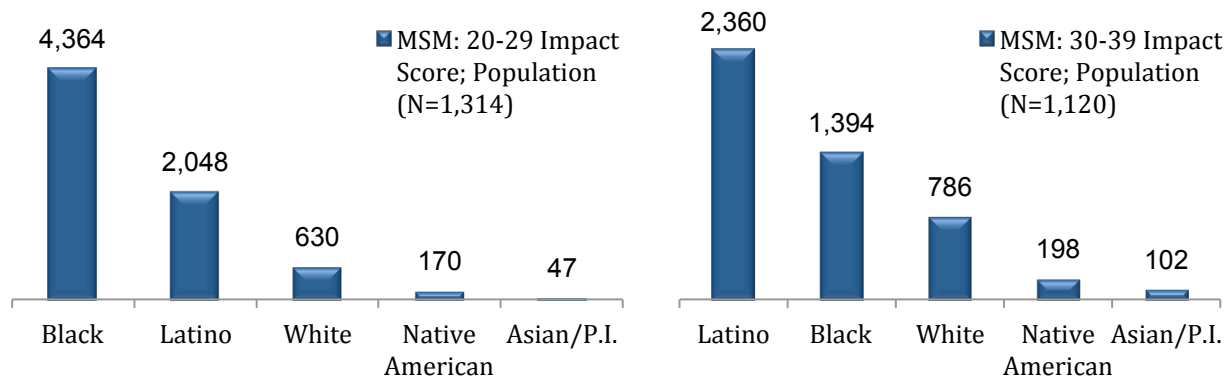
Figure 19: HIV Impact Score for HIV Positive Gay/Bisexual Men - 20-59 years old - 2012



## HIV negative gay/bisexual men – 20-39 years old

HIV is emerging among 20-29 and 30-39 year-olds exposed from male-to-male sex. Among 20-29 year-old MSM, Blacks are the most heavily impacted (60%) followed by Latino (28%), White (9%), Native American (2%) and Asian/P.I. (1%). For 30-39 year olds, Latinos have the highest HIV impact score (49%), followed by Black (29%), White (16%), Native American (4%) and Asian/P.I. (2%). “Others” are omitted since a policy cannot feasibly target “others.”

Figure 20: HIV Impact Score for 20-29 and 30-39 year old Men - MSM exposure- 2009-2012



## Aiming at younger gay or bisexual men

Approximately 3.3% of HIV diagnoses from 2009-2012 were among 13-19 year olds- 79% were gay or bisexual males, primarily Latino (45%) or Black (40%). Although 20-29 year olds are driving the HIV epidemic in Los Angeles, there may be value aiming prevention efforts at younger males (13-19 years). This is because sexual decision-making behaviors are formed at earlier ages;<sup>39</sup> and, the opportunity to inform these behaviors is greater at earlier ages. The



need for earlier intervention is made evident by results of a recent survey of LA youth that showed approximately 46% of high school age students are sexually active and sexually active gay or lesbian youth use condoms 45% less than heterosexual youth.<sup>40</sup> Given that the HIV incidence rate grew 5% for youth 0-19 years old during the past decade and most students in Los Angeles are eligible to receive opt-out HIV education once in middle school and once in high school,<sup>41</sup> there may be a need for more HIV prevention education and support services.

## Injection drug users

The previous chapter outlines the groups most impacted by HIV from IDU. It indicates that people infected with HIV from IDU are primarily male, younger (under 40 years old) and overwhelming Latino, Black or White. Given the enormous success of syringe exchange programs to reduce the number and rate of HIV infection from IDU over the past decade, whatever groups have been targeted should continue to be targeted. Administration of funds to syringe exchange programs should ensure that each high concentration group is served by at least one of the funded programs as long as changes do not alter program success.

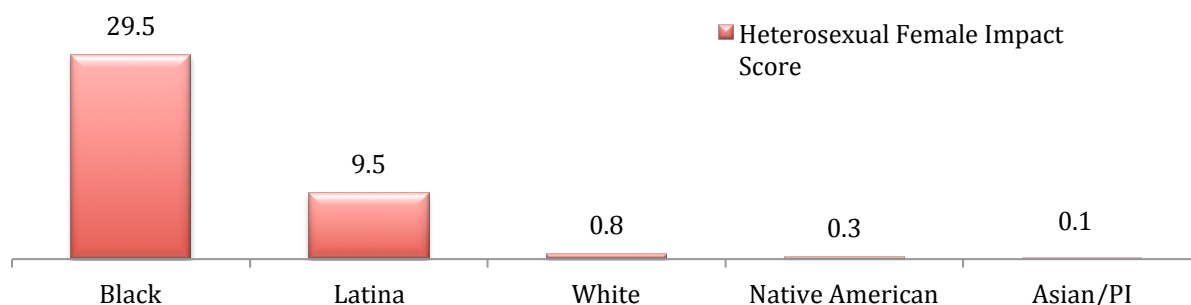
## Heterosexual women

The majority of heterosexuals infected with HIV are women. There are approximately, 2,566 heterosexuals with HIV in the City of Los Angeles, 81% are female and 19% are male. This pattern is consistent with new infections as well. Between 2009-2012, 418 people were diagnosed with HIV from heterosexual contact, 90% were female and 10% were male. As such, the focus on heterosexuals should be on women. The age distribution of HIV infections from heterosexual contact among women is 4% (13-19 years), 18% (20-29 years), 30% (30-39 years), 25% (40-49 years), 18% (50-59 years), and 4% (60 years and older). Figure 21 illustrates HIV impact scores for women by race. Black women exposed to HIV from heterosexual contact have the highest impact score (73%), followed by Latinas (24%), White (2%) Native American (0.8%) and Asian/P.I. (0.4%).

## Transgender women

Los Angeles County estimates the racial distribution of 1,088 transgender women with HIV as follows: Latina (54.7%), black (29.8%) white (8.1%), Asian/P.I. (3.6%), Native American (2.8%), Other (1.1%).<sup>viii</sup> Given the small size of this population, it may be more useful to provide resources to transgender women as a group, rather than targeting specific age or racial segments. Programs should take into consideration the linguistic needs of transgender women, making appropriate resources available as needed.

Figure 21: HIV Impact Score for Females exposed from Heterosexual Contact - 2009-2012



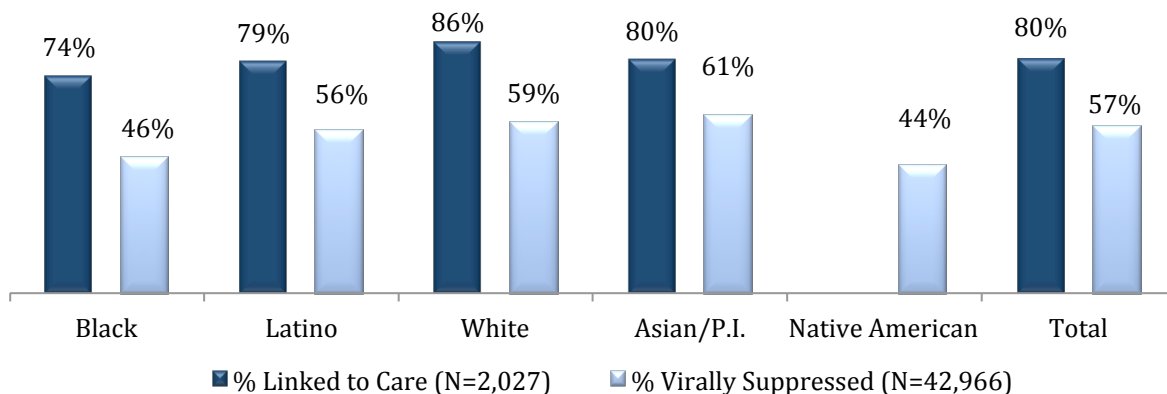
## Expanding routine opt-out HIV tests

Community Health Centers (CHC) are in a unique position to identify people living with HIV and provide linkages to support networks. CHC perceive testing costs and staff training as major barriers to implementing Routine Opt-Out HIV testing. As such, the ACO should focus efforts to increase the number of CHC offering routine opt-out HIV tests. The ACO can develop a training program that offers an accessible way in which CHC can understand how to get reimbursed for test costs and train staff on test administration. In addition, the ACO, with the support of the Mayor's Office, might encourage health providers to offer HIV services in a culturally competent manner inclusive of LGBTQ clients, and provide ancillary services like transportation and interpretation to accommodate more clients.

## Support antiretroviral therapy adherence

Viral load reduction is achieved through antiretroviral therapy (ART) adherence. Every effort, therefore, must be made to link HIV positive people to health care,<sup>hh</sup> retain them in care<sup>ii</sup> and provide resources needed to remain adherent to ART. The primary goal of the community should be to close the gap between those linked to care and virally suppressed. Figure 22 shows that for almost every group, there is a 20-percentage point gap between those linked to care and those virally suppressed.<sup>jj</sup> Closing this gap would significantly reduce new HIV infections.<sup>7</sup> The ACO can provide leadership by developing a program that links high priority groups to primary health care. Healthcare workers are in the best position to increase ART adherence by establishing rapport with patients, educating people about where and how to fill prescriptions, how to adhere to ART, even if symptoms of HIV are not present, and access other pertinent services to increase ART adherence (housing, substance programs, etc.). Healthcare workers also have access to patient information to monitor and follow-up with those who fall out of care. The ACO should provide CHC with information about HIV support services so they can better serve, monitor and follow-up with people living with HIV.

Figure 22: Los Angeles County Testing Linkage to Care Plus Treatment Cascade - 2011<sup>10</sup>



<sup>hh</sup> Linkage to care is defined as having a VL, CD4, or HIV genotyping test performed in the same month or within three months of HIV diagnosis. Native Americans linked to care were fewer than 5.

<sup>ii</sup> Retention in care is as having two or more VL, CD4, or HIV genotyping tests performed during a 12 month period at least 3 months apart.

<sup>jj</sup> HIV Viral Load Suppression is defined as having one or more VL tests performed in 2011 with a result indicating fewer than 200 copies of virus per milliliter of blood plasma.

## Forums for information exchange with community

Regular forums held by the ACO will provide the opportunity to discuss relevant matters related to research innovation, support needs, and partnership opportunities. The dissemination of information and conversations should revolve around current issues:

## Viral load suppression and serodiscordant couples

Recent studies indicate that viral suppression may reduce the risk of HIV transmission up to 99% between serodiscordant couples.<sup>37</sup> This statistic should give everyone hope that the tide can turn if people with HIV achieve viral load suppression. The caveat is that viral load is not static. As such, a person can be more or less infectious at different times. High priority groups should understand what constitutes viral suppression, how often viral load may shift, and how their risk of transmission or infection is diminished by viral load suppression. Technology that supports the monitoring and potential disclosure of individual viral load may be developed to reinforce viral load disclosure and reduce potential discrimination among serodiscordant couples.

## PrEP and PEP education

**Post-Exposure Prophylaxis (PEP)** is a course of antiretroviral medications administered within 72 hours of exposure to a person for approximately one month following exposure to HIV. This medical intervention has proven effective at reducing seroconversion of people exposed to HIV. Information about PEP should be made available to the community, especially those who, by occupation or behavior, may be exposed to HIV. Education about *where* and *how* to acquire PEP is needed.

**Pre-Exposure prophylaxis (PrEP)** is a comprehensive HIV prevention program that combines medication with condom use, monthly sexual risk reduction counseling and HIV testing. In 2012, the FDA approved the drug Truvada for PrEP to be used by gay or bisexual men at “high risk” of HIV infection and heterosexual couples in HIV serodiscordant relationships. Facts about PrEP should be made readily available to gay or bisexual men, as well as heterosexual couples in serodiscordant relationships.

## Condom fatigue among HIV positive and negative men

The local community speculates that HIV-related stigma has diminished so much that younger men are not afraid of acquiring HIV. People reflect on the massive popularity of social “hookup” apps, as potential catalysts for HIV exposure, given the increased access to sexual partners. However, access is only part of the equation in HIV transmission, decision-making is the other part. The decision to use or not use a condom is varied; and, it is relevant for people living with HIV and people who may have sex with HIV positive people.

There are some who elect to have sex without condoms because they are not afraid of acquiring HIV. These individuals might believe their risk is low for a number of reasons: they think their partner is not HIV positive, their partner, who may be HIV positive, is taking ART regularly, they, themselves, may be taking PrEP, have access to PEP or think using some form of pre-ejaculation pullout method will keep them safe. Others who do not to use condoms,

may do so based on fear of rejection from their partner, coercion from a partner, lowered inhibitions from substance use, because condom-less sex feels better, or because they are actively seeking to acquire HIV.

As public health policy makers and service providers, it is important to be honest about the multitude of reasons why a person elects to use or not use a condom. Encouraging people to use condoms is great; and, providing the community with access to the latest variety of prevention methods is essential to curbing new HIV infections in the City of Los Angeles. Frank conversations about the real ways in which high priority groups expose themselves to HIV will reinforce the relevance of the ACO as a trusted source for HIV information.

## **Transmission modes**

It is important to make sure high priority groups are aware of primary modes of HIV transmission. Clarifying what does and does not constitute risk should be well known by all persons living with HIV and within high priority populations.

## **Co-morbidity reduction**

In Los Angeles County, people living with HIV are also likely to have co-morbidities (e.g., other illnesses). Among people diagnosed with HIV in 2011, 45% were also diagnosed with early Syphilis, Chlamydia (21%) and Gonorrhea (18%).<sup>42</sup> Research indicates that STI increases infectiousness of people living with HIV and susceptibility among HIV negative people.<sup>43</sup> Effort should be made to raise awareness about the relationship between STI and HIV transmission and infection to key populations.

## **Prevention research**

As the community approaches a greater level of HIV management, it is important that the ACO keep up with advances and offer leadership throughout. Innovative research projects help solidify the ACO's leadership position within the community, by exploring emerging needs, opportunities and offering insight to the community. The only piece currently missing is a formal mechanism for distributing the results of the research. Information dissemination would help ensure the quality and timeliness of data can be best utilized by the community.

## **Syringe exchange**

If possible, the ACO should consider lobbying the County for syringe exchange program funding to expand the reach of syringe exchanges in areas of the City currently underserved; and, possibly, free up ACO funds to be repurposed for other programs. This type of collaboration would be mutually beneficial in reaching goals of the County and City. The major barrier to expansion of syringe exchange programs is identifying locations that meet City zoning requirements (e.g., a specific distance from schools, etc.).

## HOPWA

As previously mentioned, there is no current mandate that requires HOPWA to partner with the ACO in its program administration. Until such a mandate exists, the ACO can make a meaningful contribution to LACHAC, by attending meetings, offering insight and continuing to collaborate with the HOPWA program.

## Collaborate with Los Angeles County

Collaboration between the ACO and the Los Angeles County Division of HIV and STD should be formalized around planning efforts. It would be especially beneficial to identify CHC in locations with high disease burden (co-occurring HIV, Syphilis, Chlamydia and Gonorrhea) and encourage them to adopt routine opt-out HIV testing and training on HIV and cultural competency. The ACO and County Division of HIV and STD Programs should share the task of identifying and promoting HIV training and services to CHC. The County uses a syndemic approach for geospatial planning. This means the County identifies co-occurring diseases within specific locations to identify where to aim resources. If the ACO and County could collaborate to identify CHC in areas with high disease burden in the City, it would help better allocate resources and offer greater coverage of HIV services in the City.

# Appendix B – Additional Tables

Table 17: Population Estimates for City of Los Angeles - 2000 and 2010

City of Los Angeles Population 2000																					
AGE	White			Black			Latino			Asian/P.I.			Native American			Others			TOTAL Population		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
0-19	91,793	96,638	188,431	59,042	59,962	119,004	326,872	345,003	671,875	38,008	39,726	77,734	1,197	1,252	2,449	15,640	15,916	31,556	532,552	558,497	1,091,049
20-29	72,338	77,078	149,416	29,465	24,659	54,124	161,572	184,342	345,914	36,732	34,433	71,165	708	670	1,378	8,636	8,316	16,952	309,451	329,498	638,949
30-39	89,456	102,420	191,876	34,932	31,000	65,932	143,532	163,208	306,740	31,959	30,296	62,255	774	841	1,615	7,848	8,513	16,361	308,501	336,278	644,779
40-49	86,028	95,219	181,247	31,911	28,103	60,014	99,522	97,533	197,055	29,787	25,546	55,333	716	739	1,455	6,296	6,691	12,987	254,260	253,831	508,091
50-59	72,935	72,415	145,350	22,454	18,307	40,761	54,205	47,076	101,281	23,453	19,138	42,591	549	464	1,013	4,220	3,944	8,164	177,816	161,344	339,160
60+	135,313	107,555	242,868	37,333	24,818	62,151	56,933	39,275	96,208	34,568	25,688	60,256	546	441	987	5,742	4,580	10,322	270,435	202,357	472,792
All	547,863	551,325	1,099,188	215,137	186,849	401,986	842,636	876,437	1,719,073	194,507	174,827	369,334	4,490	4,407	8,897	48,382	47,960	96,342	1,853,015	1,841,805	3,694,820

City of Los Angeles Population 2010																					
AGE	White			Black			Latino			Asian/P.I.			Native American			Others			TOTAL Population		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
0-19	82,573	86,860	169,433	41,784	43,013	84,797	310,846	326,058	636,904	35,189	36,386	71,575	658	668	1,326	15,146	15,279	30,425	486,196	508,264	994,460
20-29	82,788	86,595	169,383	26,186	24,284	50,470	154,343	174,437	328,780	40,727	37,959	78,686	516	497	1,013	9,170	8,115	17,285	313,730	331,887	645,617
30-39	75,807	88,616	164,423	24,054	21,552	45,606	145,251	156,957	302,208	39,415	35,010	74,425	464	502	966	6,999	6,112	13,111	291,990	308,749	600,739
40-49	75,979	87,860	163,839	27,637	25,647	53,284	123,327	129,486	252,813	31,252	26,370	57,622	573	567	1,140	5,193	4,901	10,094	263,961	274,831	538,792
50-59	78,451	83,784	162,235	26,376	24,241	50,617	88,131	81,377	169,508	32,430	25,187	57,617	539	497	1,036	4,328	3,807	8,135	230,255	218,893	449,148
60+	139,516	118,079	257,595	36,877	25,729	62,606	85,961	62,648	148,609	49,293	35,294	84,587	615	493	1,108	5,163	4,197	9,360	317,425	246,440	563,865
All	535,114	551,794	1,086,908	182,914	164,466	347,380	907,859	930,963	1,838,822	228,306	196,206	424,512	3,365	3,224	6,589	45,999	42,411	88,410	1,903,557	1,889,064	3,792,621



**Table 18: Population Estimate of Gay and Bisexual Men in the City of Los Angeles**

Gay and Bisexual Population Estimate 2000							
	White	Black	Latino	Asian/P.I.	Native American	Other	TOTAL
Total	49,619	16,816	78,879	15,734	397	4,316	165,762
Total >20 years	40,922	11,420	47,829	12,159	284	2,884	115,498
0-19	8,697	5,397	31,050	3,575	113	1,432	50,265
20-29	6,937	2,219	16,591	3,099	60	748	29,655
30-39	9,218	2,790	14,689	2,727	76	766	30,265
40-49	8,570	2,529	8,778	2,299	67	602	22,845
50-59	6,517	1,648	4,237	1,722	42	355	14,521
60+	9,680	2,234	3,535	2,312	40	412	18,212

Gay and Bisexual Population Estimate 2010							
	White	Black	Latino	Asian/P.I.	Native American	Others	TOTAL
Total	49,661	14,802	83,787	17,659	290	3,817	170,016
Total >20 years	41,844	10,931	54,441	14,384	230	2,442	124,272
0-19	7,817	3,871	29,345	3,275	60	1,375	45,744
20-29	7,794	2,186	15,699	3,416	45	730	29,870
30-39	7,975	1,940	14,126	3,151	45	550	27,787
40-49	7,907	2,308	11,654	2,373	51	441	24,735
50-59	7,541	2,182	7,324	2,267	45	343	19,700
60+	10,627	2,316	5,638	3,176	44	378	22,180

The estimated number of people aged 20 years and older is used as the total for each racial group for the purpose of calculating HIV seroprevalence. This is to conform to the estimate projected by Lieb et al. at the Florida Department of Health Bureau of HIV/AIDS,<sup>13</sup> which utilized the male population, age 18 and older. Since the census data creates a group that ends at 19 years, we selected the next age group as the starting point for the estimate for the size of the gay/bisexual population. When calculating the seroprevalence by age, each estimated population size is used as listed in the tables above.

Table 19: People Living with HIV by Race and Age - 2012

	Total			Female			Male		
	N	%	Rate	N	%	Rate	N	%	Rate
<b>Total</b>	26,674	100%	703.3	2,763	10%	145.1	23,911	90%	1,265.8
13-19	122	0.5%	12.3	43	2%	8.8	79	0%	15.5
20-29	2,133	8%	330.4	245	9%	78.1	1,888	8%	568.9
30-39	4,783	18%	796.2	567	21%	194.2	4,216	18%	1,365.5
40-49	9,152	34%	1,698.6	886	32%	335.7	8,266	35%	3,007.7
50-59	7,493	28%	1,668.3	710	26%	308.4	6,783	28%	3,098.8
60+	2,991	11%	530.4	312	11%	98.3	2,679	11%	1,087.1
<b>Latino</b>	10,809	100%	587.8	1,248	100%	137.5	9,561	100%	1,027.0
13-19	62	1%	9.7	22	2%	7.1	40	0%	12.3
20-29	1,020	9%	310.2	133	11%	86.2	887	9%	508.5
30-39	2,582	24%	854.4	309	25%	212.7	2,273	24%	1,448.2
40-49	3,962	37%	1,567.2	386	31%	313.0	3,576	37%	2,761.7
50-59	2,360	22%	1,392.3	276	22%	313.2	2,084	22%	2,560.9
60+	823	8%	553.8	122	10%	141.9	701	7%	1,119.0
<b>White</b>	8,797	100%	809.4	373	69.7	69.7	8,424	100%	1,526.7
13-19	9	0%	5.3	3	1%	3.6	6	0%	6.9
20-29	344	4%	203.1	19	5%	23.0	325	4%	375.3
30-39	1,000	11%	608.2	45	12%	59.4	955	11%	1,077.7
40-49	2,965	34%	1,809.7	134	36%	176.4	2,831	34%	3,222.2
50-59	3,086	35%	1,902.2	110	29%	140.2	2,976	35%	3,552.0
60+	1,393	16%	540.8	62	17%	44.4	1,331	16%	1,127.2
<b>Black</b>	5,808	100%	1,671.9	1,029	100%	562.6	4,779	100%	2,905.8
13-19	45	1%	53.1	18	2%	43.1	27	1%	62.8
20-29	655	11%	1,297.8	87	8%	332.2	568	12%	2,339.0
30-39	915	16%	2,006.3	184	18%	764.9	731	15%	3,391.8
40-49	1,804	31%	3,385.6	330	32%	1,194.1	1,474	31%	5,747.3
50-59	1,741	30%	3,439.6	298	29%	1,129.8	1,443	30%	5,952.7
60+	648	11%	1,035.0	112	11%	303.7	536	11%	2,083.3
<b>Asian/P.I.</b>	731	100%	172.2	63	100%	27.6	668	100%	340.5
13-19	3	0%	4.2	0	0%	0.0	3	0%	8.2
20-29	61	8%	77.5	6	10%	14.7	55	8%	144.9
30-39	181	25%	243.2	19	30%	48.2	162	24%	462.7
40-49	241	33%	418.2	15	24%	48.0	226	34%	857.0
50-59	168	23%	291.6	14	22%	43.2	154	23%	611.4
60+	77	11%	91.0	9	14%	18.3	68	10%	192.7
<b>Native American</b>	142	100%	2,155.1	15	100%	445.8	127	100%	3,939.2
13-19	3	2%	226.2	0	0%	0.0	3	2%	449.1
20-29	12	8%	1,184.6	1	7%	193.8	12	9%	2,414.5
30-39	32	23%	3,312.6	2	13%	431.0	30	24%	5,976.1
40-49	52	37%	4,561.4	6	40%	1047.1	46	36%	8,112.9
50-59	35	25%	3,378.4	5	33%	927.6	30	24%	6,036.2
60+	8	6%	722.0	1	7%	162.6	6	5%	1,217.0
<b>Others</b>	387	100%	437.7	35	100%	76.1	352	100%	830.0
13-19	0	0%	0.0	0	0%	0.0	0	0%	0.0
20-29	41	11%	237.2	0	0%	0.0	41	12%	505.2
30-39	73	19%	556.8	8	23%	114.3	65	18%	1,063.5
40-49	128	33%	1,268.1	15	43%	288.9	113	32%	2,305.7
50-59	103	27%	1,266.1	7	20%	161.7	96	27%	2,521.7
60+	42	11%	448.7	5	14%	96.8	37	11%	881.6
<b>Total</b>	26,674	100%	703.3	2,763	10%	145.1	23,911	90%	1,265.8
Latino	10,809	41%	587.8	1,248	45%	137.5	9,561	40%	1,027.0
White	8,797	33%	809.4	373	13%	69.7	8,424	35%	1,526.7
Black	5,808	22%	1,671.9	1,029	37%	562.6	4,779	20%	2,905.8
Asian/P.I.	731	3%	172.2	63	2%	27.6	668	3%	340.5
Native American	142	1%	2,155.1	15	1%	445.8	127	1%	3,939.2
Others	387	1%	437.7	35	1%	76.1	352	1%	830.0

Table 20: People Living with HIV by Transmission Mode - 2012

	TOTAL			FEMALE			MALE			% of TOTAL	
	N	%	Rate	N	%	Rate	N	%	Rate	Female	Male
<b>Total</b>	26,674	100	703.3	2,763	100	145.1	23,911	100	1,265.8	10	90
MSM	20,810	78	18,017.7	0	0	0	20,810	87	18,017.7	0%	100%
MSM/IDU	1,799	6.7	1,557.6	0	0	0	1,799	7.5	1,557.6	0%	100%
IDU	1,288	4.8	34.0	589	21.3	30.9	699	2.9	37.0	46%	54%
Heterosexual	2,566	9.6	67.7	2,081	75.3	109.3	485	2	25.7	81%	19%
Hemo/Transf.	58	0.2	1.5	23	0.8	1.2	35	0.1	1.9	40%	60%
Other	154	0.6	4.1	70	2.5	3.7	84	0.4	4.4	45%	55%
<b>Latino</b>											
Total	10,809	100	587.8	1,248	100	137.5	9,561	100	1,027.0	12%	88%
MSM	8,387	78	17,535.4	0	0	0	8,387	88	17,535.4	0%	100%
MSM/IDU	575	5	1,202.2	0	0	0	575	6	1,202.2	0%	100%
IDU	424	4	23.1	169	14	18.6	255	3	27.4	40%	60%
Heterosexual	1,322	12	71.9	1,032	83	113.7	290	3	31.2	78%	22%
Hemo/Transf.	20	0	1.1	7	1	0.8	13	0	1.4	35%	65%
Other	81	1	4.4	40	3	4.4	41	0	4.4	49%	51%
<b>White</b>											
Total	8,797	100	809.4	373	100	69.7	8,424	100	1,526.7	4%	96%
MSM	7,515	85	18,364.3	0	0	0	7,515	89	18,364.3	0%	100%
MSM/IDU	704	8	1,720.4	0	0	0	704	8	1,720.4	0%	100%
IDU	307	3	28.2	152	41	28.4	155	2	28.1	50%	50%
Heterosexual	244	3	22.4	212	57	39.6	32	0	5.8	87%	13%
Hemo/Transf.	14	0	1.3	4	1	0.7	10	0	1.8	29%	71%
Other	13	0	1.2	5	1	0.9	8	0	1.4	38%	62%
<b>Black</b>											
Total	5,808	100	1,671.9	1,029	100	562.6	4,779	100	2,905.8	18%	82%
MSM	3,897	67	34,124.9	0	0	0	3,897	82	34,124.9	0%	100%
MSM/IDU	431	7	3,774.1	0	0	0	431	9	3,774.1	0%	100%
IDU	507	9	145.9	244	24	133.4	263	6	159.9	48%	52%
Heterosexual	904	16	260.2	751	73	410.6	152	3	92.4	83%	17%
Hemo/Transf.	15	0	4.3	9	1	4.9	6	0	3.6	60%	40%
Other	54	1	15.5	25	2	13.7	29	1	17.6	46%	54%
<b>Asian/P.I.</b>											
Total	731	100	172.2	63	100	27.6	668	100	340.5	9%	91%
MSM	622	85	5,115.5	0	0	0	622	93	5,115.5	0%	100%
MSM/IDU	22	3	180.9	0	0	0	22	3	180.9	0%	100%
IDU	17	2	4.0	7	11	3.1	10	1	5.1	41%	59%
Heterosexual	61	8	14.4	54	86	23.7	7	1	3.6	89%	11%
Hemo/Transf.	7	1	1.6	1	2	0.4	5	1	2.5	14%	71%
Other	4	1	0.9	1	2	0.4	2	0	1.0	25%	50%
<b>Native American</b>											
Total	142	100	2,155.1	15	100	445.8	127	100	3,939.2	11%	89%
MSM	95	66	33,456.6	0	0	0	95	75	33,456.6	0%	100%
MSM/IDU	23	16	8,100.0	0	0	0	23	18	8,100.0	0%	100%
IDU	10	7	151.8	5	33	148.6	4	3	124.1	50%	40%
Heterosexual	11	8	166.9	10	67	297.2	4	3	124.1	91%	36%
Hemo/Transf.	2	1	30.4	0	0	0.0	0	0	0.0	0%	0%
Other	2	1	30.4	0	0	0.0	0	0	0.0	0%	0%
<b>Others</b>											
Total	387	100	437.7	35	100	76.1	352	100	830.0	9%	91%
MSM	293	76	10,159.6	0	0	0	293	83	10,159.6	0%	100%
MSM/IDU	44	11	1,525.7	0	0	0	44	13	1,525.7	0%	100%
IDU	23	6	26.0	12	35	26.1	12	3	28.3	52%	52%
Heterosexual	25	6	28.3	22	65	47.8	3	1	7.1	88%	12%
Hemo/Transf.	0	0	0.0	0	0	0.0	0	0	0.0	0%	0%
Other	0	0	0.0	0	0	0.0	0	0	0.0	0%	0%

Table 21: Gay and Bisexual Men Living with HIV - 2002 and 2012

	Gay/Bisexual Men (MSM & MSM/IDU)			Gay/Bisexual Men (MSM & MSM/IDU)			Rate Change
	2002			2012			
	N	%	Rate	N	%	Rate	%
<b>Total</b>	14,501	100	12,555.6	22,609	100	18,193.0	45%
13-19	38	0.3%	75.4	34	0.1%	74.1	-2%
20-29	1,014	7%	307.8	1,814	8.0%	546.5	78%
30-39	5,167	36%	1,536.6	4,088	18%	1,324.2	-14%
40-49	5,608	39%	2,209.5	7,861	35%	2,860.4	29%
50-59	2,100	14%	1,301.5	6,359	28%	2,905.0	123%
60+	574	4%	283.6	2,453	11%	995.3	251%
<b>Latino</b>	5,027	100%	10511.2	8,962	100%	16,462.1	57%
13-19	18	0.4%	58.6	18	0.2%	60.3	3%
20-29	560	11%	3375.4	854	10%	5,439.1	61%
30-39	2,221	44%	15120.4	2,193	24%	15,521.6	3%
40-49	1,612	32%	18364.2	3,353	37%	28,767.6	57%
50-59	497	10%	11737.5	1,926	21%	26,291.9	124%
60+	119	2%	3363.7	620	7%	10,994.4	227%
<b>White</b>	6,118	100%	14,950.7	8,219	100%	19,641.3	31%
13-19	10	0.2%	113.8	3	0.04%	38.4	-66%
20-29	216	4%	3,119.5	318	4%	4,077.7	31%
30-39	1,822	30%	19,760.7	945	11%	11,842.6	-40%
40-49	2,627	43%	30,658.0	2,760	34%	34,902.7	14%
50-59	1,103	18%	16,924.1	2,895	35%	38,391.0	127%
60+	340	6%	3,512.4	1,299	16%	12,219.7	248%
<b>Black</b>	2,755	100%	24,127.3	4,329	100%	39,600.1	64%
13-19	9	0.3%	166.8	10	0.2%	250.6	50%
20-29	197	7%	8,872.1	541	12%	24,753.4	179%
30-39	911	33%	32,652.3	699	16%	36,042.0	10%
40-49	1,135	41%	44,878.6	1,377	32%	59,638.8	33%
50-59	411	15%	24,914.6	1,271	29%	58,248.4	134%
60+	93	3%	4,154.7	431	10%	18,630.1	348%
<b>Asian/P.I.</b>	311	100%	2,557.8	644	100%	4,475.9	75%
13-19	1	0.4%	30.8	2	0.3%	58.0	89%
20-29	20	6%	629.2	54	8%	1,571.9	150%
30-39	106	34%	3,876.6	158	25%	5,020.8	30%
40-49	120	39%	5,219.3	220	34%	9,248.7	77%
50-59	56	18%	3,233.8	146	23%	6,431.9	99%
60+	9	3%	389.3	65	10%	2,036.9	423%
<b>Native American</b>	73	100%	251,379.3	118	100%	51,295.4	-80%
13-19	2	3%	3,326.7	7	6%	12,142.4	265%
20-29	7	10%	24,137.9	11	9%	24,592.0	2%
30-39	31	42%	106,551.7	26	22%	56,883.6	-47%
40-49	27	37%	93,103.4	44	37%	86,223.8	-7%
50-59	3	4%	10,344.8	28	24%	62,597.8	505%
60+	3	4%	10,344.8	2	2%	4,507.6	-56%
<b>Other</b>	217	100%	7,514.0	337	100%	13,800.8	84%
13-19	3	1%	174.5	3	1%	189.1	8%
20-29	11	5%	1,469.7	36	11%	4,915.5	234%
30-39	77	35%	10,050.0	65	19%	11,798.3	17%
40-49	87	40%	14,430.7	109	32%	24,688.8	71%
50-59	25	12%	7,155.7	94	28%	27,347.3	282%
60+	14	6%	3,372.1	31	9%	8,206.9	143%
<b>Total</b>	14,501	100%	12,555.6	22,609	100%	18193.0	45%
Latino	5,027	35%	10,511.2	8,962	40%	16,462.1	57%
White	6,118	42%	14,950.7	8,219	36%	19,641.3	31%
Black	2,755	19%	24,127.3	4,329	19%	39,600.1	64%
Asian/P.I.	311	2%	2,557.8	644	3%	4,475.9	75%
Native	73	1%	251,379.3	118	1%	51,295.4	-80%
Other	217	1%	7,514.0	337	1%	13,800.8	84%

Table 22: 20-29 Year Olds Living with HIV by Transmission Mode - 2012

	Total			Female			Male		
	N	%	Rate	N	%	Rate	N	%	Rate
<b>Total</b>	2,133	100	329.6	245	11.4	77.5	1,888	88.6	568.0
MSM	1,727	81%	5,781.4	-	-	-	1,727	91.9	5,781.4
MSM/IDU	87	4%	290.6	-	-	-	87	4.6	290.6
IDU	49	2%	7.6	28	11	8.8	21	1.1	6.4
Heterosexual	194	9%	30.0	182	77	58.1	11	0.6	3.3
Other	72	3%	11.2	33	10.5	10.5	39	2.1	11.8

Table 23: Projection of People Living with HIV and HIV Seroprevalence by 2022

	1992	2002	2012	% CHANGE			PROJECTED CHANGE		
				1992-02	2002-12	92-02 vs. 02-12	% 2012-2022	No. (2022)	Total
<b>Male</b>									
Total	9,786	15,633	23,911	60%	53%	-11%	47%	35,132	36,658
MSM	8,097	12,974	20,810	60%	60%	0%	61%	33,413	33,413
MSM/IDU	1,023	1,527	1,799	49%	18%	-64%	6%	1,915	1,915
IDU	473	649	699	37%	8%	-79%	2%	710	710
Heterosexual	86	369	485	329%	31%	-90%	3%	500	500
Hemo/Transf.	63	40	35	-37%	-13%	-66%	-4%	34	34
Other	44	73	84	66%	15%	-77%	3%	87	87
<b>Female</b>									
Total	665	1,790	2,763	169%	54%	-68%	17%	3,246	3,239
IDU	247	499	589	102%	18%	-82%	3%	608	608
Heterosexual	354	1,205	2,081	240%	73%	-70%	22%	2,538	2,538
Hemo/Transf.	34	27	23	-21%	-15%	-28%	-11%	21	21
Other	30	59	70	97%	19%	-81%	4%	73	73
<b>Total</b>								<b>%</b>	<b>No.</b>
<b>HIV RATE</b>	299.9	471.6	703.3	57.3	49.1	-8.1%			
TOTAL	10,451	17,423	26,674					100%	39,898
MSM	-	-	-	-	-	-	-	84%	33,413
MSM/IDU	-	-	-	-	-	-	-	5%	1,915
IDU	-	-	-	-	-	-	-	3%	1,318
Heterosexual	-	-	-	-	-	-	-	8%	3,038
Hemo/Transf.	-	-	-	-	-	-	-	0%	54
Other	-	-	-	-	-	-	-	0%	159
<b>Population</b>	1990	2000	2010	1990-00	2000-10	92-02 vs. 02-12	% 2012-2022	No (2022)	Total
Total	3,485,398	3,694,820	3,792,621	6%	3%	-56%	1%	3,836,846	3,837,431
Female	1,756,425	1,853,015	1,903,557	5%	3%	-50%	1%	1,929,309	1,929,309
Male	1,728,973	1,841,805	1,889,064	7%	3%	-61%	1%	1,908,122	1,908,122
<b>Prevalence</b>								<b>%</b>	<b>No.</b>
Total	0.3%	0.5%	0.7%	-	-	-	-	-	1.0%
Female	0.0%	0.1%	0.1%	-	-	-	-	-	0.2%
Male	0.6%	0.8%	1.3%	-	-	-	-	-	1.9%

Table 24: HIV Diagnoses (single year) and HIV Transmission Rate - 2002 vs. 2012

	2002			2012			Rate Change
	HIV Diagnoses		Transmission Rate	HIV Diagnoses		Transmission Rate	%
	N	%		N	%		
<b>Total</b>	1,345	100	7.7	1,062	100	4.0	-48
MSM	961	72	7.4	903	85	4.3	-41
MSM/IDU	114	8	7.5	40	4	2.2	-70
IDU	94	7	8.2	35	3	2.7	-67
Heterosexual	168	13	10.7	83	8	3.2	-70
Hemophilia	4	0	6.0	0	0	0.0	-100
Other	3	0	2.3	2	0	1.3	-43
Female	178	13	9.9	92	9	3.3	-67
Male	1167	87	7.5	970	91	4.1	-46
<b>Race/Ethnicity</b>							
Total	1,345	100	7.7	1,062	100	4.0	-48
Latino	559	42	8.9	492	46	4.6	-49
White	407	30	6.2	260	25	3.0	-52
Black	324	24	8.4	239	23	4.1	-51
Asian/P.I.	31	2	8.6	47	4	6.4	-25
Native American	5	0	5.3	5	0.5	3.5	-33
Other	19	1	7.6	19	2	4.9	-36
<b>BASE USED TO CALCULATE TRANSMISSION RATE ((HIV INFECTION/PLWH)*100).</b>							
	<b>People Living with HIV - 2002</b>		<b>People Living with HIV - 2012</b>				
Total	17,423		26,674				
MSM	12,974		20,810				
MSM/IDU	1,527		1,799				
IDU	1,148		1,288				
Heterosexual	1,575		2,566				
Hemophilia	67		58				
Other	132		154				
Female	1,790		2,763				
Male	15,633		23,911				
<b>Race/Ethnicity</b>							
Total	17,423		26,674				
Latino	6,247		10,809				
White	6,612		8,797				
Black	3,860		5,808				
Asian/P.I.	360		731				
Native American	95		142				
Other	249		387				



**Table 25: Average HIV Diagnosis Rate by Race and Gender -  
1993-2002 vs. 2003-2012**

	1993-2002			2003-2012			Rate Change
	N	%	Average Rate	N	%	Average Rate	%
<b>Total Population</b>							
Total	15,385	100	41.6	12,806	100	33.8	-19
Female	1,731	11	9.3	1,455	11	7.6	-18
Male	13,654	89	74.1	11,351	89	60.1	-19
<b>Latino</b>							
Total	5,945	100	34.6	5,669	100	30.8	-11
Female	723	12	8.6	664	12	7.3	-15
Male	5,222	88	59.6	5,005	88	53.8	-10
<b>White</b>							
Total	5,175	100	47.1	3,402	100	31.3	-34
Female	229	4	4.2	171	5	3.2	-24
Male	4,946	96	89.7	3,231	95	58.6	-35
<b>Black</b>							
Total	3,663	100	91.1	3,029	100	87.2	-4
Female	717	20	33.3	556	18	30.4	-9
Male	2,946	80	157.7	2,473	82	150.4	-5
<b>Asian/P.I.</b>							
Total	310	100	8.4	418	100	9.8	17
Female	30	10	1.5	34	8	1.5	-3
Male	280	90	16.0	384	92	19.6	22
<b>Native American</b>							
Total	76	100	85.4	77	100	116.9	37
Female	12	16	26.7	9	12	26.7	0
Male	64	84	145.2	68	88	210.9	45
<b>Other</b>							
Total	216	100	22.4	211	100	23.9	6
Female	20	9	4.1	21	10	4.6	10
Male	196	91	40.9	190	90	44.8	10

Table 26: Average HIV Diagnosis Rate by Age, Race, Gender - 2012

	Total			Female			Male		
	N	%	Average Rate	N	%	Average Rate	N	%	Average Rate
<b>Total Population</b>	12,806	100%	33.8	1,455	100%	7.6	11,351	100%	60.1
0-29	3,965	31%	24.2	429	29%	5.4	3,536	31%	42.1
30-39	4,167	33%	69.4	391	27%	13.4	3,776	33%	122.3
40-49	3,164	25%	58.7	359	25%	13.6	2,805	25%	102.1
50+	1,510	12%	14.9	276	19%	5.0	1,234	11%	26.5
<b>Latino</b>									
Total	5,669	100%	30.8	664	100%	7.3	5,005	100%	53.8
0-29	2,027	36%	21.0	236	36%	5.1	1,791	36%	35.8
30-39	1,971	35%	65.2	185	28%	12.7	1,786	36%	113.8
40-49	1,157	20%	45.8	137	21%	11.1	1,020	20%	78.8
50+	514	9%	16.2	106	16%	6.1	408	8%	28.3
<b>White</b>									
Total	3,402	100%	31.3	171	100%	3.2	3,231	100%	58.6
0-29	702	21%	20.7	36	21%	2.2	666	21%	38.4
30-39	1,137	33%	69.2	42	25%	5.5	1,095	34%	123.6
40-49	1,073	32%	65.5	53	31%	7.0	1,020	32%	116.1
50+	490	14%	11.7	40	23%	1.8	450	14%	22.3
<b>Black</b>									
Total	3,029	100%	87.2	556	100%	30.4	2,473	100%	150.4
0-29	1,011	33%	74.7	146	26%	21.5	865	35%	128.5
30-39	792	26%	173.7	136	24%	56.5	656	27%	304.4
40-49	797	26%	149.6	155	28%	56.1	642	26%	250.3
50+	429	14%	37.9	119	21%	18.8	310	13%	62.0
<b>Asian/Others</b>									
Total	706	100%	13.6	64	100%	2.3	642	100%	26.5
0-29	225	32%	11.2	11	17%	1.1	214	33%	21.6
30-39	267	38%	30.2	28	44%	6.0	239	37%	57.4
40-49	137	19%	19.9	14	22%	3.8	123	19%	38.6
50+	77	11%	4.8	11	17%	1.2	66	10%	9.5
<b>0-29 Year Olds</b>									
Total	3,965	100%	24.2	429	100%	5.4	3,536	100%	42.1
Latino	2,027	51%	21.0	236	55%	5.1	1,791	51%	35.8
White	702	18%	20.7	36	8%	2.2	666	19%	38.4
Black	1,011	25%	74.7	146	34%	21.5	865	24%	128.5
Asian/Other	225	6%	11.2	11	3%	1.1	214	6%	21.6

Table 27: Average HIV Diagnosis Rate by Transmission Mode, Race, Gender - 2012

	TOTAL			FEMALE			MALE			% of TOTAL	
	N	%	Rate	N	%	Rate	N	%	Rate	Female	Male
<b>Total</b>	12,806	100%	33.8	1,455	100%	7.6	11,351	100%	60.1	11	89
MSM	10,181	80%	819.3		0%	0.0	10,181	90%	819.3	0	100
MSM/IDU	639	5%	51.4		0%	0.0	639	6%	51.4	0	100
IDU	593	5%	1.6	292	20%	1.5	301	3%	1.6	49	51
Heterosexual	1,353	11%	3.6	1,142	78%	6.0	211	2%	1.1	84	16
Hemo/Transf.	10	0.1%	0.0	6	0.4%	0.0	4	0.04%	0.0	60	40
Other	30	0.2%	0.1	15	1%	0.1	15	0.1%	0.1	50	50
<b>Latino</b>											
Total	5,669	100%	30.8	664	100%	7.3	5,005	100%	53.8	12	88
MSM	4,527	80%	831.5		0%	0.0	4,527	90%	831.5	0	100
MSM/IDU	239	4%	43.9		0%	0.0	239	5%	43.9	0	100
IDU	211	4%	1.1	92	14%	1.0	119	2%	1.3	44	56
Heterosexual	679	12%	3.7	566	85%	6.2	113	2%	1.2	83	17
Hemo/Transf.	<5			<5			<5				
Other	11	0.2%	0.1	5	1%	0.1	6	0.1%	0.1	45	55
<b>White</b>											
Total	3,402	100%	31.3	171	100%	3.2	3,231	100%	58.6	5	95
MSM	2,935	86%	701.4				2,935	91%	701.4		100
MSM/IDU	223	7%	53.3				223	7%	53.3		100
IDU	120	4%	1.1	62	36%	1.2	57	2%	1.0	52	48
Heterosexual	118	3%	1.1	105	61%	2.0	13	0.4%	0.2	89	11
Hemo/Transf.	<5			<5			<5				
Other	6	0.2%	0.1	<5			<5				
<b>Black</b>											
Total	3,029	100%	87.2	556	100%	30.4	2,473	100%	150.4	18	82
MSM	2,136	71%	1,954.1	0	0%	0.0	2,136	86%	1,954.1	0	100
MSM/IDU	147	5%	134.5	0	0%	0.0	147	6%	134.5	0	100
IDU	231	8%	6.6	121	22%	6.6	110	4%	6.7	52	48
Heterosexual	498	16%	14.3	425	76%	23.2	74	3%	4.5	85	15
Hemo/Transf.	6	0.2%	0.2	<5			<5				
Other	11	0.4%	0.3	6	1%	0.3	5	0.2%	0.3	55	45
<b>Asian/Other</b>											
Total	706	100%	13.6	64	100%	2.3	642	100%	26.5	9	91
MSM	583	83%	341.8	0	0%	0.0	583	91%	341.8	0	100
MSM/IDU	30	4%	17.6	0	0%	0.0	30	5%	17.6	0	100
IDU	32	5%	0.6	16	25%	0.6	16	2%	0.7	50	50
Heterosexual	58	8%	1.1	47	73%	1.7	11	2%	0.5	81	19
Hemo/Transf.	<5			<5			<5				
Other	<5			<5			<5				

Table 28: Average HIV Diagnosis Rate by MSM and MSM/IDU, Race, Age - 1993-2002 and 2003-2012

	1993-2002			2003-2012			Rate Change
	N	%	Avg. Rage	N	%	Avg. Rage	%
<b>Total Pop.</b>	12,372	100	1,071.2	10,820	100	870.7	-19%
<b>0-29</b>	<b>2,921</b>	<b>20%</b>	<b>985.0</b>	<b>3,431</b>	<b>15.2%</b>	<b>1,148.7</b>	<b>17%</b>
30-39	5,516	38%	1,822.6	3,624	16%	1,304.2	-28%
40-49	2,792	19%	1,222.2	2,648	12%	1,070.6	-12%
50+	1,144	8%	349.5	1,114	5%	266.0	-24%
<b>Latino</b>							
Total	4,652	100%	972.6	4,766	100%	875.4	-10%
<b>0-29</b>	<b>1,532</b>	<b>30%</b>	<b>923.4</b>	<b>1,742</b>	<b>19%</b>	<b>1,109.6</b>	<b>20%</b>
30-39	2,065	41%	1405.8	1,702	19%	1,204.9	-14%
40-49	756	15%	861.2	956	11%	820.3	-5%
50+	299	6%	384.7	365	4%	281.6	-27%
<b>White</b>							
Total	4,730	100%	1,155.9	3,158	100%	754.7	-35%
<b>0-29</b>	<b>746</b>	<b>12%</b>	<b>1,075.4</b>	<b>657</b>	<b>8%</b>	<b>843.0</b>	<b>-22%</b>
30-39	2,154	35%	2,336.8	1,074	13%	1,346.6	-42%
40-49	1,258	21%	1,468.0	992	12%	1,254.5	-15%
50+	573	9%	358.8	434	5%	238.9	-32%
<b>Black</b>							
Total	2,484	100%	2,175.2	2,283	100%	2,088.6	-4%
<b>0-29</b>	<b>529</b>	<b>19%</b>	<b>2,383.6</b>	<b>827</b>	<b>19%</b>	<b>3,783.9</b>	<b>59%</b>
30-39	1,080	39%	3,871.0	615	14%	3,170.6	-18%
40-49	644	23%	2,546.2	583	13%	2,525.7	-1%
50+	232	8%	597.7	258	6%	573.7	-4%
<b>Asian/Other</b>							
Total	504	100%	328.8	613	100%	359.4	9%
<b>0-29</b>	<b>114</b>	<b>37%</b>	<b>291.7</b>	<b>205</b>	<b>32%</b>	<b>489.1</b>	<b>68%</b>
30-39	217	70%	608.1	233	36%	622.0	2%
40-49	134	43%	451.5	117	18%	408.3	-10%
50+	40	13%	81.9	57	9%	91.2	11%
<b>Total Pop.</b>	<b>12,372</b>	<b>100%</b>	<b>1,071.2</b>	<b>10,820</b>	<b>100%</b>	<b>870.7</b>	<b>-19%</b>
Latino	4,652	32%	972.6	4,766	21%	875.4	-10%
White	4,730	33%	1,155.9	3,158	14%	754.7	-35%
Black	2,484	17%	2,175.2	2,283	10%	2,088.6	-4%
Asian/Other	504	3%	328.8	613	3%	359.4	9%
<b>0-29 Years</b>							
Total	2,921	100%	985.0	3,431	100%	1,148.7	17%
Latino	1,532	52%	923.4	1,742	51%	1,109.6	20.2%
White	746	26%	1,075.4	657	19%	843.0	-21.6%
Black	529	18%	2,383.6	827	24%	3,783.9	58.7%
Asian/Other	114	4%	291.7	205	6%	489.1	67.7%

Table 29: Average HIV Diagnosis Rate by Females, Race, Age - 2012

	1993-2002			2003-2012			Rate Change
	N	%	Average Rate	N	%	Average Rate	%
<b>Total Pop.</b>	1,731	100%	9.3	1,455	100%	7.6	-18
0-29	556	32%	6.6	429	29%	5.4	-19
30-39	605	35%	19.6	391	27%	13.4	-32
40-49	377	22%	14.8	359	25%	13.6	-8
50+	193	11%	4.3	276	19%	5.0	17
<b>Latino</b>							
Total	723	100%	8.6	664	100%	7.3	-15
0-29	277	38%	5.7	236	36%	5.1	-11
30-39	242	33%	16.9	185	28%	12.7	-24
40-49	120	17%	12.1	137	21%	11.1	-8
50+	84	12%	7.6	106	16%	6.1	-19
<b>White</b>							
Total	229	100%	4.2	171	100%	3.2	-24
0-29	60	26%	3.7	36	21%	2.2	-40
30-39	83	36%	9.3	42	25%	5.5	-40
40-49	54	24%	6.3	53	31%	7.0	11
50+	32	14%	1.5	40	23%	1.8	19
<b>Black</b>							
Total	717	100%	33.3	556	100%	30.4	-9
0-29	204	28%	23.0	146	26%	21.5	-7
30-39	259	36%	74.1	136	24%	56.5	-24
40-49	183	26%	57.3	155	28%	56.1	-2
50+	71	10%	11.9	119	21%	18.8	58
<b>Asian/Other</b>							
Total	62	100%	2.5	64	100%	2.3	-8
0-29	15	24%	1.5	11	17%	1.1	-27
30-39	21	34%	5.2	28	44%	6.0	15
40-49	20	32%	5.4	14	22%	3.8	-30
50+	6	10%	0.9	11	17%	1.2	37
<b>50+ Year Olds</b>							
Total	193	100%	4.3	276	100%	5.0	17
Latino	84	44%	7.6	106	38%	6.1	-19
White	32	17%	1.5	40	14%	1.8	19
Black	71	37%	11.9	119	43%	18.8	58
Asian/Other	6	3%	0.9	11	4%	1.2	37

Table 30: Average HIV Diagnosis Rate by Age - 1993-2002 vs. 2003-2012

	1993-2002			2003-2012			Rate Change
	N	%	Rate	N	%	Rate	%
<b>Total Pop.</b>	15,385	100%	41.6	12,806	100%	33.7	-19
0-29	3725	24%	21.5	3965	31%	24.2	12
30-39	6575	43%	102.0	4167	33%	69.4	-32
40-49	3553	23%	69.9	3164	25%	58.7	-16
50+	1532	10%	18.9	1510	12%	14.9	-21

Table 31: Recent HIV Diagnoses by IDU, Age - 2002-2005 vs. 2009-2012

	2002-2005			2009-2012			Rate Change
	N	%	Rate	N	%	Rate	%
<b>Total Pop.</b>	695	100	18.8	298	100	7.9	-58
13-19	13	1.2	1.2	11	3.7	1.1	-7%
20-29	133	12.7	20.8	77	25.8	11.9	-43%
30-39	262	32.6	40.6	88	29.5	14.6	-64%
40-49	199	32.3	39.2	77	25.8	14.3	-64%
50-59	75	18.0	22.1	35	11.7	7.8	-65%
60+	13	3.1	2.7	10	3.4	1.8	-36%



Table 32: Recent HIV Diagnosis Rate by Transmission Mode - Females: 2002-2005 vs. 2009-2012

	2002-2005			2009-2012			Rate Change
	N	%	Rate	N	%	Rate	%
<b>Total</b>	603	100	32.5	457	100	24.0	-26.2
IDU	148	25	8.0	77	17	4.0	-49.4
Heterosexual	441	73	23.8	378	83	19.9	-16.6
Hemophilia	4	1	0.2	0	0	0.0	-100.0
Other	10	2	0.5	2	0	0.1	-80.5

Table 33: Recent HIV Diagnosis Rate by Transmission Mode - 2002-2005 vs. 2009-2012

	2002-2005			2009-2012			Rate Change
	N	%	Rate	N	%	Rate	%
<b>Total</b>	5,035	100	136.3	4,545	100	119.8	-12
MSM	3,733	74	3,232.1	3,821	84	3,074.7	-0.2
MSM/IDU	373	7	323.0	152	3	122.3	-60
IDU	322	6	8.7	146	3	3.8	-56
Heterosexual	579	11	15.7	418	9	11.0	-30
Hemo/Transf.	11	0	0.3	0	0	0.0	-100
Other	17	0	0.5	8	0	0.2	-60

**Table 34: Recent HIV Diagnosis Rate by MSM and MSM/IDU, Race, Age  
2002-2005 vs. 2009-2012**

	2002-2005			2009-2012			Rate Change
	N	%	Rate	N	%	Rate	%
<b>Total Population</b>	4,106	100	3.6	3,973	100	3.2	-10
0-19	92	2	0.2	117	3	0.3	40
20-29	950	23	3.2	1,385	<b>35</b>	4.6	45
30-39	1,636	40	5.4	1,201	30	4.3	-20
40-49	1,065	26	4.7	864	22	3.5	-25
50-59	281	7	1.9	323	8	1.6	-15
60+	81	2	0.4	83	2	0.4	-16
<b>Latino</b>	1,742	100	2.2	1,829	100	2.2	-1
0-19	45	3	0.1	52	3	0.2	22
20-29	537	31	3.2	671	<b>37</b>	4.3	32
30-39	700	40	4.8	634	35	4.5	-6
40-49	341	20	3.9	328	18	2.8	-28
50-59	90	5	2.1	112	6	1.5	-28
60+	29	2	0.8	31	2	0.5	-33
<b>White</b>	1,396	100	2.8	1,028	100	2.1	-26
0-19	9	1	0.1	14	1	0.2	73
20-29	203	15	2.9	264	<b>26</b>	3.4	16
30-39	579	41	6.3	287	28	3.6	-43
40-49	448	32	5.2	308	30	3.9	-25
50-59	123	9	1.9	125	12	1.7	-12
60+	34	2	0.4	31	3	0.3	-17
<b>Black</b>	768	100	4.6	873	100	5.9	29
0-19	31	4	0.6	46	5	1.2	107
20-29	160	21	7.2	369	<b>42</b>	16.9	134
30-39	271	35	9.7	188	22	9.7	0
40-49	230	30	9.1	182	21	7.9	-13
50-59	59	8	3.6	74	8	3.4	-5
60+	16	2	0.7	13	1	0.6	-22
<b>Asian/P.I.</b>	119	100	0.8	154	100	0.9	15
0-19	0	0	0.0	2	1	0.1	
20-29	38	32	1.2	46	<b>30</b>	1.3	10
30-39	48	40	1.8	60	39	1.9	8
40-49	23	19	1.0	34	22	1.4	43
50-59	6	5	0.3	7	5	0.3	-11
60+	4	3	0.2	3	2	0.1	-45
<b>Native American</b>	20	100	5.0	26	100	9.0	78
0-19	0	0	0.0	0	0	0.0	
20-29	6	30	10.0	10	42	22.4	125
30-39	11	55	14.5	10	42	22.1	52
40-49	1	5	1.5	3	13	5.9	291
50-59	1	5	2.4	1	4	2.2	-7
60+	1	5	2.5	0	0	0.0	-100
<b>Others</b>	58	1	1.3	63	100	1.7	23
0-19	3	6	209.4	1	1	0.1	-100
20-29	6	13	801.7	27	40	3.7	-100
30-39	20	42	2,610.4	22	33	4.0	-100
40-49	12	25	1,992.7	11	16	2.5	-100
50-59	4	8	1,126.9	5	7	1.5	-100
60+	3	6	727.8	1	1	0.3	-100
<b>Total</b>	4,106	100	3.6	3,973	100	3.2	-10
Latino	1,742	42	2.2	1,829	46	2.2	-1
White	1,396	34	2.8	1,028	26	2.1	-26
Black	768	19	4.6	873	22	5.9	29
Asian/P.I.	119	3	0.8	154	4	0.9	15
Native American	20	0	5	26	1	9	78
Others	58	1	1.3	63	2	1.7	23

# Appendix C – Community Recommendations

**Table 35: Community Recommended Prevention Target**

The community recommends the ACO focus on people living with HIV and people at high risk for acquiring HIV. Community members listed the following for prevention resources:

1. The ‘15.8%’ of PLWH who are unaware of their HIV status
2. Newly diagnosed PLWH in need of peer support
3. Young MSM of all ethnicities
4. Non-MSM: women, marginalized and underserved people of color
5. Substance users: Crack and Methamphetamine
6. High School youth (public/charter/private) all need consistent health education<sup>kk</sup>
7. Primary Care Health Providers
8. People in serodiscordant relationships

**Table 36: Community Recommendation for Prevention Strategy**

The community recommends the ACO focus its prevention efforts on educational activities and research. Specific activities include:

- 1 Educate community and service providers**
  - a Hold Public forums
  - b Establish Peer Education
  - c Community Outreach at events for Council Members and other City Events
  - d Partner with other City departments serving similar communities (e.g., GRYD)
  - e Encourage City Contractor information sharing across organizations and community
  - f Develop an ACO website with a greater level of relevant consumer information
- 2 Explore emerging community needs through research**
  - a Fund innovative research (e.g., sex among foster children, MSM risk assessment, etc.)
  - b Measure efficacy of HIV Services and Programs

---

<sup>kk</sup> Working with school communities to ensure consistent health education for all high schools including charter schools and private schools. LA has more charter schools than any other in the nation (248). Retrieved on March 26, 2014 from <http://www.scpr.org/blogs/education/2014/03/15/16099/study-los-angeles-charter-schools-outperform-tradi/>

**Table 37: Community Recommendation to Increase Access to Health Care and Treatment**

**1 Increase presence of HIV/AIDS services in the City**

- a. Take a public stand on issues like PrEP and PEP
- b. Use provocative messages to engage the public about safe sexual behaviors
- c. Communicate the availability and benefits of health care engagement
- d. Attend LA City Council Meetings
- e. Develop Advisory Commission with City Council Member representatives
- f. Educate public about living with HIV, HIV testing and available support

**2 Engage HOPWA to offer HIV insight to HOPWA leadership**

- a. Lend insight about PLWH for complimentary services for HOPWA clients
- b. Advocate for continued and increased funding for HOPWA
- c. Participate in the Los Angeles County-wide HOPWA Advisory Committee (LACHAC)

**Table 38: Community Recommendations to Reduce HIV-Related Disparity**

**1 Peer support program**

- a. Establish a volunteer based peer support network for recently diagnosed PLWH
- b. Educate community about City Office to which they may file discrimination complaints

**2 Collaborate with the County**

- a. Meet prior to releasing RFPs
- b. Identify areas where City can advise County on programs
- c. Provide gap funding to bed County Hospital patients with HIV after discharge
- d. Advise County on areas in need of Routine and Rapid HIV Testing programs
- e. Develop a plan for undocumented immigrants in case Ryan White comes under attack

# Appendix D – Methods

## Phase I: 20-year analysis of epidemiologic HIV data in the City of Los Angeles

HIV epidemiologic data was assembled and provided by the Los Angeles County Department of Public Health Division of HIV and STD Programs. The raw data includes:

- Number of People Living with HIV/AIDS by transmission category: 1992, 2002, 2012
- Number of HIV/AIDS Diagnoses by transmission category: 1992, 2002, 2012
- Cumulative Number of HIV/AIDS Diagnoses: 2002-2005, 2009-2012, 1993-2002, 2002-2012
- Annual & Cumulative Number of Transgender HIV/AIDS Diagnoses: 1992, 2002, 2012
- Cumulative Number of HIV/AIDS Deaths: 1983-1992, 1983-2002, 1983-2012

Data is based on the City of Los Angeles. The LA County Department of Public Health species that: (1) Data are provisional due to reporting delay, (2) persons without an identified risk factor are assigned a risk factor using multiple imputation (MI) methods, (3) “Other” race group includes people with multiple races/ethnicities or missing race/ethnicity, (4) Asian/Other includes Asian, Pacific Islander, American Indian, Alaska Native and people with multiple races/ethnicities or missing race/ethnicity, (5) the number of deaths among persons of HIV infection is based on the date of death report when the actual year of death is unknown, (6) data are based on the end of each year, and (7) data is valid as of June 30, 2013.

Effort is made to provide the base (denominator) for all tables and figures. Percentages and Rates of HIV in the City were calculated using population estimates from the US Census as the denominator (Table 17, page 45). Rates are based on 100,000 people in the population, unless specified as something different. For instance, an average HIV diagnosis rate of 20.1 between 2003-2012 should be interpreted as annual average of 20.1 HIV diagnoses per 100,000 people across the 10-year period from 2003-2012.

The data was analyzed for comparison in ten-year blocks of time (1993-2002 vs. 2003-2012) and four-year blocks (2003-2005 vs. 2009-2012). Population data was obtained from the US Census Bureau corresponding to census years 1990, 2000 and 2010. These years formed the baseline for calculating rates and prevalence measures for HIV data in 1992, 2002, and 2012, respectively. We opted for decennial census data, rather than population estimates to provide a more consistent approach to calculations across the twenty-year time period. This was a more accurate approach, given that population shifts should be minimal during the two-year lag between Census reporting years and HIV data reporting years. Data was analyzed using Microsoft Excel, a statistical analysis program.

### Calculations include:

- Average HIV Diagnosis Rate<sup>ll</sup>
- Average HIV Mortality Rate<sup>mmm</sup>
- Transmission Rate<sup>nn</sup>
- Proportion of People Living with HIV<sup>oo</sup>
- Percentages
- HIV Seroprevalence

<sup>ll</sup> Average HIV diagnosis rate - ((Cumulative HIV Diagnoses time A-B/10)/(Population at time B/100,000)).

<sup>mmm</sup> Average Mortality rate ((Cumulative HIV Mortalities time A-B/10)/(Population at time B/100,000)). The population corresponds to all people in the City, each race/ethnicity and gender – transgender, not included.

<sup>nn</sup> Transmission rate was calculated by [(HIV diagnoses in point A/Cumulative PLWH at Point A) \*100].

<sup>oo</sup> Proportion of people living with HIV was calculated by dividing PLWH by the corresponding population during each point in time.



### Phase 2: 25 in-depth interviews with HIV community stakeholders

In-depth interviews lasted between 30 minutes and 60 minutes. Interviews were administered by research staff and relied on a semi-structured interview guide to prompt discussion. Topics covered related to the individual's participation in the HIV/AIDS community, their perspective about how well the ACO and community had performed achieving the 2003 White paper goals, challenges that the community currently faces and the direction the ACO should take confronting the HIV/AIDS epidemic in the future.

Participants were recruited based on referral from other participants and project affiliates. This convenience, "snowball," sampling approach was iterative, allowing for more comprehensive inclusion of diverse community members (i.e., policy makers, program administrators, evaluators, PLWH, and transgender persons). Interview data was analyzed by relying on direct quotes transcribed from recorded interviews. Themes emerged from the quotes, which were compiled according to various codes for analysis. These themes formed the bases for analyzing and interpreting interviews.

### Phase 3: 50 web-based surveys of community stakeholders

Surveys included quantitative and qualitative measures related to how the ACO should prioritize its efforts in the areas of education, research, Pilot programs, and policy/legislation. A list of 123 community members was developed based on participation in the current project, participation in a previous ACO research project, and other community members identified by the ACO project team. The majority of respondents were invited to participate via e-mail; and, a few responded after a public announcement was made at a Los Angeles County Commission on HIV meeting. Data was analyzed using SPSS, a statistical analysis program.

### Phase 4: Roundtable community discussion

A panel discussion was held with 30 members of the community to verify and further explore themes that emerged in the previous phases of the research. The format of the discussion include (1) a summary of (a) the 2003 White paper goals, (b) activities by the ACO to accomplish the 2002 goals, (c) a list of programmatic and epidemiologic accomplishments to date, and (d) characteristics of the current HIV/AIDS epidemic in the City and (2) Discussion about how the ACO might form a response to the epidemic that integrates the National HIV/AIDS Strategy. The discussion included open dialogue, smaller group discussions and written responses to questions related to what the ACO should do to (a) Increase Access to Health Care & Treatment, (b) Reduce HIV Related Disparity, and (c) Reduce New Infections.

The panel discussion lasted 3 ½ hours and was audio recorded. Data from the audio recordings and written responses from participants were analyzed by identifying new themes and themes previously expressed during individual interviews. These participant responses were added to the previous analysis from phases 1, 2 and 3.

# REFERENCES

---

<sup>1</sup> White House Office of National AIDS Policy. *National HIV/AIDS strategy for the United States*. Washington, DC: White House Office of National AIDS Policy; 2010

<sup>2</sup> Mayor's AIDS Leadership Council. *HIV and AIDS in Los Angeles: 21<sup>st</sup> century challenges and approaches*. Los Angeles, CA: City of Los Angeles Mayor's Office; 2003. Available at: [http://disability.lacity.org/pdf/White\\_Paper.pdf](http://disability.lacity.org/pdf/White_Paper.pdf). Accessed May 10, 2013.

<sup>3</sup> Walensky R, Paltiel AD, Losina E, et al. The survival benefits of AIDS treatment in the United States. *J infectious Disease*; 2006;194:11-9.

<sup>4</sup> U.S. Department of Health and Human Services. *Ryan White HIV/AIDS program fact sheet*. October 2014. Rockville, MD: Health Resources and Services Administration, HIV/AIDS Bureau; 2014. Available at: <http://hab.hrsa.gov/about/hab/files/programoverviewfacts2012.pdf> Accessed: December 1, 2014.

<sup>5</sup> Pollack D, Volk D, Watson G, et al. *National evaluation of the Housing Opportunities for Persons with AIDS Program*. Washington, D.C.: The Office of Policy Development and Research Department of Housing and Urban Development; 2000. Available at: [http://www.huduser.org/Publications/pdf/hopwa\\_oioi.pdf](http://www.huduser.org/Publications/pdf/hopwa_oioi.pdf) Accessed December 1, 2014.

<sup>6</sup> Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents*. Rockville, MD: Department of Health and Human Services. Available at: <http://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf> Accessed section 1, December 1, 2014, A-1.

<sup>7</sup> World Health Organization. *Second generation surveillance for HIV/AIDS*. Geneva, Switzerland: W.H.O.; 2014. Available at: <http://www.who.int/hiv/topics/surveillance/2ndgen/en/> Accessed: August 15, 2014.

<sup>8</sup> Aidala A, Sumartojo E. Why housing? *AIDS & Behavior*. 2007;11(6,Suppl 2):S1-S6.

<sup>9</sup> Whiteside Y, Cohen S, Bradley H, et al. Progress along the continuum of HIV care among Blacks with diagnosed HIV – United States, 2010. *MMWR*; 2014;63: 85-120.

<sup>10</sup> Division of HIV and STD Programs, Los Angeles County Department of Public Health. *2013 Annual HIV surveillance report*. Los Angeles, CA: Department of Public Health; 2014. Available at: <http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/2013AnnualSurveillanceReport.pdf> Accessed Table 25, page 31: August 8, 2014.

<sup>11</sup> Centers for Disease Control and Prevention. *HIV in the United States*. Atlanta, GA: CDC; 2013. Available at: [http://www.cdc.gov/hiv/pdf/statistics\\_basics\\_factsheet.pdf](http://www.cdc.gov/hiv/pdf/statistics_basics_factsheet.pdf) Accessed: August 5, 2014.

<sup>12</sup> Centers for Disease Control and Prevention. *MMWR*, Vol. 30, No. 21; June 1981.

---

<sup>13</sup> Lieb S, Fallon S, Friedman S, Thompson D, Gates G, et al. Statewide estimation of racial/ethnic populations of men who have sex with men in the U.S. *Public Health Reports*. 2010;126:60-72.

<sup>14</sup> Purcell D, Johnson CH, Lansky A, et al. Estimating the population size of men who have sex with men in the United States to obtain HIV and syphilis rates. *The Open AIDS Journal*. 2012; 6(Suppl 1: M6): 114–123. Available at: <http://benthamopen.com/toaidj/articles/Voo6/S1oo65TOAIDJ/98TOAIDJ.pdf> Accessed: August 20, 2014.

<sup>15</sup> Division of HIV and STD Programs. Los Angeles County Department of Public Health. 2012 – Special report – New HIV/AIDS diagnoses in 2012 by transmission category and race/ethnicity, City of Los Angeles as of 6/30/2013. Los Angeles, CA: Department of Public Health; 2014.

<sup>16</sup> San Francisco Department of Public Health. HIV/AIDS epidemiology annual report, 2012. San Francisco, CA: Department of Public Health; 2013. Available at: <https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/HIVAIDAnnRpt2012.pdf> Accessed: August 1, 2014.

<sup>17</sup> Dallas County Health and Human Services. Profile of HIV in Dallas county, 2012. Dallas, TX: County Health and Human Services; 2013. Available at: [http://www.dallascounty.org/department/hhs/documents/DCHHS\\_HIVAIDS\\_Profile\\_2012.pdf](http://www.dallascounty.org/department/hhs/documents/DCHHS_HIVAIDS_Profile_2012.pdf) Accessed August 1, 2014.

<sup>18</sup> Chicago Department of Public Health. HIV/STI surveillance report, 2013. Chicago, IL: Department of Public Health; 2013. Available at: [http://www.cityofchicago.org/content/dam/city/depts/cdph/infectious\\_disease/STI\\_HIV\\_AIDS/HIV\\_STISurveillanceReport2013.pdf](http://www.cityofchicago.org/content/dam/city/depts/cdph/infectious_disease/STI_HIV_AIDS/HIV_STISurveillanceReport2013.pdf) Accessed: August 1, 2014.

<sup>19</sup> The 2013 Houston Area Integrated Epidemiologic Profile for HIV/AIDS Prevention and Care Services Planning. Reporting period: January 1 to December 31, 2011. Houston, TX: Houston Area Ryan White Planning Council; 2013. Available at: [http://www.houstontx.gov/health/HIV-STD/2013\\_Epi\\_Profile%20--APPROVED--05-09-13.pdf](http://www.houstontx.gov/health/HIV-STD/2013_Epi_Profile%20--APPROVED--05-09-13.pdf) Accessed: August 1, 2014.

<sup>20</sup> Florida Department of Health. Number of reported AIDS and HIV cases in 2011, 2012 and 2013, Miami-Dade County. Miami, FL: Department of Health; 2014. Available at: [http://www.dadehealth.org/downloads/Reported\\_AIDS\\_&\\_HIV\\_cases\\_2011-2013-New.pdf](http://www.dadehealth.org/downloads/Reported_AIDS_&_HIV_cases_2011-2013-New.pdf) Accessed: August 1, 2014.

<sup>21</sup> New York City Department of Health and Mental Hygiene. HIV surveillance annual report, 2012. NY, NY: Department of Health and Mental Hygiene; 2013. Available at: <http://www.nyc.gov/html/doh/downloads/pdf/dires/surveillance-report-dec-2013.pdf> Accessed: August 1, 2014.

<sup>22</sup> Georgia Department of Public Health. HIV surveillance update. July 22, 2013. Atlanta, GA: Department of Public Health; 2013. Available at: [http://dph.georgia.gov/sites/dph.georgia.gov/files/HIV%20Surveillance\\_Deepali%20Rane\\_Jan%20Kelly\\_07.22.13.pdf](http://dph.georgia.gov/sites/dph.georgia.gov/files/HIV%20Surveillance_Deepali%20Rane_Jan%20Kelly_07.22.13.pdf) Accessed September 23, 2014.

- 
- <sup>23</sup> District of Columbia Department of Health. HIV/AIDS, Hepatitis, STD, and TB Administration. Annual epidemiology & surveillance report surveillance data through December 2012. Washington, D.C.: Department of Health; 2013. Available at: <http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2012AESRFINAL.pdf> Accessed August 1, 2014.
- <sup>24</sup> AIDS Activities Coordinating Office. Surveillance report 2012: HIV/AIDS in Philadelphia. Philadelphia, PA: AIDS Activities Coordinating Office; 2013. Available at: <http://www.phila.gov/health/pdfs/2012SurveillanceReportFinal.pdf> Accessed: August 1, 2014.
- <sup>25</sup> Division of HIV and STD Programs. Los Angeles County Department of Public Health. 2012 Sexually transmitted disease morbidity report. Los Angeles, CA: Department of Public Health; 2013.
- <sup>26</sup> Centers for Disease Control and Prevention. HIV among African American gay and bisexual men. Atlanta, GA: CDC; 2013. Available at: <http://www.cdc.gov/hiv/risk/raciaethnic/aa/brief/> Accessed: August 20, 2014.
- <sup>27</sup> Raymond HF, McFarland W. Racial mixing and HIV risk among men who have sex with men. *AIDS Behav.* 2009;13:630-637.
- <sup>28</sup> US. Department of Labor. Dol Policies On Gender Identity: Rights and responsibilities. United States; 2013. Available at: <http://www.dol.gov/oasam/programs/crc/20130712GenderIdentity.pdf> Accessed: July 10, 2014.
- <sup>29</sup> Division of HIV and STD Programs, Los Angeles County Department of Public Health. Los Angeles county transgender population estimates 2012. Los Angeles, CA: Department of Health; 2013. Available at: <http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/Transgender%20Population%20Estimates%202-12-13%20pub.pdf> Accessed: August 20, 2014.
- <sup>30</sup> Grant JM, Mottet LA, Tanis J, et al. Injustice at every turn: a report of the National Transgender Discrimination Survey. Washington, D.C.: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011. Available at: [http://www.thetaskforce.org/static\\_html/downloads/reports/reports/ntds\\_full.pdf](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf) Accessed: August 20, 2014.
- <sup>31</sup> California Department of Fair Employment and Housing. Cases filed: by bases (19,839 employment cases). Calendar year: 2012. Sacramento, CA: Department of Fair Employment and Housing. Available at: <http://www.dfeh.ca.gov/res/docs/Statistics/Statistics%202013/12CasesFiledByBasesEmp.pdf> Accessed: December 2, 2013.
- <sup>32</sup> Dunkle KL, Wingood GM, Campo CM, DiClemente RJ. Economically motivated relationships and transactional sex among unmarried African American and White women: results from a U.S. national telephone survey. *Public Health Reports.* 2010;Suppl. 4(125)90-100.
- <sup>33</sup> Johnson C, Mimiaga M, Reisner S, VanDerwarker R, Mayer K. Barriers and facilitators to routine HIV testing: perceptions from Massachusetts community health center personnel. *AIDS Patient Care and STDS.* 2011; 25(11): 647-655.

- 
- <sup>34</sup> Centers for Disease Control and Prevention. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *CDC. MMWR*. 2006; 55(RR14):1-17. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm> Accessed: August 2, 2011.
- <sup>35</sup> National Association of Community Health Centers, Inc. Fact sheet: health centers on the front lines of HIV/AIDS prevention and treatment. Bethesda, MD: NACHC; 2007. Available at: <https://www.nachc.com/client//HIVAIDSFS.pdf> Accessed: January 2, 2013.
- <sup>36</sup> Celious A. Routine Opt-Out HIV Testing. *AIDS Prevention Research*. Los Angeles, CA: AIDS Coordinator's Office; 2012.
- <sup>37</sup> Rodger A, Bruun T, Cambiano V, et al. HIV transmission risk through condomless sex if HIV+ partner on suppressive ART: Partner Study. Abstract 153LB, CROI 2014, Boston, MA; March 3-6, 2014.
- <sup>38</sup> Husted C. Los Angeles County Five-Year Comprehensive HIV Plan (2013-2017). Los Angeles, CA: Department of Public Health; 2013. Available at: [http://publichealth.lacounty.gov/aids/docs/LAC\\_FiveYear\\_ComprehensiveHIVPlan2013-2017.pdf](http://publichealth.lacounty.gov/aids/docs/LAC_FiveYear_ComprehensiveHIVPlan2013-2017.pdf) Accessed: February 2, 2014.
- <sup>39</sup> Dinaj-Koci V, Lunn S, Deveaux L, et al. Adolescent age at time of receipt of one or more sexual risk reduction interventions. *The Journal of adolescent health*. 2014;62-67.
- <sup>40</sup> Conklin, K. Adolescent sexual health and behavior in the United States. Positive trends and areas in need of improvement. Washington, D.C.: Advocates for Youth; 2012. Available at: <http://advocatesforyouth.org/storage/advfy/documents/adolescent-sexual-behavior-demographics.pdf> Accessed: May 29, 2014.
- <sup>41</sup> Los Angeles Unified School District. Complying with the california comprehensive sexual health and HIV/AIDS prevention education act. *Article 3. Section 51934 California Code*. Los Angeles, CA: LAUSD; 2008.
- <sup>42</sup> Division of HIV and STD Programs, Los Angeles County Department of Public Health. Sexually transmitted diseases screening and vaccination recommendations for HIV-infected adults and adolescents. April 20, 2012. Los Angeles, CA: Department of Public Health; 2012. Available at: <http://publichealth.lacounty.gov/aids/MAC/STDScreening4-12.pdf> Accessed August 20, 2014.
- <sup>43</sup> Centers for Disease Control and Prevention. The role of STD prevention and treatment in HIV prevention. Atlanta, GA: CDC; 2014. <http://www.cdc.gov/std/hiv/stds-and-hiv-fact-sheet.pdf> Accessed: August 20, 2014.