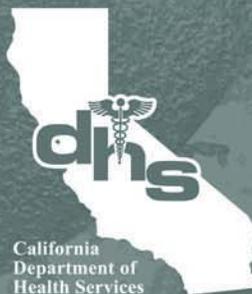


# California *and the* HIV/AIDS Epidemic



## The State of the State Report 2002-03

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# Introduction

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# Introduction

The Department of Health Services, Office of AIDS (DHS/OA), is pleased to release the tenth edition of *California and the HIV/AIDS Epidemic – The State of the State Report, 2002-03*. Since the first document was released in 1992, the California and the HIV/AIDS Epidemic - The State of the State Report, has evolved into a comprehensive overview of the activities, trends, challenges, and accomplishments related to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) in California.

The report describes detailed DHS/OA activities including epidemiologic research, education, prevention, and care and treatment as well as brief descriptions of the activities of other entities that receive state and/or federal funding to fight HIV/AIDS.

DHS/OA, as designated by California Health and Safety Code Section 100119, has lead responsibility for coordinating state programs, services, and activities relating to HIV/AIDS. DHS/OA comprises three branches: HIV/AIDS Epidemiology; HIV Education and Prevention Services; and HIV Care.

The mission of DHS/OA is to:

- Assess, prevent, and interrupt the transmission of HIV and provide for the needs of infected Californians by identifying the scope and extent of HIV infection and the needs which it creates and disseminating timely and complete information;
- Assure high-quality preventive, early intervention, and care services that are appropriate, accessible, and cost effective;

- Promote the effective use of available resources through research, planning, coordination, and evaluation; and
- Provide leadership through a collaborative process of policy and program development, implementation, and evaluation.

DHS/OA works collaboratively with other state agencies, local health jurisdictions (LHJs), universities, and community-based organizations (CBOs) to ensure that efforts to combat the HIV/AIDS epidemic are targeted and effective.

The total DHS/OA budget was \$315.190 million for fiscal year (FY) 2002-03 and \$330.066 million for FY 2003-04. Each fiscal year over 94 percent of the funding was allocated to local assistance.

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# Executive Summary

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# Executive Summary

AIDS is a deadly disease caused by HIV, a retrovirus that infects and kills certain infection-fighting cells in the body. HIV is transmitted from one person to another through a variety of methods including sexual transmission, sharing injection drug paraphernalia, direct contact with infected blood, perinatal transmission (from an infected woman to her fetus), or neonatal transmission (from infected breast milk to an infant). An individual may be infected with HIV for as long as ten years before the effects of the disease become apparent. Throughout this entire period, the individual is capable of infecting others with HIV.

## HIV/AIDS Epidemiology Branch

- On July 1, 2002, DHS/OA implemented new regulations establishing a non-name based HIV surveillance system to capture data for HIV cases diagnosed in California.
- As of April 30, 2004, 27,632 cumulative HIV cases were reported to DHS/OA for the period July 1, 2002, through December 31, 2003. The majority of these cases were prevalent cases (diagnosed prior to July 1, 2002).
- By gender and race, White men represented the majority of HIV cases at 54 percent. African American females and transgender individuals represented the largest racial/ethnic groups of HIV cases at 37.4 percent and 40.5 percent, respectively. Latino transgender HIV cases (38.5 percent) significantly outweigh Latino male and female cases.
- The majority of HIV infections (70.3 percent) were reported among males whose risk category was men who have sex with men (MSM).
- Among female HIV cases, 44.9 percent were reported in the heterosexual exposure category, 23.9 percent reported injection drug use, and nearly 30 percent of female HIV cases reported no identified risk.
- Over 97 percent of transgender HIV cases were reported in either the MSM or MSM/injection drug use exposure category.
- California AIDS cases do not mirror the national perspective. In comparison to the rest of the United States (U.S.), California continues to have a higher proportion of cumulative AIDS cases among males. For cases diagnosed in 2002, in California, 86.5 percent were males compared to 73.0 percent nationally. However, the trend is different for females, where during 2002, 27.0 percent of AIDS cases diagnosed in the rest of the U.S. occurred among females, in California this proportion was 13.5 percent.
- California had a larger proportion of diagnosed AIDS cases among Whites in 2002, compared to the rest of the nation (41.6 percent versus 27.2 percent). While over 53 percent of 2002 AIDS cases in the rest of the nation were African American, in California this percentage was 22.3 percent, which is reflective of the state having a smaller proportion of African Americans in its general population. The proportion of Latinos among cases diagnosed in 2002 is much higher in California (31.8 percent) than in the rest of the U.S. (18.0 percent). Among Asian/Pacific Islanders, California also had a larger percentage of diagnosed AIDS cases in 2002 (3.4 percent) than the rest of the nation (0.9 percent).

- In 2002, California had a higher percentage of diagnosed AIDS cases among the MSM population than the rest of the U.S. at 53.9 percent versus 31.2 percent, but had a lower percentage of diagnosed AIDS cases for 2002 attributable to injection drug use at 13.1 percent versus 17.5 percent.
- Since 1992, the number of California's annually diagnosed AIDS cases has declined each year. However, from 2001 to 2002 the decline was less than 100 cases.
- In 2002 and 2003, DHS/OA conducted or funded epidemiologic surveys of childbearing women; children under age 13; clients of sexually transmitted disease (STD) clinics; high-risk populations; inmates entering San Quentin State Prison; blood and plasma donors; civilian applicants for military service; and Latino, and binational populations. In addition, DHS/OA began a survey of young men aged 18-35 to determine the prevalence of HIV, STD, hepatitis B and C, and related risks.
- In 2003, DHS/OA released a request for proposal to solicit projects to address the needs of African American and Latino MSM who do not identify as gay. In collaboration with the Universitywide AIDS Research Program (UARP).
- In 2002 and 2003, the HIV high-risk prevention initiatives targeting women, people of color, gay men/MSM, and youth were funded. The lessons learned will enable LHJs to plan and incorporate successful activities into their programs using existing HIV education and prevention funding.
- In 2003, the HIV Education and Prevention Services and HIV Care Branches collaborated to develop Prevention with Positives: A Guide to Effective Programs. DHS/OA funded three statewide prevention with positives projects to meet the technical assessment and training needs of HIV prevention providers. Additionally, DHS/OA funded an evaluation of the Shanti Project's Learning Immune Function Enhancement (L.I.F.E.) program to determine its efficacy in prevention, treatment, and adherence of enrolled clients.

## **HIV Education and Prevention Services Branch**

- Community planning at the local and state level was conducted in 2002 and 2003. DHS/OA staff provided technical assistance and guidance to local implementation groups (LIGs) on their HIV prevention plans. The California HIV Planning Group (CHPG) addressed HIV/AIDS-related education, prevention, and care issues statewide. In 2002 and 2003, four CHPG task forces were developed to make recommendations to DHS/OA on funding allocations, hepatitis C co-infection, gay men/MSM, and prevention with positives activities.
- The Neighborhood Interventions Geared to High-Risk Testing (NIGHT) Outreach program provides services in 21 local health departments. Outreach workers provide education, counseling, HIV testing, referrals, and follow-up services in venues where high-risk populations congregate.
- The California Corrections Initiative is a collaborative effort by DHS/OA, the City and County of San Francisco, Los Angeles County, the California Department of

# Executive Summary

Corrections, the California STD/HIV Prevention Training Center, and CBOs Centerforce and Continuum to provide HIV prevention, intervention, and continuity of care within correctional settings and the community. In 2003, hepatitis B and C screenings and vaccinations were added to the demonstration project in San Francisco County jails.

- The HIV Transmission Prevention Project (HTPP) is a collaborative demonstration project that provides intensive, specialized transmission prevention and support for HIV-positive and HIV-negative high-risk persons. DHS/OA funds the interventions in five jurisdictions (Butte, Humboldt, Long Beach, Orange, and Riverside).
- The HIV Partner Counseling and Referral Services (PCRS) Program helps ensure that the sex and needle-sharing partners of HIV-positive persons are informed of their potential risk, offered HIV prevention counseling services, and referred to social and medical services as necessary. In calendar years 2002 and 2003 combined, 549 HIV-positive clients were offered PCRS and almost half (48 percent) chose to participate. Of those who participated, 81 percent chose to counsel their partners themselves. PCRS is available in 12 LHJs.
- The HIV Counseling and Testing Program provides free anonymous and/or confidential HIV antibody counseling and testing services. In 2002 and 2003 combined, approximately 400,000 HIV tests were performed in 61 LHJs, rural primary care clinics, and Indian health clinics.
- In 2003, rapid HIV testing began in California. Rapid HIV tests, done by a finger stick blood sample, are highly accurate and can provide a definitive HIV-negative and preliminary HIV-positive test result to clients in approximately 20-40 minutes. Rapid HIV testing was piloted in August 2003 in five jurisdictions and by December 2003 four more jurisdictions were conducting tests. By mid-2004 rapid HIV tests will be available in over half of California's LHJs.
- The Prevention of Perinatal Transmission of HIV Project is a collaborative project between Stanford University and DHS/OA. The project goal is to increase the level of HIV education, counseling, and testing offered to pregnant women in California. Counties participating in the project include Alameda, Los Angeles, Sacramento, San Diego, and San Joaquin.
- The DHS/OA HIV Prevention Research and Evaluation Section evaluates the HIV counseling and testing program. The evaluation process has two components: 1) ongoing and quality assurance evaluation of counselor and client data reported to DHS/OA, and 2) periodic formal on-site evaluation of contractors. The 2003 Counselor Survey was sent to experienced HIV counselors in state-funded HIV testing sites. Survey results were disseminated to LHJs and as a statewide report.
- In 2003, DHS/OA received funding from the Centers for Disease Control and Prevention (CDC) to conduct a demonstration project to evaluate the use of hepatitis C counseling and testing as an incentive to attract larger numbers of injection drug users (IDUs) into HIV counseling and testing services. Five sites were identified to participate in the project (Riverside, Humboldt, Solano, and

Fresno Counties, and the City of Berkeley). These sites were chosen based on their ability to reach a significant number of IDUs, sufficient staffing to administer the project, ability to provide clients with targeted educational and harm reduction materials and appropriate referrals, and presence of little or no ongoing hepatitis C screening or related research.

## HIV Care Branch

- In federal FYs 2002 and 2003, Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funding for California totaled over \$240 million each year for Title I, Title II (formula and the AIDS Drug Assistance Program (ADAP)), Title III, Title IV, and Part F.
- Funding for ADAP, which provides drugs to individuals who cannot otherwise afford them, increased from \$184.645 million in FY 2002-03 to \$212.355 million in FY 2003-04. As of December 31, 2003, 151 drugs were on the ADAP formulary; one new drug was added in 2002, and four in 2003. ADAP has over 3,400 participating pharmacies and 275 local ADAP enrollment sites throughout California. The ADAP formulary is posted on the Internet at <http://www.dhs.ca.gov/AIDS> and <http://www.ramsellcorp.org>.
- The CARE/Health Insurance Premium Payment (HIPP) Program helps people with HIV/AIDS maintain their private health insurance coverage. Beginning in 2002, the program experienced a steady increase in health insurance premium costs and client enrollees, ultimately resulting in a budget increase from \$867,501 in FY 2001-02, to \$1.39 million in FY 2002-03, and eventually \$1.7 million in FY 2003-04.
- The Care Services/Consortia Program provides funding to local agencies for planning, developing, and delivering essential health care and support services to individuals with HIV disease. Funds are made available to all 58 counties in California. In both FYs 2002-03 and 2003-04, \$12.2 million was allocated to counties, of which approximately 78 percent was expended on health care services, including primary medical care, treatment adherence and medications; 14 percent on case management to assist persons with HIV/AIDS to enter and remain in the care system; and 8 percent on other services and costs.
- The Housing Opportunities for Persons with AIDS (HOPWA) Program is federally funded through the Department of Housing and Urban Development. In FY 2001-02, DHS/OA received \$2.75 million in HOPWA funds. In FY 2002-03 and FY 2003-04, that amount increased to \$2.9 million and \$3.04 million, respectively. HOPWA served over 4,000 eligible clients and families experiencing homelessness or at risk of homelessness.
- The HIV Housing Program provides funding for the development of rental housing projects or programs designed to prevent or alleviate homelessness of persons living with HIV/AIDS and their families by providing long term, affordable, supportive housing units. Awards are made annually on a competitive basis to nonprofit housing providers, local governments, and HIV/AIDS service providers working collaboratively to develop HIV-designated housing units within the 11 counties (excluding Eligible Metropolitan Statistical Areas [EMSAs]) with

# Executive Summary

the highest need for affordable HIV/AIDS housing.

- The Residential AIDS Licensed Facilities (RALF) Program is designed to provide direct subsidy payments to residential AIDS facilities licensed under the Residential Care Facility for the Chronically Ill (RCFCI) licensing category. As of December 31, 2003, there were 28 licensed RCFCIs in California with a total capacity of 400 beds per night.
- The AIDS Case Management Program (CMP) provides comprehensive, cost effective, home- and community-based services for persons with AIDS or symptomatic HIV infection who are unable to function independently. CMP funding has remained stable at \$8.6 million in state and federal Ryan White CARE Act funding. In both 2002 and 2003, 1,314 client slots were allocated statewide.
- The AIDS Medi-Cal Waiver Program (MCWP) provides comprehensive, cost effective, home- and community-based services to Medi-Cal beneficiaries with mid-to-late stage HIV/AIDS. In calendar year 2002 and 2003, MCWP contracted with 36 local health departments and CBOs to administer the program in 47 counties, served over 3,000 unduplicated clients, and expended approximately \$16 million for client services and administrative fees.
- The Early Intervention Program (EIP) addresses the needs of HIV-infected individuals from the time of an HIV-positive test result until more intensive AIDS treatment may become necessary. The total EIP budget for both FYs 2002-03 and 2003-04 was \$7.182 million. In 2002, over 10,000 clients were actively enrolled in EIP sites throughout the state.
- The Bridge Project goal is to prevent further transmission of HIV in communities of color by bridging the gap between HIV testing and treatment. Funding for the program is a combination of federal CDC, federal Health Resources and Services Administration (HRSA) Minority AIDS Initiative, and state General Funds. In FY 2002-03, the program budget was \$1.61 million; in FY 2003-04 funding was slightly decreased to \$1.55 million. Bridge Projects operates in 21 EIP sites statewide.
- HTPP is a collaborative, two-segment demonstration project of DHS/OA HIV Care and HIV Education and Prevention Services Branches. HTPP provides intensive, individualized, prevention interventions for HIV-infected clients who are at high risk for transmitting HIV and for whom the more standard EIP risk reduction interventions have not been enough to sustain safe transmission behaviors. Ten EIP sites provide HTPP services.
- The Therapeutic Monitoring Program (TMP) (formerly HIV Diagnostic Assay Program) provides access to laboratory tests through a voucher-based program to HIV-positive Californians who have no medical insurance or third party coverage, are not Medi-Cal eligible, and have an annual federal adjusted gross income below \$50,000. As a result of the Budget Act of 2003, \$7 million of TMP's \$8 million budget was redirected to ADAP.

## Collaboration

- UARP provides state funding for the support of merit-reviewed, AIDS-related research to be conducted at nonprofit research institutions throughout California. UARP is a component of the Office of Health Affairs in the University of California, Office of the President. Cooperative activities in 2002 and 2003 for DHS/OA and UARP included:
  - Collaboration and dissemination of the prevention evaluation projects to evaluate high-priority prevention interventions;
  - Evaluation of care and treatment program activities;
  - Assessment of member satisfaction within CHPG; and
  - Collaboration on request for proposals for prevention interventions targeting high-risk populations.
- DHS/Division of Communicable Disease Control, STD Control Branch maintains an ongoing collaboration with DHS/OA on an array of programmatic issues that impact both STDs and HIV/AIDS.
- DHS/Division of Communicable Disease Control, Tuberculosis (TB) Control Branch and DHS/OA continue to collaborate on TB and HIV/AIDS epidemiologic and surveillance issues to improve AIDS and TB reporting, prevention, and care services.
- The Department of Alcohol and Drug Programs (DADP) allocates five percent of its total block grant award to provide AIDS-related services to persons who are in treatment for substance abuse. DHS/OA provides support services and technical assistance for the DADP HIV antibody-testing program and to agencies that utilize the HIV Test Reporting System.
- DHS/OA collaborates with the Department of Housing and Community Development (HCD) on the statewide Consolidated Plan and Annual Updates. This collaboration has created an ongoing relationship between affordable housing programs currently administered by DHS and HCD, and has raised awareness of the ongoing affordable housing needs of persons living with HIV/AIDS.
- DHS/OA and a variety of other state agencies participated on the Interagency Task Force on Homelessness in 2002 and 2003. The task force developed collaborative strategies to address homelessness among a variety of populations.
- DHS/OA contracts with the University of California at Berkeley, Davis, and San Francisco, to conduct various HIV/AIDS research projects, program support, and consultation services.





HIV/AIDS  
Epidemiology Branch

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# HIV/AIDS Epidemiology Branch

The HIV/AIDS Epidemiology Branch collaborates with LHJs, CBOs, universities, and other state organizations, to conduct a variety of epidemiologic studies funded by both state and federal governments.

Epidemiologic data help guide resource allocation and program strategies for HIV/AIDS education, prevention, and care and treatment. DHS/OA's epidemiologic research helps public health officials monitor and project the extent of the HIV/AIDS epidemic in California. Throughout this section, some data figures may use the term Latino/Hispanic to identify race/ethnicity. In the narrative, the term Latino has been used to describe those individuals who self-identify as either.

## HIV in California

### *HIV Reporting*

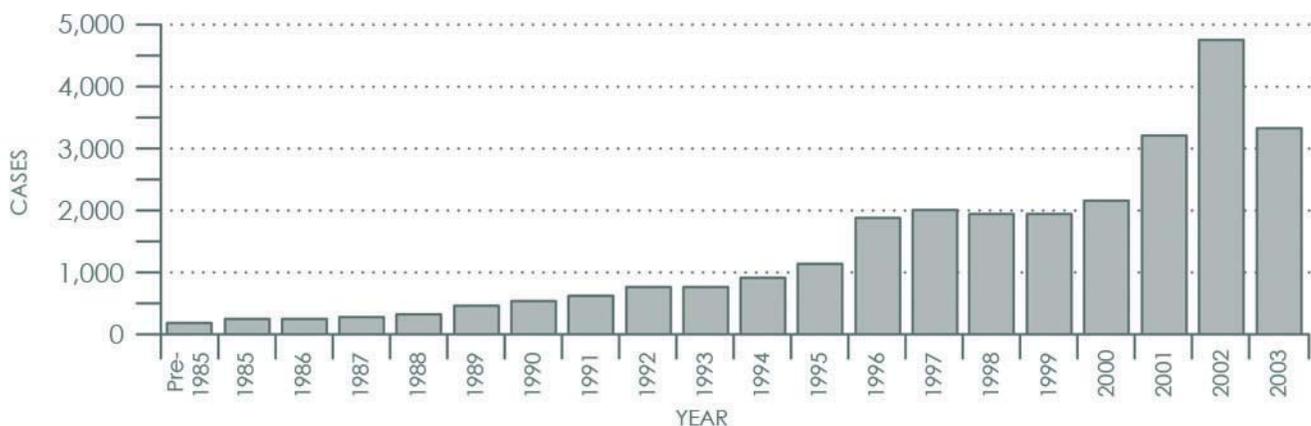
California's regulations for reporting HIV infection by non-name code became effective July 1, 2002. California has the second largest

number of reported AIDS cases in the nation, yet the incidence of HIV infection, the precursor to AIDS, was unknown until the HIV regulations took effect. Reporting HIV infection in addition to AIDS case data allows DHS/OA to better monitor the progress of the epidemic and to more effectively target prevention, education, and care resources to affected populations.

### *HIV Case Trends July 2002 – December 2003*

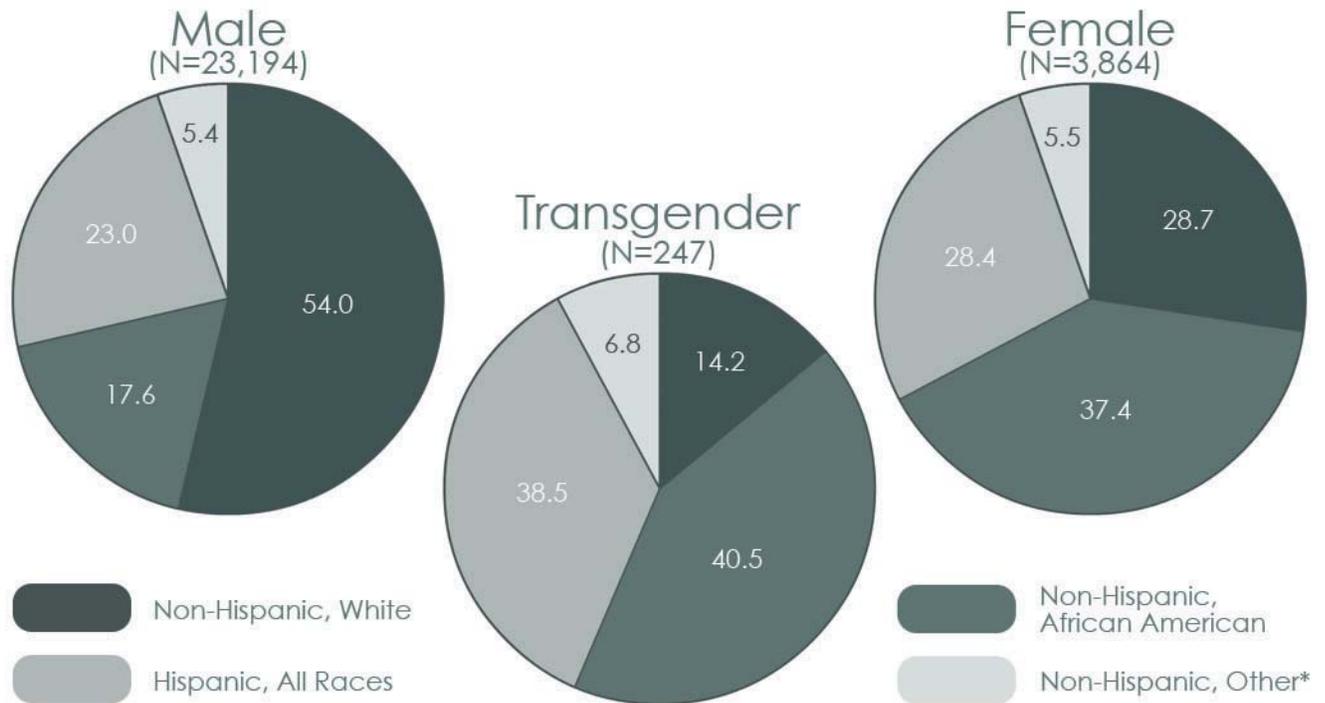
Based on data available as of April 30, 2004, there were 27,632 HIV (non-AIDS) cases reported to DHS/OA between July 1, 2002, and December 31, 2003. The majority of these cases were prevalent cases (diagnosed prior to July 1, 2002), and it is expected that such cases will continue to comprise a significant portion of cases reported through 2004. The number of reported HIV cases diagnosed between 1996 and 2000 was steady (Figure 1); the largest number of cases diagnosed annually was approximately 5,000 in 2002, the year HIV reporting began in California. (The number of cases diagnosed in 2003 is incomplete due to reporting delay.)

**Figure 1. HIV Cases by Year of Diagnosis**



California Department of Health Services, Office of AIDS, HIV Case Registry - HIV cases reported between 7/1/02 and 12/31/03.

**Figure 2.** Gender and Race/Ethnicity Breakdown of Reported Adult/Adolescent HIV Cases



California Department of Health Services, Office of AIDS, HIV Case Registry - HIV cases reported between 7/1/02 and 12/31/03.  
 \* Includes Asian/Pacific Islanders, Native Americans and Multi-Race. It also includes 480 adult/adolescent males and 67 adult/adolescent females with missing race/ethnicity information.

### HIV Cases by Gender and Race

While the majority of male HIV infections have been diagnosed among White men, the majority of female and transgender infections have occurred among people of color (Figure 2). As of December 31, 2003, African

Americans were the largest racial/ethnic group among female and transgender HIV cases. Both African American and Latino representation are expected to rise within all genders due to the backlog of prevalent HIV cases yet to be reported from larger, more ethnically diverse counties.

# HIV/AIDS Epidemiology Branch

## HIV Cases by Gender and Mode of Exposure

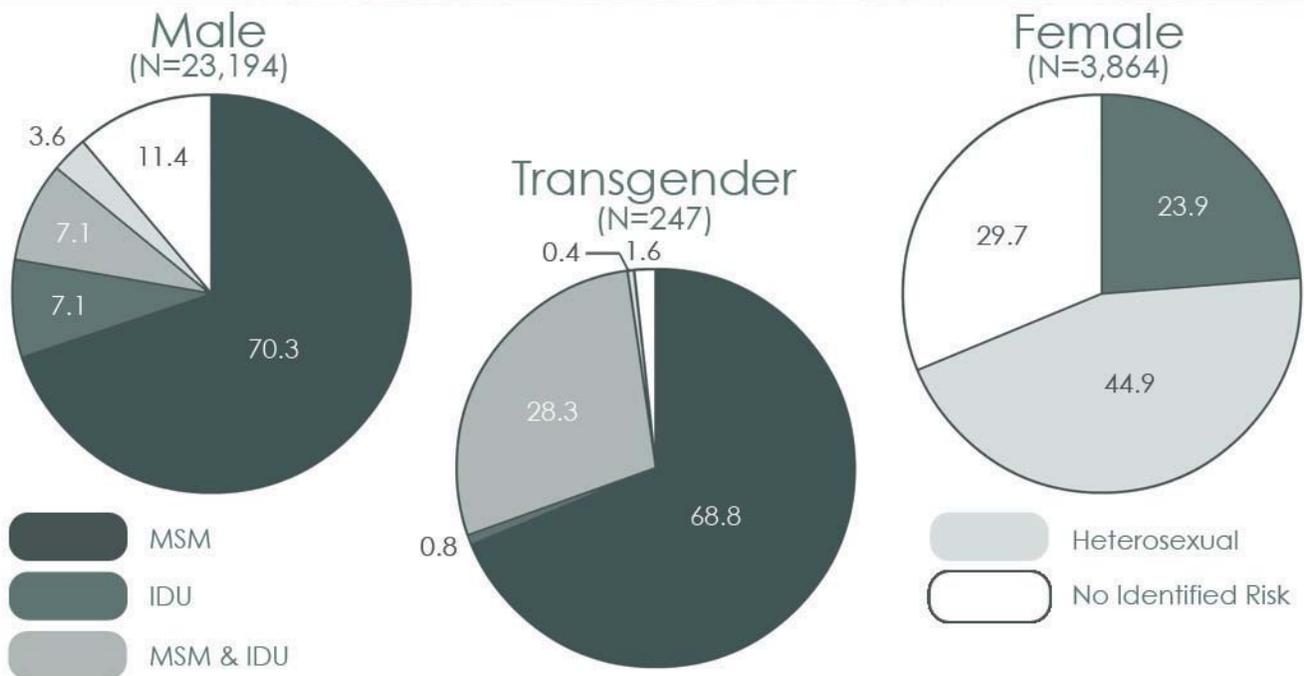
The majority of all HIV infections were reported among MSM (Figure 3). Over 70 percent of male HIV cases were reported among MSM. The injection drug use and MSM/injection drug use categories each represented just over seven percent of male cases, which is almost double the cases reported from heterosexual exposure (3.6 percent). Among female HIV cases, nearly twice as many were reported in the heterosexual exposure category (44.9 percent) than injection drug use (23.9 percent). However, almost 30 percent of female cases reported no identified risk, over 2.5 times the rate among male cases. Over 97 percent of transgender HIV cases were reported in either

the MSM or MSM/injection drug use exposure categories.

## HIV Reporting Evaluation Activities

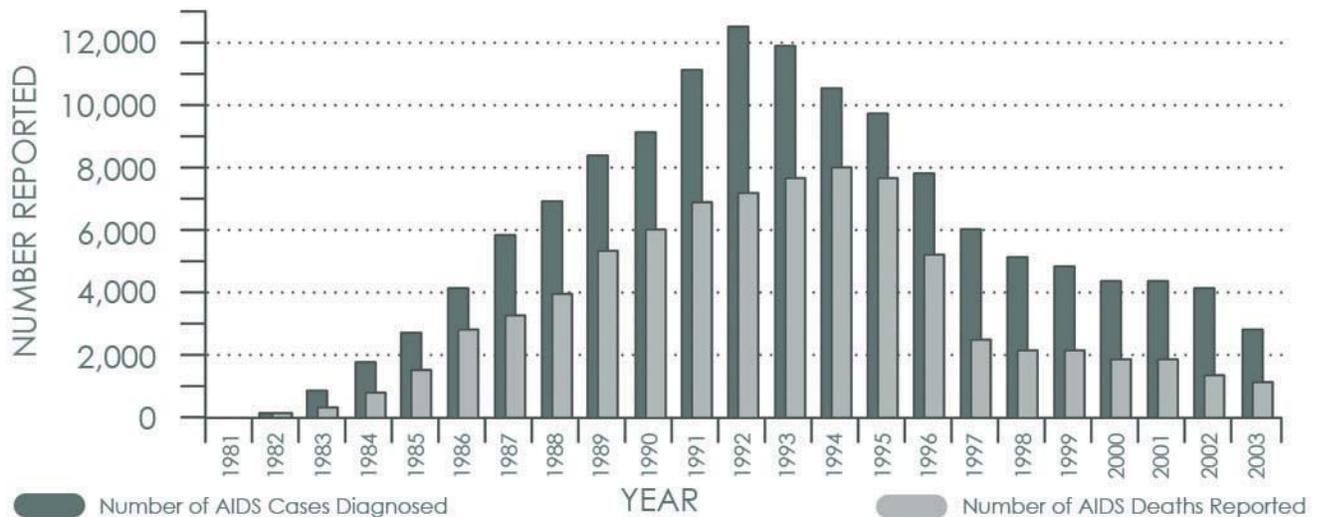
Evaluation activities in 2003 included planning and developing a compliance survey to determine the effectiveness of California's HIV non-name code reporting system. Implementation of the survey is scheduled for 2004 and the results will help identify any reporting gaps, suggest ways to correct underreporting, and increase compliance, timeliness, and completeness of reporting by health care providers and laboratories. DHS/OA will provide a brief summary report on two years of HIV reporting in 2004.

**Figure 3.** Gender and Mode of Exposure to HIV Among Reported Adult/Adolescent HIV Cases



California Department of Health Services, Office of AIDS, HIV Case Registry - HIV cases reported between 7/1/02 and 12/31/03. Figure excludes 96 adult/adolescent males and 62 adult/adolescent females who received blood products, and one adult/adolescent male with pediatric exposure.

**Figure 4.** Annual AIDS Cases and Deaths in California, 1981-2003



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry.  
Data represents AIDS cases and deaths diagnosed through December 31, 2003, as reported through January 31, 2004.

## AIDS in California

### *AIDS and Population Shifts in California*

Since peaking in 1992, the number of annually diagnosed AIDS cases has declined each year. However, the decline from 2001 to 2002 was less than 100 cases (from 4,191 to 4,107), which may indicate that the decade-long decrease is nearing an end (Figure 4).

The number of annual deaths among AIDS cases has declined each year since its 1994 peak (Figure 4). Due largely to highly active antiretroviral therapy (HAART), the number of deaths in 1997 was about half that of 1996, and since 1997 the number has remained in decline, though the rate of decline has decreased.

## *Racial/Ethnic Representation in the General Population and in AIDS Cases, 1981-2003*

Since the start of the HIV/AIDS epidemic in 1981, the diversity has grown within both the state's general population and population diagnosed with AIDS each year.

The proportion of White persons among the general population decreased from over 65 percent in 1981 to below 49 percent in 2003 (Figure 5a). The decrease among annually diagnosed male AIDS cases was more dramatic, going from over 80 percent during 1981-85 to roughly 40 percent in 2002 and 2003. The proportion of White females among annually diagnosed female AIDS cases steadily decreased from about 60 percent in 1985 to roughly 25 percent each year since 2001.

While the proportion of African Americans among the general population has been steady since 1981 (between 6.6 percent and 7.3 percent), African Americans have been disproportionately impacted by AIDS since the start of the epidemic (Figure 5b). The percentage of African Americans among annually diagnosed male AIDS cases went from under 10 percent for each year during 1982-85 to over 20 percent for each year since 1997. African Americans have

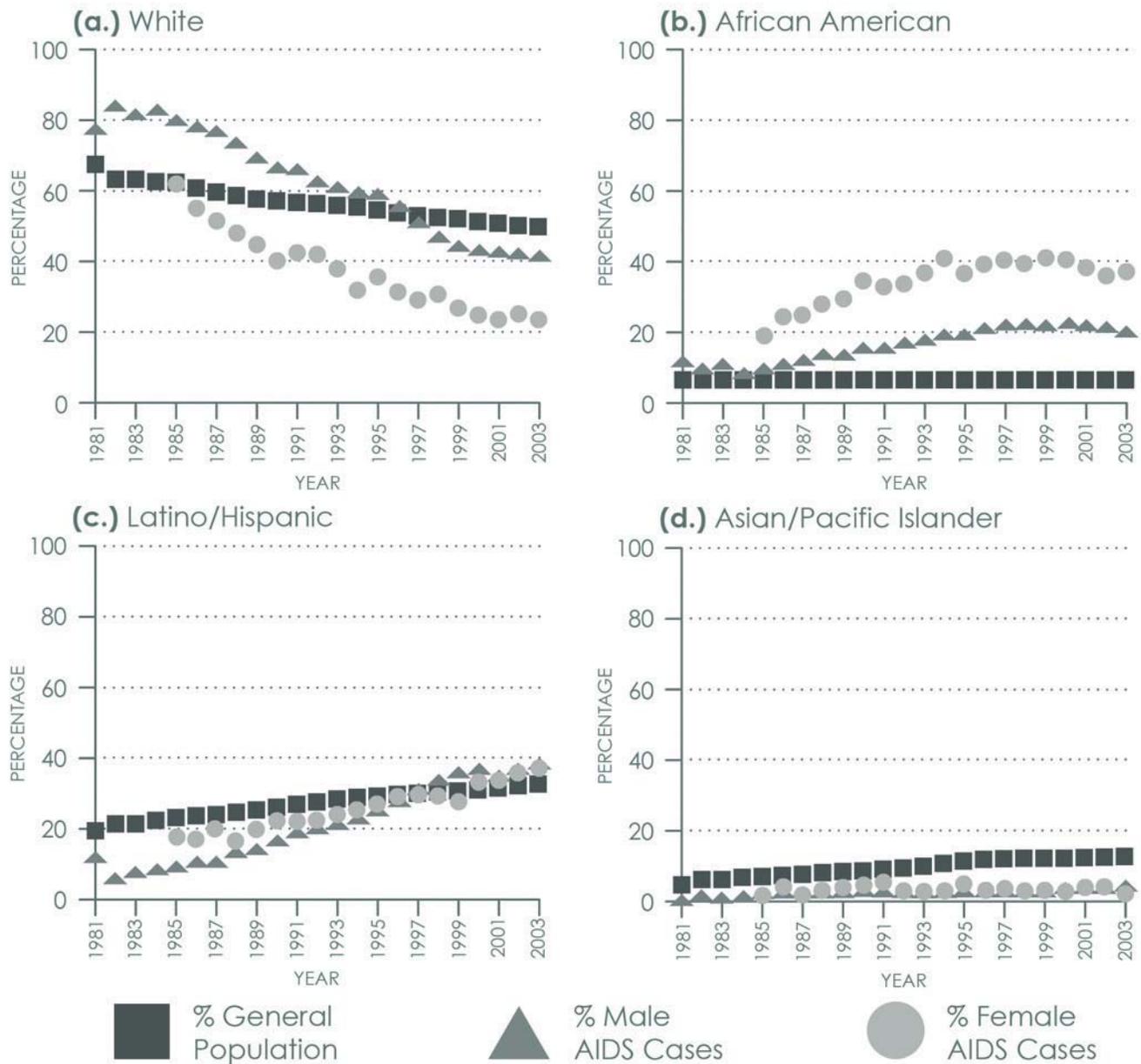
constituted roughly 40 percent of annual female AIDS cases each year since 1996; this percentage also steadily increased in the preceding ten years.

Latino representation both within the general population and among annually diagnosed AIDS cases has steadily risen since 1981 (Figure 5c). In 1981, Latinos comprised about 20 percent of the California population; in 2003 this proportion exceeded 32 percent. For each year since 2001, the proportion of Latinos among both male and female AIDS cases has exceeded this proportion within the general population.

The proportion of Asian/Pacific Islanders in California's general population increased steadily between 1981 and 2003 (from under 6 percent to over 12 percent), while the proportion among annual AIDS cases was comparatively steadily (Figure 5d). The percentage of Asian/Pacific Islanders among annual male AIDS cases has shown a slight increase, ranging between 1.2 percent and 2.0 percent during 1985-91, between 2.2 percent and 2.8 percent during 1992-2000, and between 3.4 percent and 3.9 percent during 2001-03. The proportion of Asian/Pacific Islanders among annual female AIDS cases has fluctuated between 2.4 percent and 3.8 percent since 1986.

# HIV/AIDS Epidemiology Branch

**Figure 5.** Racial/Ethnic Composition Among the General Population and Annual Male and Female AIDS Cases in California, 1981-2003



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry - Population data from California Department of Finance. Data represents AIDS cases and deaths diagnosed through December 31, 2003, as reported through January 31, 2004.

## *Adult/Adolescent AIDS Incidence by Racial/Ethnic Groups, 2001-03*

AIDS incidence (number of AIDS cases per 100,000 population) for males and females within each racial/ethnic group has mirrored the pattern of annual AIDS cases shown in Figure 4.

Significant success in preventing mother-to-child HIV transmission has led to very few AIDS cases diagnosed among those younger than 13 since 1997 (data not provided).

In Figures 6 and 7, AIDS incidence is presented for 2001-03 among adolescents/adults (aged 13 to 69).

In Figures 6 and 7 from 2001 to 2002, AIDS incidence among males and females changed very little for all racial/ethnic groups, while rates in 2003 were lower due to reporting delay.

Incidence among African American men during 2001-03 was roughly 2.5 times the rate for Latino men and more than triple the rate for White men (Figure 6).

Latino men were the only group with a higher incidence in 2002 (31.1) than in 2001 (29.9), and have the second highest rate in the state (Figure 6).

AIDS incidence among White and Native American men were similar during 2001-03 (Figure 6).

Asian/Pacific Islander men had the lowest AIDS incidence among all racial/ethnic groups, less than half that for White men in 2001, 2002, and 2003 (Figure 6).

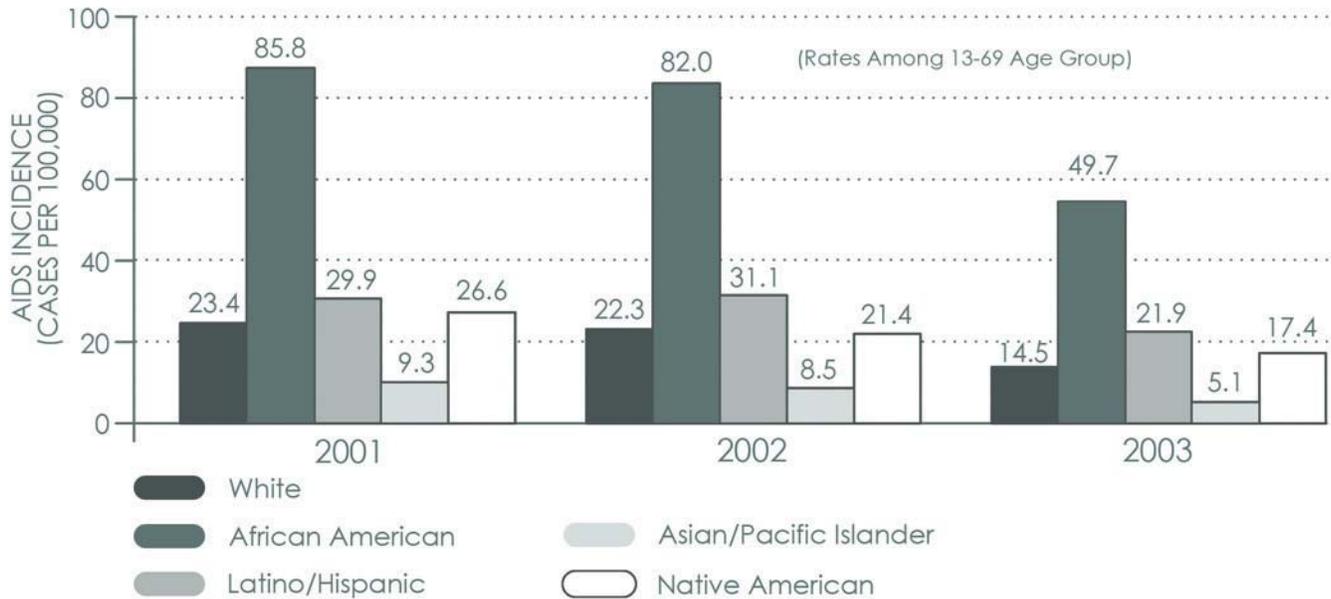
AIDS incidence among African American women exceeded that of White men in 2001 and 2002 and was equal the incidence in 2003 (Figures 6 and 7).

AIDS incidence among women was highest among African American women during 2001-03; the rate among African American women was over four times that of Latinas and more than ten times that of White women during 2001-03 (Figure 7).

AIDS incidence for Latinas in 2001-03 was about 2.5 times the rate for White women (Figure 7).

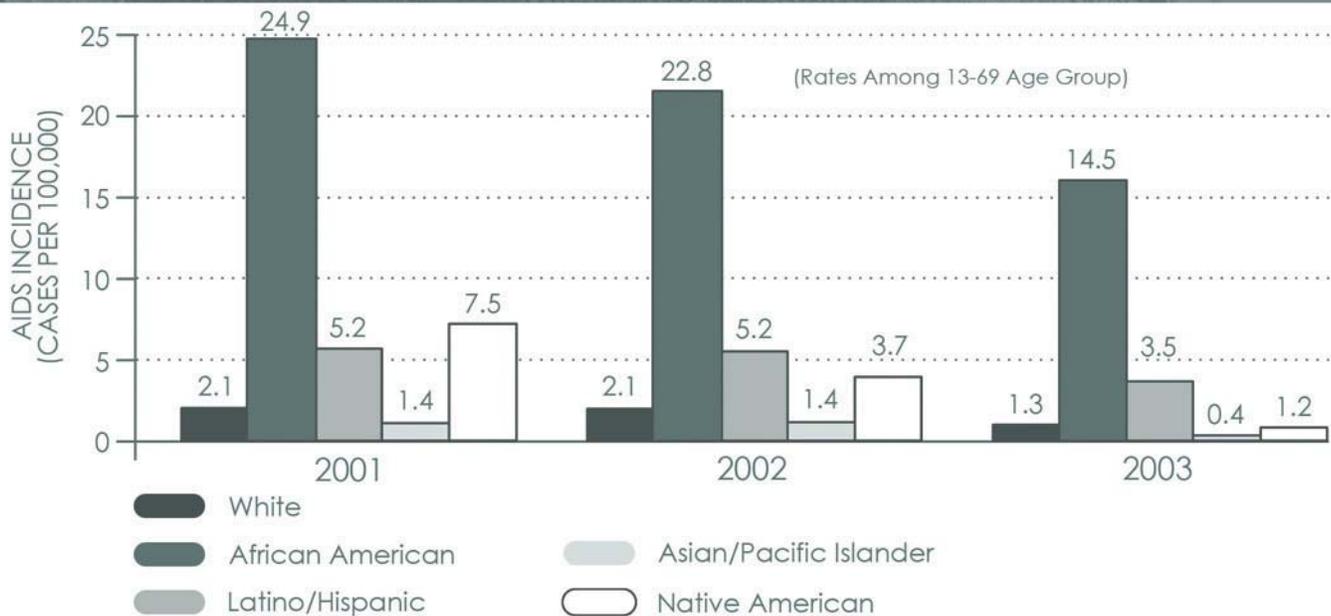
Like men, Asian/Pacific Islander women had the lowest AIDS incidence rates for all ethnic groups during 2001-03. In 2001 and 2002, Native American women had the second highest incidence rates for women and were similar to White women in 2003 (Figure 7).

**Figure 6.** Annual AIDS Incidence Among California Adult/Adolescent Males by Race/Ethnicity, 1981-2003



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry - Population data from California Department of Finance. Data represents AIDS cases and deaths diagnosed through December 31, 2003, as reported through January 31, 2004.

**Figure 7.** Annual AIDS Incidence Among California Adult/Adolescent Females by Race/Ethnicity, 1981-2003



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry - Population data from California Department of Finance. Data represents AIDS cases and deaths diagnosed through December 31, 2003, as reported through January 31, 2004.

## *Mode of HIV Exposure Among Male AIDS Cases, 2002-03*

The proportion of male AIDS cases diagnosed in 2002-03 reported with MSM exposure to HIV varied across racial/ethnic groups, with over 70 percent among White males, Asian/Pacific Islander and Latino males at 66 percent and 62 percent, respectively, and Native American and African American males at 58 percent and 45 percent, respectively (Figure 8).

Male AIDS cases diagnosed in 2002-03 and reported with injection drug use HIV exposure varied among racial/ethnic groups, with the percentage among African Americans (19.3 percent) more than double that for Whites (9.0 percent) and Latinos (7.9 percent), and more than triple that for Native American and Asian/Pacific Islander males (Figure 8).

The proportion of male AIDS cases in 2002-03 reported with heterosexual HIV exposure was tiered into two groups, with

African Americans (8.5 percent), Asian/Pacific Islanders (7.6 percent), and Latinos (6.5 percent) in the higher tier, and Native Americans (3.2 percent) and Whites (2.9 percent) in the lower tier (Figure 8).

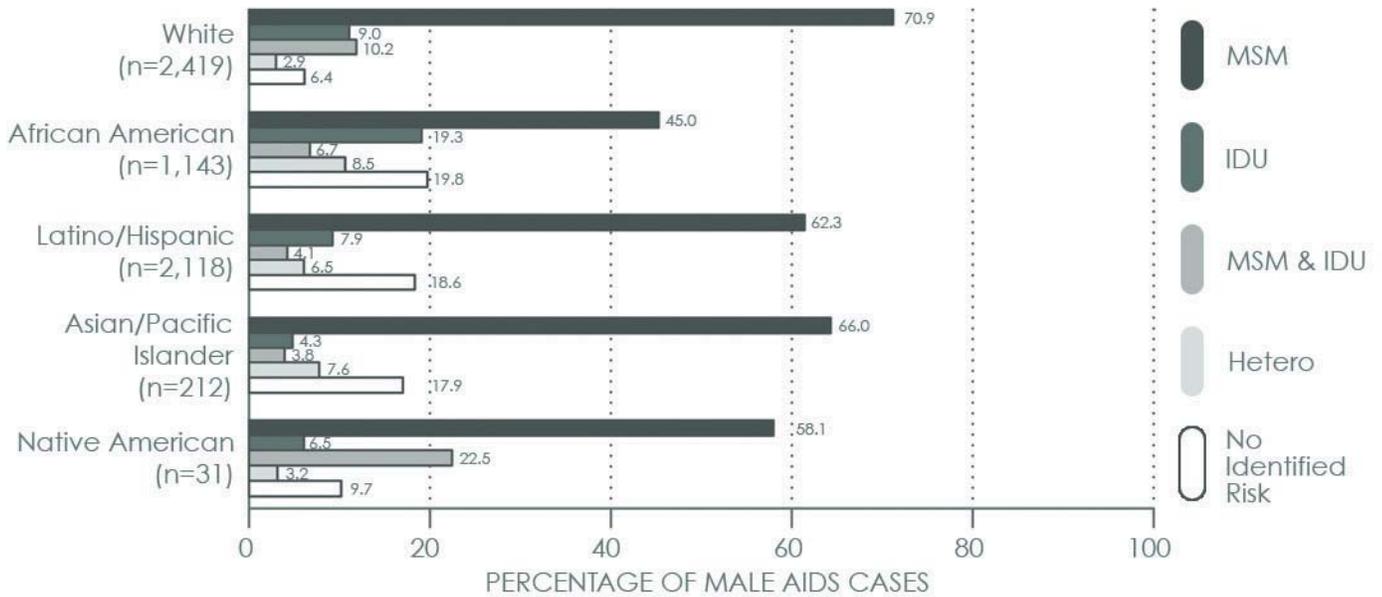
## *Mode of HIV Exposure Among Female AIDS Cases, 2002-03*

Over 63 percent of Asian/Pacific Islander female AIDS cases diagnosed in 2002-03 and 55 percent of Latina AIDS cases diagnosed in 2002-03 were reported with heterosexual HIV exposure, compared to under 46 percent for both White and African American female cases (Figure 9).

White and African American females had significantly higher proportions of AIDS cases in 2002-03 reported with injection drug use exposure to HIV (34.1 percent and 29.2 percent, respectively) than either Latinas (11.2 percent) or Asian/Pacific Islanders (3.3 percent) (Figure 9).

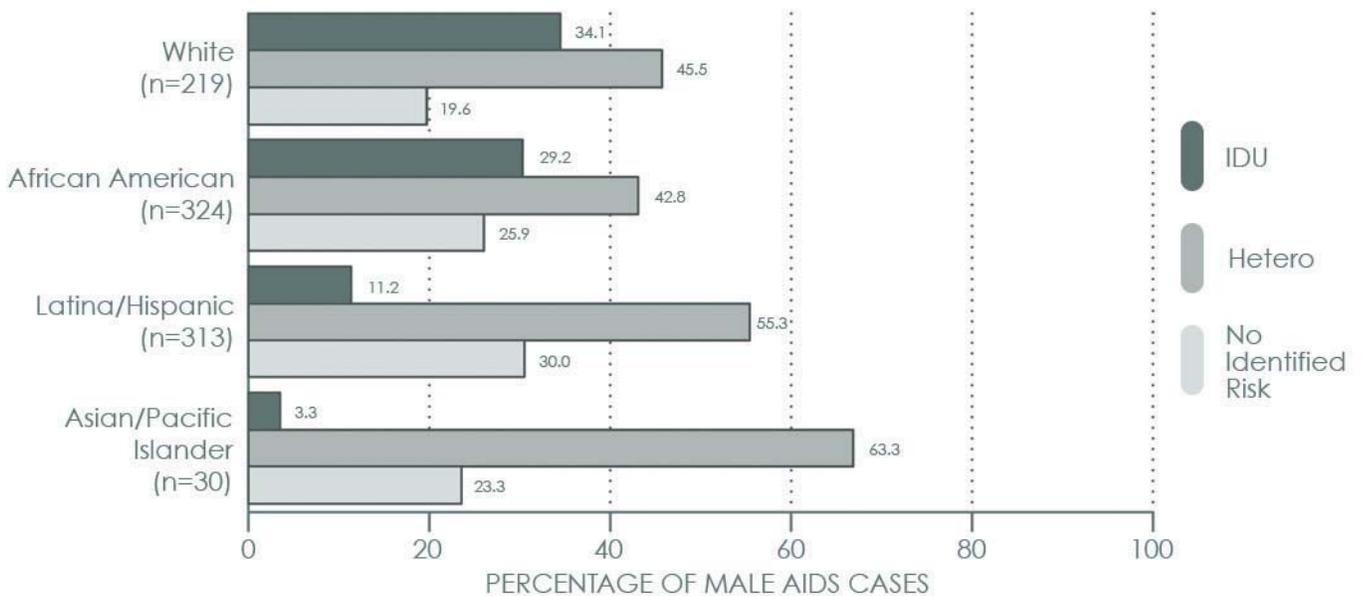
# HIV/AIDS Epidemiology Branch

**Figure 8.** Reported Mode of HIV Exposure Among California Male AIDS Cases by Race/Ethnicity, 2002-03



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry. Data represents AIDS cases and deaths diagnosed through December 31, 2003, as reported through January 31, 2004.

**Figure 9.** Reported Mode of HIV Exposure Among California Female AIDS Cases by Race/Ethnicity, 2002-03



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry - Data represents AIDS cases and deaths diagnosed through December 31, 2003, as reported through January 31, 2004. Native Americans not shown due to small numbers.

## **AIDS Cases in California Versus the United States**

Among AIDS cases diagnosed through December 31, 2002, (and reported through January 31, 2004, in California; reported through June 30, 2003, in the U.S.), California accounts for about 15 percent of cumulative AIDS cases diagnosed and 13.7 percent of presumed living AIDS cases in the U.S. and Puerto Rico (data not presented).

### *AIDS Cases by Gender*

Compared to the rest of the U.S., California continues to have a significantly higher proportion of AIDS cases among males. While 27 percent of AIDS cases diagnosed during 2002 in the rest of the U.S. occurred among

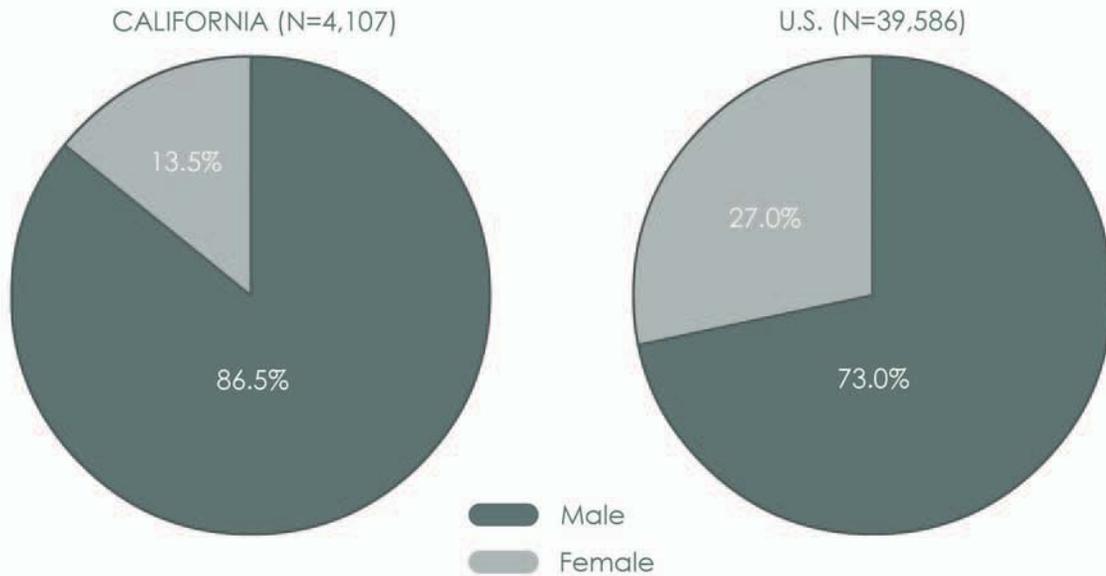
females, in California this proportion was 13.5 percent (Figure 10). The proportion of females among AIDS cases has risen steadily in both areas during the past 15 years (data not presented).

### *AIDS Cases by Age at Diagnosis*

For AIDS cases diagnosed in 2002, the age distribution in California is similar to that for the rest of the nation (Figure 11). Over 85 percent of cases diagnosed in 2002 within each region occurred among persons between 25 and 54 years old. A general shift of increasing age at AIDS diagnosis has occurred in both California and the U.S., particularly since the introduction of HAART, which helps to extend the time between HIV infection and AIDS diagnosis.

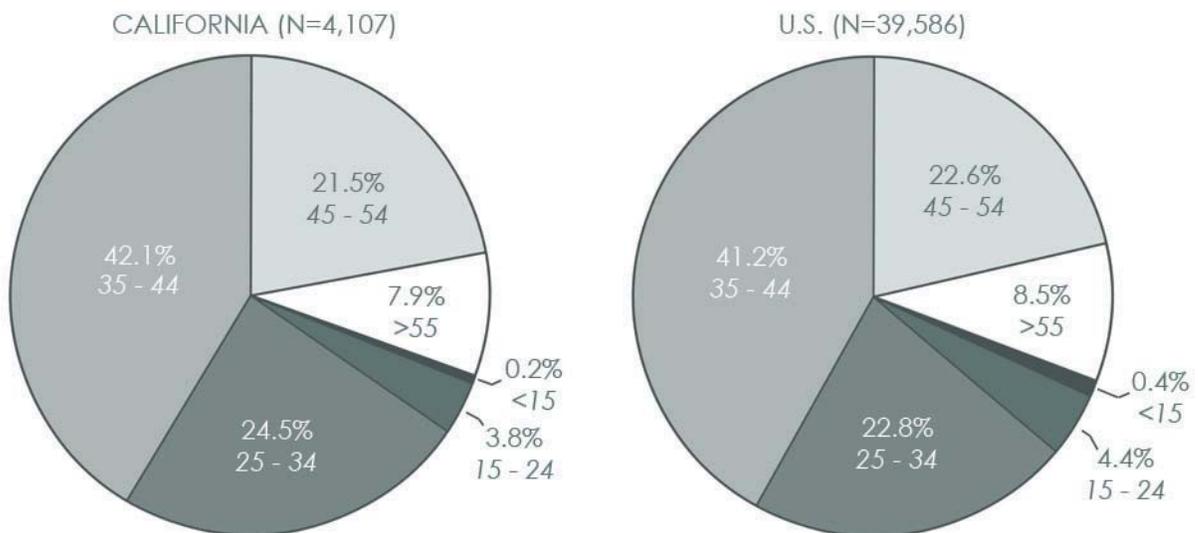
# HIV/AIDS Epidemiology Branch

**Figure 10.** AIDS Cases Diagnosed in 2002 by Gender, California Versus Remaining U.S.



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry (State Data); Centers for Disease Control and Prevention (U.S. Data) - State data as reported through January 31, 2004; national data reported through June 30, 2003 (adjusted for reporting delay). U.S. cases excluding California cases.

**Figure 11.** AIDS Cases Diagnosed in 2002 by Age at Diagnosis, California Versus Remaining U.S.



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry (State Data); Centers for Disease Control and Prevention (U.S. Data) - State data as reported through January 31, 2004; national data reported through June 30, 2003 (adjusted for reporting delay). U.S. cases excluding California cases. Age in years.

## *AIDS Cases By Race/Ethnicity*

During the past 20 years, the HIV/AIDS epidemic in California and the rest of the nation has shifted into communities of color, and the result of this trend is reflected among AIDS cases diagnosed in 2002. Over half of the AIDS cases diagnosed in 2002 in both the state and the rest of the nation were among people of color (Figure 12), but differences also occurred between the state and the rest of the nation. California, compared to the rest of the nation, had a larger proportion of AIDS cases diagnosed among White persons in 2002 (41.6 percent versus 27.2 percent). While over 53 percent of 2002 AIDS cases in the rest of the nation were African American, in California this percentage was 22.3 percent, which is reflective of the state having a smaller proportion of African Americans in its general population. However, the proportion of Latinos among cases diagnosed in 2002 is much higher in California (31.8 percent) than in the rest of the U.S. (18.0 percent); this is also true for Asian/Pacific Islanders (3.4 percent versus 0.9 percent). Both are reflective of larger representation of these groups within California's population.

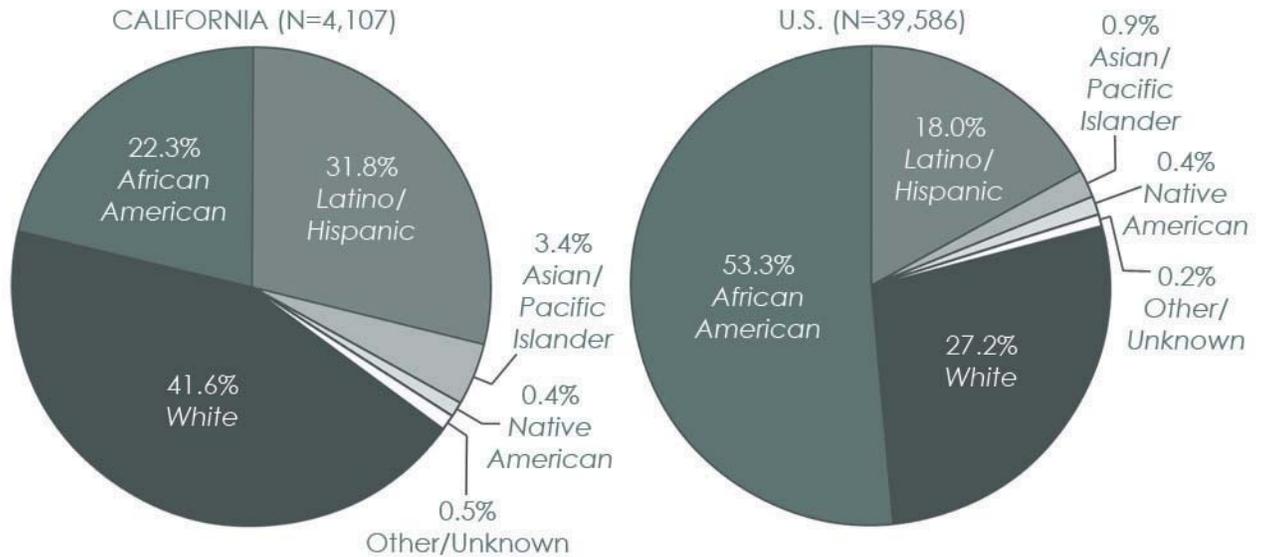
## *AIDS Cases by Reported Mode of HIV Exposure*

During the past 20 years, the HIV/AIDS epidemic has shifted out of the MSM population, but this shift has been much slower in California than in the rest of the U.S., and the result of this difference is reflected among AIDS cases diagnosed in 2002. While 53.9 percent of California AIDS cases diagnosed in 2002 were MSM, for the rest of the nation this proportion was 31.2 percent (Figure 13). These trends within the state and the rest of the nation are also reflected among 2002 AIDS cases reported in the MSM and IDUs category (7.3 percent in California; 3.2 percent in the rest of the nation).

California had a lower percentage of AIDS cases diagnosed in 2002 reported in the heterosexual risk category than the rest of the nation (10.4 percent versus 18.8 percent) (Figure 13). Much of this disparity is attributable to the difference in the proportions of cases diagnosed in each gender (Figure 10). The proportion of IDUs among AIDS cases diagnosed in 2002 is slightly lower in California than the rest of the nation (13.1 percent versus 17.5 percent) (Figure 13).

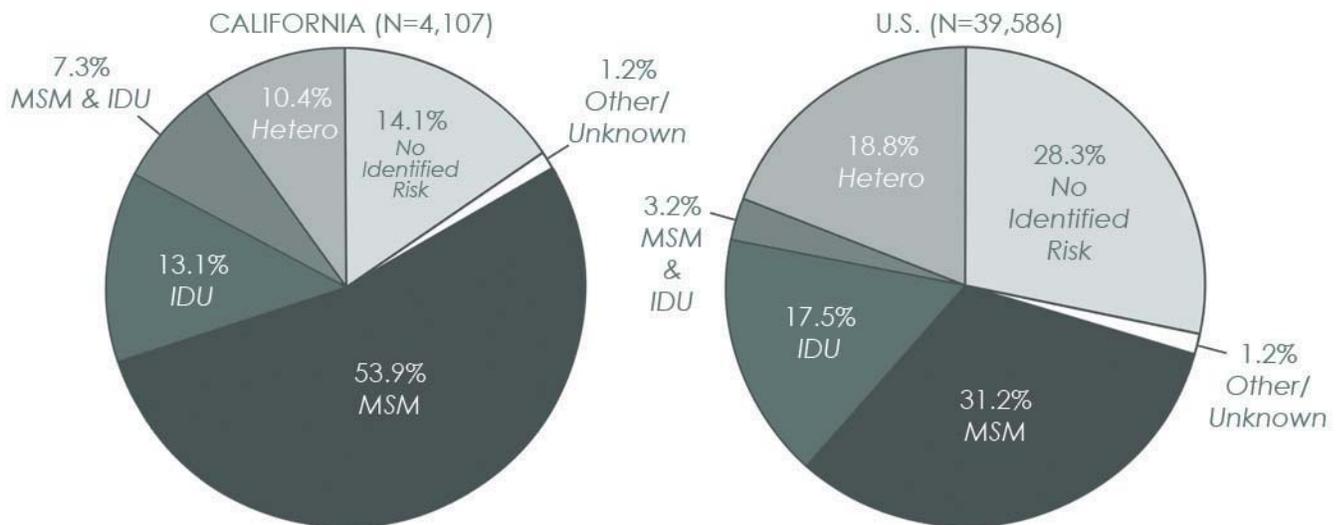
# HIV/AIDS Epidemiology Branch

**Figure 12.** AIDS Cases Diagnosed in 2002 by Race/Ethnicity, California Versus Remaining U.S.



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry (State Data); Centers for Disease Control and Prevention (U.S. Data) - State data as reported through January 31, 2004; national data reported through June 30, 2003 (adjusted for reporting delay). U.S. cases excluding California cases.

**Figure 13.** AIDS Cases Diagnosed in 2002 by Mode of HIV Exposure, California Versus Remaining U.S.



California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry (State Data); Centers for Disease Control and Prevention (U.S. Data) - State data as reported through January 31, 2004; national data reported through June 30, 2003 (adjusted for reporting delay). U.S. cases excluding California cases.

## Enhanced Perinatal Surveillance

In 2002 and 2003, DHS/OA continued its contract with Leland Stanford University School of Medicine to conduct active surveillance in major HIV referral centers and pediatric facilities outside Los Angeles County. This study showed the extent of HIV infection among California's children under 13 years of age, and contributed to the epidemiologic understanding of HIV infection and exposure in children.

As of December 31, 2003, approximately 199 enhanced perinatal surveillance forms were completed for mothers whose infants were delivered between 1999 and 2003. Use of zidovudine (AZT) by HIV-infected mothers during pregnancy and at labor and delivery were 76 percent and 84 percent, respectively in 2002. In 2003, use of AZT during pregnancy and at labor and delivery increased to 86 percent and 100 percent, respectively.

## HIV Serosurveillance

In collaboration with eight LHJs (the counties of Fresno, Kern, San Bernardino, San Diego, San Joaquin, and Santa Clara; the cities of Berkeley and Long Beach), DHS/OA supported HIV serosurveillance in selected STD clinics. All of the sites conduct anonymous and blinded HIV testing. The objectives of HIV serosurveillance are to:

- Provide state and local health officials, as well as the public, with information on HIV prevalence in various populations;
- Assess the magnitude and extent of HIV infection by demographic and behavioral subgroup and geographic area;

- Identify regional and national changes over time in the prevalence of infection in specific populations; and
- Project the number of children and adults who will develop HIV-associated illness and require medical care.

In 2003, DHS/OA completed the analysis of 2001 data collected from STD clinics. These clinics tested a total of 4,314 serum samples. The HIV seroprevalence at STD clinics was 1.4 percent. Men represented 62 percent (2,678) of the STD clinic population tested, of which 2.1 percent (56) were HIV seropositive. Women represented 37 percent (1,593) of those tested, of which 0.2 percent (3) were HIV seropositive. In 2001, the highest HIV seroprevalence (17 percent) was among MSM/IDUs.

## HIV Testing Survey

Since 2001, the HIV Testing Survey (HITS), an anonymous cross-sectional study, has been conducted in three high-risk population groups in San Diego, Alameda, and Sacramento Counties. HITS monitors HIV testing patterns, assesses why at-risk individuals seek or delay HIV testing, and identifies what factors influence their decisions.

In 2002, additional funds became available to expand HITS to improve understanding of HIV testing behaviors and perceptions in at-risk communities of color. In collaboration with CDC, DHS/OA developed plans to conduct HITS with migrant and seasonal farm workers in San Joaquin, Yolo, and Solano Counties.

In 2003, HITS was repeated in Alameda County to increase the sample size from

the original sample targeted in 2001. Data collection was completed as of December 2003 and a report will be published in 2004.

## **Blood Banks and Plasma Centers**

In 2002, 1,686,054 units of donated blood and blood products were donated through blood banks and plasma centers. Of these, 61 were confirmed HIV positive, resulting in a prevalence rate of 3.6 per 100,000 units tested. The first half of 2003 had 638,410 units of blood and blood products, with 27 confirmed HIV test results. Of those who donated blood or plasma during that six-month period, about 4.2 per 100,000 had blood that was infected. This is a low rate for blood and plasma, however, for blood banks alone, the rate was even lower. Results from the second half of 2003 will be collected and analyzed by summer 2004.

## **Civilian Applicants for Military Service**

Since October 1985, all civilian applicants for U.S. military service have been required to undergo testing for HIV infection as part of their medical entrance examination. The most recent data available (calendar year 2001) regarding prevalence of HIV among California military applicants showed a total of 11,850 specimens from seven selected counties were tested for HIV antibodies. Of these, 0.06 percent tested HIV positive. In 2001, male applicants in age group 30 to 34 had the highest prevalence, at 0.21 percent, but overall, prevalence was highest (0.32 percent) for African American male applicants.

## **HIV Prevalence, Infection, and Incidence Among Young Latino MSM - Imperial County and Mexicali, Mexico**

Sexual contact with another man is the most common mode of exposure among California Latino and Mexican male AIDS cases. In 2003, DHS/OA began a study at the California and Mexico border to assess HIV among Latino MSM between 18 to 29 years old. Previous studies have shown this cohort of MSM to be particularly at risk for HIV. DHS/OA worked with the Imperial County Health Department in El Centro, California, and La Iniciativa de Salud Fronteriza in Mexicali, Mexico, with support from CENSIDA in Mexico City, Mexico. The intent of this study is to assess HIV infection, incidence, prevalence of HIV-related perceptions, sexual and drug using behaviors, and access to health care and prevention information. A final report will be released in 2005.

## **HIV Serostatus, Risk Behaviors, and Associated Perceptions Among Binational Populations-San Francisco and Monterey Counties**

Roughly 140,000 Mexicans migrate annually between California and Mexico. California is home to 3.2 million Mexican-born individuals, and attracts 28 percent of temporary Mexican migrants to the U.S. Mexican states with the largest out-migration to the U.S. represent an alarming percentage of all HIV/AIDS cases in Mexico and rates have been on the rise. In 2003, DHS/OA, in collaboration with University of California, San Francisco, San Francisco

State University, and Clínica de Salud del Valle de Salinas in Monterey, began a study among two cohorts of Mexican communities in California: 1) migrant and seasonal workers in the agricultural sector in Monterey County, and 2) urban day laborers in San Francisco. Ethnographic and epidemiologic methods were used iteratively for an in-depth understanding of the sociocultural, structural, and environmental factors that shape HIV-risk/preventive behavior and perceptions. HIV infection was assessed using Orasure testing (rapid HIV test) with counseling and referral services provided. Data collection began in 2004 and a final report will be available in 2005.

## **Behavioral Surveillance-San Diego County**

As part of a new initiative that started at CDC in 2003, DHS/OA began a behavioral surveillance project in San Diego County, focused on high-risk populations such as MSM and IDUs. This project was a multi-year project and will be expanded to include other areas in the state. Two local CBOs with experience working with these high-risk groups will conduct formative research and behavioral interviews in English and Spanish. Data from this project site will be assessed alongside those from 24 other participating sites nationwide.

## **Young Men Survey**

The Young Men Survey (YMS) is a one-stage, cluster-sample, population-based, door-to-door, cross-sectional survey of the prevalence of HIV infection, STDs, hepatitis B, hepatitis C, and related risk behavior. This study began in late 2001 and will conclude in 2005.

Eligibility criteria includes males, age 18 to 35, who are fluent in English or Spanish, and reside in a low-income neighborhood within Alameda, Contra Costa, San Francisco, San Joaquin, and San Mateo Counties. The purpose of this study is to: 1) estimate the prevalence of important infectious diseases including HIV, syphilis, chlamydia, gonorrhea, herpes simplex virus types 1 and 2, hepatitis B, and hepatitis C; 2) examine the association of specific sexual and injection/nondrug using behaviors with the prevalence of the infections; and 3) assess the impact that demographic, attitudinal, and environmental factors have on certain risk behaviors as well as prevalence of infections.

YMS will provide population-based estimates of the prevalence of eight infectious diseases and related risk behavior within a population for whom data are often difficult to collect.



HIV Education and  
Prevention Services Branch

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# HIV Education and Prevention Services Branch

The HIV Education and Prevention Services Branch collaborates with LHJs, CBOs, service providers, advocacy organizations, universities, and other state and federal agencies to develop and implement focused HIV education and prevention programs. Many of these programs focus on preventing HIV transmission, changing individual attitudes about HIV and risk behaviors, promoting the development of risk-reduction skills, and changing community norms that may sanction unsafe sexual and drug-taking behaviors.

## Community Planning

Community planning is one of the nine required components of a comprehensive HIV prevention program as defined by CDC. Community planning is a participatory partnership between health departments and populations infected with or at risk for HIV. CDC expects HIV community planning to improve HIV prevention programs by strengthening the scientific basis, community relevance, and population- or risk-based focus of HIV prevention interventions. The basic intent of the process has been to:

- 1) increase meaningful community involvement in prevention planning;
- 2) improve the scientific basis of program decisions;
- and 3) target resources to those communities at highest risk for HIV transmission.

## Local HIV Prevention Community Planning

HIV prevention community planning at the local level is accomplished through LIGs who provide guidance to LHJs on HIV prevention efforts. Each jurisdiction is responsible for the coordination of its LIG. LIGs are comprised of advocates from the communities served, representatives from CBOs, and LHJ staff.

Their participation strengthens the partnership and collaboration between public health and community providers. Local HIV prevention plans are developed every three to five years. DHS/OA staff provides technical assistance, guidance, and timelines for implementing and assessing HIV prevention plans and measuring the progress of local planning groups.

## Statewide HIV Community Planning

CHPG helps guide statewide community planning in California. CHPG provides community perspectives, advice, and recommendations to DHS/OA in the planning and development of programs and allocation of resources.

In 2003, CHPG was restructured to incorporate HIV care and treatment issues along with education and prevention. CHPG is composed of people living with HIV/AIDS, community advocates, public health officials, and representatives from communities of color. Four CHPG task forces make recommendations to the entire planning group and DHS/OA. In 2002 and 2003, these task forces included:

### *Resource Allocation Task Force*

LHJ funding allocations are established through a formula developed by the Resource Allocation Task Force. In FY 2003-04, DHS/OA implemented the CHPG recommendation to adjust the LHJ formula allocations for HIV education and prevention services. The allocation adjustments improved the distribution of funds to the larger, more HIV affected communities.

# HIV Education and Prevention Services Branch

In 2003, the Resource Allocation Task Force created a new HIV prevention initiatives funding formulary for LHJs; it will become effective in FY 2005-06.

## *Gay Men/MSM Task Force*

In 2002 and 2003, the Gay Men/MSM Task Force analyzed HIV counseling and testing data, AIDS case data, STD data, and funding allocations and drafted two documents to help improve service delivery to gay men/MSM. The first document includes guiding principles for LHJs to ensure appropriate resource allocation to gay men/MSM programs, and to improve interventions provided to clients. The second document views HIV prevention from a gay men's health perspective and focuses on HIV prevention in the context of overall health and wellness. Once these documents are finalized, the Task Force will develop an implementation plan. (For additional information, see the Gay Men/MSM HIV Prevention Initiative section of this document.)

## *Viral Hepatitis C Task Force/Injection Drug Use Task Force*

The Viral Hepatitis C Task Force made recommendations to CHPG and DHS/OA during calendar years 2002 and 2003 to integrate hepatitis C education into existing HIV prevention and drug treatment programs. The Task Force recognized that the needs of IDUs are broader than hepatitis C and in 2003 requested that they evolve into a task force to address HIV-related risk factors of IDUs. The mission of the new Injection Drug Use Task Force includes developing recommendations to incorporate HIV prevention and care programs that are specifically targeted to this population.

## *Prevention with Positives Task Force*

The Prevention with Positives Task Force worked to integrate HIV/AIDS prevention and care initiatives to foster a comprehensive continuum of prevention and care for those at risk of acquiring and transmitting HIV. In 2003, based on the recommendations of CHPG, DHS/OA required LHJs to dedicate a portion of HIV prevention funds to prevention with positives activities. Simultaneously, CDC emphasized prevention with positives in its "HIV Prevention Strategic Plan Through 2005." (For additional information, see the Prevention with Positives—Statewide Contracts/Projects section of this document.)

## *Evaluating CHPG*

In 2003, CHPG improved its structure and approach to address HIV prevention and care initiatives. During 2003, a DHS/OA-funded evaluator conducted periodic surveys with CHPG and invited non-CHPG community members to provide constructive feedback to the CHPG Steering Committee, DHS/OA, CHPG members, and CDC. Results indicated that over 80 percent agreed that their task force included members with expertise in decision-making and planning and that decisions were based on the priority needs of targeted populations. However, members also indicated that task force decisions could be more thoroughly based on behavioral science, the needs of local communities, and California's epidemiologic profile. Evaluation activities for 2004 will be enhanced to provide additional feedback, support, and suggestions to the statewide planning body while monitoring the progress of the state community planning process.

## **African American Church Outreach Program**

The objectives of the African American Church Outreach program, a health promotion and communications campaign, are to mobilize African American church leaders to address HIV/AIDS; expand AIDS ministries among African American churches; provide consistent and accurate information to religious leaders; and disseminate prevention and testing information directly to the African American community. DHS/OA contracts with Bauman Curry and Company to oversee and implement activities of the African American Church Outreach program.

The program provided resources and activities during relevant milestone events throughout the year such as World AIDS Day, National Black HIV/AIDS Awareness Day, Black Church Week of Prayer, and National HIV Testing Day. In June 2002, the program launched the Black Church HIV Testing Outreach Campaign coinciding with National HIV Testing Day to mobilize members of the African American community to get tested. Representatives from the statewide Church Advisory Board, California Health and Human Services Agency, and DHS participated at the event held in Los Angeles. To demonstrate solidarity and leadership, board members signed a "Covenant Agreement" that committed them to dedicate four Sunday services a year to HIV/AIDS and mentor other churches to help them provide HIV prevention and testing.

Since the beginning of the program (2000), over 3,000 copies of Healing Begins Here: A Pastor's Guidebook for HIV/AIDS Ministry through the Church have been distributed to religious and public health leaders.

The Guidebook is posted on the Ark of Refuge, an African American faith-based agency, web site at <http://www.arkofrefuge.org>. In 2002, the Statewide HIV/AIDS Church Outreach Advisory Board updated and revised the Guidebook and a companion "quiz card" to distribute to church members for discussion on HIV prevention and to encourage HIV testing.

Results of an evaluation of the Pastor's Guidebook, completed in 2003, indicate that the resource is highly regarded and useful to church leaders and public health programs that work with African American faith-based communities. Based on the evaluation results, the Statewide HIV/AIDS Church Outreach Advisory Board will launch a new web site (<http://www.healingbeginshere.org>) in late 2004 to allow quick access to Guidebook updates, fact sheets, resources, new sermons, testimonials, flyers, and linkages to other AIDS related resources. Additional opportunities for technical assistance and training will be expanded and explored.

## **HIV Prevention for African American and Latino MSM Who Do Not Identify as Gay**

Subpopulations of African American and Latino gay men/MSM are experiencing dramatic increases in rates of new infections in California and nationally. Research has shown increased risk behavior among MSM of color who do not identify as gay. Interventions targeting gay men often fail to reach this population, and prevention interventions targeting African American and Latino heterosexual men often lack specific information about MSM behavior. In 2003, DHS/OA through UARP funded a Request for Proposal (RFP) for up to four demonstration projects to develop, implement, and evaluate

an HIV prevention intervention for MSM of color that do not identify as gay.

## **Local HIV Prevention High Risk Behavior Change Campaign Efforts**

In 2002 and 2003, DHS/OA funded seven LHJs to participate in a three-year HIV Prevention High Risk Behavior Change Campaign. As part of the campaign, each jurisdiction implemented an integrated set of HIV prevention activities targeting high-risk populations to reach specific behavioral goals. The primary strategies defined in localized social marketing plans include workshops, coalition building, community mobilization, outreach, media advocacy, public relations, advertising, and materials development. This approach follows the trend of local community planning and outreach efforts that emphasize targeted local strategies for high-risk individuals, and adds flexibility to develop specific products and/or services to reach those at greatest risk for contracting HIV.

Funding will continue for several LHJs that successfully responded to a Request for Application (RFA) process. The next three-year funding cycle will include increased emphasis on expanding evaluation efforts and targeting specific high-risk audiences.

## **Women and People of Color**

In 2002 and 2003, LHJs continued to work with CBOs to develop, expand, and implement HIV primary prevention interventions for women and people of color at high risk for HIV infection. State and federal CDC funds were allocated to Alameda, Humboldt, Imperial, Orange, San Diego, San Luis Obispo, and

Santa Clara Counties for projects that target high-risk women and their sex and needle-sharing partners. High-risk people of color projects, funded in 2002 and 2003, included the City of Berkeley and the counties of Alameda, Humboldt, Sacramento, San Diego, San Joaquin, San Luis Obispo, Santa Clara, and Sonoma. Although funding for these high-risk initiatives ended June 30, 2004, lessons learned will be incorporated into funding decisions made by LHJs for other HIV education and prevention funds.

## **Gay Men/MSM HIV Prevention Initiative**

Planning for the Gay Men/MSM HIV Prevention Initiative began December 2000. The goal of the Initiative is to reduce HIV incidence and prevalence among gay men and non-gay identified MSM. It is used as the framework to guide HIV prevention efforts and includes research, programmatic, and evaluation efforts. The following activities were included in this initiative.

### *Gay Men/MSM Who Use Methamphetamine*

Methamphetamine (meth) use is on the rise in California and has been linked to increased risk for HIV infection among gay men/MSM. In April 2003, a meeting was convened to discuss how DHS/OA could respond to the HIV prevention needs of gay men/MSM who use meth. The meeting brought together researchers, community providers, local public health officials, and representatives from the California DADP, DHS/STD Control Branch, and DHS/OA to discuss data and innovative programs that are currently implemented in California.

Also in 2003, DHS/OA identified funding for demonstration projects that support the development, implementation, and evaluation of HIV prevention interventions designed to serve gay men/MSM who use meth. The demonstration projects will be a community provider/research partnership, and will be distributed through UARP in 2004.

## *Internet-based HIV Prevention Intervention Targeting Gay Men/MSM*

Recent research has shown that the Internet is used heavily by gay men and MSM to connect with sexual partners, with some users reporting behaviors that put them at risk for HIV. In 2003, through collaboration with UARP, DHS/OA funded a RFP to support the development and pilot testing of an innovative environmental/structural Internet-based HIV/STD prevention intervention for gay men/MSM in California. Each funded project will be a community-research partnership. Phase one will conduct formative research and design, and pilot test the intervention. The second phase will implement the intervention and conduct a process evaluation. The final phase will include data analysis and findings dissemination.

## *Sexual Networks*

Sexual networks are groups of people who are connected to each other sexually. Several factors influence how quickly HIV can spread in sexual networks, such as the number of persons in a network, how high-risk persons interact within a network, and the number of links each person has with others.

In 2003, DHS/OA and DHS/STD Control Branch co-sponsored a meeting with

researchers, prevention providers, and public health and community representatives to address sexual networks. The major theme of the meeting was to direct HIV prevention efforts toward those that are transmitting HIV versus those that may acquire it. Another theme addressed venues where men connect for sex (e.g., bathhouses, sex clubs, and the Internet). These venues were identified as primary contributors to HIV and STD transmission in sexual networks.

Discussions focused on how to identify core groups of high-risk men from low-risk men and how sexual partners are found. Additionally, participants discussed the impact of racial disparities for gay men/MSM of color and how to disseminate information to HIV and STD prevention providers for integration into their work.

## *Commercial Sex Venues*

Based on the nature of their businesses, commercial sex venues (CSVs) are optimal locations for HIV prevention. In California, owners and managers of most venues are committed to HIV and STD prevention and have instituted various programs including rules for safer sex, educational materials distribution, improved interior lighting, condom distribution, and STD and HIV counseling and testing. Although disease prevention is conducted in CSVs, there is a need to increase collaborative efforts between CSVs and LHJs. In 2003, DHS/OA and the DHS/STD Control Branch convened a series of meetings to provide owners and managers of CSVs an opportunity to identify barriers and successes in HIV prevention, and to improve collaborative relationships.

# HIV Education and Prevention Services Branch

During the meetings, CSVs mentioned a need to standardize HIV and STD prevention services. At the conclusion, participants agreed that a series of interviews would be conducted with owners and managers and local public health officials to understand the HIV prevention needs of patrons. Together, groups of owners and managers, DHS/OA, and DHS/STD Control Branch will develop recommendations for HIV and STD prevention. Implementation of these guidelines will be voluntary and adaptable to the needs of each CSV.

## Youth Drop-In Centers

Fresno, Humboldt, Imperial, Mendocino, Orange, San Diego, San Luis Obispo, Santa Clara, Santa Cruz, and Shasta Counties were funded to operate 15 youth drop-in centers during 2002 and 2003. A drop-in center is a small, storefront-style building located on an active pedestrian street, near public transportation. Its purpose is to provide prevention services in a private and comfortable setting to low-income youth at high risk for HIV infection. Drop-in centers are a neutral space where positive health maintenance is the primary objective.

Each county health department collaborates with at least one CBO with the capacity and programmatic expertise to provide risk reduction and prevention services to high-risk youth between the ages of 12 to 24. DHS/OA provides technical assistance to these projects and facilitates collaboration between the counties.

In 2003, DHS/OA consolidated feedback on proposed funding priorities from LHJs, AIDS directors, staff, and CHPG. Based on this

feedback, funding for the youth drop-in program will end June 30, 2004.

## Prevention with Positives – Statewide Contracts/Projects

Education alone does not change behaviors; therefore, DHS/OA has encouraged LHJs to focus on behavioral change interventions for targeted high-risk populations, and to de-emphasize educational interventions for low-risk populations.

Historically, prevention efforts have been focused on persons who were HIV negative. There has been a recent shift to direct prevention efforts to those who are HIV infected. This new public health policy focuses efforts toward those who are at risk for transmitting HIV. DHS/OA has been at the forefront of focusing prevention efforts on those who are HIV positive.

In 2003, HIV Education and Prevention Services and HIV Care Branches collaborated to develop *Prevention with Positives: A Guide to Effective Programs*. The guide includes information for HIV prevention providers to develop science-based programs and can be used by policy makers, administrators, and advocates to ensure that appropriate HIV prevention services are targeting HIV-positive individuals and those at highest risk for contracting HIV. The guide is available on the CDC web site at <http://www.cdc.gov> and the DHS/OA web site at <http://www.dhs.ca.gov/AIDS>.

In 2003, DHS/OA funded three statewide prevention with positives projects to meet the technical assessment and training needs of HIV prevention providers:

# HIV Education and Prevention Services Branch

- AIDS Health Project (AHP) offers education and prevention and care and treatment providers a two-day training: “Prevention with People Living with HIV: Developing a New Relationship,” designed to enhance the ability of providers to work with HIV-infected clients on issues related to prevention. The goal of this training is to help providers understand the complex and varied psychological, social, behavioral, and cultural factors associated with risk-related behavior. DHS/OA added a new one-day follow-up training: “Supporting Positive Sexual Health.” This training focuses on advanced clinical interventions with people who are HIV positive and may be sexually active.
- AIDS Project Los Angeles (APLA) offers a series of two-day training workshops that consist of an evaluation training module and a program planning and development training module. These trainings are designed to provide a baseline understanding of prevention with positives program planning, development, and evaluation, specific to people of color. CBOs are eligible to receive further one-on-one technical assistance from APLA after attending these workshops.
- Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) developed a training curriculum and protocol on prevention strategies for HIV-positive populations. The training included a review of behavioral theories that can be used in the development, implementation, and evaluation of prevention efforts targeting HIV-positive populations. CHIPTS conducted five regional trainings throughout California

on prevention strategies for HIV-positive populations. In addition to the trainings, CHIPTS offered technical assistance to LHJs that need assistance in developing their prevention with positives initiative(s).

Based on the recent development of prevention with positive interventions, there is limited research on their efficacy. In 2003, DHS/OA funded an evaluation of the Shanti Project’s L.I.F.E. program. L.I.F.E. is an immune-boosting program for persons living with HIV based on mind/body medicine. It is a comprehensive, “biopsychosocial” approach that enhances traditional medicine by looking at internal psychological responses and external social factors that affect immunity and the course of a disease. The evaluation will determine L.I.F.E.’s efficacy in three areas: 1) prevention – reducing HIV risk behavior; 2) treatment – increasing immune system functioning; and 3) adherence – improving adherence to medication and other health enhancing protocols. The impact of the L.I.F.E. program on the physical health (HIV symptoms and disease progression) of enrolled clients will also be examined.

## Targeted Interventions to High-Risk Groups

The NIGHT Program provides services in 21 LHJs and targets individuals at highest risk for contracting HIV. Services are provided to at-risk populations in venues where they congregate (e.g., streets, bars, parks, nutrition programs, and homeless shelters). In 2003, large mobile testing vans were used in seven LHJs to provide STD and TB screening with rapid HIV testing piloted in some. Twelve other LHJs use smaller vans to provide a safe, private, confidential setting where counseling

can occur. Mobile van staff, typically former members of at-risk populations, use one-on-one interactions to establish rapport, with the goal of offering HIV counseling, testing, and referrals for social services and follow-up services.

DHS/OA evaluated the NIGHT Program in 2002 and 2003. In part, the study evaluated the implementation of the Evaluating Local Interventions (ELI) system, and outcome data on the program's ability to reach high-risk clients. Results showed that the program reached its goal of providing counseling and testing services to extremely high-risk populations, especially communities of color. Client data for 2002 showed that African Americans represented 41.6 percent of clients served and Latinos accounted for 24.9 percent. Although not yet complete, data for 2003 showed that 41.9 percent of clients served were African American and 23.7 percent Latino. Overall, in 2002, 27 percent of the HIV testing at the 21 LHJs was attributable to the NIGHT Program.

## California Corrections Initiative

In 2002 and 2003, DHS/OA funded the California Corrections Initiative, a cooperative agreement that provides HIV prevention, intervention, and continuity of care within correctional settings and the community. The Initiative supports demonstration projects that develop models of comprehensive surveillance, prevention, and health care activities for HIV, STD, TB, substance abuse, and hepatitis. The program focuses on transitional links for pre- and post-release HIV-positive and high-risk negative inmates while promoting health and reducing recidivism.

DHS/OA monitors the demonstration projects and coordinates the evaluation. At the state level DHS/OA and California Department of Corrections Peer Education program, and Parole and Transitional Case Management program participated in this project.

The San Francisco Department of Public Health and Los Angeles County Office of AIDS Programs and Policy in collaboration with their county jail systems provide programmatic coordination and evaluation oversight for ten community providers.

Centerforce, a CBO, works collaboratively with the California Department of Corrections Peer Education and Parole and Transitional Case Management programs to provide peer education, pre-release health education, and prevention case management for high-risk, HIV-negative clients. Centerforce provides services in San Quentin State Prison, Central California Women's Facility, and Valley State Prison for Women.

Continuum, another CBO, works closely with the San Francisco County Sheriff's Department, and administers the Homebase Program, which targets incarcerated HIV-positive individuals in the San Francisco County jail system. When possible, clients are met at the jail's release facility where case managers help them access support and medical services. Services are provided at a transitional housing site, which improves a client's ability to access the full constellation of services.

With the high density and turnover in the jail population, coupled with the infectivity of hepatitis, inmates are at a significantly higher risk for contracting hepatitis B and C than the

# HIV Education and Prevention Services Branch

general population. In 2003, DHS/OA added a hepatitis B and C screening and vaccination demonstration program to the California Corrections Initiative in the San Francisco County jail.

Los Angeles County Office of AIDS Programs and Policy collaborates with the Los Angeles County Sheriff's Department to support services provided by seven CBOs (Tarzana Treatment Center, Minority AIDS Project, JWCH, Inc., AIDS Healthcare Foundation, Los Angeles Gay and Lesbian Center, Correct Help, and Los Angeles Centers for Alcohol and Drug Abuse). These organizations provide HIV counseling and testing, and various case management services that enhance the continuum of care for HIV-positive inmates who are transitioning back to their communities.

The California Corrections Initiative will end in 2004 and a final evaluation report will outline results, lessons learned, and plans to sustain successful components of the project.

## HTPP

In calendar years 2002 and 2003, DHS/OA funded HTPP to provide intensive individual risk reduction counseling and case management services to high-risk individuals. HTPP has two distinct segments:

- 1) Interventions targeting HIV-negative, high-risk persons (funded through CDC and coordinated by the HIV Education and Prevention Services Branch); and
- 2) Interventions targeting HIV-positive, high-risk persons (funded through CDC and coordinated by the HIV Care Branch).

These two segments have different protocols and interventions, but are closely coordinated to share information, expertise, and resources, and to facilitate participation of both HIV-positive and HIV-negative persons who are linked through family or other networks. (See the HIV Care Branch section of this report for information on the HIV-positive component of this program.)

HTPP has five funded jurisdictions (Butte, Humboldt, Orange, and Riverside Counties and the City of Long Beach). Sites were selected based on their willingness to participate in the project, the number of high-risk clients in their jurisdictions, statewide geographic distribution, and client risk exposure (e.g., MSM and needle sharing).

Among MSM, HTPP data shows: 1) decreases in unprotected sex; 2) increases in condom use; 3) decreases in diagnosis of STDs; and 4) decreases in meth and amyl nitrate use (drugs linked to high-risk behavior and HIV infection among MSM).

## PCRS

DHS/OA provides funding, training, and technical assistance for the PCRS program. PCRS counselors help clients learn how to disclose their HIV status to their partners in a productive and sensitive manner, and teach them how to encourage their partners to seek HIV counseling and testing and PCRS services. Training is provided by the STD/HIV Prevention Training Center to local STD and HIV prevention staff, including case managers and nurses.

HIV PCRS providers bring partners to counseling, testing, and other medical services

# HIV Education and Prevention Services Branch

through a coordinated approach that involves prevention, care, HIV and STD treatment, and local field services. PCRS is offered in anonymous and confidential HIV counseling and testing sites, expanded counseling services, early intervention programs, private medical venues and HIV case management, and community-based care facilities in 12 LHJs.

During calendar years 2002 and 2003, 549 HIV-positive clients were offered PCRS. Of those offers, 265 (48 percent) chose to participate in PCRS. Most clients who participated (81 percent) chose to counsel their partner themselves and received services accordingly, while 18 percent chose to have a provider notify partners of their potential HIV exposure anonymously.

PCRS providers followed up on 77 partners from January 2002 to December 2003. Of the 77 partners, all were sexual partners of referring clients and 3 were also needle-sharing partners. Fifty-three (69 percent) of the partners were located based on information provided by the client. Of the 53 contacted, 4 stated they were already HIV positive. Thirty-three partners (62 percent) tested for HIV as a result of PCRS, the majority (73 percent) testing for the first time. All tested HIV negative. Providers were unable to locate 18 partners and 6 partners refused contact with health workers.

## HIV Counseling and Testing

The HIV Counseling and Testing program provides anonymous and confidential HIV counseling and testing services to Californians with perceived risk for HIV. Annually, the HIV Counseling and Testing program provides

approximately \$8 million in state and federal funds to all 61 LHJs, rural primary care clinics, and Indian health clinics. In 2002 and 2003 combined, approximately 400,000 HIV tests were performed with a seropositivity rate of 1.38 percent.

Both anonymous and confidential HIV counseling and testing services provide client-focused prevention counseling and assessment of client needs regarding HIV transmission, personal risk behaviors, risk-reduction planning, and referral to other services.

## Rapid HIV Testing

In 2003, rapid HIV testing began at several HIV testing sites throughout California. On November 7, 2002, the first second generation rapid HIV test, OraQuick, was approved by the federal Food and Drug Administration (FDA) for testing finger stick blood samples for antibodies to HIV. OraQuick, developed by OraSure Technologies, is highly accurate and provides results in 20-40 minutes. A preliminary positive OraQuick test result requires confirmation by a standard laboratory-based test, a blood or oral fluid sample. A sample is collected from the client and sent to a DHS approved licensed clinical laboratory for further testing prior to reporting any results. A negative OraQuick result is considered definitive and does not require confirmation. The test can be used by an HIV counselor, trained by DHS/OA and who works in a DHS/OA-funded HIV counseling and testing site, provided they meet other federal and state requirements.

In August 2003, rapid HIV testing was pilot tested in five projects (San Diego, Sonoma, Alameda, and San Francisco Counties and the

City of Long Beach). In addition to the five, as of December 2003, Sacramento, Los Angeles, Orange, and Fresno Counties were conducting tests. Ideally, by the end of 2005, up to 85 percent of all HIV tests conducted in the state will be rapid tests.

In 2003, DHS/OA developed and evaluated protocols and quality assurance guidelines for the use of OraQuick in a variety of HIV testing sites. In October 2003, the final version of the quality assurance guidelines was provided to all LHJs in California. These guidelines and quality assurance measures will serve as a supplement to the California OA HIV Counseling and Testing Guidelines.

## **Prevention of Perinatal Transmission of HIV Project**

In 2000, DHS/OA began its five-year collaboration with Stanford University to develop a perinatal project to increase the levels of HIV education, counseling, and testing offered to pregnant women. The two-tiered strategy of needs assessment and perinatal services were targeted to five counties (Alameda, Los Angeles, Sacramento, San Diego, and San Joaquin), because of their diverse socioeconomic, racial, and ethnic populations.

The project identified populations that experience difficulty accessing care, and subsequently developed culturally and socially appropriate interventions that were implemented and evaluated. Throughout the project, evaluation measures were conducted by internal interviews and surveys of providers and pregnant women to assess outcome measures regarding the immediate impact of interventions among providers and clients as

well as quantitative outcomes, such as the efficacy of HIV counseling, testing, education, and treatment programs.

In 2003, resource materials were revised in English and Spanish to enhance the efforts of health care and service providers offering HIV counseling and voluntary testing to all pregnant women.

## **Counseling and Testing Program Evaluation**

The counseling and testing program evaluation process has two components: ongoing and quality assurance evaluation of counselor and client data reported to DHS/OA, and periodic formal on-site evaluation of contractors.

Ongoing process and quality assurance evaluation provides information that is shared with LHJs and may be used by DHS/OA to make policy and program decisions. Counselor training and activities are examined to ensure that counselors have completed required training and that individuals permitted to attend DHS/OA-funded trainings actively provide HIV counseling and testing. Site utilization data demonstrates whether sites are testing adequate numbers of high-risk clients.

The periodic formal evaluation of the HIV counseling and testing program was conducted in 2002. DHS/OA staff reviewed counseling and testing activities, local quality assurance procedures, administrative structure, and program management during site visits. Specific processes such as 'no show' policies, crisis intervention protocols, referral practices, and partner notification services were also reviewed.

The 2003 Counselor Survey was sent to experienced HIV counselors in state-funded

HIV testing sites. The four-page anonymous survey covered basic demographics and counseling experiences to accurately characterize the present HIV counselor population.

When compared to the previous 1994 Counselor Survey results, basic demographic findings indicate that 2003 HIV counselors are generally older and more experienced and a higher proportions are male and non-White. Overall job satisfaction averaged five on a six point scale, with work environment ratings generally high, but varying individually and across jurisdictions.

Information gathered from the 2003 Counselor Survey was used to develop new and refine existing HIV counselor trainings. Survey results were disseminated to individual LHJs and as a statewide report.

## **Hepatitis C Testing as an Incentive to Increase HIV Testing among IDUs in California**

In 2003, DHS/OA received funding from CDC to conduct a demonstration project to evaluate the use of hepatitis C counseling and testing as an incentive to attract larger numbers of IDUs into HIV counseling and testing services. The project objective was to better understand how alternative approaches might influence HIV counseling and testing rates among IDUs in California, and to assist local, county, and state health officials to address viral surveillance and prevention efforts among IDUs.

DHS/OA identified five sites in California to participate in the project (Riverside, Humboldt, Solano, and Fresno Counties and the City of Berkeley). The counties were chosen based

on their ability to reach a significant number of IDUs, sufficient staffing to administer the project, ability to provide clients with targeted educational and harm reduction materials and appropriate referrals, and little or no ongoing hepatitis C screening or related research.

A comprehensive evaluation of the demonstration project found that HIV testing rates increased 86 percent and HIV disclosure rates increased 21 percent when HIV and hepatitis C counseling and testing were offered concurrently. All five sites found that more IDUs tested and returned for their HIV test result during the intervention. Overall, hepatitis C prevalence among IDUs who were tested across all five sites was 37 percent. Riverside, Humboldt, and Solano Counties and the City of Berkeley all had similar hepatitis C prevalence, at 32 percent, 31 percent, 31 percent, and 23 percent, respectively, while Fresno County had a prevalence of 75 percent. Actual hepatitis C prevalence in the five sites is possibly higher, since site staff only tested IDUs who had not previously tested positive for the virus.

Because of the increase in HIV testing and disclosure rates observed during the demonstration project, DHS/OA will provide additional funding to qualified LHJs for 2004 through 2006. Such funding will facilitate similar HIV and hepatitis C integration initiatives across the state in an attempt to further increase HIV counseling and testing rates among IDUs.

## **HIV Prevention Counselor Training**

The HIV Prevention Counselor Training program ensures a uniform, high standard of service to all DHS/OA-funded HIV counseling and testing sites. The training curriculum helps

prevention counselors gain the necessary skills to provide consistent assessment, effective intervention, and appropriate referral services for at-risk clients. The HIV Prevention Counselor Training is a seven-day course delivered in two separate trainings, Basic I and II.

Basic I, a five-day training, includes an introduction to client-centered counseling skills relating to risk assessment, risk reduction, counseling guidelines, and cultural issues. Basic II, a two-day training, focuses on enhancing client risk assessment skills and emphasizes behavior change models, risk reduction planning, and secondary risk factors for HIV infection.

Successful completion of both trainings authorizes an HIV Prevention Counselor to provide HIV prevention counseling services. Each year all counselors participate in Continuing Education Training (CET) to maintain eligibility as an HIV Prevention Counselor. In 2003, a new CET was developed to train counselors on single-session counseling. This CET is also used to train existing HIV counselors on rapid HIV testing and counseling protocol.

## **Community Health Outreach Worker Training**

Since 1988, DHS/OA has contracted with the Institute for Community Health Outreach (ICHO) to train community health outreach workers (CHOWs) for DHS/OA education and prevention contractors. CHOWs provide health education services to high-risk populations such as IDUs, their sexual partners, and high-risk youth. ICHO training methods have become an international model for targeted interventions to at-risk populations.

ICHO continually expands its training by developing innovative health education strategies for targeted interventions to MSM, women of childbearing age, sex industry workers, IDUs, runaways, gang members, the homeless, migrant workers, transgender individuals, and communities of color.

Effective July 1, 2003, the length of the beginning CHOW training was reduced from ten to five days.

## **ELI**

In response to CDC program evaluation requirements, DHS/OA implemented an innovative web-based evaluation system for HIV prevention providers. Piloted in fall 2001 and spring 2002, ELI enables California's HIV prevention providers to systematically collect and access client-based information critical to tracking program activities and evaluating their programs. ELI provides DHS/OA with information on the state of HIV prevention interventions in California.

Statewide implementation of ELI began July 1, 2002. Throughout 2002, individuals from each of the 61 LHJs were trained on how to use ELI and evaluation basics. Ongoing trainings are provided every other month around the state. As of December 2003, there were 1,015,226 client contacts recorded. The majority of those client contacts come from street outreach interventions. Over 1,200 users from 206 CBOs in 61 LHJs utilize the system.

The California Technical Assistance Project (CTAP) a proactive, responsive technical

# HIV Education and Prevention Services Branch

assistance program, provides programmatic technical assistance on the use of ELI and regional trainings. Training focuses on evaluation, including the rationale for collecting data, how to use ELI forms for recording data, and how to use the information generated from ELI to enhance and evaluate programs. In addition, CTAP conducts ELI technical assistance site visits to LHJs and their subcontractors, and provides individualized technical assistance in areas such as scope of work review.

ELI is accessible via the DHS/OA web site at <http://www.dhs.ca.gov/AIDS>.

## **California AIDS Clearinghouse (CAC)**

In 2002 and 2003, CAC, administered by the Los Angeles Gay and Lesbian Center, acted as a repository and distribution resource center

that provided culturally appropriate technical support in the areas of HIV/AIDS/STD client materials and information. CAC supports DHS/OA through materials collection, community materials development training and grants, and a multimedia resource center. CAC services are available at no cost to DHS/OA-funded local community planning groups, HIV education and prevention programs, and HIV counseling and testing programs. Based on availability, materials are made accessible at no cost to California nonprofit public health HIV and related prevention programs (STD, TB, etc.) that are listed with the California HIV/AIDS Hotline. A cost recovery price is charged if the program is not listed with the California HIV/AIDS Hotline, is a for-profit entity, or is located outside California. Additional information can be obtained from CAC's web site <http://www.HIVINFO.org>.





HIV Care Branch

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# HIV Care Branch

The HIV Care Branch has responsibility for the administration and oversight of state and federal programs related to the care and treatment of people living with HIV/AIDS in California. HIV care services assist people living with HIV by providing primary health care and medications, as well as support services to ensure access to and retention in care. Programs administered through the HIV Care Branch fill gaps in care where other resources are not available.

## Ryan White CARE Act

The federal Ryan White CARE Act (RWCA) established a variety of AIDS programs under five titles or parts:

- Title I, the Emergency Relief Grant Program, provides emergency funding to eligible metropolitan areas (EMAs) hardest hit by the HIV epidemic. There are nine EMAs in California (Los Angeles, Oakland [Alameda and Contra Costa Counties], Santa Rosa/Petaluma [Sonoma County], Riverside/San Bernardino, Sacramento [Sacramento, Placer, and El Dorado Counties], San Diego, San Francisco [San Francisco, San Mateo, and Marin Counties], San Jose [Santa Clara County], and Santa Ana [Orange County]) that receive Title I funds and administer them at the local level;
- Title II, the HIV CARE Grants program, provides formula-based financial assistance to states. In California, Title II funds are administered by DHS/OA and are described in more detail on the following pages;
- Title III, Early Intervention Services, provides competitive grants for early health care intervention, counseling, testing,

and treatment services. Title III planning grants provides funds for one year to eligible agencies to plan high quality comprehensive HIV primary health care services in rural or urban underserved areas and communities of color. Title III capacity building funds allow eligible entities to strengthen their organizational infrastructure and enhance their capacity to develop, enhance, or expand high quality HIV primary health care services in rural or urban underserved areas and communities of color;

- Title IV provides coordinated services and access to research for women, infant, children, and youth. Title IV also addresses notification and training programs for emergency response programs; and
- Part F includes the HIV/AIDS Dental Reimbursement Program, Special Projects of National Significance (SPNS) and AIDS Education and Training Centers (AETCs).

The following table shows California's RWCA funding for federal FYs 2002-03 and 2003-04 based on information provided by HRSA.

In federal FYs 2002-03 and 2003-04, California continued to use Title II funds to administer HIV Care Services, the AIDS CMP, CARE/HIPP, and ADAP. Other program activities mandated under the RWCA include: 1) the Minority AIDS Initiative (MAI), which was created to increase access to primary care and HIV therapies for people of color; 2) Emerging Communities grants which provide funds to metropolitan areas that do not meet the criteria of an EMA and have between 500 and 999 reported AIDS cases; and 3) Quality Management (QM) that requires states to develop, implement,

## Ryan White CARE Act: California Allocations for Federal Fiscal Years 2002-03

TITLE	2002-03	2003-04
Title I	\$108,666,313	\$111,173,791
Title II - State Formula	\$32,885,805	\$31,561,611
Title II - Minority AIDS Initiative	\$643,263	\$595,047
Title II - Emerging Communities	\$0	\$0
Title II - ADAP	\$82,051,914	\$86,118,340
Title III - Capacity Building	\$270,983	\$225,000
Title III - Early Intervention Services	\$8,948,986	\$4,691,520
Title III - Planning	\$350,000	\$50,000
Title IV	\$1,598,065	\$1,397,788
Part F - SPNS	\$200,000	\$1,300,000
Part F - Dental	\$300,000	\$1,056,119
Part F - AETC	\$5,012,000	\$5,000,000
<b>TOTAL</b>	<b>\$240,927,329</b>	<b>\$243,169,216</b>

California Department of Health Services, Office of AIDS - February 2004

and monitor QM programs. In October 2003, DHS/OA along with other private and public agencies hosted a Cross-Titles QM forum to inform participants about HRSA's QM mandate and to share successful methods for developing and implementing QM activities.

### ADAP

ADAP provides HIV/AIDS drugs for individuals who could not otherwise afford them. Drugs on the ADAP formulary slow the progression of HIV disease, prevent and treat opportunistic infections among people with HIV/AIDS, and treat the side effects of antiretroviral therapy.

- In FY 2002-03, the ADAP budget of \$184.645 million was comprised of \$67.443 million in state General Fund; \$93.241 million in RWCA Title II funds; and \$23.961

million in statutorily mandated drug manufacturer rebates. In FY 2002-03, ADAP provided over 775,600 prescriptions to nearly 25,800 ADAP eligible clients.

- In FY 2003-04, the ADAP budget of \$212.355 million was comprised of \$64.338 million in state General Fund; \$97.675 million in RWCA Title II funds; and \$50.342 million statutorily mandated drug manufacturer rebates.

As of December 31, 2003, there were over 3,400 participating ADAP pharmacies and 275 local ADAP enrollment sites located throughout the 61 LHJs of California. Monthly client utilization of the program increased 12 percent in the 12-month period from December 2002 to December 2003. Additionally, there was a two percent increase in the percentage of clients

# HIV Care Branch

accessing three or more antiretroviral drugs, a six percent increase in four drugs, and a three percent increase in four or more drugs. This is likely due to changes in preferred HIV therapies, which include more complicated treatment regimens and possibly salvage therapies.

The ADAP Medical Advisory Committee (MAC) met twice in both 2002 and 2003 to review the ADAP formulary, evaluate available HIV/AIDS drugs, and recommend changes to the formulary. As of December 31, 2003, there were 151 drugs on the formulary, including all FDA-approved antiretrovirals. The ADAP formulary is posted on the Internet at <http://www.dhs.ca.gov/AIDS> and <http://www.ramsellcorp.org>.

## CARE/HIPP

CARE/HIPP assists people with HIV/AIDS to maintain their private health insurance coverage. Because participants' health insurance policies must cover outpatient prescription drugs, the program also helps ensure that CARE/HIPP clients have access to AIDS drugs, and preserves ADAP access for clients with no other method of obtaining drug coverage. CARE/HIPP clients must meet financial eligibility criteria (income under 400 percent of federal poverty level (FPL) and assets under \$6,000 excluding one car and one house), have applied and be eligible for public or other disability programs, be medically disabled as a result of HIV/AIDS, and have a health insurance plan that covers outpatient prescription drugs and HIV-related treatment services. Enrollment services are provided through 148 participating agencies in all counties except Alpine, Amador, Glenn, Modoc, and Sierra.

Beginning in 2002, the program experienced a steady increase in health insurance premium costs and client enrollees, ultimately resulting in a budget increase from \$867,501 in FY 2001-02, to \$1.39 million in FY 2002-03, and eventually \$1.7 million in FY 2003-04.

The program enrolled 385 new clients in 2002 and 316 new clients in 2003. CARE/HIPP staff processed health insurance premium payments for over 700 clients each year, and provided benefits counselor trainings throughout the state. A full-time HIV benefits consultant provides AIDS service providers and DHS/OA staff with technical assistance in the areas of public and private benefits, health insurance programs, and consultation services.

## Care Services/Consortia Program

The Care Services/Consortia Program (formerly HIV Consortia and Direct Services Program) provides funding to local agencies for medical and support services for persons living with HIV/AIDS. Funding is made available for the provision of care and treatment services and to support local HIV planning processes, as required by HRSA.

The local planning bodies such as HIV Care Consortia, Title I Planning Councils, and local advisory groups, are responsible for conducting or updating an assessment of HIV/AIDS service needs for their geographic services area, establishing an HIV service delivery plan based upon prioritized services, coordinating and integrating the delivery of HIV-related services, evaluating the success in responding to service needs, and evaluating the cost-effectiveness of the mechanism used to deliver comprehensive HIV care.

Funds are made available to all counties for the provision of primary medical care and a variety of supportive services that facilitate access to primary medical care. Services include ambulatory/outpatient medical care, case management, oral health care, transportation, drug reimbursement, substance abuse treatment and counseling, mental health therapy, nutritional services, and other services of a treatment nature. In both FYs 2002-03 and 2003-04, \$12.2 million was allocated to counties, of which approximately 78 percent was expended on health care services, including primary medical care, treatment adherence and medications; 14 percent on case management to assist persons with HIV/AIDS enter and remain in the care system; and 8 percent on other services and costs.

## **HOPWA Program**

The U.S. Department of Housing and Urban Development (HUD) provides funding for housing and supportive services for low-income persons living with HIV/AIDS through the HOPWA Program. The program objective is to prevent or alleviate homelessness by providing rental, mortgage and utility assistance, supportive services, and other housing assistance.

HOPWA funding allocations are distributed by HUD to eligible metropolitan statistical areas (EMSAs) and eligible state grantees. DHS/OA, as the state grantee for HOPWA funds, receives funds on behalf of the 44 non-EMSA counties.

In FY 2001-02, the HOPWA allocation was \$2.75 million. In FYs 2002-03 and 2003-04, HOPWA funding increased to \$2.9 million and \$3.04 million, respectively. For the last two

FYs, HOPWA funds provided affordable HIV housing and supportive services to over 4,000 eligible clients and families experiencing homelessness or at risk of homelessness.

California counties in designated EMSAs that receive direct HOPWA funding from HUD are Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, Sacramento (including El Dorado and Placer), San Bernardino, San Diego, San Francisco, San Mateo, and Santa Clara.

## **HIV Housing Program**

The HIV Housing Program provides funding for the development of rental housing projects or programs designed to prevent or alleviate homelessness of persons living with HIV/AIDS and their families by providing long term, affordable, supportive housing units. The HIV Housing Program is funded jointly through the state General Fund and HOPWA. Awards are made annually on a competitive basis to nonprofit housing providers, local governments, and HIV/AIDS service providers working collaboratively to develop HIV-designated housing units within the 11 counties (excluding EMSAs) with the highest need for affordable HIV/AIDS housing, specifically the counties of Santa Cruz, Monterey, San Luis Obispo, Santa Barbara, Ventura, Fresno, Kern, Stanislaus, San Joaquin, Sonoma, and Solano.

In 2002 and 2003, eight new housing units were established and will provide affordable supportive housing for many years to come. The success of this program is due to the collaborative efforts of HIV service agencies and a variety of housing agencies.

## **RALF Program**

The RALF Program is designed to provide direct subsidy payments to residential AIDS facilities licensed under RCFCI licensing category. RCFCIs are the only facilities licensed by the Department of Social Services that California law permits to accept and retain adults with HIV/AIDS in need of a high level of care. As of December 31, 2003, there were 28 licensed RCFCIs in California with a total capacity of over 400 beds per night.

The RALF Program provides operating funds based upon the total number of beds designated for persons living with AIDS. In FY 2002-03, the RALF Program provided assistance to 23 RCFCI facilities, ensuring that over 110,000 bed nights continued to be designated for persons living with AIDS. The assistance made available through RALF has proven to be a cost-effective approach to lowering the high costs associated with providing high-level care at acute care facilities. In FYs 2002-03 and 2003-04 RALF received \$1 million dollars in state General Fund.

## **AIDS CMP**

The AIDS CMP provides comprehensive, cost effective, home- and community-based services for persons with AIDS or symptomatic HIV infection who are unable to function independently. Adult clients must be scored at 70 or less on the Cognitive and Functional Ability Scale, which includes factors affecting abilities that are specific for adults with HIV infection, and children under the age of 13 at any stage of HIV infection.

The program maintains clients safely in their homes, which avoids more costly institutional

care in a nursing facility or hospital. It provides comprehensive nurse and social work case management with the participation of the client and/or a legal representative.

DHS/OA contracts with 44 agencies to administer the program in 52 counties. These agencies subcontract with qualified providers for direct care services. Funding for CMP has remained stable at \$8.6 million (\$6.7 million in state General Funds and \$1.9 million in federal RWCA Title II funds) for several years. Of the \$8.6 million, \$300,000 in state General Funds was allocated to San Francisco, Alameda, Los Angeles, and Monterey Counties, specifically for services to people of color. In both 2002 and 2003, 1,314 client slots were allocated statewide.

## **AIDS MCWP**

The AIDS MCWP provides comprehensive, cost effective, home- and community-based services to Medi-Cal beneficiaries with mid-to-late stage HIV/AIDS. To be eligible for MCWP, clients must be certified as needing nursing facility level of care or above, and adults must have a score of 60 or less on the Cognitive and Functional Ability Scale. Children must be classified as A, B, or C on the "Centers for Disease Control and Prevention Classification System for HIV Infection in Children Less than 13 Years of Age."

Like CMP, MCWP maintains clients safely in their homes and avoids more costly institutional care in a nursing facility or hospital. DHS/OA currently contracts with 36 county health departments and CBOs to administer the program at the local level in 47 counties. These agencies subcontract with qualified providers for direct care services.

In calendar years 2002 and 2003, MCWP served over 3,000 unduplicated clients and expended approximately \$16 million for client services and administrative fees, each year.

## EIP

Implemented in 1987, EIP provides transmission prevention interventions for HIV-infected persons within the context of their HIV care and treatment. The goals of the program are to prolong the health and productivity of HIV-infected persons and to interrupt the transmission of HIV. These goals are achieved through the provision of comprehensive, multidisciplinary services that include medical care, transmission prevention counseling and support, treatment and health education, psychosocial support, and case management. Periodic client assessments, case conferencing, and individual service plans are utilized to tailor services to meet individual client needs and to maximize successful client outcomes.

EIP has 34 sites located throughout California. In 2002, EIP had nearly 10,000 active clients and provided over 121,000 units of services to those clients. Calendar year 2002 demographic data indicate that EIP clients are 38 percent White, 36 percent Latino, 22 percent African American, 2 percent Asian/Pacific Islander, and 2 percent Other/Not Reported.

EIP local assistance budget for both FYs 2002-03 and 2003-04 was \$7.182 million. Of this total, \$600,000 was CDC federal funds and the balance was from the state General Fund.

## Bridge Project

The primary goal of the Bridge Project is to prevent further transmission of HIV within

disproportionately affected communities of color by increasing the number of HIV-infected individuals who are successfully engaged in comprehensive HIV care, treatment, and prevention services. The Bridge Project was developed in response to data that suggest that many HIV-infected persons of color, or members of other vulnerable or marginalized populations, do not seek treatment until advanced stages of disease progression, have lower rates of retention in treatment programs, and lower rates of adherence to treatment regimens. The Bridge worker (typically a member of the community they serve) locates out-of-care, HIV-infected individuals through street outreach, contacts with emergency rooms and testing sites, and through referrals. The Bridge worker uses a variety of techniques and support strategies to remove the barriers that have prevented the client from accessing or remaining in care. The Bridge worker is also a certified treatment educator and helps the client to understand treatment options and to resolve adherence issues.

The Bridge Project was one of the five national pilot projects funded through the CDC's Prevention for HIV-Infected Persons Program (PHIPP) and is part of a national PHIPP evaluation. The Bridge Project operates in 21 EIP sites statewide.

In FY 2002-03, the program's total local assistance budget was \$1.61 million, a combination of \$465,000 federal CDC funds, \$680,000 federal MAI funds, and \$465,000 from the state General Fund. In FY 2003-04, the program's total local assistance budget was \$1.55 million, a combination of \$465,000 federal CDC funds, \$550,000 MAI funds, and \$535,000 from the state General Fund.

Since March 2001, Bridge workers have recruited 1,280 clients into the Bridge Project. Seventy-seven percent of clients are people of color, 40 percent African American, 35 percent Latino, and 2 percent Asian/Pacific Islander and Native American. Most clients are men (76 percent) and 43 percent identified as MSM. Bridge workers engage marginalized clients into care: 331 Bridge clients are IDUs, of which one-fifth are MSM.

## **HIV Transmission Prevention Program for Positives (HTPP+)**

HTPP+ was established in 1999 as part of a collaborative effort by the HIV Care Branch and the HIV Education and Prevention Services Branch. HTPP+ provides intensive, individualized, prevention interventions for HIV-infected clients who are at high risk for transmitting HIV and for whom the more standard EIP risk reduction interventions have not been enough to sustain safe transmission behaviors. HTPP+ services are provided by licensed mental health professionals with a background in HIV, or a related field such as substance abuse and behavior change. There are currently ten EIP sites that provide HTPP+ services.

HTPP+ was one of five national pilot projects funded through the CDC's PHIPP and was part of the national PHIPP evaluation.

Initial analysis of HTPP+ data demonstrated a 53 percent increase in condom use among HIV-positive clients at high risk for transmitting HIV. Behavior changes from California's HTPP+ intervention resulted in a 62 percent decrease in STDs over a one-year period of time. HTPP+ has also had a substantial effect on alcohol and illicit drug use. Clients have reported decreasing alcohol consumption

and use of heroin, cocaine, crack, and meth, and have shown a significant increase in their adherence to HIV medications since enrolling in the intervention.

## **TMP**

The HIV TMP (formerly the HIV Diagnostic Assay Program (HDAP)) provides access to specific laboratory tests (viral load and resistance testing) through a voucher-based program for low income, HIV-infected Californians who are uninsured or underinsured.

HIV therapeutic monitoring provides clinicians with objective tools to measure the efficacy of a particular course of HAART, thereby increasing successful outcomes, and ensuring the quality of life and longevity of HIV-infected persons. Viral load tests measure the amount of HIV in an individual's blood plasma. Viral load testing services began in FY 1997-98, and as of December 31, 2003, the program conducted over 150,000 viral load tests to eligible individuals.

HIV resistance testing measures the degree to which an individual's HIV strain has become resistant (or less sensitive) to antiretroviral drugs. In FYs 2000-01 and FY 2002-03, a total of 3,896 genotypic and phenotypic tests were analyzed and processed.

In FY 2002-03, the budget was \$8 million (\$5.8 million state General Funds and \$2.2 million RWCA funds). The Budget Act of 2003, redirected \$7 million from HDAP to ADAP. In 2003, HDAP was renamed the HIV TMP and codified in the California Health and Safety Code. Funding priority is given to state-funded EIP sites for viral load tests.



Collaboration

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DHS/OA, as lead state agency in California's fight against HIV/AIDS, collaborates with numerous organizations including CBOs and local, state (including state-supported universities), and federal government entities. In addition, some state government entities support their own independent HIV programs or projects. Collaboration enhances project/program diversity and optimizes use of limited fiscal and personnel resources. Some collaborative projects are described in the preceding sections on HIV/AIDS epidemiology, HIV education and prevention services, and HIV care. This section describes collaborative and independent state-supported projects that may not be discussed elsewhere in this report.

## **The 2003 California Summit on African Americans and HIV**

In June 2002, DHS/OA, DHS/Office of Multicultural Health, and Drew Center for AIDS Research, collaborated to develop and convene the 2003 California Summit on African Americans and HIV. HIV has had a devastating affect on African Americans, thus, the inspiration for the summit was to initiate critical dialogue and strategize new coordinated efforts to significantly reduce new HIV infections, increase HIV testing, and improve linkage between HIV testing, prevention, and care for African Americans in California, by 2010, all with the leadership by the African American community.

In order to obtain broader dialogue prior to the Summit, five regional meetings (Bay Area, Central Valley, Inland Empire, Los Angeles, and San Diego) were held with over 500 people attending. The Summit kicked off with a Town Hall Forum at Preservation Park in Oakland, California, on October 8, 2003. The following

two days involved over 100 participants who came together as a community to inspire one another, discuss the affects that HIV/AIDS has had on African Americans, and to initiate critical change.

At the conclusion, participants developed a framework for a strategic plan that included recommendations, strategies, goals, and objectives for private, local and government agencies, and African Americans to establish effective solutions to eliminate HIV within the African American community. The strategic plan was financed by the meeting participants and is planned for release in 2004.

## **Urban Migrant Latino Study**

DHS/OA, in collaboration with the City of Berkeley Public Health Department, completed a study in 2003 of sexually active, male Latino migrants working as urban day laborers. The specific goal of the study was to collect data on basic demographics, sexual risk behaviors, injection drug use risk behaviors, migration patterns, and HIV testing patterns. Outreach workers visited areas alongside roadways where day laborers are offered employment to recruit a minimum of 250 participants using convenience sampling. A 30-minute in-person interview was conducted with each eligible participant and a short HIV education and counseling session was conducted post-interview. A report of findings will be available in 2004.

## **Transborder Latina Study**

In 2002, DHS/OA in collaboration with Proyecto de Consejo y Apoyo Binacional (PROCABI), a binational CBO, and the San Diego County Health Department began a transborder study

among Latinas in the San Diego, California, and Tijuana, Mexico, area. The total study population includes 515 Latina's between the ages of 18 to 35. Women complete an in-depth interview, including questions on HIV-related sexual and drug risk behaviors. Following the interview women are tested for HIV, syphilis, chlamydia, gonorrhea, hepatitis B, and hepatitis C. Test results, counseling, and referral services are provided during a follow-up visit. Data collection is schedule to be completed in 2004.

## **Report on HIV/AIDS Surveillance in California and Mexico**

California and Mexico have several similarities, which creates challenges for control of HIV and other infectious diseases. In 2002 and 2003, DHS/OA and the Centro Nacional para la Prevención y Control del VIH/SIDA (CENSIDA), Mexico's Office of AIDS, completed an in-depth assessment of AIDS in Mexico and California, with emphasis on cases of Mexican descent. This report, to be published in English and Spanish, is being written to share information between the two offices. It will present descriptions of the HIV/AIDS surveillance systems in both California and Mexico, provide perspectives on the migration of Mexico's population between Mexico and the U.S., in particular California, and help encourage information exchange and bilateral collaboration to better serve those populations that spend time in both regions.

## **UARP**

UARP provides state funding for the support of merit-reviewed AIDS-related research to be conducted at nonprofit research institutions throughout California. UARP is a component

of the Office of Health Affairs in the University of California, Office of the President, and is advised by the Universitywide Task Force on AIDS, whose membership includes California researchers representing a variety of scientific disciplines, institutions, and persons affected by HIV/AIDS.

## *HIV Education and Prevention*

In 2002 and 2003, UARP and DHS/OA continued their collaboration on prevention evaluation activities for the state of California. Twenty-five community collaborative prevention evaluation projects were supported to evaluate high priority prevention interventions statewide, including HIV counseling and testing; outreach; and individual and group level interventions serving gay/MSM, youth, people of color, substance users, and high-risk youth populations. Results from these projects were distributed to stakeholders through the UARP/DHS/OA Dissemination Project. A Prevention Indicator Project was conducted to synthesize data from multiple sources, assess the current status of the epidemic and the long-term impact of prevention services on populations at highest risk for transmission. DHS/OA funded UARP to support high priority projects for gay, bisexual and MSM populations, Internet users, meth users, and men of color who do not identify as gay. Finally, these evidence-based prevention interventions were integrated into the prevention service system.

## *HIV Care*

UARP and the HIV Care Branch continued its interagency agreement in 2002 and 2003 to collaborate on care and treatment evaluation activities for California. The overall goal of the

collaboration was to ensure the ultimate quality and effectiveness of HIV/AIDS care-related services and programs in California. The objectives were two-fold: 1) to plan, assess, and develop strategies for evaluating HIV-related care services and programs in California that are supported by the federal RWCA and other public funds, and 2) to fund scientifically rigorous evaluations of care and treatment programs. Consistent with these objectives, the following activities occurred:

- The evaluation component was conducted by the University of California, San Francisco and the San Francisco Department of Public Health. The evaluation examined the predictors of care coordination services; impact of these services on the utilization of health services; clients receipt and adherence of antiretroviral therapy; impact of care coordination services on change in health status; and cost-effectiveness of care coordination services. A final document will be available in 2004.
- The California Consortium on HIV/AIDS Health Services Research, formed and funded by UARP and DHS/OA, is comprised of health services researchers. In September 2002, UARP published the Consortium report that proposed a research agenda of specific, targeted questions for researchers to consider in their work for the next few years.

## **AIDS Regional Information and Evaluation System (ARIES) Project**

In 2002 and 2003, DHS/OA continued meeting with representatives from the Texas

Department of Health, HIV/STD Epidemiology Division; the County of San Diego, Office of AIDS Coordination (Title I EMA); and the Riverside-San Bernardino Title I EMA to discuss the common need for a care and treatment management information system. In early 2002, these four HRSA administrative entities (two Title I grantees and two Title II grantees) entered into a formal agreement to collaboratively develop a web-based tool to track clients receiving publicly funded care and treatment services; the four partners selected UARP to be the ARIES project manager. While the four entities have combined funding to develop the tool, each jurisdiction will independently implement the final product. In December 2002, UARP released the ARIES RFP and in June 2003 UARP entered into a contract with Architier (a San Francisco based company). Architier met numerous times with each of the partners to determine the needs and requirements of the system and the partners continued to finalize the system specifications and screen shots for Architier to develop. Testing of the system is expected to begin in fall 2004.

## **DHS/STD Control Branch**

In 2002 and 2003, DHS/OA convened meetings and collaborated with the DHS/STD Control Branch on several programmatic issues that affect HIV/AIDS and STDs. The meetings allowed representatives to discuss program data, exchange knowledge of high-risk behaviors, and identify and plan effective interventions that would contribute to lower risk behaviors for gay men/MSM in California. Additionally, the STD Control Branch continued providing PCRS training for STD and HIV prevention staff.

## DHS/TB Control Branch

In 2002 and 2003, DHS/OA continued collaboration with the DHS/TB Control Branch on epidemiologic and surveillance aspects of TB and HIV/AIDS, and to match and verify TB and AIDS reporting system data. Data results are used to improve AIDS and TB reporting, prevention, and care services.

## DADP

The Comprehensive Alcohol and Other Drug Prevention and Treatment Program of DADP allocates at least five percent of its total allocation to provide HIV/AIDS-related services to persons who are in treatment for substance abuse. Allocations are distributed to counties using a needs-based methodology. Counties are required to develop plans for spending their allocation and must comply with "County/Provider Block Grant Guidelines." Programs provide a range of early intervention services from pre- and post-test counseling to referrals for related medical and social services.

DHS/OA continues to provide support services for the DADP HIV antibody testing program for people enrolled in alcohol and other drug treatment programs. These services include training DADP counselors to conduct risk assessment and disclosure sessions for in-treatment clients. DHS/OA also provides technical assistance to agencies using the HIV Test Reporting System, and collects and analyzes data and prepares reports on HIV testing in county drug treatment programs.

## Department of Housing and Community Development

DHS/OA collaborates with the Department of Housing and Community Development (HCD) in the development of the statewide Consolidated Plan and Annual Updates. This collaboration, along with the close relationship between DHS/OA housing programs and many of the other HUD-funded housing programs administered by HCD, has raised awareness of the affordable housing needs of persons with HIV/AIDS.

DHS/OA has developed joint funding and training strategies with HCD to address the supportive housing needs of persons with HIV/AIDS. Many of these individuals meet the requirements for participation in housing programs for the low-income and homeless populations. Service providers who are knowledgeable about a wide range of programs are able to access a greater number of housing opportunities for their clients.

## Interagency Task Force on Homelessness

DHS/OA and other DHS staff participate on the Interagency Task Force on Homelessness, a task force of representatives from a variety of state agencies and departments including DADP, Mental Health, Education, Employment, Veteran's Affairs, Social Services, HCD, Corrections, and Aging. Also included are Governor's Office representatives. This task force has developed collaborative strategies to address homelessness among a variety of populations, including HIV/AIDS.

## **HIV, Hepatitis B Virus, and Hepatitis C Virus Prevalence Study at San Quentin Prison**

DHS/OA has collaborated with CDC, DHS/Viral and Rickettsial Disease Laboratory, California Department of Corrections, and Centerforce, a CBO, since March 2001 to implement a study to measure the prevalence and incidence of HIV, hepatitis B, and hepatitis C among inmates of San Quentin State Prison. This study assessed drug use and risky sexual behaviors of 500 incoming inmates who received HIV counseling and voluntary HIV testing. Data collection was completed at the end of 2003 and the report findings will be released in 2004.

## **California Statewide Treatment Education Program**

DHS/OA contracted with San Francisco's Asian and Pacific Islander Wellness Center to provide HIV treatment education certification classes in English and Spanish through the California Statewide Treatment Education Program. The Center provides training and certification throughout California to HIV service providers who are potential certified treatment educators on medical, behavioral, and adherence related aspects of HIV treatment.

## **University of California, San Francisco, Pacific AIDS Education and Training Center (PAETC)**

The interagency agreement with the University of California, San Francisco, PAETC continued in 2002 and 2003 to provide consultation to clinicians regarding the use of HIV resistance tests.

Consultation services are available to California physicians via the National HIV

Telephone Consultation Service (The Warmline). The Warmline, (800) 933-3413, is staffed by HIV-experienced clinicians, and assists physicians with patient-specific questions regarding the use and interpretation of HIV resistance tests. Complex cases are referred to a panel of expert HIV clinicians for review, comprehensive interpretation of HIV resistance test results, and recommendations for treatment options.

In 2002 and 2003, PAETC staff met quarterly with HIV Care Branch staff regarding progress reports, medical and pharmaceutical issues, treatment standards, and quality management issues related to HIV/AIDS care and treatment services.

In 2003, PAETC staff began reviewing all client requests for access to Fuzeon. Fuzeon, an expensive, new class of antiretroviral therapy, was added to the ADAP formulary in 2003. ADAP clients must meet eligibility criteria established by DHS/OA and ADAP MAC to receive the drug. PAETC staff evaluates client access forms, antiretroviral history forms, and supporting documentation to determine if ADAP clients are eligible for Fuzeon.

## **University of California, San Francisco, Psychosocial Trainings Section**

The interagency agreement with the University of California, San Francisco, to provide trainings to HIV medical/social service providers entitled, "Psychological Challenges of HIV Adherence" continued in 2002 and 2003. Ten trainings were held each year. The goals of the statewide trainings were to: 1) enhance providers' effectiveness in confronting the psychosocial issues clients may experience as a result of new treatments; and 2) afford

providers the skills necessary to help their clients adhere to demanding drug regimens. Trainings were offered to all DHS/OA-funded service providers; however, in 2003 the interagency agreement was terminated due to budget constraints.

## University of California, Berkeley, School of Public Health

In 2002 and 2003, DHS/OA in collaboration with the University of California, Berkeley, School of Public Health, conducted various HIV/AIDS research projects on subjects that include:

- Analyzing data collected from the statewide Knowledge, Attitudes, Beliefs, and Behavior Survey; preparing summary and technical reports; and assisting with writing manuscripts;
- Providing consultation to DHS/OA researchers on complex statistical procedures;
- Assisting with serosurveillance projects such as a transborder Latina's health study to assess the prevalence of HIV, chlamydia, syphilis, gonorrhea, and hepatitis B and C, and determine the associated risk factors in this population;
- Assisting with the implementation of the CDC-funded HIV Testing Survey to assess why persons at risk for HIV sought or delayed HIV testing and what factors influenced their decisions; and
- Assisting with a study to determine the prevalence and associated risk factors in HIV-positive prisoners in the Vacaville Correctional Medical facility.

## University of California, Davis, Epidemiology Graduate Group

DHS/OA collaborates with the University of California, Davis, Epidemiology Graduate Group to obtain graduate students to assist with various time-limited research studies. Graduate students aid DHS/OA staff in collecting, analyzing, interpreting, and disseminating HIV/AIDS epidemiologic findings to support program and policy development. In addition, graduate students gain knowledge and experience in their field of study. Projects conducted in 2002 and 2003 include:

- Conducting assessments of risk behaviors among populations at high risk of contracting HIV;
- Conducting studies on migration patterns among HIV/AIDS patients in California;
- Assessing the prevalence of HIV-Associated Dementia (HAD) and conducting behavioral and clinical risk assessments as well as neuropsychological and neurophysiological screens for HAD with HIV-infected and HIV-seronegative prisoners at Vacaville Correctional Medical Facility;
- Analyzing databases, conducting literature reviews, and writing reports on HIV, hepatitis B, and hepatitis C prevalence and incidence, and associated risk behaviors among inmates entering the California correctional system at San Quentin State Prison; and
- Conducting a pilot survey of African American individuals access to HIV care and reported sexual and drug behaviors.



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