WHITE PAPER

HIV and AIDS in Los Angeles: 21st Century Challenges and Approaches

A Report to the
Mayor and City Council of Los Angeles

Prepared by the Mayor's AIDS Leadership Council

December 2003

WE, THE MEMBERS OF THE MAYOR'S AIDS LEADERSHIP COUNCIL, PRESENT THIS WHITE PAPER TO THE MAYOR AND CITY COUNCIL OF THE CITY OF LOS ANGELES

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EXECUTIVE SUMMARY

The Mayor's AIDS Leadership Council presents this White Paper, *HIV and AIDS in Los Angeles: 21st Century Challenges and Approaches*, to the Mayor, City Council, and residents of Los Angeles. We wrote this Paper to provide City policy makers with a roadmap for addressing the key challenges with HIV and AIDS issues in the City of Los Angeles, and in response to the City Council's Resolution adopted November 22, 2002, that committed the City to addressing these challenges. This Paper outlines ways that the City should reinvigorate its HIV/AIDS policies and recommit to its historic role as a leader combating HIV and AIDS stigma and discrimination.

To understand the challenges facing the City as it addresses HIV and AIDS, we must understand the characteristics of the epidemic here, and the populations that are particularly affected:

1. The AIDS epidemic has heavily impacted Los Angeles compared to the rest of the country.
2. The primary route of exposure to HIV in Los Angeles remains sexual contact, especially male-to-male sexual contact.
3. The majority of new AIDS cases are found in communities of color.

Through our analysis, we also identify five populations for which prevention resources are frequently lacking, limited, or reduced: immigrants, homeless individuals, non-injection drug users, transgenders, and sex workers.

The guide that we present for the City's HIV/AIDS policies falls into three broad categories: prevention efforts, fighting HIV/AIDS stigma and discrimination, and providing effective housing and supportive services programs through the Housing Opportunities for People Living with AIDS Program (HOPWA).

Prevention Efforts

We identify five primary barriers to the provision of prevention services in Los Angeles: A lack of City / County coordination, federal restrictions, fiscal restrictions, a lack of community involvement, and a need for new prevention interventions. We identify the following challenges associated with each barrier, and make the following recommendations

- Lack of City / County Coordination.
    - Challenge: Despite several successful collaborations with the County, the AIDS Coordinator has been criticized for not coordinating effectively with the County.

- Recommendation: The AIDS Coordinator should include in its strategic planning direct and periodic meetings with leaders of the County Office of AIDS Programs and Policy in an ongoing effort to complement but not duplicate the County's efforts.

- Federal Restrictions.
  - Challenge: Federal policy supports funding for abstinence-only prevention programs, while downplaying the value of condoms and prohibiting needle exchange and the use of frank, culturally sensitive prevention messages that include sexually explicit materials.
  - Recommendation: The AIDS Coordinator should support prevention services that cannot be supported through federal programs and target groups that are most neglected due to federal restrictions, including transgenders, gay men and other men who have sex with men, men who have sex with men and women, the female partners of MSM/W, drug users, and sex workers.

- Fiscal Restrictions.
  - Challenge: Prevention programs that specifically target certain groups that are at high or emerging risk have received limited or no funding.
  - Recommendation: The AIDS Coordinator should respond to fiscal restrictions by identifying and advocating for these groups, which include people of color, immigrants, homeless individuals, non-injection drug users, transgenders, and sex workers, and fill prevention gaps where possible.

- Lack of Community Involvement.
  - Challenge: There are many lost opportunities to cross-promote HIV prevention messages through the many community groups and activities citywide.
  - Recommendation: The AIDS Coordinator should partner with the Department of Neighborhood Empowerment, elected representatives, and community groups to foster collaboration among community-based organizations and public entities to create a more integrated, broad-based HIV prevention effort in the City of Los Angeles.

Fighting Stigma and Discrimination

HIV/AIDS stigma and discrimination cripples effective public health prevention interventions. It can also have a profound negative impact on the well-being of people living with HIV/AIDS in institutional, community, family, and individual settings. In order to build on the City's historic national leadership role in fighting stigma and discrimination, we propose the following actions:

- Multi-Pronged Approach. The City should combat stigma and discrimination through a multi-pronged approach that includes the development and dissemination of educational materials, outreach to

communities, counseling, prevention interventions to address the impact of stigma and discrimination, and enhancing legal services. Such an approach – which is based on the premise that the greater the number of activities the greater the effect – has been shown to be successful in a variety of settings.

- Update City Employee Education and Training. The AIDS Coordinator should work with the Personnel Department to provide updated HIV/AIDS education and training to all City employees and establish a mechanism to ensure HIV/AIDS education and training is provided to all new employees.

- Educate City Contractors. The AIDS Coordinator should consider ways to work with City Contractors to help them educate their employees regarding HIV/AIDS and to help them maintain employment policies that treat people living with HIV/AIDS in accordance with anti-discrimination laws.

- Update City AIDS Workplace Policies. The AIDS Coordinator should work with the City Attorney, the Personnel Department, and the City Medical Director to review and revise the City's AIDS Workplace Policies to ensure the fair and equal treatment of City employees with HIV/AIDS and City residents who receive City services.

Housing and Supportive Services

The City can improve the quality of life for residents living with HIV/AIDS through the continued provision of adequate affordable housing and supportive services. The need, however, is complicated by a broad housing crisis throughout the region. In order to ensure that people living with HIV/AIDS continue to have access to adequate housing and supportive services, and in the face of a changing epidemic, the City should consider the following recommendations regarding the Housing Opportunities for People Living with AIDS (HOPWA) Program:

- Hire a HOPWA Coordinator.
- Work with the County to develop mechanisms for coordination of housing and supportive services for people living with HIV/AIDS.
- Enhance the opportunities for community oversight of the HOPWA Program.
- Build on recent improvements to find ways to spend the full allocation of HOPWA funds even more effectively.
- Incorporate into HOPWA's general practice the development of strategic plans supported by a needs assessment for the use of HOPWA funding before releasing requests for proposals.
- Continue to seek and access funds that can be used to provide housing for undocumented immigrants who are living with AIDS.
- Study the appropriate departmental location for HOPWA.

- Direct the HOPWA Coordinator to work to ensure that Section 8 units continue to be available for people living with AIDS in the communities in which they can access medical, community, and other support networks.

CHAPTER 1: INTRODUCTION

The Mayor's AIDS Leadership Council presents this White Paper, *HIV and AIDS in Los Angeles: 21st Century Challenges and Approaches*, to the Mayor, City Council, and residents of Los Angeles. Mayor James K. Hahn established his AIDS Leadership Council in recognition of the 20th World AIDS Day in 2001. We extend our gratitude to the Mayor for his ongoing commitment to combating the spread of HIV and improving the quality of life for those living with HIV/AIDS in Los Angeles. His leadership and support, which began early in the epidemic when he was the City Attorney and continues today, has contributed to the City's leading role in the fight against AIDS.

The Mayor's AIDS Leadership Council includes representatives from the City's leading HIV/AIDS organizations, academic and research institutions, and advocacy groups. It formalizes the important existing partnership between these groups and the City to prevent the spread of HIV and improve the quality of life for Los Angeles residents living with AIDS. Our membership consists of organizations that address the AIDS epidemic from a variety of perspectives, with a variety of approaches, and serving the full range of Los Angeles' communities. We include organizations that are run by and serve people living with AIDS. We include those that provide health, case management, housing and legal services. We are advocates both within our communities and on a national level. We educate our communities to increase tolerance through our targeted prevention efforts. Finally, we include leading researchers of the HIV/AIDS epidemic in Los Angeles.

We have been working on this White Paper since December of 2002. While we have drawn upon our own experiences, expertise, and knowledge, we have also asked and received comments and suggestions from a wide range of other experts that we incorporated into this Paper. We have spoken to organizations run by and for people living with AIDS, community groups, Los Angeles City Council Offices, and other County and City government departments. While the Paper reflects its presenters, we hope that it also speaks for a broad range of the voices that constitute Los Angeles.

Our point of departure was to review the history of the epidemic. We noted that when AIDS first struck the gay community, the community mobilized to educate and inform its members about this disease and about ways of reducing sexual risk through practicing safer sex. Gay and bisexual men were socialized to "use condoms" as part of targeted and explicit public health campaigns generated by community agencies. Initially described as a "gay disease," rampant homophobia that is rooted in institutional, social, and personal levels precluded any type of

government response to this disease. Today in Los Angeles, the epidemic continues to impact primarily large numbers of gay and bisexual men of color, but has grown to include men who do not identify as gay or bisexual but engage in male-to-male sexual contact, as well as their female partners

We conclude that it is vital for the City to reassume its historic role as a national leader in combating discriminatory HIV/AIDS policies and reinvigorate its own HIV/AIDS policies. Indeed, the City of Los Angeles is at a critical juncture in its experience with the HIV epidemic, including an increasing number of new HIV infections each year among segments of the population that are subject to high levels of stigma and discrimination. In fact, HIV-related stigma and discrimination are among the greatest impediments to public health efforts to combat the disease. Yet, with the HIV/AIDS epidemic well into its third decade and no cure available, the only means of controlling HIV transmission in the City is through comprehensive and targeted HIV prevention activities that can overcome the impediments of stigma and discrimination.

The Mayor's AIDS Leadership Council applauds the City Council for its November 22, 2002, Resolution that has rededicated the City to its historic national leadership role of combating stigma and discrimination in order to strengthen AIDS public health efforts (see Appendix 1.) Specifically, the Resolution recognized that stigma and discrimination are profound barriers to the City's administration of effective HIV/AIDS prevention, supportive services, and housing programs. In the Resolution the City committed itself to:

- Reviewing and revising its 1990 Policy on the HIV/AIDS epidemic, and engaging City residents, especially people living with HIV/AIDS, in the process;
- Providing safe, affordable and decent housing, as well as accessible supportive housing services;
- Recognizing a local crisis in the City of Los Angeles because HIV infection rates in certain affected communities are very high;
- Addressing the disproportionate impact of HIV among Angelenos of African American, Latino, American Indian and Asian/Pacific Islander descent, including men who have sex with men and their female partners, and substance abusers;
- Ensuring that innovative and evidence-based HIV prevention programs are provided to residents, including sexually explicit materials targeted to those in at-risk groups and newly emerging risk groups, by agencies that are indigenous to those communities, and to leverage resources to carry out education and prevention activities;
- Calling upon and encouraging the City's neighborhoods, communities, agencies, and leaders to join in confronting stigma and discrimination by responding to the challenges of HIV/AIDS in the early 21st Century.

This White Paper analyzes and makes recommendations to guide City leaders and residents in fulfilling the vision of this Resolution. It includes steps the City can take to fight stigma and discrimination so that vital public health interventions to reduce the HIV transmission can be effective, and to improve the quality of life of City residents living with HIV/AIDS. Each of the White Paper's sections, summarized briefly below, expands upon a section of the Resolution.

Background
We present an historical context to illustrate the City's landmark efforts to demonstrate the role of fighting HIV/AIDS discrimination in order to promote effective public health, and the innovative research and prevention activities of the AIDS Coordinator's Office.

Profile
We identify the specific groups in the City most affected by the HIV/AIDS epidemic. The Los Angeles epidemic remains most pronounced among gay men and other men who have sex with men. We call special attention to people of color, immigrants, the homeless, transgenders, non-injection drug users, and those who engage in sex work and what is known as survival sex.

Prevention
We argue that reducing HIV transmission requires coordinated, comprehensive HIV prevention efforts targeting those at greatest risk. As public funding for such efforts becomes more limited and as prevention strategies change, we explain how the City can fill the gaps in current HIV prevention activities.

Stigma and Discrimination
We show how HIV/AIDS stigma and discrimination cripples effective public health prevention interventions. We discuss the effect of stigma and discrimination on the well-being of people living with HIV/AIDS. We then discuss how stigma and discrimination arise in institutional, community, family, and individual settings. Finally, we propose a series of actions the City can take to build on its HIV/AIDS discrimination enforcement efforts to further diminish the impact of stigma and discrimination on City residents.

Housing
We argue that stable housing and related services are essential to ensuring that people with HIV/AIDS can meet their basic need for subsistence and good health. We make recommendations for strengthening the City's Housing Opportunities for People With AIDS Program (HOPWA).

Through the White Paper, we believe we fulfill the Mayor's mandate in forming this Leadership Council and respond to the City Council's renewed commitment to combating the HIV/AIDS epidemic. We have strived to equip the City with the background information and recommendations necessary to craft effective

approaches to the challenges of HIV/AIDS in the 21st Century and we look forward to working with the City policy makers as the City considers these recommendations for implementation.

CHAPTER 2: BACKGROUND

The City of Los Angeles has been a national leader in the fight against the AIDS epidemic, and especially against discriminatory HIV/AIDS policies. While many of the initiatives described in this Chapter were unique at the time, it is a tribute to the City's leadership that since then they have been mirrored by many jurisdictions throughout the Country.

THE 1980s

Los Angeles Enacts the World's First AIDS Discrimination Law

Los Angeles has a long history of setting nationwide trends in the over 20 years of the epidemic; In fact, among the first AIDS cases ever reported were in Los Angeles. Those reports from UCLA doctors, describing severe, unexplained immunodeficiency among five young men, were published by the U.S. Centers for Disease Control and Prevention on June 5, 1981.[1]

Four years later, Los Angeles was once again the focal point when movie star Rock Hudson authorized his UCLA physicians to acknowledge his AIDS diagnosis to the world, becoming the first celebrity to do so. Two weeks later – on August 14, 1985 – the City of Los Angeles again was the focus as it enacted the world's first AIDS discrimination law.[2] Led by Councilmember Joel Wachs, the City acted to combat the growing tide of discrimination against people living with AIDS – unlawful evictions, terminations from employment, refusal of service by restaurants and other businesses – that Councilmember Wachs had documented in Council committee hearings.

The City's action provoked immediate and widespread attention. The national network news programs reported on the new law, and the *New York Times* lauded Los Angeles for its action in an editorial.[3] Not all the reactions, however, were positive. Shortly after enactment of the City's law, outraged letters to the editor began appearing in the *Los Angeles Times*, accusing the City Council of caving into "special interests" and putting the public's health at risk.

Nonetheless, soon several other cities enacted similar laws, followed over the next several years by an ever-increasing number of states. In 1990, Congress enacted the Americans with Disabilities Act, extending anti-discrimination protections to people with HIV/AIDS throughout the nation.

The City's enactment of its historic AIDS discrimination law was the first in a series of measures that have served as a national model of enlightened, progressive AIDS policies.

City Attorney Establishes Nation's First AIDS Anti-Discrimination Unit
In January 1986, City Attorney James K. Hahn responded to the rapidly increasing number of AIDS discrimination complaints coming into his office by creating the nation's first AIDS discrimination enforcement unit. The City Attorney's Office quickly gained a national reputation for its innovative AIDS anti-discrimination enforcement strategies, and for its understanding that effective AIDS civil rights protections were essential for effective AIDS public health interventions.

The City Attorney's Office also began to pioneer the role of legal advisor to the Mayor, City Council and City Departments on an ever-increasing range of AIDS workplace law and policy matters. Soon, the City Attorney's Office began being contacted by President Reagan's HIV Commission, the U.S. Surgeon General, the U.S. Department of Health and Human Services, the U.S. Department of Justice, and other agencies for comment and assistance about AIDS and the law.

City Council Adopts Model AIDS Workplace Policies
In 1987, the City, under the leadership of Councilmember Ruth Galanter, adopted one of the nation's most ambitious AIDS workplace policies.
The policy's innovative integration of two key goals – education about AIDS prevention, and education about AIDS legal rights and duties – won the praise of U.S. Surgeon General C. Everett Koop. Key features of the policy included:

- Roundtable seminars for all elected officials and department heads.
- Use of the City's Wellness Program for City employee education.
- Development of City department AIDS policies.
- Use of City interactions with the public to educate frankly about AIDS prevention, and about AIDS civil rights.

Mayor Creates City AIDS Coordinator's Office
In 1989, Mayor Tom Bradley appointed Dave Johnson, a person living with AIDS, to head the newly created City AIDS Coordinator's Office in the Community Development Department. The AIDS Coordinator's Office's mission was to work closely with the Mayor and the City Council to identify gaps in HIV/AIDS-related services throughout the City, and then partner with community-based organizations to fill those gaps through prevention programs, special studies, technical assistance, and media campaigns.

THE 1990S – TODAY

Los Angeles Adopts Comprehensive City AIDS Policy

In 1990, the AIDS Coordinator spearheaded the development of a comprehensive City AIDS Policy. The purpose of the Policy was to be a blueprint for the City's long-range, multi-pronged efforts to combat AIDS. To achieve this ambitious goal, Dave Johnson relied heavily on community input, as well as the expertise of the City Attorney's Office and the City's Medical Director. On October 16, 1990, the City Council adopted the landmark policy.

Because of its comprehensiveness, the Policy quickly became a national model. It outlined the City's own employment policy, suggested a role for the City in AIDS prevention and the system of care, and pushed the City to advocate for progressive legislation on the state and federal levels.

Upon adoption of the Policy, the City quickly took the following steps:

1. The City Attorney's Office provided City department heads with special high-level briefings on their legal duties, the impact of the epidemic on their workforce, and ways their departments could better serve people living with HIV/AIDS.
2. Each department head was asked to designate a departmental AIDS coordinator responsible for ensuring that employees were trained in non-discrimination, workplace safety, privacy and confidentiality principles, and general HIV prevention education.
3. Department AIDS coordinators were then trained by the City Attorney's Office and the City's Medical Director.

City AIDS Coordinator's Office

The City AIDS Coordinators have been Dave Johnson (1989-1992), Phill Wilson (1992-1994), Ferd Eggan (1994-2001), and Mary Lucey (Interim, 2001-2003). Each voluntarily disclosed that he or she was a person with AIDS, providing inspiration to residents throughout the City. In November 2003, Stephen David Simon was appointed as the City's fifth AIDS Coordinator. The AIDS Coordinator's Office has undertaken a never-ending series of actions and studies – many that would not have occurred in its absence – to assist local AIDS education and prevention efforts.

Needle Exchange

In the early 1990s, research studies documented that needle exchange programs slowed the spread of HIV and did not contribute to an increase in drug abuse.[4] Guided by these studies, the AIDS Coordinator's Office (ACO) focused upon the spread of HIV through the sharing of dirty needles by injection drug users. In 1994, the ACO assisted the Council and the Mayor's Office in the issuance of a declaration of a local health emergency that directed City departments to take all steps permitted by law to ensure the availability and uninterrupted operation of needle exchange programs throughout the City.

Special Needs Studies

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

- The relationship between crystal methamphetamine use and HIV risk behavior among gay and bisexual men.
- The incidence of domestic violence against women living with HIV.
- Risk behaviors of heterosexual men who sometimes have sex with other men or transgenders.
- Adherence to medication regimes by the homeless, substance abusers and/or the severely mentally ill.
- The feasibility of post-exposure prophylaxis for people with recent sexual or intravenous drug use exposure to HIV.
- The effectiveness of prevention messages aimed at women, particularly African-American women.
- Prevention and outreach efforts to men who frequent bathhouses.
- Housing needs of people living with HIV.

Return to Work

By the late 1990s, new AIDS medications had begun to dramatically improve the health of many people living with AIDS. As a result, the City began to examine the needs of people living with HIV who wished to return to work. In 1997, Mayor Richard Riordan convened a task force chaired by the City AIDS Coordinator to explore ways to persuade employers to hire people living with HIV, and to assist job-training programs in working with people with HIV/AIDS. The Mayor's Task Force also commissioned a major study of return to work issues that was used by many regions of the country in setting return to work policy.

AIDS Coordinator Moves to Department on Disability

In 2000, the City transferred the AIDS Coordinator's Office into the Department on Disability. This transfer was the first of its kind in the country. Doing so acknowledged that as people living with HIV lived longer, they faced many of the same challenges faced by people living with other long-term disabilities. By combining the energies of people living with HIV with those living with other long-term disabilities, the City recognized that more effective policies and programs could be developed for all.

HOPWA

In December 1992, the City began distributing Housing Opportunities for People With AIDS (HOPWA) dollars – federal funds for housing and supportive services for low-income or homeless people living with HIV/AIDS and their families. Programs supported by HOPWA dollars, which are distributed countywide, include emergency funds for food and shelter, short-term rental assistance, rental

subsidies, and other services to support independent living. This Program gives the City a significant opportunity to improve the quality of life for people living with HIV/AIDS. In fact, during Program Year 2002-03, HOPWA contractors provided services to over 18,000 clients.[5]

City Attorney's Office

Throughout the 1990s, the City Attorney's Office continued its pioneering HIV legal work. Locally, the City Attorney's Office played an important leadership role in the drive to merge local HIV legal services programs into one, high quality countywide program, the HIV & AIDS Legal Services Alliance, Inc. (HALSA). The City Attorney also continued to advise City departments, especially the Police and Fire Departments, in the development of appropriate AIDS workplace policies, and advised the AIDS Coordinator's Office on a range of issues.

Nationally, the City Attorney's Office continued to play a leadership role, as well. In February 1998, the City Attorney filed a friend of the court brief in the U.S. Supreme Court's first AIDS discrimination case, *Bragdon v. Abbott*. That spring, the Court ruled in favor of the HIV positive patient who had been denied care by her dentist, holding that the Americans with Disabilities Act could protect asymptomatic HIV positive people.[6]

In late 2000, the City Attorney's Office advised the Centers for Disease Control and Prevention that more people were likely to come forward to be tested if all newly-diagnosed HIV positive people were referred to legal services for counseling on protecting privacy to prevent discrimination in employment, housing, and public accommodations. On November 9, 2001, the CDC adopted the City Attorney's recommendation in its *Revised Guidelines for HIV Counseling, Testing and Referral*.[7]

CHAPTER 3: A PROFILE OF THE AIDS EPIDEMIC IN LOS ANGELES

INTRODUCTION

To develop effective policies to reduce the transmission of HIV and to improve the quality of life for Los Angeles residents living with HIV/AIDS, there must be an understanding of HIV/AIDS prevalence in the City and in specific vulnerable populations. This Chapter will serve that purpose. The remainder of the White Paper and its recommendations are informed by the epidemiological analysis presented in this Chapter.

As this Chapter will show, male-to-male sex remains the primary mode of contracting HIV in Los Angeles. Included in this group are men who identify as gay and bisexual and men who identify as heterosexual even though they engage in male-to-male sex. In 1999, the Los Angeles County Department of Health revised its terminology for describing modes of HIV transmission. The new terminology was behavior-focused using the terms “men who have sex with men (MSM)” and “men who have sex with men and women (MSM/W)” as a way of more accurately referring to both gay/bisexual men and men who did not identify as such. Thus, more recent HIV/AIDS surveillance reports list HIV and AIDS cases by behavior. Throughout the White Paper we use these terms gay and bisexual and MSM and MSM/W in their proper context.

HIV/AIDS IN LOS ANGELES

There are three key elements to the AIDS epidemic in Los Angeles. First, the AIDS epidemic has heavily impacted Los Angeles compared to the rest of the country. Second, the primary route of exposure to HIV in Los Angeles remains sexual contact, especially male-to-male sexual contact. Finally, new AIDS cases are increasingly found in communities of color. (See Appendix 2.)

Los Angeles is Disproportionately Impacted by the Epidemic

Los Angeles County, with 45,241 cumulative reported AIDS cases,[8] has the second highest number of AIDS cases in the nation, exceeded only by the City of New York. Furthermore, the City of Los Angeles accounts for 25,696, or 56%, of all AIDS cases ever reported in the County, despite the fact that it accounts for only 40% of the County population. In fact, while the City is home to 1.4% of the total U.S. population, it has 3.2% of all U.S. AIDS cases ever reported.[9] Thus, City residents are disproportionately impacted by HIV/AIDS.

In addition, while in the general population it is estimated that the prevalence of AIDS is less than 1%,[10] in Los Angeles, some prevalence estimates indicate rates that rival those in developing countries:

- 61% of gay and bisexual men clinically diagnosed as abusing methamphetamines and seeking outpatient drug abuse treatment in Hollywood. [11]
- 3.7% in some Skid Row populations.[12]
- 22% in transgenders contacted through street outreach in Hollywood.[13]

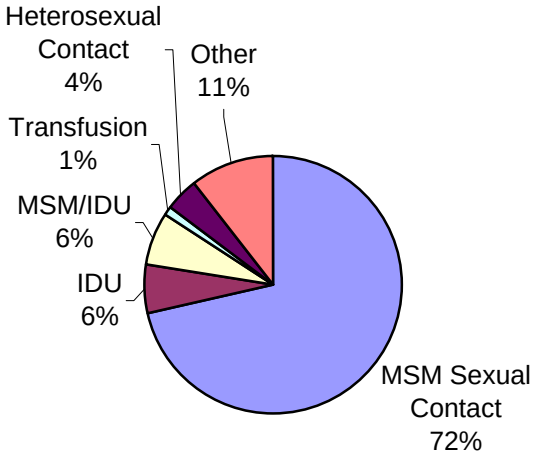
Sexual Contact is the Primary Route of Exposure

Not only is the impact in Los Angeles greater than in most other parts of the country, the nature of the epidemic is also different. In many large U.S. cities, intravenous drug use is a major source of transmission. In Los Angeles, however, the predominant route of HIV exposure is sexual contact and especially male-to-male sexual contact.

As of June 30, 2003, 72% of the cumulative AIDS cases reported in the City of Los Angeles were exposed through male-to-male sexual contact and 4% were exposed through heterosexual contact, making sexual behavior the most common mode of HIV infection.[14] Among women, 41% of cumulative AIDS cases in the City were attributed to heterosexual contact making it the most common route of HIV exposure among women. In 2002, injection drug use (IDU) as a mode of transmission in the City of Los Angeles (8%) was relatively low as compared with eastern cities such as New York and Chicago, where IDU transmission was very high, 26% and 32% respectively.[15,16]

Figure 1[17]

Cumulative AIDS Cases, City of Los Angeles, as of June 30, 2003



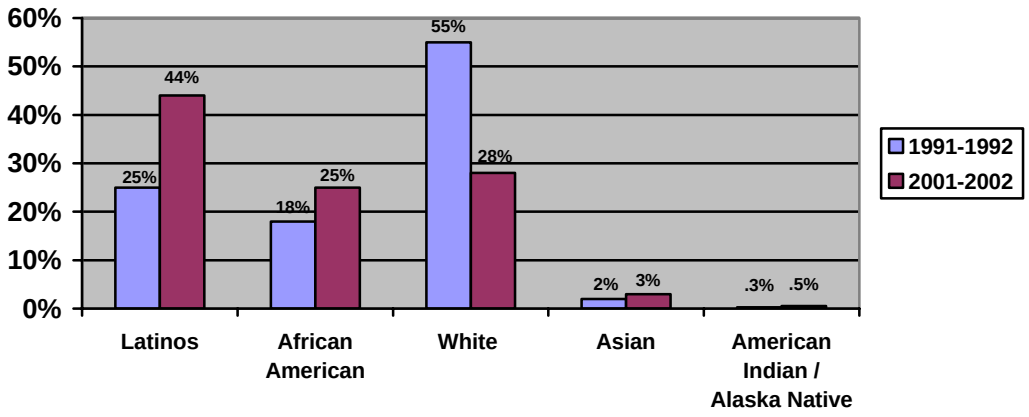
There is a Growing Impact in Los Angeles' Communities of Color

New AIDS cases are increasingly occurring in communities of color and among women of color in Los Angeles. In 1991-1992, whites accounted for the largest

single number of new AIDS cases.[18] Ten years later, however, the largest number of new AIDS cases was among Latinos, while rates among African Americans also markedly increased. In fact, the proportion of new cases among all communities of color had grown, while whites were the only reported ethnicity whose proportion had declined.[19] Among women living with AIDS in Los Angeles, women of color are disproportionately impacted by HIV/AIDS, with 75% of cumulative AIDS cases among women found among Latinas and African American women.

Figure 2[20]

Annual AIDS Cases by Ethnicity, City of Los Angeles, 1991-1992 and 2001-2002



While generally the proportion of new HIV cases is growing among all communities of color, we will show below that the epidemic takes on different characteristics within each community. While there is great diversity within each community discussed below, a thorough investigation of that diversity is beyond the scope of this White Paper.

African Americans

The African American community is disproportionately impacted by the HIV/AIDS epidemic in the City. Specifically, while African Americans account for only 11% of the City population, they made up over 25% of all new AIDS cases in 2001-02.[21,22] Countywide, the reported rate of living African American AIDS cases is very high at 405 per 100,000. While the majority of these cases are among men, African American women are also heavily impacted. In fact, in 2000 their rate of contracting HIV/AIDS was four times higher than that of any other group of women in the County – 22 cases per 100,000 among African American women as compared to five for Latinas, three for white women, and one for Asian women.[23]

American Indians

Although American Indians represent approximately 1% of Los Angeles County's population, with 270 living AIDS cases per 100,000 they have the County's second highest rate.[24]

Latinos

Latinos, with nearly 46% of the new AIDS cases, represented the largest number of new cases in the City in 2001-2002 far exceeding all other communities. Latino men were most likely to contract HIV through male-to-male sexual contact. While among all populations in the County women are most likely to be exposed to HIV through their male sexual partners, Latinas appear to be even more likely to be exposed to in this way. In 2000, for example, Latinas were much less likely to have been exposed to HIV through intravenous drug use – only 7% of the new cases in 2000, as compared to 27% for white women and 22% for African American women.[25] As we will discuss below, the prevalence of HIV/AIDS in Latino immigrant communities is also a significant characteristic of the Latino epidemic.

Asian / Pacific Islanders

Asian / Pacific Islanders (API) account for just under 3% of the reported HIV/AIDS cases in the City. Several factors suggest that demographic data for API populations may be underreported. Unfortunately, some of the most important studies available to us did not provide demographic data for API populations. Further, many of the numbers gathered for the API communities understate the epidemic's impact in those communities. Not only may many Filipinos be misclassified as "Latino," or be misplaced into the "other" category because they may have Spanish surnames, but stigma and discrimination within API communities may also reduce the willingness of many API to be tested. Additionally, while the currently reported prevalence in API communities is low, risky sexual and drug use behaviors among API gay and bisexual men are high, creating a potential for an explosion of new HIV cases in these communities.[26]

Young People of Color

Youth of color represent the vast majority of AIDS cases among youth. In the County, Latino youth represent 41% and African American youth represent 21% of all AIDS cases reported among youth ages 13-29.[27] The CDC-funded Young Men's Survey of MSM, conducted in seven cities including Los Angeles, found that HIV prevalence varied widely among racial/ethnic groups. HIV prevalence among white males in their study was 4%, African Americans 16%, Latinos 8% and API/AI 10%. Thus, while in this study young men who have sex with men have high rates of HIV infection in general, the rates are even greater for young men of color who have sex with men.[28] These troubling numbers suggest a need for more study of HIV among youth in Los Angeles.

As presented in the profile above men who have sex with men, communities of color, women of color, and youth are among the groups currently highly impacted

by HIV/AIDS in Los Angeles. In response, the County's prevention efforts have focused on these groups and dedicated resources to them. In the following section we turn our attention to emerging or stigmatized groups that may not receive the same level of prevention resources.

FIVE HARD TO REACH POPULATIONS

In Los Angeles, the high incidence of HIV, especially among gay men and communities of color, requires sustained prevention efforts. City policymakers must remain mindful of these important general characteristics of the AIDS epidemic in Los Angeles when considering how to develop prevention efforts. In addition, policymakers should address five populations for which prevention resources are lacking, limited, or reduced: immigrants, homeless individuals, non-injection drug users, transgenders, and sex workers.

We focus on these populations for several reasons. First, members of these groups often do not access prevention services because of anticipated stigmatization or discrimination due to their status, e.g. undocumented immigrants or transgenders.[29] Second, prevention funding and services have not been directed to these high-risk populations. Finally, the high prevalence of HIV/AIDS in these groups and the possibility that they may transmit the virus through sexual contact is a significant public health concern.[30]

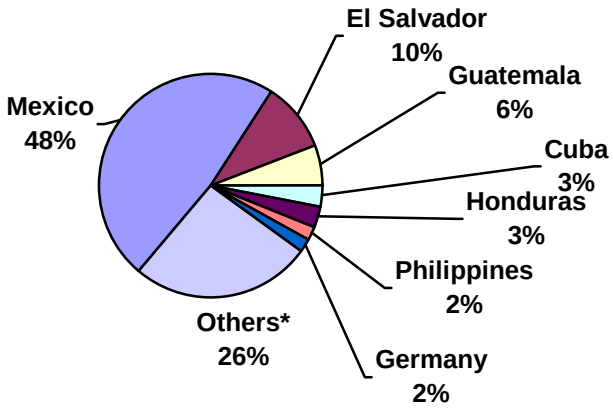
Immigrants in Los Angeles

As of 1999, 24% of the people living with AIDS in the County were born outside the United States.[31] Conducting effective prevention with immigrant populations, and specifically men who have sex with men, men who have sex with men and women, and the female partners of MSM/W, requires programs that address several challenges. These include homophobia, ineligibility for services because of resident status, lack of insurance, lack of knowledge about availability of services, and prohibitive amount of paperwork to receive services.[32, 33] Furthermore, interventions with immigrants must be culturally and linguistically appropriate. Finally, immigrants in Los Angeles, regardless of resident status, constitute a mobile population including traveling to and from their countries of birth. Prevention efforts may need to consider the role of cross-border travel in virus transmission.

- Data from HIV/AIDS testing and counseling sites indicated that half of the cumulative AIDS cases among immigrants occurred among individuals born in Mexico.[34]

Figure 3

AIDS Cases by Country of Origin/Birth
City of Los Angeles, 2003

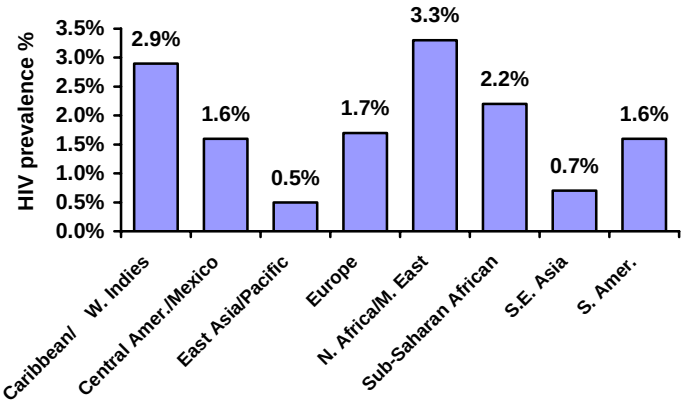


** The category of "Others" included Canada, United Kingdom, Nicaragua, Argentina, Colombia, Peru, Brazil, Belize, Thailand, Ethiopia, Ecuador, Japan, France, Vietnam, Iran, Italy, Chile, Panama, Costa Rica, Venezuela, Australia, and Country of origin not specified.*

- Data from selected STD clinics suggests HIV prevalence is highest among immigrants from North Africa and the Middle East, from the Caribbean and West Indies, and from Sub-Saharan Africa.[35] Clearly, immigrants from these regions of the world should receive targeted prevention messages.

Figure 4

HIV Prevalence Among Foreign-Born Clients at Public STD Clinics in Los Angeles, 2002



- One study found that fully 74% of Latinos living with AIDS in the County were born outside of the United States.[36]

- In an indication of delayed service-seeking among immigrants, 47% of foreign-born Latinos compared with 38% of U.S. born Latinos learned about their HIV infection only six months prior to receiving an AIDS diagnosis.[37]
- Access to care is especially challenging for undocumented immigrants. Of an estimated 766,667 undocumented immigrants in Los Angeles, over 2,600 are believed to be living with HIV/AIDS.[38]
- Finally, the mobility of the immigrant population illustrates that effective prevention cannot occur in a geographic vacuum. For example, among agricultural workers in California, 46% are individuals who lived in Mexico for part of the year.[39] This mobility makes the strikingly high HIV/AIDS rates among gay and bisexual Latinos in the border towns of Tijuana and San Diego – 19% and 35% respectively in a 2002 study – a Los Angeles issue.[40]

Individuals Who Are Homeless, or at Risk for Homelessness in Los Angeles

Although the homeless population is difficult to count and in need of additional study, one confidential testing program that operated in Skid Row from 1993 to 1995 found that 3.7% of those tested were HIV positive, at least three times higher than the national prevalence. [41] Reaching this population is challenging and requires the ability to track and maintain contact with transient individuals, to provide short-term and intense interventions, to provide safe and affordable housing, and to build on existing resources to provide appropriate health care.

Other important challenges include:

- The Skid Row results revealed that, in their program, HIV prevalence among homeless men who have sex with men was an astounding 20%.[42]
- One study of people living with AIDS which included mostly people who either had a history of homelessness or were at risk of becoming homeless found the following demographic information:[43]
    - 39% were African American, 27% Latino, 20% White, and 2% were Asian/Pacific Islander or Native American.
    - 78% were male, 20% were female, and 2% were transgender.
- Many of the respondents in that same study faced multiple challenges to receiving effective services. For example, 86% were unemployed and 38% reported some substance use. [44]

Non-injection drug users (NIDU) in Los Angeles

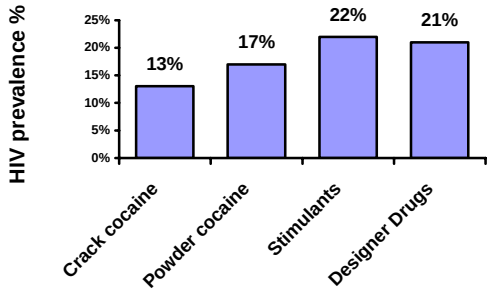
Non-injection drug use, including the use of alcohol, is considered a primary drug-related factor promoting HIV infection and transmission because being under the influence of alcohol and other drugs can impair judgment and loosen inhibitions thus tending to result in more frequent high-risk sexual behaviors. Among the non-injection drugs of primary concern are stimulants including crack, powder cocaine and methamphetamine. Targeted interventions for those who

use non-injection drugs must directly address stimulant use, especially among men who have sex with men. Important findings about NIDU include:

- One study of clients at Los Angeles County STD Clinics showed that men who have sex with men and who use non-injection drugs but were not necessarily seeking treatment for their drug use have elevated rates of HIV/AIDS. As illustrated below, HIV rates were highest among those who used stimulants, at 22%.[45]

Figure 5

HIV Prevalence Among MSM Non-Injection Drug Users at Public STD Clinics in Los Angeles, 1999



- Another study found that 61% of methamphetamine-abusing gay and bisexual men who sought outpatient drug abuse treatment in Hollywood were HIV positive.[46]
- Among those same men who have sex with men and use non-injection drugs, 44% were Latino, 28% were African America, and 25% were white. The survey did not provide the ethnicities of the remaining 3%.[47]
- Women who use non-injection drugs also appear to be more likely to engage in high-risk sexual behaviors. One study shows that women living with HIV/AIDS in Los Angeles are much more likely to exchange sex for money or drugs if they use non-injection drugs than if they do not. For example, 32% of African American women who used non-injection drugs also exchanged sex for money or drugs as compared to 19% of those who did not use non-injection drugs. The same comparison for Latinas showed a 30% versus 4% disparity; while for white women the difference was 22% to 11%.[48]

Transgenders in Los Angeles

There are currently no reliable estimates of the number of transgenders living in Los Angeles City and County, but it is believed that they are one of the most severely affected groups in the County.[49] One study has shown that as many as 22% of transgenders in the greater Los Angeles area are living with HIV/AIDS.[50] Transgenders, however, have very few service venues that are tailored to their needs and they frequently encounter cultural insensitivity or discrimination when

seeking services.[51] Prevention for this group must address the high levels of stigmatization experienced by, and the lack of appropriate services for, transgenders. The following data illustrate some significant trends:

- Among transgenders with HIV who used County services, 48% were Latino, 35% African American, 10% White, 5% Asian/Pacific Islander, and 2% Native American or other.[52]
- Many transgenders in one study participated in high-risk sexual behavior. For example, 50% identified sex work as a major source of income, and 53% reported having had sex while high on drugs or alcohol.[53]
- That same study showed that transgenders had only limited access to service networks. For example, 65% of transgenders were uninsured, and 32% had no regular source of care.[54]

Survival Sex and Sex Work in Los Angeles

The fact that sexual contact is the primary route of transmission in Los Angeles requires that prevention also target individuals who exchange sex for money or other resources such as drugs, food or shelter. Whether the exchange occurs as a means of survival or as part of involvement in the sex industry, these individuals are at higher risk for STDs and HIV.[55] There are limited data available that identify the prevention needs of these individuals who may feel stigmatized about seeking services because of their behaviors. As with the other at-risk groups described in this section they may have multiple risks for HIV (e.g., drug use, sex work, and homelessness). For example in unpublished data on gay and bisexual male substance users who were contacted through street outreach, approximately 20% had engaged in sex work during the previous 30 days.[56] Another study has indicated the prevalence of survival sex among gay, homeless youth.[57] Due to federal and County prevention priorities it is unlikely that programs explicitly targeting those who exchange sex for resources will be funded.

SUMMARY: PROFILING HIV/AIDS IN LOS ANGELES

HIV/AIDS in Los Angeles is transmitted primarily through sexual contact. Rates of HIV among the groups we have identified are much higher than the rates found in the general population. Among the at-risk groups requiring continued prevention resources are gay men, bisexual men and their female partners, transgenders and people of color. Among the emerging risk groups for which prevention resources are limited or lacking are immigrants, homeless individuals, non-injecting drug users and individuals who exchange sex for resources.

In the previous Chapters we have described where the City has been and specifically its role as a national leader in the fight against HIV/AIDS. We have also described the current face of the epidemic in Los Angeles through an epidemiological profile. We identified communities that we fear are showing signs

that they could act as hosts to the next wave of the epidemic, perpetuating Los Angeles' status as home to the second highest number of AIDS cases in the country. For the remainder of the White Paper, we present a vision of how the City can take proactive steps to administer and promote prevention, anti-discrimination, and housing programs that will ensure that this does not occur.

CHAPTER 4: ADDRESSING THE PROVISION OF INNOVATIVE AND EVIDENCE-BASED HIV PREVENTION PROGRAMS

INTRODUCTION

In the early 1980s key locally developed and managed programs emerged to prevent the spread of the HIV/AIDS epidemic. Led by community-based organizations, these programs incorporated frank, culturally sensitive prevention materials and clear messages about practicing safer sex, and were targeted toward specific communities. Then, as public health efforts increasingly came under the management of federal and County agencies, prevention began to reflect policies and practices designed for national-level or County-level at-risk groups.

In the late 1980s, growing concern about the outbreak of HIV into low risk populations prompted a shift of funding to the low risk, general population. As a result, fewer resources were available for prevention efforts that targeted the City's most at-risk residents that we identified in the last chapter. And yet, to illustrate the value of effective prevention, the failure to reduce the projected rate of new HIV infections by 50% by 2005 may result in 130,000 additional infections in the U.S. in 2010, and cost the nation over $18 billion.[58] Therefore, The City must continue to lead the County and the U.S. by its example of sponsoring targeted and innovative prevention programs serving City residents who are at-risk or stigmatized.

This Chapter describes how policies and practices at the federal, County, and local community levels create barriers to effective HIV prevention. These barriers inhibit the provision of evidence-based or innovative prevention programs to the stigmatized and emerging risk groups in the City most in need of them. Therefore, we offer recommendations for appropriately responding to these needs.

Among the major barriers to the provision of prevention services in Los Angeles County, which we discuss in turn below, are:

1. Lack of City / County coordination
2. Federal restrictions
3. Fiscal restrictions
4. Lack of community involvement
5. Need for new prevention interventions.

HIV PREVENTION AND TREATMENT IN LOS ANGELES

City AIDS Coordinator's Office (ACO)

The City AIDS Coordinator's Office is the single most direct avenue through which the City can act to prevent HIV among its residents. Historically, the AIDS Coordinator has been an individual whose vision and dedication led to the implementation of innovative programs that may not have otherwise been implemented. Specifically, the City AIDS Coordinator's Office engages in the following prevention activities:

- Education and prevention programs, through contracts with community-based organizations. Examples of these activities include outreach, peer education, group and individual risk counseling, provision of condoms and other risk reduction supplies, and needle exchange. In the FY 2002-03 these programs served 22,439 people.[59]
- Policy planning for HIV/AIDS prevention needs.
- Special studies on effective or innovative interventions such as post-exposure prophylaxis (i.e., medical treatment immediately after high-risk HIV exposure), evaluation of prevention messages such as those targeting African American women at sexual risk, and assessment of prevention needs within niche communities, such as men who have sex with men but don't identify as gay or bisexual.
- Technical assistance, in the form of workshops to help HIV/AIDS agencies improve their outreach and services, and small grants to help agencies develop workshops, forums, and media materials relevant to HIV/AIDS prevention in the City of Los Angeles.
- Media campaigns promoting HIV/AIDS awareness, testing and protection.

Unfortunately, the AIDS Coordinator position was vacant from August 2001 until November 2003. Mary Lucey, the interim AIDS Coordinator, was only available to fill that vacancy through the end of 2002. The lack of leadership in this key advocacy position hindered City prevention efforts because there was no designated voice to speak on behalf of Los Angeles residents and their needs at the City, County, or national levels. We are pleased that the position was finally filled, and urge the City not to allow such a prolonged vacancy in the future. The leadership of the AIDS Coordinator's Office fulfills a vital advocacy role on behalf of City residents who are and will be affected by HIV/AIDS.

CHALLENGES AND RECOMMENDATIONS

Challenge #1: Lack of City / County Coordination

The City and County AIDS offices have successfully collaborated on projects in the past. Despite the many innovative programs that the AIDS Coordinator's Office has supported and initiated, however, they have been criticized for not coordinating effectively with the County. While the AIDS Coordinator's Office has directed many of its past efforts to fill what it identified as gaps in area prevention

and research efforts, it would be able to better leverage its limited funds by improving its coordination with the County. This is especially vital to the implementation of the recommendations in this Chapter, which encourage the AIDS Coordinator to continue and enhance its role of filling area prevention gaps.

Recommendation
The AIDS Coordinator should include in its strategic planning efforts direct and periodic meetings with leaders of the County Office of AIDS Programs and Policy in an ongoing effort to compliment but not duplicate the County's efforts.

Challenge #2: Federal Restrictions
Currently, there appears to be a shift underway in federal policy. The federal government has increased funding for abstinence outside of marriage-only programs, downplaying the effectiveness of condoms, and more actively discouraging the use of frank, culturally sensitive prevention materials that are sexually explicit.

The basis for this approach is the accurate understanding that the only way to be certain to avoid sexual exposure to HIV is by abstaining from sex. It is true that using a condom is not 100% effective at preventing AIDS, and that no message can assure that people will not engage in risky sexual behavior.

The federal policy shift, however, abandons or ignores the government's own data that certain prevention strategies do work to reduce the spread of HIV. For example, the National Institutes of Health concluded that consistent condom use "significantly reduced the risk of HIV infection in men and women."[60] There is no similar data that supports the effectiveness of abstinence outside of marriage-only prevention programs.

This policy shift and its rejection of evidence regarding effective prevention could have an especially chilling effect in Los Angeles where the fact remains that the epidemic is spread primarily by sexual behaviors, and the virus in Los Angeles is spread most commonly between men who have sex with men and their sexual partners, including women. Thus, federal efforts that shy away from directing prevention toward these groups, or that prohibit the use of frank, culturally sensitive language in prevention campaigns, are a direct threat to the health of sexually active Los Angeles residents. All residents should have access to prevention messages and services that help keep them from becoming infected with this fatal, but preventable disease. As we enter the third decade of the HIV/AIDS epidemic, the City of Los Angeles must help to reinvigorate and re-direct policies and practices for HIV prevention.

We will now turn to evidence of the federal policy restrictions. First, new statements, policies, and the activities at the federal level indicate support for abstinence-only programs, skepticism toward condom use, and opposition to the use of sexually explicit prevention materials.

- There are increased budget allocations to support abstinence only programs.[61,62,63,64,65] Since 2001, funding for these programs has increased from $100 million per year to $135 million for 2003.[66] The promotion of abstinence-only programs ignores scientific reviews stating that there are simply no available data to substantiate the effectiveness of such programs.[67,68] In fact, a federally-funded project to evaluate abstinence-only programs will not be published until 2005.[69]

- In 2002, statements regarding the demonstrated effectiveness of condom use in reducing the risk of HIV infection were removed from the Centers for Disease Control's fact sheet on male latex condoms and STDs website[70] as were links to descriptions of evidence-based programs that focused on condom use.[71,72,73,74,75]

- While federal guidelines have prohibited the use of federal funds to develop sexually explicit prevention materials since 1992,[76] the federal government is taking a newly aggressive stance against their use. Since August 2001, prevention projects that use frank, culturally sensitive sexually explicit prevention materials to target at-risk groups have been subject to federal investigations, audits, and requests to halt programs.[77,78,79]

In addition, programs that target controversial groups such as transgenders or men who have sex with men – the very groups that we showed above to be at the highest risk in Los Angeles – are being singled out for loss of funding or intense scrutiny.

- In October 2003, Congressional staff gave the National Institute of Health a list of federally funded scientists who do research on AIDS, sexuality, and high-risk behaviors. The list was presented to NIH as a list of projects that had been the subject of Congressional scrutiny for being controversial.[80,81]

- In the past few months staff members at the National Institutes of Health and the Centers for Disease Control and Prevention have spoken unofficially to potential grantees and informed them that proposed research with controversial groups is likely not to receive funding, even if the proposed study receives a priority score from a scientific review committee indicating the importance of the work.[82] This situation effectively halts federal support for research or service programs that target transgenders or sex workers. Research that targets gay and bisexual men has faced similar problems with funding decisions at the federal level.

- Projects already funded that involve study of controversial groups such as commercial sex workers and men who have sex with men have been singled out for intense scrutiny.[83] Actions of this type will discourage researchers from continuing to work with these groups since even scientifically "outstanding" applications face low probabilities for funding.

The continuation of federal policies that are out of step with the realities of HIV and AIDS is also seen in the example of needle exchange programs. Since 1992, the Centers for Disease Control and Prevention have disallowed the use of funding "to provide education or information designed to promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse."[84] Similarly, the Health Resources and Services Administration bars the use of Ryan White CARE Act funds for needle exchange.[85] These restrictions on funding continue to exist despite the 1995 conclusion of the National Research Council and the Institute of Medicine that needle exchange programs reduce the risk of HIV transmission and do not increase illegal drug use.[86] Furthermore, California State law that requires the declaration of a local state of emergency in order to run a needle exchange program complicates the implementation of these programs.

Recommendation

The City must remain mindful that HIV/AIDS is transmitted primarily through sexual contact and intravenous drug use that impacts communities throughout Los Angeles and must ensure that all of the residents of Los Angeles who are at high risk for HIV transmission have access to the prevention programs and services that may prevent HIV infection. The City should direct its limited resources to prevention efforts that are currently curtailed under federal policy. Specifically, the AIDS Coordinator should:

Action Steps

- Promote and provide support for programs that target groups that are most likely to lose prevention services as a result of the federal policy restrictions described above. Specifically, the AIDS Coordinator should support programs that target transgenders, men who have sex with men, men who have sex with men and women, the female partners of MSM/W, drug users, and sex workers.
- Promote the use of appropriate prevention messages that use frank and/or venue-specific images and materials such as explicit posters for use in sex clubs, bathhouses and other public sex venues.
- Advocate for and promote the availability and use of condoms to prevent the spread of AIDS by: Partnering with community groups to ensure condoms are easily available in communities at risk and provided in a culturally appropriate manner; Working with the County and owners of sex clubs, bath houses and other high risk venues to ensure the availability of condoms in these venues; and, Reporting to the City Council on these efforts.

- Document ways in which federal policy restrictions translate to local discrimination for specific groups at risk for HIV transmission and to potential increases in HIV infections in the City and County of Los Angeles, and advocate at the federal level to reverse these restrictions.
- Advocate for a change of federal and state policy to support needle exchange programs.

Challenge #3: Fiscal Restrictions

Federal and County funding priorities also serve to limit prevention targeting segments of the population. The City must fill the resulting gaps by using its available resources for prevention programs that target groups that are selectively omitted due to political and other restrictions by the County or the federal government. Specifically, immigrants, homeless individuals, non-injection drug users, transgenders, and sex workers, all of whom are disproportionately affected by HIV/AIDS, are not explicitly targeted in federal or County prevention efforts. For example:

- The Centers for Disease Control and Prevention listed prevention priorities for 2003 including: integrating HIV testing into medical care, implementing new HIV testing models outside of medical settings, preventing new infections among HIV positive people and their partners, decreasing perinatal transmission.[87]
- In 2000 the County dramatically changed its prevention funding priorities from targeting demographic or social group members (e.g., people of a certain ethnicity or sexual orientation) to targeting behavioral risk groups (e.g., men who have sex with men, men who have sex with men and women, female injecting drug users).[88,89] Although immigrants, homeless individuals, non-injecting drug users, transgenders, sex workers, and people of color are represented within these risk groups they are not explicitly targeted for prevention.

Recommendation

To address the barrier of fiscal restrictions, the City AIDS Coordinator should identify and advocate for risk groups, both current and emerging, whose prevention needs are unmet. Where possible, the AIDS Coordinator should use its own resources to fund programs that will fill gaps in local prevention efforts.

Action Steps

- Continue funding prevention programs that are effective in reducing HIV among gay and bisexual men, transgenders, and women.
- Advocate for prevention resources to develop prevention services for groups of Los Angeles residents whose needs for HIV prevention remain largely unmet, specifically immigrants, homeless individuals, non-injection drug users, transgenders, and sex workers.
- Identify newly emerging groups at risk for HIV in Los Angeles and advocate for development and provision of prevention services that target these groups above as well as men who have sex with men, men who

have sex with men and women, the female partners of MSM/W, and people of color.
- Work with OAPP and State Office of AIDS, and other appropriate government agencies, to leverage scarce City dollars with these larger funders to maximize prevention resources targeting groups of individuals whose needs for prevention are underserved.
- Fund prevention programs that are not, and are unlikely to be, funded through other efforts.

Challenge #4: Lack of Community Involvement

Limited community involvement to disseminate or implement innovative interventions is a significant barrier to HIV prevention. There is a need for dialogue regarding HIV/AIDS across such community-based organizations as neighborhood councils, labor unions, religious and faith communities, ethnic / cultural communities, and business alliances. An informal search of the discussion topics at the website of the Los Angeles City Alliance of Neighborhood Councils, for example, yielded no items including the terms “HIV” or “AIDS.”

Few organizations, other than HIV prevention providers, sexually transmitted diseases, drug abuse, and HIV or STDs treatment planning groups, discuss HIV prevention issues. There are, however, many missed opportunities to cross-promote disease prevention messages, representing an underutilization of the available organizational capacity for prevention. An organization that seeks to improve the lives of young gang members, for example, has the opportunity to also educate these youth about the importance of HIV testing and counseling for risk behaviors such as drug use or unprotected sexual intercourse. Similarly, a program to provide housing opportunities to those at-risk for homelessness has the ability to link these individuals to appropriate health counseling and HIV support services. The City can promote HIV prevention by encouraging dialogue among organizations that do not traditionally address HIV and by advocating for resources to, for example, hold town meetings, public forums, or mini-trainings. Such resources can help CBOs to identify ways in which they can also become involved in HIV prevention efforts.

Recommendation

To address the barrier of limited community involvement in HIV prevention, the AIDS Coordinator should work with the Department of Neighborhood Empowerment, elected representatives, and community groups to foster collaboration among community-based organizations and public entities to create a more integrated, broad-based prevention effort in the City of Los Angeles.

Action Steps

- Address meetings of neighborhood councils, community service organizations and other coordinating bodies to discuss HIV and other prevention needs.

- Encourage City-funded organizations and programs to integrate HIV information into their activities by, for example, recognizing World AIDS Day and offering educational information.
- Provide HIV/AIDS informational training sessions for community organizations that want to integrate prevention information into their programs.
- The AIDS Coordinator's Office should work with a broad range of communities, including underserved communities, and periodically report to the City Council on its outreach activities.

Challenge #5: Need for New Prevention Interventions

Los Angeles' leadership in sponsoring innovative interventions and commitment to targeting at-risk, emerging and stigmatized groups must continue. There continues to be an urgent need for new, targeted prevention interventions as HIV-negative and HIV-positive individuals begin to experience "prevention message burnout."

After 20 years of successful public awareness and health education regarding HIV/AIDS, the general public and those who are HIV-positive are knowledgeable but also weary of such messages as "practice safer sex" and "always use a condom." Many people may have become desensitized to these messages, believe that HIV/AIDS is now treatable with medications, or may be tiring of maintaining the necessary sexual behaviors to prevent risk of transmission.[90,91,92] Recent syphilis outbreaks in Los Angeles, San Francisco and other major metropolitan cities and reported reductions in safer sex practices among gay/bisexual men have been attributed to such burnout. Increases in syphilis and other STDs such as Hepatitis C may be forewarnings of the fading effectiveness of existing prevention campaigns.

Among older gay/bisexual men, who may have come-of-age during the height of the epidemic in the 1980s and early 1990s, prevention message burnout may facilitate the abandonment of safer sexual practices. Among younger gay/bisexual men, who were not present during these early years, heeding calls to practice safer sex may not seem a high priority.[93, 94, 95, 96]

Further, the interventions developed in the early 1980s were exclusively targeted to individuals newly diagnosed with a fatal disease. Today, the AIDS epidemic includes a large proportion of HIV-positive individuals who are living longer due to highly active anti-retroviral therapy (HAART) and are finding it harder to maintain safer sex behaviors.

A new generation of interventions is needed for gay/bisexual men of various ages and for gay/bisexual men who are living with HIV. As with other media-based campaigns, these messages and slogans must periodically be reinvented to maintain the attention of the target audiences. The City can continue to lead in

the development and promotion of this next generation of HIV prevention interventions.

In addition to innovative interventions targeting men at risk there must be parallel efforts to address the risks faced women. According to international and domestic public health institutions microbicides that prevent the spread of HIV, STDs, and prevent pregnancy are absolutely necessary to empower women to protect their health.[97, 98, 99] Microbicides include any creams, gels, or foams that can be used in the vagina or rectum to kill or block HIV and other sexually transmitted diseases.[100] Nonoxynol-9, once a widely used microbicide, is no longer recommended due to safety risks and increased likelihood of HIV infection. Several clinical trials of potential topical microbicides are underway, funded by a new federal initiative, but much more developmental research is needed on these biomedical barriers.

Prevention tools that are under women's control are necessary to address issues of gender inequality and power, women's greater susceptibility to infection, and the limited availability of cheap, safe, and effective interventions tailored for women. The availability of such preventative barriers will enable women to take more control of their risk of exposure to HIV without needing to negotiate their use with sexual partners who might not know their HIV status or are not forthright about their sexual behaviors.[101]

Finally, the old interventions were never intended to take into consideration the new set of risk factors that must be addressed to effectively prevent the spread of HIV in the groups that are increasingly impacted today. As we discussed in the Profile Chapter, these groups include communities of color, immigrants, the homeless, non-injection drug users, transgenders, and those that exchange sex for resources.

As a result, there is a lack understanding regarding:

- Factors that put individuals at risk for HIV infection and transmission, such as prevention message burnout, fear of social rejection due to disclosure, lack of information about services, and transportation challenges.
- Factors that protect individuals from HIV infection such as social support, community involvement, limited venues for risk, and access to drug abuse treatment.
- Sociocultural and structural factors such as poverty, experiences of discrimination, shame, social rejection, and limited access to care that promote or inhibit risk.

As we discussed earlier in this White Paper, the AIDS Coordinator's Office has a history of supporting innovative interventions. There are, however, currently limited or no prevention interventions that target the long-term or emerging risk groups in the following ways:[102]

- Explicitly target immigrants, homeless individuals, non-injection drug users, and sex workers.
- Provide individual prevention counseling or health communications (hotlines, media campaigns, information clearinghouses) to transgenders.
- Explore the delivery of prevention messages and interventions via the Internet.
- Develop innovative interventions in collaboration with the owners of bathhouses, sex clubs, and spas or the characteristics of the clientele that frequent them.

Recommendation

To address the barrier of a need for new prevention interventions the City must promote and financially support or seek funding to support efforts by the AIDS Coordinator to conduct research and implement new interventions. The AIDS Coordinator should:

Action Steps

- Support the development and implementation of cutting edge prevention interventions with the primary focus of countering the impact of awareness burnout.
- Advocate for continued and increased federal and state funding for the accelerated development of microbicides and other innovative biomedical interventions for the female sexual partners of men at risk.
- Advocate and provide support for research and new interventions for emerging risk groups such as people of color, immigrants, homeless individuals, non-injection drug users, transgenders, and sex workers.
- Support the efforts of owners of bathhouses, sex clubs, and spas to understand the ways to best target HIV and STD prevention messages to their clientele.

CHAPTER 5: FIGHTING HIV/AIDS STIGMA AND DISCRIMINATION

INTRODUCTION

The City of Los Angeles was the nation's pioneer in addressing stigma and discrimination among people living with HIV/AIDS. On August 14, 1985, the City enacted the world's first AIDS discrimination law.[103] Led by City Councilmember Joel Wachs, the City Council, Mayor Tom Bradley, and City Attorney James K. Hahn provided leadership at a time when neither state nor national leaders were willing to address this issue. The City's law established that people living with HIV/AIDS were entitled to be treated like anyone else with a significant health problem. Unfortunately, despite these efforts, and even though much has changed in the treatment of people with HIV, HIV/AIDS stigma and discrimination remain significant problems today.

HIV/AIDS stigma and discrimination are recognized as significant barriers to effective public health efforts to combat HIV both globally and locally. In fact, in 2000, Peter Piot, executive director of UNAIDS, identified HIV/AIDS stigma as a "continuing challenge" that prevents concerted action at community, national, and global levels to address this epidemic.[104] Stigma and discrimination frequently:

- Inhibit HIV preventive behaviors, including the willingness to discuss and use condoms and to be tested for HIV;
- Hinder accessing care by HIV positive individuals;
- Impair the quality of care received by persons with HIV/AIDS;
- Negatively affect perception and treatment of HIV positive individuals by communities, families, and partners.[105]

In Los Angeles, the need to address HIV/AIDS stigma and discrimination is of growing concern as the epidemic increasingly impacts communities of color and already marginalized residents including gay and bisexual men, transgenders, immigrants, sex workers, homeless individuals, and drug users.

HIV/AIDS Stigma and Discrimination

Stigmatization is a process of devaluing individuals or groups based on their difference in a way that reinforces negative social attitudes. By doing so, stigma transforms those differences into social inequalities.[106] By its very nature, HIV/AIDS stigma entails prejudice and discrimination. HIV/AIDS stigma is the result of fears, ignorance, attitudes, and beliefs about a range of complex issues, including sexuality, gender, race, ethnicity, culture, drug use, poverty, contagion, illness, and death.[107, 108]

In the U.S., and more specifically in Los Angeles, stigma is particularly associated with homophobia – bias and prejudice against individuals attracted to individuals of the same sex – since gay men were the first group in the city affected by HIV. In fact, the belief that gay men are the only group at risk for HIV is still common. In addition, because HIV/AIDS is associated with marginalized behaviors (e.g., men who have sex with men, having multiple or anonymous sex partners, and drug use) and marginalized groups (e.g., gay and bisexual men, transgenders, sex workers, homeless individuals and drug addicts), all individuals with HIV/AIDS are presumed to have participated in one or more of these behaviors or to be from one of these groups.

While HIV/AIDS stigma is particularly associated with homophobia, women living with HIV/AIDS are also victims of stigma. Just as men living with HIV/AIDS are presumed to be gay or to be intravenous drug users, women with HIV/AIDS are presumed to be promiscuous, prostitutes, or intravenous drug users. In fact, however, women are often exposed to HIV through their husband or boyfriend who does not disclose his HIV status to her for fear of rejection or an unwillingness to disclose sexual relations with men or intravenous drug use. This can be further complicated if the relationship is unequal due to gender bias or marred by domestic violence.

Current Attitudes Towards People Living with HIV/AIDS
The following results of public opinion polls about HIV/AIDS taken in 2002 demonstrate that HIV/AIDS stigma and discrimination persists in the 21st Century.

Misconceptions about HIV transmission still exist
A significant number of people still think that the disease can be transmitted through the following forms of casual contact:

- 31% - kissing.
- 15% - sharing a drink or glass.
- 10% - touching a toilet seat.[109]

Fear of being stigmatized is directly correlated to whether or not to be tested
A third (33%) of Americans polled stated that if they were to be tested for HIV they would be "very" or "somewhat" concerned people would think less of them just for being tested.[110]

Discrimination against people living with HIV/AIDS
51% of Americans believe there has been "a lot of discrimination" against people with HIV and AIDS.[111]

Negative attitudes towards people living with HIV/AIDS

- 1 in 5 Americans "feared" people with AIDS.
- 1 in 6 had "feelings of disgust" related to people with AIDS.[112]

- 30% of Americans reported that they would feel “somewhat” or “very uncomfortable” having their son or daughter go to school with a child with AIDS.
- 22% of Americans reported that they would feel “somewhat” or “very uncomfortable” working in an office with a person with AIDS.
- 27% of Americans reported that they would feel “somewhat” or “very uncomfortable” shopping at a neighborhood grocery store whose owner had AIDS.[113]
- Public attitudes that HIV and AIDS is a “gay disease” or that people living with HIV and AIDS “got what they deserved” remain strong to this day.[114]

Attitudes about people with HIV in the workplace

Half (51%) of survey respondents held the attitude that the right to know whether a co-worker was infected was more important than the right of the infected person to keep the information private.[115]

CONSEQUENCES OF HIV/AIDS STIGMA AND DISCRIMINATION

The effects of HIV/AIDS stigma and discrimination on individuals at greatest risk of HIV and those living with HIV/AIDS are complex, and far-reaching. The following examples illustrate the breadth and severity of the consequences HIV/AIDS stigma and discrimination can have on individuals:

- Unwillingness to access HIV services (preventive or treatment)
- Unwillingness to seek HIV testing
- Non-disclosure of HIV status to sex partners
- Low self-esteem
- Hate crimes and persecution
- Shame
- Social isolation
- Alienation
- Withdrawal
- Secretive behaviors
- Leading dual lifestyles
- Anonymous sex
- Poor coping strategies
- Sexual silence and hiding
- Poor mental health
- Fear of rejection
- Denial
- Fear of being judged unfairly
- Fear of lack of confidentiality
- Social ostracism
- Dissolution of personal and family relationships

- Prejudice and discrimination towards people who are gay or HIV positive
- Denial of educational, employment, vocational and other institutional opportunities
- Loss of employment
- Loss of housing
- Violence
- Self-stigmatization and feelings of worthlessness.[116]

The impact of these consequences on HIV prevention efforts and on the care, treatment, and quality of life of persons living with HIV/AIDS is incalculable. To illustrate this further, we expand on the lack of willingness to be tested for HIV.

Unwillingness to be tested for HIV

HIV testing is an essential component in preventing the spread of HIV. Several studies have documented an immediate decrease in HIV risk behaviors among individuals upon learning they were HIV positive.[117] Unfortunately, individuals are reluctant to be tested for fear of being stigmatized if they are HIV positive. This lack of awareness will also delay access to medical treatment for those who are HIV positive. This scenario demonstrates how stigma can hinder HIV prevention and negatively affect the health outcomes of persons who are HIV positive but unaware of their serostatus.

CONTEXTS OF HIV/AIDS STIGMA AND DISCRIMINATION

HIV/AIDS stigma and discrimination take different forms and are manifested in different contexts – societal, community, family, and individual.[118] Included in this section are some of the more frequently documented forms.[119]

Societal Contexts

There are a wide range of societal contexts in which people living with HIV/AIDS experience stigma and discrimination. As a result of these negative experiences, such AIDS anti-discrimination laws as the City's ordinance and the Americans with Disabilities Act were established to prohibit discrimination in employment, housing, public accommodations, and government services. They also prohibit discrimination against individuals, such as a caregiver or family member, who might mistakenly be assumed to have HIV/AIDS, but do not.

As with most discrimination laws, however, such laws can be difficult to enforce. Furthermore, people living with HIV/AIDS face added difficulties in enforcing their rights.[120] People with HIV/AIDS often wish to protect their privacy in order to prevent additional discrimination, and yet this can be very difficult during litigation.

Education and schools

Children with HIV/AIDS or associated with HIV through family may experience stigma and discrimination against them in schools (e.g., Ryan White). Discrimination against such children has led to the adoption of non-discrimination legislation.[121] Less concern, however, has been shown for young people perceived to be responsible for their HIV infection, such as young gay people or young drug users. These young people may even become the victims of violence as a result of their HIV infection.[122]

Employment and the workplace

Individuals with HIV and AIDS face a wide range of discrimination in the workplace, including termination, limitations on advancement, and hostility from co-workers.[123] Some employers may even refuse employment to individuals who have or are thought to have HIV. In fact, the U.S. military excludes from employment those who are HIV positive and is exempt from the ADA.

Health care providers

People with HIV/AIDS may be refused care by dental or medical providers.[124] Such refusals further compound the difficulties already faced by members of such marginalized populations as the homeless, sex workers, substance abusers, or racial and ethnic populations, who often find it particularly difficult to obtain health services even under the best of circumstances.[125]

Religious Institutions

HIV/AIDS stigma and discrimination and homophobia are continuing to be perpetuated by some religious leaders and organizations. Religious beliefs have been used to justify stigma and discrimination against people living with HIV/AIDS. Exclusion from caring communities of faith serves to further isolate individuals with HIV compounding the physical suffering they face from their illness. Some religious doctrines even hold that individuals infected with HIV got what they deserved because they have sinned.[126]

Community Contexts

The values of all communities can reinforce HIV/AIDS stigma and discrimination in a variety of ways. In the U.S., for example, where we place great emphasis on individualism, HIV infection may be perceived as the consequence of personal irresponsibility.[127] As a result, individuals with HIV/AIDS are often blamed for their circumstances. The degree of stigma and discrimination is often associated with a community's knowledge, attitudes, and beliefs about HIV/AIDS, in particular how it is transmitted and the groups most affected by the disease. In Los Angeles, where HIV/AIDS is most prevalent among gay men, particularly gay men of color, any man with HIV/AIDS may be perceived as gay or having had same sex relations.

In communities of color, HIV stigma and discrimination and homophobia may be manifested in different ways, particularly for gay and bisexual men of color. The

following examples are from a two-day symposium, *Fighting Oppression: Preventing HIV among MSM and MSM/W of Color*, held in Los Angeles in June 2003. In the Latino community, for example, the expectation is for men to always be strong or "macho" and possess "machismo" and not express emotions.[128] In the African American community, gay and bisexual men are often seen as weak and blamed for bringing AIDS into the black community.[129] In the API community, gay and bisexual men fear bringing shame to their family and community due to their sexual orientation.[130] In each of these communities there are prescribed concepts of masculinity and manhood that are introduced during childhood, modeled by male figures in the community and family, and preclude any expression homosexuality or bisexuality. These expectations place severe pressure on gay and bisexual men of color to hide their sexual identity or to lead dual lives (i.e., maintaining a heterosexual relationship while also engaging in sex with men).

Family Contexts

For most people with a serious illness, family is often the main source of support. For a person with HIV/AIDS, however, the stigma and shame associated with this disease can lead to rejection and isolation.[131] In extreme situations a person living with HIV/AIDS may be rejected by his/her family, due not only to HIV but because it is associated with stigmatized behaviors (e.g., sexual behavior between men and drug use).[132]

Individual Contexts

For individuals, the damaging effects of HIV/AIDS stigma and discrimination are closely tied to the degree to which they have accepted themselves in terms of their sexuality or as someone living with HIV/AIDS. A supportive social network, including family and friends, is often essential to avoiding the internalized stigma, shame and blame. When individuals suffer significantly from stigma and discrimination, they often withdraw. Such isolation can result in failing to seek vital medical or support services,[133] and discourage them from disclosing their HIV status to their sex partners.[134]

RECOMMENDATIONS TO ADDRESS HIV/AIDS STIGMA AND DISCRIMINATION

The City can complement the pioneering work of the City Attorney's AIDS/HIV Discrimination Unit by combating stigma and discrimination in a variety of ways. Presented below are action steps the City can take to help reduce HIV-related stigma and discrimination. The action steps are based, in part, on interventions that have been shown to reduce HIV/AIDS stigma attitudes and behaviors as well as recommendations from leading advocacy groups.[135]

Recommendation #1: A Multi-Pronged Intervention

The City should combat HIV/AIDS stigma and discrimination through a multi-pronged approach. Such an approach – which is based on the premise that the greater the number of activities the greater the effect – has been shown to be successful in a variety of settings.[136] Such interventions can be implemented at the individual, small group, and community-level. The following are suggested elements of such a program:

Action Step – Develop Educational Materials

The City AIDS Coordinator should work with relevant City departments to develop educational and informational materials that address the inter-related issues of HIV/AIDS stigma and discrimination and HIV prevention and transmission. Materials might include advertisements, leaflets, brochures, and information packets. The content of the materials should:

- Provide clear and accurate information on how HIV is transmitted in order to combat fears and misconceptions, including the effectiveness of condoms in preventing HIV transmission.
- Include information on the relationship between HIV/AIDS stigma and related forms of discrimination such as homophobia and gender bias.
- Include HIV prevention messages targeted at people who are HIV-positive and HIV-negative.
- Be developed within appropriate cultural frameworks.
- Help the general public carefully examine their attitudes and feelings about people living with HIV/AIDS.

The City should disseminate these materials in a variety of ways, both to the general public, and in more targeted approaches, both to people who are HIV-positive and HIV-negative. For example, materials might be disseminated as inserts in DWP bills or other City mailings, and at Neighborhood Council or other City meetings.

Action Step – Community Education and Awareness

The City should engage in different activities to create greater community awareness of the issues of HIV/AIDS stigma and discrimination. These might include:

- A social marketing campaign about HIV/AIDS stigma and discrimination developed for targeted groups, such as different racial ethnic populations.
- Work with media outlets to increase media exposure about people living with HIV and AIDS in the City.
- Distribute specifically targeted materials at community events, such as racial/ethnic celebrations, farmers markets, street festivals, and local sporting events.

Action Step – Individual and Small Group Counseling

The AIDS Coordinator should sponsor the development of individual and small group counseling sessions to address HIV/AIDS stigma and discrimination. These sessions should be sited in neighborhood venues and available to

residents as well as staff from local agencies, including neighborhood councils, medical providers, social service agencies, and community centers.

- Individual and small group counseling sessions can include the acquisition of such coping skills such as master imagery and group desensitization.
- Counseling approaches might include praise and social support for positive attitudes, and behavior change.

Action Step – Community Level Interventions

The AIDS Coordinator, the City Attorney's AIDS/HIV Discrimination Unit, the Department of Neighborhood Empowerment, and the City Human Relations Commission should work together to encourage Neighborhood Councils, religious institutions, and other community groups to take positive steps to reduce HIV/AIDS stigma and discrimination within their own communities. Such activities could include:

- Hosting community workshops and trainings about HIV/AIDS stigma and discrimination.
- Developing opportunities for greater contact and communication with affected populations (e.g., opportunities in which community members can interact with the stigmatized group, either directly or vicariously through neighborhood media outlets).
- Developing closer links between non-HIV community organizations and HIV prevention providers.

Action Step – Address Specific Manifestations of Stigma and Discrimination

The AIDS Coordinator should implement or support interventions and activities that attempt to address specific manifestations of stigma and discrimination, by:

- Developing strategies to promulgate effective HIV prevention programs that address stigma and discrimination. For example, a successful HIV prevention program may incorporate HIV prevention messages in a broader health context so that people don't feel stigmatized by participating in an HIV/AIDS prevention program.
- Assisting the County's efforts to implement rapid HIV testing, such as the OraQuick test, in communities with populations that are least likely to be tested because of stigma.[137]
- Developing interventions that provide skills for disclosure of HIV status to sex partners and that increase knowledge of the legal consequences of not disclosing ones status.

Action Step – Continue Strengthening Legal Services

The AIDS Coordinator and City Attorney's AIDS/HIV Discrimination Unit should continue the development and support services of AIDS discrimination prevention strategies. This should include:

- Continuing to support the HIV & AIDS Legal Services Alliance's (HALSA) pioneering HIV Legal Checkup Project.
- Continuing to work with the Centers for Disease Control and Prevention and the American Bar Association in demonstrating the vital role of timely legal

counseling about the importance of protecting privacy to prevent discrimination for newly-diagnosed HIV positive individuals.

- Work with area businesses to maintain effective HIV/AIDS anti-discrimination workplace policies.

Recommendation #2: Training for City Employees
The AIDS Coordinator should work with the Personnel Department to provide updated HIV/AIDS education and training to all City employees and establish a mechanism to ensure HIV/AIDS education and training is provided to all new employees.

Recommendation #3: Outreach to City Contractors
The AIDS Coordinator should consider ways to work with City Contractors to help them to educate their employees regarding HIV/AIDS and to help them to maintain employment policies that treat people living with HIV/AIDS in accordance with anti-discrimination laws.

Recommendation #4: Review and Revise the City's AIDS Workplace Policies
The AIDS Coordinator should work with the City Attorney, the Personnel Department, and the City Medical Director to review and revise the City's AIDS Workplace Policies to ensure the fair and equal treatment of City employees with HIV/AIDS and City residents who receive City services.

CHAPTER 6: PROVIDING ACCESS TO SAFE, AFFORDABLE, AND DECENT HOUSING, AND ACCESSIBLE SUPPORTIVE HOUSING SERVICES FOR PEOPLE LIVING WITH HIV/AIDS

INTRODUCTION

The City of Los Angeles must continue to take an active role to improve the quality of life for residents living with HIV/AIDS. Adequate affordable housing, combined with supportive services, allows those living with HIV/AIDS to better manage their disease by providing a stable, comfortable, and sanitary living environment and easy access to storage for medications. Therefore, through its November 2002 World AIDS Day Resolution, the City Council affirmed as one of its primary responsibilities the provision of safe, affordable and decent housing and accessible supportive housing services for those living with HIV/AIDS.[138]

An increasing number of people living with HIV/AIDS are living longer and while many have always been living in poverty, they are even more likely to be living in poverty today. These recent changes in the epidemic have increased the demand for HIV/AIDS-related housing and supportive services.

In fact, the very medications that have allowed people to live longer lives can also cause the same people to suffer severe and debilitating side effects that sometimes limit their ability to work. Further, the average cost of HIV medical care, including medications, is extremely high, ranging from $14,000 for a person with early-stage HIV disease to $34,000 for those with late-stage AIDS.[139] Fortunately, using a combination of federal Ryan White CARE Act and state resources, Los Angeles County has been able to assemble a comprehensive medical care delivery and pharmacy distribution system that provides both healthcare and AIDS drugs to low-income residents. The stability of that system, however, may be in question in the future as the state and federal government face unprecedented budget deficits.

Not only is managing the disease costly for City residents, but discrimination in the workplace based on HIV status and/or sexual orientation can also lead to a loss of income and benefits. Landlords may also act in similarly discriminatory ways in their tenant selection or eviction practices.[140]

The increased need for housing and supportive services is complicated by a broad housing crisis throughout the region.[141] The rental market is tight with vacancy rates in Los Angeles County estimated at 4.2% as compared to 9% nationwide. In addition, more than 36% of residents live in housing that is not

affordable for them, which means they spend more than 35% of their annual income on housing.[142]

At the same time, the growing need for Section 8 housing continues to outpace the increases in federal funding for the program.[143] This is of great concern to the Mayor's AIDS Leadership Council because Section 8 gives priority to clients of HOPWA's long-term housing assistance program – a priority that is both laudable and vital.

It is of no surprise, then, that many people living with HIV/AIDS are in extremely unstable housing situations. In 1999, Shelter Partnership examined the relationship between homelessness and people living with HIV/AIDS. Based on their data collected from 785 people living with AIDS who were involved in various social service and housing programs:

- 46% were currently homeless;
- 65% had been homeless at some point in their lives;
- 50% feared that they were at risk of becoming homeless.[144]

The City administers the Housing Opportunities Program for People With AIDS (HOPWA) Program for the entire County using close to $10.4 million in federal funding. HOPWA is the best tool available for the City to directly and immediately address the growing need for housing and supportive services for people living with HIV/AIDS. Through HOPWA, the City contracts with many service providers and area Housing Authorities to provide these services, and through these contracts HOPWA serves over 18,000 people living with AIDS – a tremendous accomplishment. While the cost of providing services and the need for services has continued to rise, the level of federal HOPWA funding has not consistently increased to address the need. For the most part, this section presents analysis and recommendations for how to enhance the HOPWA Program in the face of several challenges.

CHALLENGES AND RECOMMENDATIONS

In order to ensure that people living with HIV/AIDS continue to have access to adequate housing and supportive services, and in the face of a changing epidemic, the City must continuously reevaluate and refine the HOPWA Program.

Challenge #1: Lack of a HOPWA Coordinator

The HOPWA Coordinator position has been vacant since July 2002, while the City's effort to enhance and fill the position has been stalled. Although the Housing Department has made recent significant strides to improve the administration of the Program, having a HOPWA Coordinator is especially important at this time. First, the HOPWA Coordinator would be in a unique position to advocate for the program, the community, and the City and provide a

national voice at this time of a growing need for housing assistance for people living with HIV/AIDS. Further, the HOPWA Coordinator would have been able to provide additional support and direction to the program as it undergoes the RFP process for the next three years of HOPWA funding.

The lack of a HOPWA Coordinator complicates the resolution of all of the other challenges that we identify below.

Recommendation
Hire a HOPWA Coordinator.
Action Step

- Elevate the status of the HOPWA Coordinator position in order to attract a high quality list of candidates, exempt the position from the City's hiring freeze, and hire a HOPWA Coordinator.

Challenge #2 Lack of Coordination with Los Angeles County Resources
Although it has a lower level of funding than the County, the City of Los Angeles is an integral player in the delivery of vital services for people living with HIV/AIDS or at high-risk for contracting this disease. While the County and the City each have a unique role, there is also substantial overlap. Currently there is no mechanism (formal or informal) for the coordination of services (care, treatment, housing, supportive or prevention) between the City of Los Angeles and the County of Los Angeles.

This lack of coordination results in significant gaps in vital services desperately needed by people living with HIV/AIDS. It greatly increases the amount of work and the complexity of the work on the part of community-based organizations attempting to "piece together" funding from two different, but geographically overlapping, sources. The City and County have vastly different contractual and operating requirements, making it significantly more challenging for community based organizations to provide the best possible services for people living with HIV/AIDS. Finally, the current system is extraordinarily confusing and complicated for clients – they cannot understand why they must fill out multiple sets of conflicting paperwork to access services.

Recommendation
The HOPWA Program should work with the County to develop mechanisms for coordination of housing and supportive services for people living with HIV/AIDS.
Action Steps

- Develop a formal process for ongoing communication and coordination between the HOPWA Coordinator and the City AIDS Coordinator and the Los Angeles County Office of AIDS Programs and Policy. Included in that process should be the coordination of strategic planning functions, to insure that both funding sources are working together to develop the best possible service delivery model for people living with HIV/AIDS.

- Evaluate the eligibility requirements for both HOPWA funded and CARE Act funded programs and attempt, wherever possible, to make them consistent.

Challenge #3: Community Oversight
The primary avenue for community oversight of the HOPWA Program is the Los Angeles Countywide HOPWA Advisory Committee (LACHAC). LACHAC is the advisory body to the City for HOPWA's policy, design, and operational issues. LACHAC is comprised of representatives from the HIV/AIDS housing and service arena and includes seats dedicated to people who are living with HIV/AIDS.

Many of the members of LACHAC contract with the City for HOPWA funding, and indeed it is those people who are most familiar with the need in the community and best able to provide general policy oversight. As contractors, however, it is inappropriate for many members of LACHAC to make decisions related to funding or potential funding. As a result LACHAC has only a limited opportunity to actively participate in substantive budgetary decisions and some feel that it is not able to accomplish a significant element of its mission. Indeed, some recent resignations by LACHAC members may reflect their sense LACHAC cannot fulfill the policy role that they had hoped it would. Currently, LACHAC is working with the Housing Department to propose revisions to their bylaws that would address this challenge.

As a Countywide program, HOPWA serves some clients – those that live in the County but not City of Los Angeles – who are not represented by the elected officials who ostensibly oversee the program. All clients have access to the same complaint proceedings, and the HOPWA Program, which by practice and law treats all clients equitably, can ultimately handle all complaints. At the same time non-City residents do not have elected representatives to whom they can turn if they remain unsatisfied by the complaint proceedings.

Recommendation
Enhance the opportunities for community oversight of the HOPWA Program.
Action Steps
- The HOPWA Program should work with LACHAC members to clarify the mission of LACHAC and consider ways to make it more active in the HOPWA policy planning process. This process may include a revision of LACHAC's membership and/or purpose, as is currently underway.
- Designate the AIDS Coordinator as the ombudsperson to, when necessary, advocate on behalf of HOPWA clients who live outside of the City since they are not represented by any elected official who oversees the program.

Challenge #4: HOPWA Contract Administration
In the past, the HOPWA Program often did not spend its funds in a timely manner. This problem was largely explained by a combination of the City's bulky invoice payment process and, in some cases, contractors' inability to comply with contract requirements. While the Housing Department has done an admirable job

of streamlining the HOPWA invoice process to facilitate the reimbursement of contractors, approximately 10% of HOPWA funds were not spent in Program Year 2002-03. That some funds remain unspent suggest that the expenditure problems continue, albeit on a smaller scale.

Some HOPWA Program funds, such as those allocated to the Fast Track Program, which provides transitional funding for people who will soon enter the Section 8 program, are nearly always spent in a timely manner. While somewhat constrained by the limitations in the Los Angeles Administrative Code regarding reprogramming contract funds,[145] the HOPWA Program has not taken advantage of opportunities to reallocate unspent funds in a systematic way during the contract year.

Recommendations

The Housing Department should continue to find ways to more effectively spend the full allocation of HOPWA funding:

Action Steps

- For agencies that acknowledge that they are going to be unable to fulfill their contract obligations, consider ways to reprogram unspent funds during the same contract year to agencies that are likely to be able to use the additional funds for services.
- Develop and publicize a strategy in advance of each contract year to determine how unspent funds will be reprogrammed during that contract year.
- Include the ability to provide the services required by the contract as a important consideration in the renewal of contracts.
- Conduct an investigation, including a comparison of spending levels in other similar grant funded programs, in an attempt to understand and improve the spending rate.

The Mayor and City Council should evaluate Los Angeles Administrative Code Section 14.8, which regulates contract reprogramming, and consider whether it is appropriate to amend it to facilitate reprogramming funds during the course of a contract.

Challenge #5: Developing a Strategic Plan Supported by a Needs Assessments

At the request of the HOPWA Program, Shelter Partnership is developing an analysis of housing and supportive services needs of people who are living with HIV/AIDS.[146] The current draft proposes a five-year plan for a comprehensive, countywide, multi-agency approach to addressing those needs. While HOPWA is part of the plan, the current draft does not lay out a specific set of recommendations for the use of HOPWA funds.

The HOPWA Program, therefore, is in need of an updated strategic plan supported by regular needs assessments to direct the best use of its limited resources. The actual amount of federal funding changes slightly from year to

year, but there has not been a general increase in funding commensurate with the increased need. Given that HOPWA funding cannot address the full need for housing and supportive services for those living with AIDS, the City needs to be increasingly strategic and use funds where they are most needed.

Besides limited resources, two other issues make the need for a strategic plan supported by a regular needs assessment all the more acute. First, there is an ongoing debate about how to best balance HOPWA funds between its essential components: long-term housing, short-term housing, and supportive services. In recent years, HOPWA has not funded the development of new housing dedicated to people living with HIV/AIDS, potentially the most stable source of long-term housing. Second, HOPWA needs to be able to respond to Los Angeles' changing epidemic in which people are living for a longer time and different communities are increasingly impacted.

Recommendation
Incorporate into HOPWA's general practice the development of strategic plans supported by a needs assessment for the use of HOPWA funding before releasing requests for proposals.
Action Steps

- Request that the HOPWA Program work with the AIDS Coordinator's Office, the Los Angeles Homeless Services Authority, other relevant departments, and experts who do not have conflicts as HOPWA contractors to develop regular needs assessments.
- Request that the HOPWA Program work with the AIDS Coordinator's Office, other relevant departments, and experts who would not have conflicts as HOPWA contractors to use this needs assessment to propose an ideal balance of short-term housing, long-term housing, new housing development, and supportive services for HOPWA funding in advance of each new RFP process.
- Present the proposal to the community through a series of public hearings in which all members of the public, including HOPWA clients and contractors, can provide input that would then be used to adjust the recommendations of HOPWA's proposal.
- Base the mix of funding for long-term housing, short-term housing, new housing development, and supportive services in HOPWA RFPs on the final proposal.

Challenge #6: Serving Undocumented Immigrants
The federal government prohibits the use of HOPWA funds to provide services to undocumented immigrants. At the same time, as we discussed in the Profile Chapter, immigrants including undocumented immigrants are increasingly in need of HIV/AIDS services. The federal government does not require that non-profits inquire as to the immigration status of their federally funded clients, and as a result HOPWA may provide services to undocumented immigrants living with HIV/AIDS through several programs administered by non-profits. The bulk of the

actual housing provided through HOPWA, however, is through housing authorities and they must inquire about immigration status and may not serve undocumented immigrants. Through the Housing Department the City has been able to provide some housing subsidies to undocumented immigrants who are living with HIV/AIDS by identifying other funds that may be used to serve them. Given the City's current fiscal crisis, access to these funds could be curtailed.

Recommendation
The City should continue to seek and access funds that can be used to provide housing for undocumented immigrants who are living with HIV/AIDS.

Challenge #7: Finding the Right Department for the HOPWA Program
The HOPWA Program is not a perfect fit for any one City department because effectively operating the program requires a diverse set of departmental skills. In order for the Program to be effective, its host department must be able to support its need for both high quality technical grant management, and a high level of sensitivity to the community. Given the need for this delicate balance, there is ongoing discussion as to the ideal location for the HOPWA Program and how to better coordinate it with the AIDS Coordinator Office, currently located in the Department on Disability.

Recommendation
Study the appropriate departmental location for HOPWA.
Action Step

- The City Council should request the City Administrative Officer to prepare a report with recommendations on the appropriate departmental location of the HOPWA Program. The report should expand upon the following options and analysis of advantages and disadvantages of each:
    - Option 1: Keep HOPWA in the Housing Department.
        - Advantages: Avoids unnecessary dislocation of program and personnel; HOPWA can currently take advantage of the Housing Department's housing expertise.
        - Disadvantage: HOPWA's supportive services component is somewhat outside of the core mission of the Housing Department's.
    - Option 2: Move HOPWA under the AIDS Coordinator's Office in the Department on Disability.
        - Advantages: Merging the City's primary HIV/AIDS programs would provide opportunities for synergies, reduce the potential for duplication among contracts, and provide one-call for City service for people living with HIV/AIDS; The AIDS Coordinator's Office has a great deal of experience working with the HIV/AIDS service community.
        - Disadvantage: May reduce the amount of time that the AIDS Coordinator can spend working on other important issues.

- Option 3: Create a new City Department that consolidates all City human service functions and locate HOPWA and the AIDS Coordinator in that Department.
  - Advantage: Could result in synergies that would increase the access to all human services for people living with HIV/AIDS.
  - Disadvantages: Potential for temporary dislocation as the divisions reorganize in a new department; Unique status of HIV/AIDS programs could be compromised if folded into a overarching human services department.
- Option 4: Create a Department for HIV/AIDS Programs.
  - Advantage: Issues of HIV/AIDS would enjoy a higher status through their independence from other departments.
  - Disadvantages: Need for staffing for functions that are currently provided by host departments would introduce new costs during tight fiscal times; Need for additional administrative focus instead of a focus on providing services.
- Option 5: Contract the administration of the HOPWA Program to an outside entity.
  - Advantage: The City could choose an entity that has both a high level of expertise in administering large programs, and a high level of sensitivity to community relations.
  - Disadvantage: The City would lose direct oversight of the Program and as a result would have less ability to change the Program during the course of the contract.

Challenge #8: The Section 8 Program

Section 8 is a vital housing resource for people living with HIV/AIDS because clients of the HOPWA long-term rental assistance program can transition into permanent, Section 8 housing. They do, however, need the highest level of flexibility possible within the Section 8 Program to choose where they live in order to ensure that they can remain connected to their service and support networks.

At the same time, there are proposals at the federal level to convert the Section 8 Program to block grants – a change that could result in substantial cuts.[147] Any associated loss of affordable housing would impose a great harm on people living with HIV/AIDS who rely on Section 8 housing. The City Council considered taking a position of opposition to the federal legislation that would have converted Section 8 to block grants,[148] but the legislation was shelved. It could well emerge again.

Recommendation

Direct the HOPWA Coordinator to work to ensure that Section 8 units continue to be available for people living with AIDS in the communities in which they can access medical, community, and other support networks.

Action Steps

- In future contracts with Housing Authorities, the HOPWA Coordinator should include provisions that would require the Housing Authorities to accept HOPWA rental vouchers issued through any of the other Housing Authorities in the Program. This would expand the range of geographical choices available to HOPWA clients as they try to live in an area where they can access service and support networks.
- The City should oppose efforts to convert Section 8 into a block grant program.

CONCLUSION

We have offered this White Paper with the goal of providing a focal point for City policy makers to consider the most effective means for addressing HIV and AIDS in the City of Los Angeles in the 21st Century. It is, however, also a starting point. The ultimate success of this White Paper will be measured by the conversations that it spawns, and we will join you in these conversations and partner with you as you ultimately craft the City's approaches to the challenges of combating HIV and AIDS in Los Angeles in the 21st Century.

APPENDIX 1: COUNCIL RESOLUTION FROM NOVEMBER 22, 2003

RESOLUTION

Whereas it was in the City of Los Angeles in 1981 that physicians reported the first cases of what was later identified as AIDS to the U.S. Centers for Disease Control and Prevention; and

Whereas the City of Los Angeles became the nation's leader in the fight against stigma and discrimination when it enacted the world's first AIDS anti-discrimination law in August 1985; and

Whereas the City has continued to fight stigma and discrimination through such policies as

- Establishing the nation's first AIDS Discrimination Unit in the City Attorney's Office;
- Enacting one of the nation's first model AIDS workplace policies;
- Establishing the City AIDS Coordinator's Office, headed by a person living with AIDS;
- Adopting the City's 1990 *Policy on the HIV/AIDS Epidemic*, which included progressive prevention methods to combat the spread of HIV/AIDS;
- Administering the Housing Opportunities for Persons with AIDS (HOPWA) Program;
- Securing domestic partner health benefits through the City's Domestic Partner policy for City employees, and through the Equal Benefits Ordinance for employees of City contractors; and

Whereas now there is a rising tide of institutional and social stigma and discrimination such as inadequate resources and funding, abstinence-only programs, and attacks on such proven methods of AIDS prevention and education as condom use and needle exchange programs; and

Whereas Los Angeles continues to be the nation's second largest epicenter of HIV/AIDS cases, with increasing numbers of new cases among women, youth, transgenders, and other people belonging to disproportionately-affected, marginalized communities; and

Whereas the United Nations has declared that combating stigma and discrimination is the theme of World AIDS Day, December 1, 2002:

Now therefore be it resolved that by the adoption of this Resolution, the City of Los Angeles on the occasion of World AIDS Day 2002 hereby rededicates itself

to our historic national leadership role in the fight against HIV/AIDS stigma and discrimination by:

Committing to review and revise the City's 1990 Policy on the HIV/AIDS Epidemic and engaging its residents, especially people living with HIV/AIDS, in this process;

Affirming as one of our primary responsibilities the provision of safe, affordable, and decent housing, as well as accessible supportive housing services;

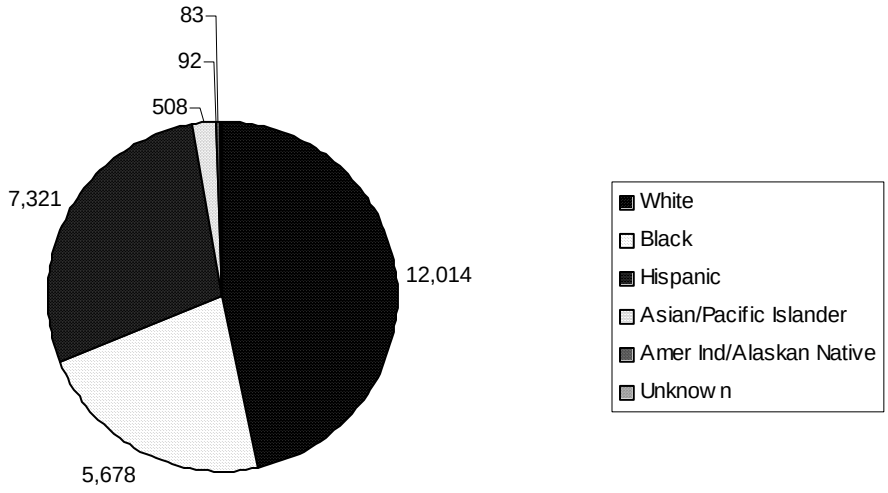
Recognizing a local state of crisis in the City of Los Angeles with HIV infection rates in certain affected communities that at times surpass those of the most heavily impacted nations in the developing world, and promoting efforts to address the disproportionate impact of HIV in Angelenos of African American, Latino, American Indian and Asian/Pacific Islander descent, including men who have sex with men and their female partners, and substance abusers;

Committing to ensuring that innovative, evidence-based HIV prevention programs are provided to residents, including sexually explicit materials targeted to those in groups at-risk and newly emerging risk groups, by agencies that are indigenous to those communities, and to leveraging resources to carry out education and prevention activities.

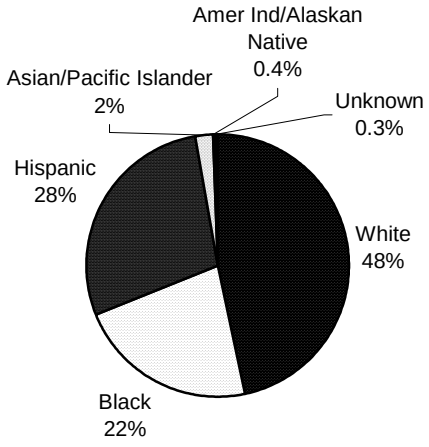
Calling upon and encouraging the City's neighborhoods, communities, agencies, and leaders to join in confronting stigma and discrimination by responding to the challenges of HIV/AIDS in the early 21st Century.

APPENDIX 2: DEMOGRAPHIC INFORMATION[149]

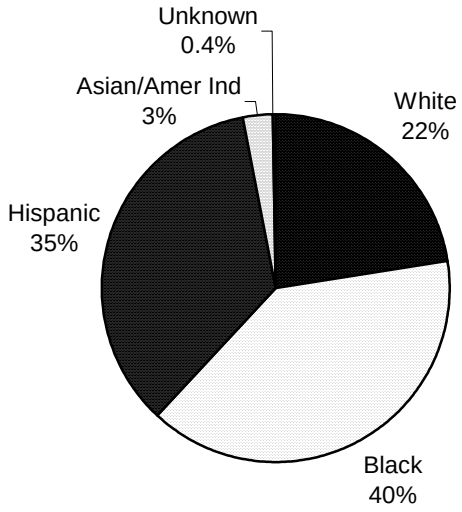
Cumulative Number of City of Los Angeles AIDS Cases by Race/Ethnicity, as of June 30, 2003



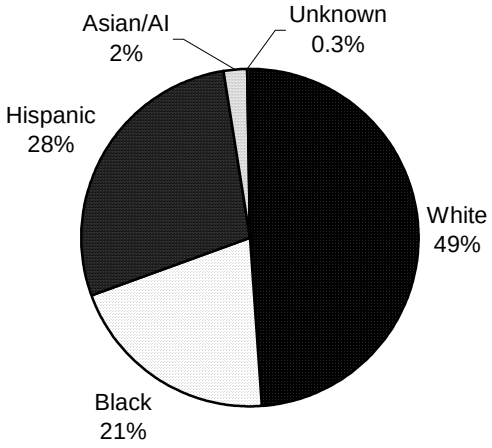
Cumulative Percent of City of Los Angeles AIDS Cases by Race/Ethnicity, as of June 30, 2003



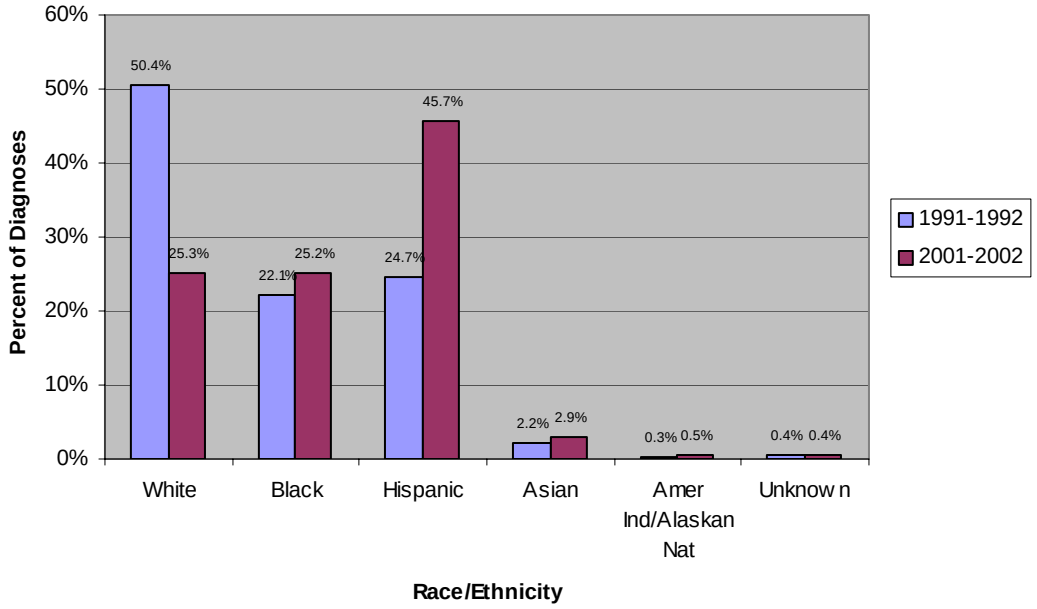
Cumulative Percent of Women's AIDS Cases by Race/Ethnicity, City of Los Angeles, as of June 30, 2003



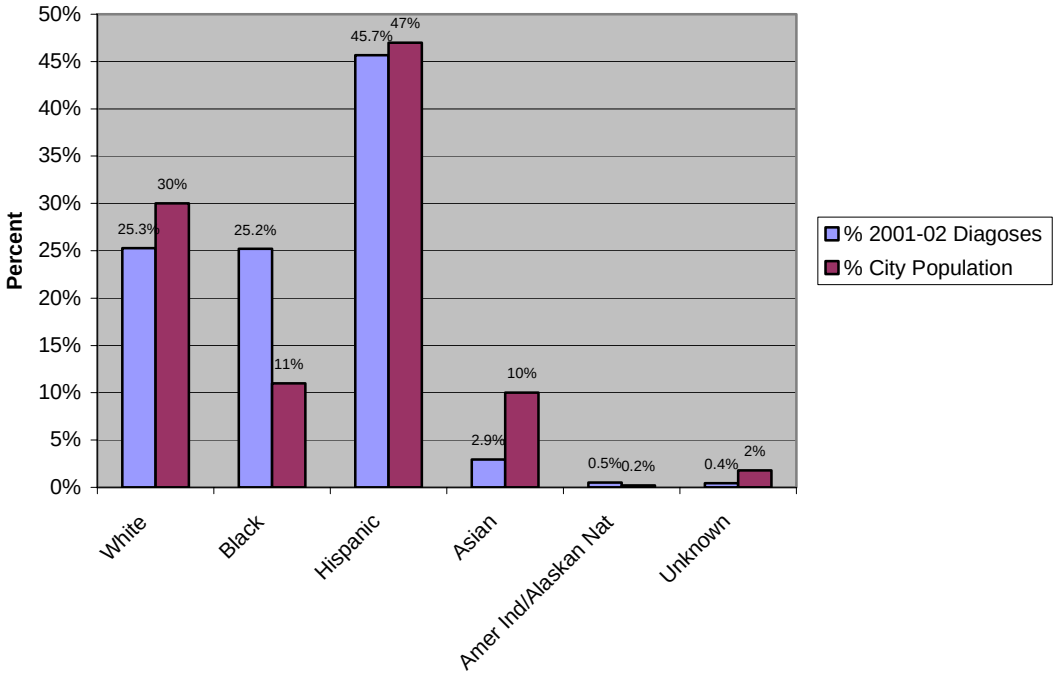
Cumulative Percent of Men's AIDS Cases by Race/Ethnicity, City of Los Angeles, as of June 30, 2003

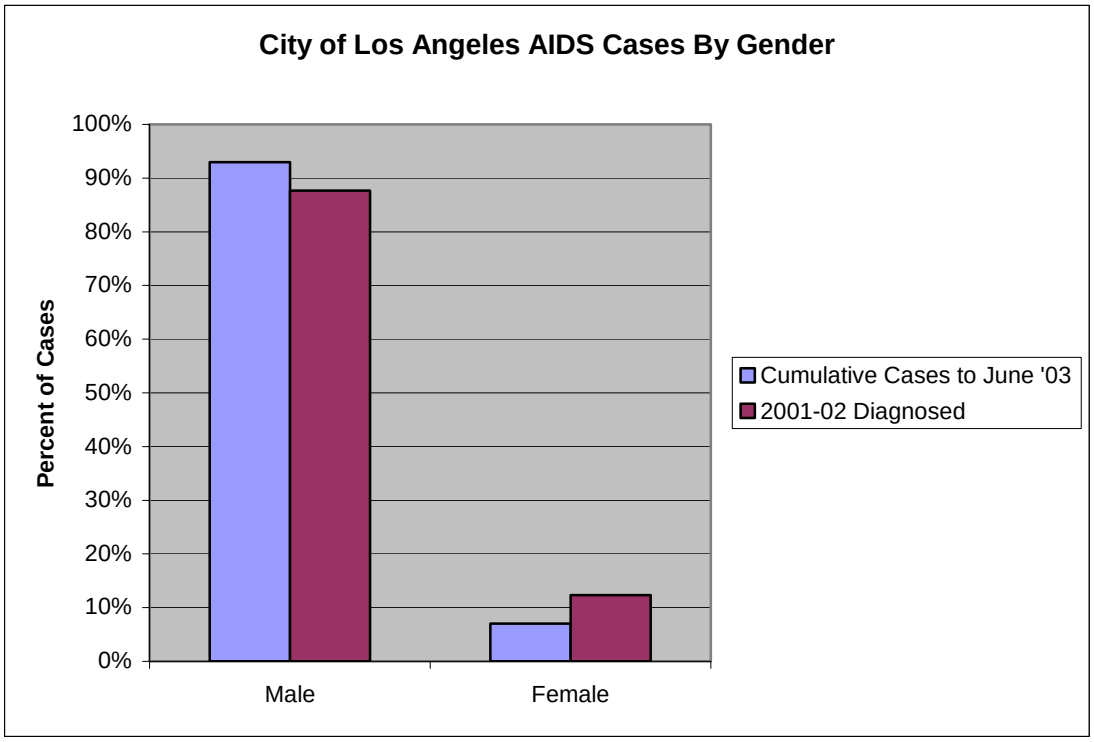


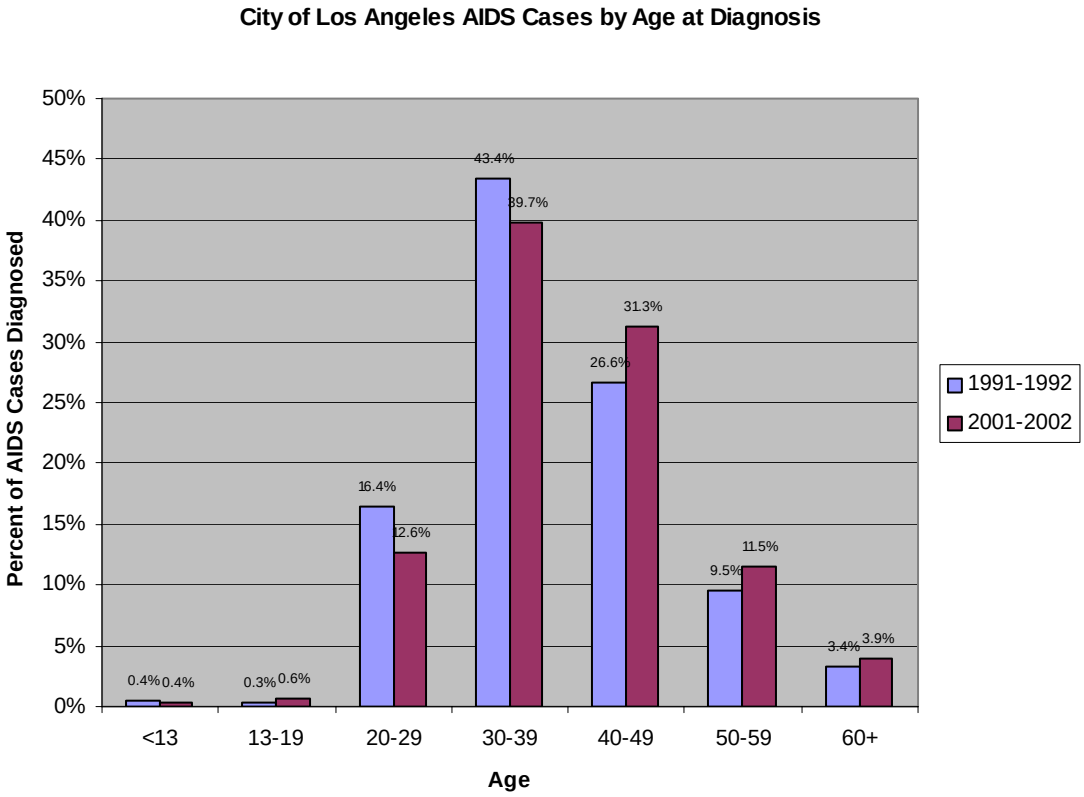
City of Los Angeles AIDS Diagnoses by Race/Ethnicity, 1991-1992 and 2001-2002



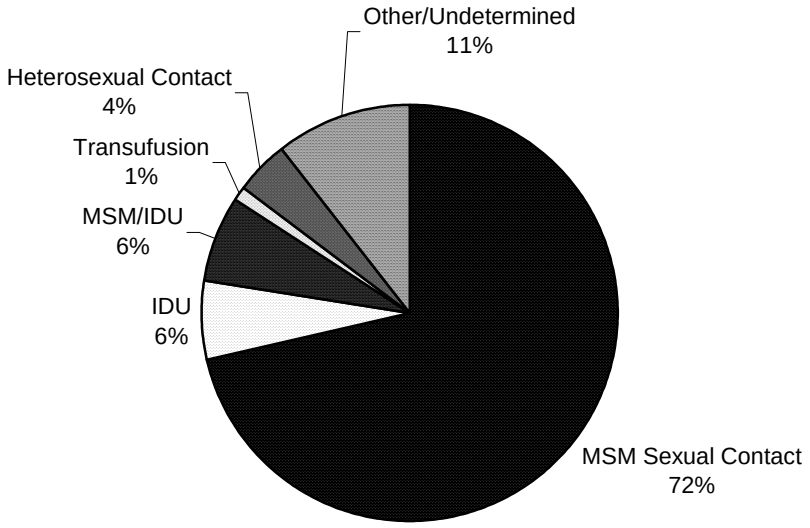
Racial/Ethnic Composition of Recently Diagnosed AIDS Cases Proportionate to City of Los Angeles Population



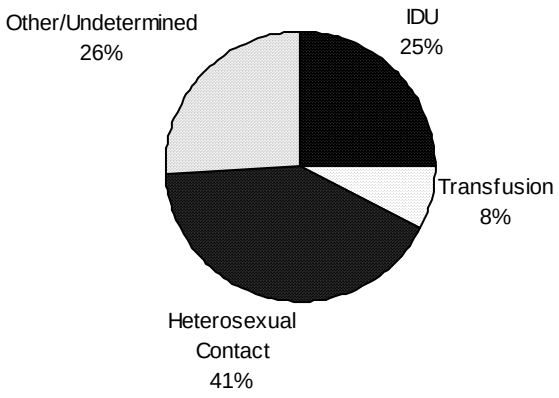

City of Los Angeles AIDS Cases By Gender
Percent of Cases
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Male
Female
Cumulative Cases to June '03
2001-02 Diagnosed


City of Los Angeles AIDS Cases by Age at Diagnosis
Percent of AIDS Cases Diagnosed
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
0.4%
0.4%
0.3%
0.6%
16.4%
12.6%
43.4%
39.7%
26.6%
31.3%
9.5%
11.5%
3.4%
3.9%
<13
13-19
20-29
30-39
40-49
50-59
60+
Age
1991-1992
2001-2002

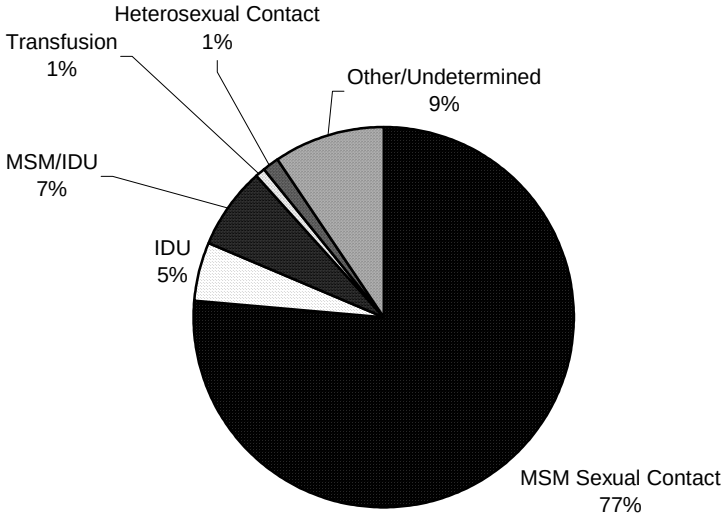
Cumulative AIDS Cases by Mode of Exposure, City of Los Angeles, as of June 30, 2003

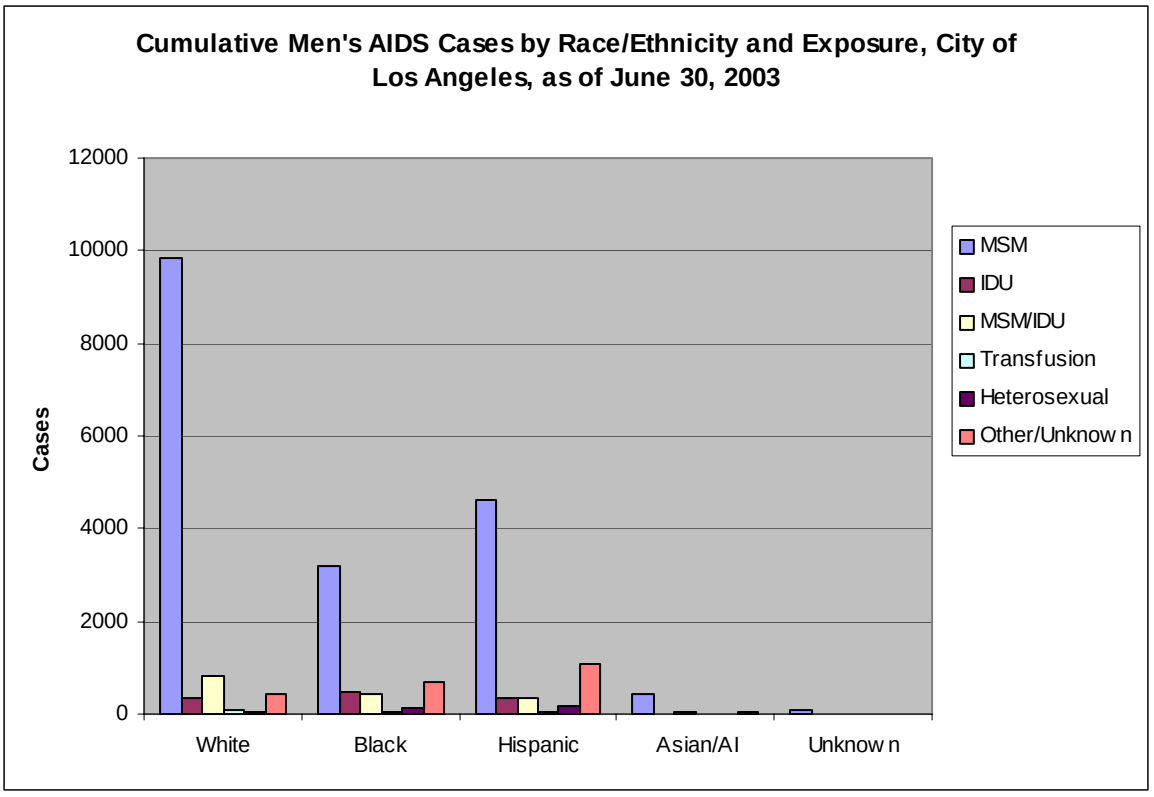


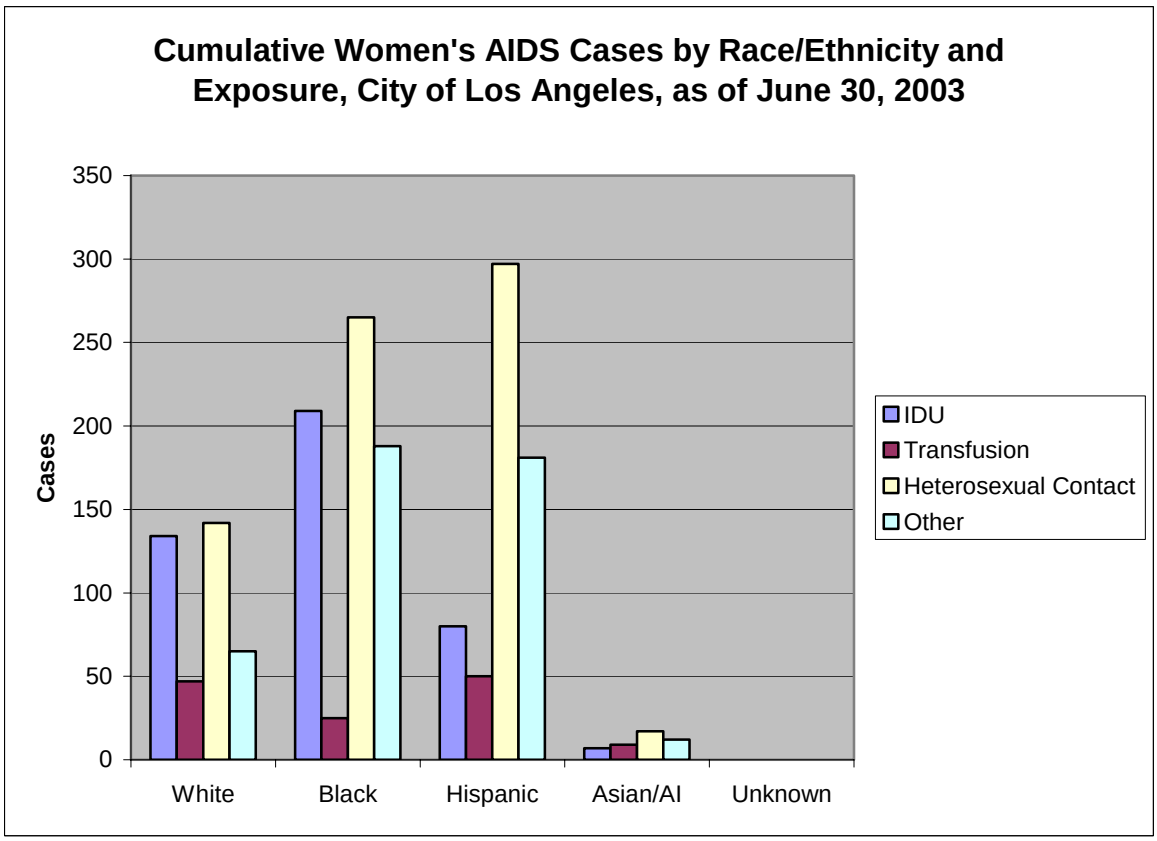
Cumulative Women's AIDS Cases by Mode of Exposure, City of Los Angeles, as of June 30, 2003



Cumulative Men's AIDS Cases by Mode of Exposure, City of L.A., as of June 30, 2003




Cumulative Men's AIDS Cases by Race/Ethnicity and Exposure, City of Los Angeles, as of June 30, 2003
Cases
12000
10000
8000
6000
4000
2000
0
White
Black
Hispanic
Asian/AI
Unknown
MSM
IDU
MSM/IDU
Transfusion
Heterosexual
Other/Unknown


Cumulative Women's AIDS Cases by Race/Ethnicity and Exposure, City of Los Angeles, as of June 30, 2003
Cases
350
300
250
200
150
100
50
0
White
Black
Hispanic
Asian/AI
Unknown
IDU
Transfusion
Heterosexual Contact
Other

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[141] We strongly support City's ongoing and impressive efforts to increase the stock of affordable housing through such means as the Affordable Housing Trust Fund and recognize the benefit it will have not just for people living with HIV/AIDS but also for all people who are faced with unstable housing situations. A thorough discussion of the efforts to create new affordable housing, however, is beyond the scope of this White Paper.
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