



REPORT ON RACE / ETHNICITY
California HIV Prevention Indicators
2nd Edition

A Collaborative Effort of the:

Universitywide AIDS Research Program
University of California Office of the President
300 Lakeside Drive, 6th Floor, Oakland, California 94612

and the

HIV Prevention Research and Evaluation Section
Office of AIDS, California Department of Health Services
1616 Capitol Avenue, Sacramento, California 95814

February 2, 2005

Please submit comments to: Roy R. McCandless, MA, MPA, DrPH
Tel. 510-287-3359. E-mail roy.mccandless@ucop.edu

This project was supported by funds received from the State of California,
Department of Health Services, Office of AIDS.

Forward

This report looks at California HIV Prevention Indicators as they pertain to five race/ethnic groups. This report supplements a *Summary Report* which provides summary data for California overall. More detailed tabular information can be found in an accompanying *Detailed Data* report.

The race/ethnic groups of interest are: African American, Asian and Pacific Islander, Hispanic, Native American (American Indian and Alaska Native), and White (non-Hispanic). Definitions for the groups reflect those used by the United States Census, except that no multi-racial category is considered. This means that the groups do not overlap and that, while Hispanic persons may be of any race, they are not counted by race. They are counted as a separate group.

This report generally does not consider Other or Unknown race groups because the numbers from the respective data sources are usually too small for meaningful analysis. Also, for some of the indicators, the numbers for one or more of the groups are too small, and they are omitted from the presentation. In any case, where data are presented as percents and ratios, the reader should be cautious in interpreting large gyrations. Where the numbers are small, a minor change in the raw numbers can result in a large percentage change. Thus, the reader should refer to the *Detailed Data* report before making any firm conclusions about changes over time.

Because of space limitations, graphical information uses the following abbreviations:

Black = African American (non-Hispanic)
API = Asian and Pacific Islander (non-Hispanic)
Hispanic = Hispanic
Native = American Indian and Alaska Native (non-Hispanic)
White = White (non-Hispanic)

The information in this report is presented in parallel to the *Summary Report*, that is, each indicator is presented in the same order and with the same numbering as shown in the *Summary Report*. However, because data on race/ethnicity are not available for all indicators, some of the items are missing. This means that some of the indicator numbers may be skipped. For example, no meaningful data could be found for Indicator 2-2-2. So that number is passed over, and the next item presented is Indicator 2-2-3.

Table of Contents

2. POPULATIONS

2-1. Numbers in High Risk Groups

2-1-1. Number of Gay and Bisexual Men
Data from California Health Interview Survey

2-1-2. Number of Injection Drug Users
Data from the California Alcohol and Drug Data System

2-1-3. Number of Non-Injection Methamphetamine, Cocaine and Crack Users
Data from the California Alcohol and Drug Data System

2-2. Prevalence of HIV Infection

2-2-2. HIV Prevalence among MSM respondents in a San Francisco Street Survey
Data from the Stop AIDS Program

2-2-3. HIV Prevalence among HIV Counseling and Testing Program Clients
Data from the Office of AIDS HIV Counseling and Testing Program

3. INTERVENTIONS

3-1. Availability and Utilization

3-1-1. Adults Who Ever Tested for HIV
Data from the Behavioral Risk Factor Surveillance System

3-1-2. Annual Volume of HIV Testing Services
Data from the Office of AIDS HIV Counseling and Testing Program

3-2. Timeliness and Continuity

3-2-1. HIV Tests Where Clients Do Not Return for Results
Data from the Office of AIDS HIV Counseling and Testing Program

3-2-2. Positive HIV Tests Where Clients Do Not Return for Results
Data from the Office of AIDS HIV Counseling and Testing Program

3-2-3. Earliest Positive HIV Test Was Less than or Equal to Six Months before AIDS Diagnosis
Data from the California AIDS Registry

3-2-4. Persons Successfully Referred by Outreach to HIV Counseling and Testing Program
Data from the Office of AIDS HIV Counseling and Testing Program

4. RISK-TAKING AND PROTECTIVE BEHAVIORS

4-1. High Risk Sex

4-1-1. Counseling and Testing Program Clients with More than Five Sex Partners in Past Year
Data from the Office of AIDS HIV Counseling and Testing Program

- 4-1-2. Counseling and Testing Program Clients with Sex Partners who are Positive for HIV
Data from the Office of AIDS HIV Counseling and Testing Program
- 4-1-4. Unprotected Anal Intercourse among MSM Respondents in a San Francisco Street Survey
Data from the Stop AIDS Program
- 4-1-5. Unprotected Receptive Anal Intercourse
Data from the Office of AIDS HIV Counseling and Testing Program

4-2. Needle Sharing

- 4-2-1. Needle Sharing among Injection Drug Users
Data from the Office of AIDS HIV Counseling and Testing Program

5. DISEASE IMPACTS

5-1. New Infections

- 5-1-1. Number of New HIV Infections
Data from the California No-Names HIV Reporting System
- 5-1-2. Number of New HIV Cases Identified in the Counseling and Testing Program
Data from the Office of AIDS HIV Counseling and Testing Program
- 5-1-3. New HIV Infections per 100 Person-Years at Risk
Data from the Office of AIDS HIV Counseling and Testing Program
- 5-1-4. Primary and Secondary Syphilis
Data from the California Department of Health Services, STD Control Branch

5-2. AIDS

- 5-2-1. New Diagnoses of AIDS
Data from the California AIDS Registry
- 5-2-2. Number of Persons Living with AIDS
Data from the California AIDS Registry
- 5-2-3. Deaths of Persons with AIDS
Data from the California AIDS Registry

Indicator 2-1-1: Number of Gay and Bisexual Men

Category: Populations

Domain: Numbers in High Risk Groups

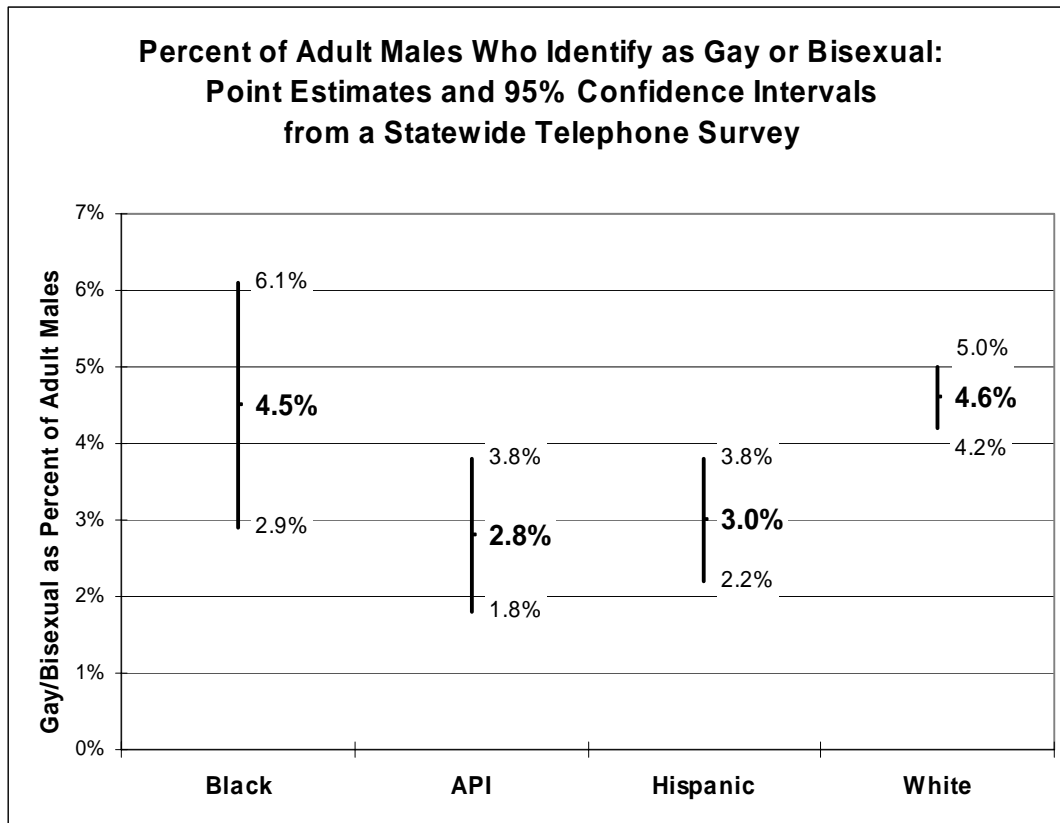
Question: Men Who Have Sex with Men: How many are there?

Why it's important: In California, men who have sex with men (MSM) have been at high risk for HIV infection since the inception of the epidemic.

How it's measured: Adult males, ages 18-64, were asked "Are you gay or bisexual?" in a statewide telephone sample survey.

Findings: The survey produced point estimates for the respective groups that ranged from 2.8% to 4.6%. Ranges for the number of non-elderly adult males in 2003 who consider themselves to be gay or bisexual are estimated as follows:

Black	21,000 – 45,000
API	23,000 – 49,000
Hispanic	85,000 – 147,000
White	219,000 – 261,000



Strengths/Limitations: Telephone surveys have a number of limitations, particularly in connection with sensitive questions. Also, the questions asked for self-identification as a member of a group, not about sexual behavior. Confidence intervals are wide.

Sources: Analysis of 2001 California Health Interview Survey by UCLA Center for Health Policy Research. Population denominators from California Department of Finance estimates release in 2003.

Acknowledgment: Nadereh Pourat

Indicator 2-1-2: Number of Injection Drug Users

Category: Populations

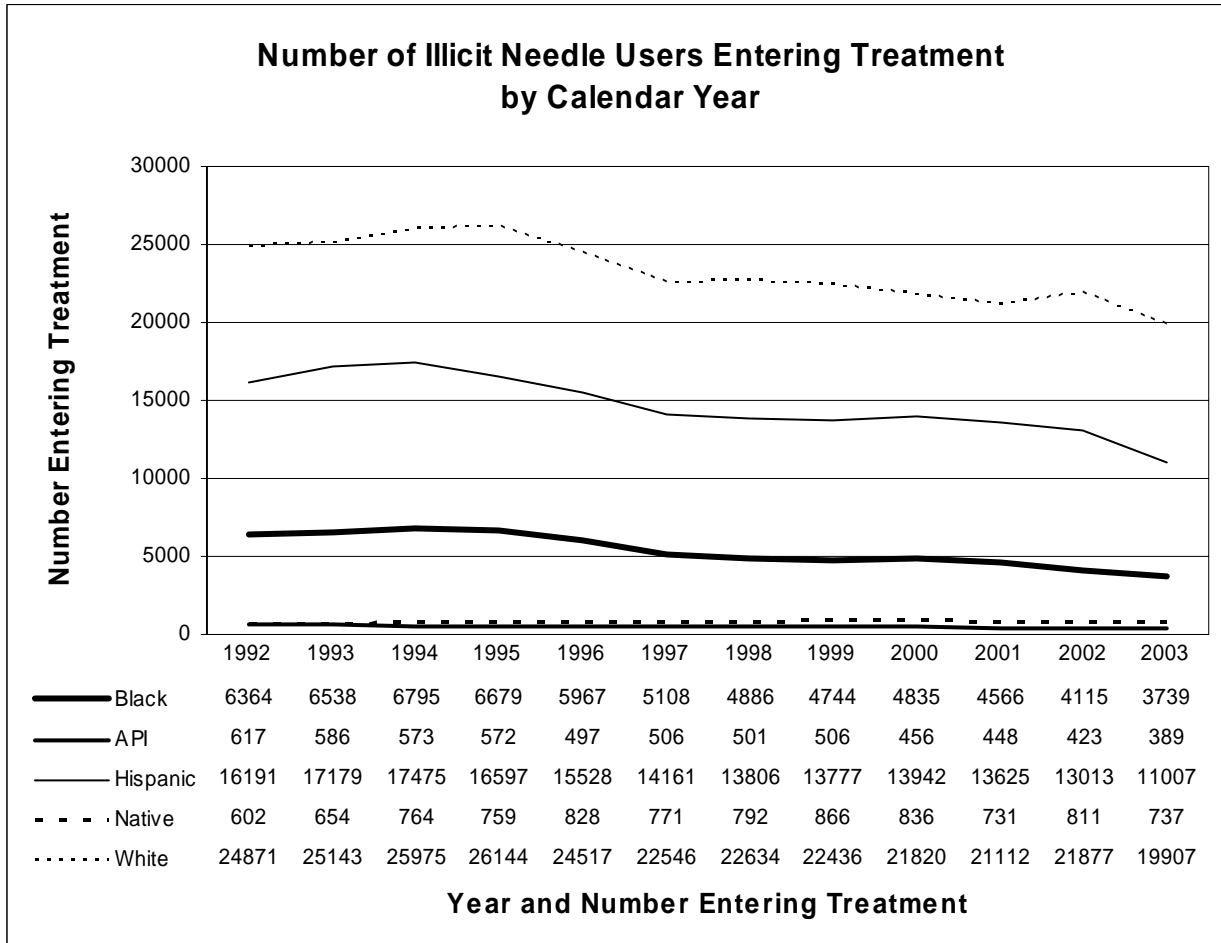
Domain: Numbers in High Risk Groups

Question: Injection Drug Users: How many are there?

Why it's important: Injection drug users (IDU) are at high risk for HIV infection.

How it's measured: Number of persons having a history in the past 12 months of illicit needle use who entered treatment at publicly funded or licensed alcohol and drug treatment programs.

Findings: The number of IDU entering treatment declined for each group except Native Americans.



Strengths/Limitations: The measure does not satisfy. The numbers omit IDU who did not enter treatment during the year, and counts of those who entered treatment may reflect availability of services and propensity to enter treatment.

Additional measures: Within each group, the number of IDU declined as a percent of all persons entering treatment. The HIV Counseling and Testing Program reports increases from 1995 to 2003 in the numbers of clients who are IDU among African Americans, Hispanics and Native Americans.

Sources: (1) California Alcohol and Drug Data System (CADDs), California Department of Alcohol and Drug Programs. (2) Counseling and Testing Program Data, Office of AIDS, California Department of Health Services.

Acknowledgment: Sally Jew

Indicator 2-1-3: Number of Non-Injection Methamphetamine, Cocaine and Crack Users

Category: Populations

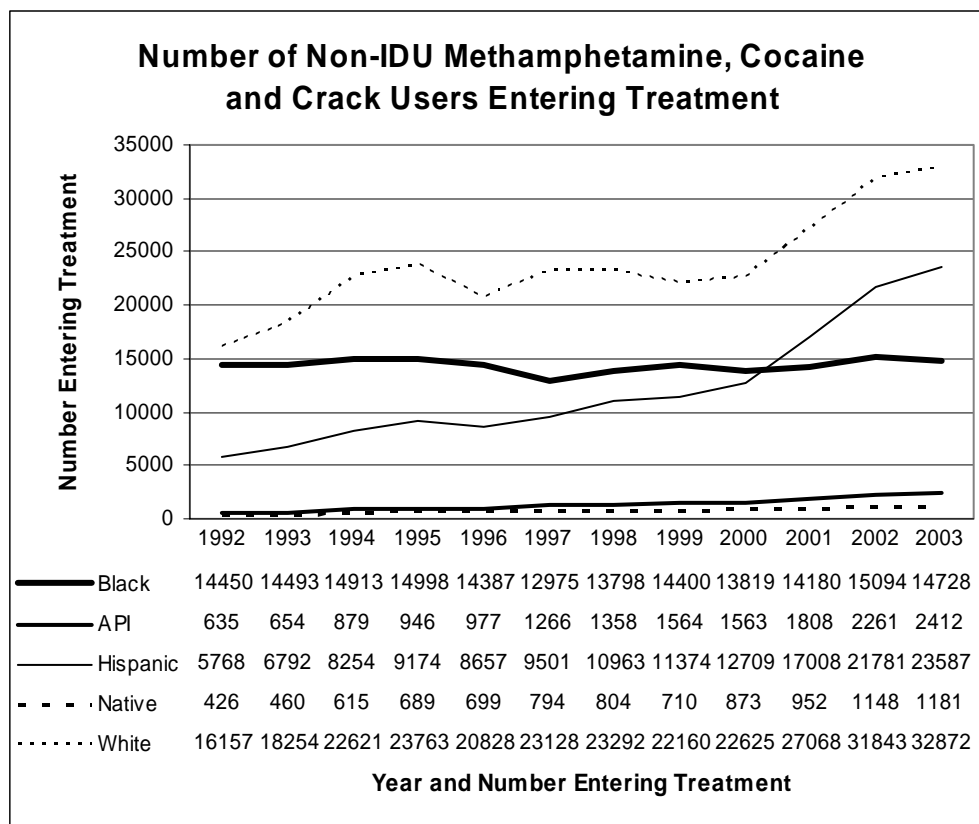
Domain: Numbers in High Risk Groups

Question: Non-Injection Methamphetamine and Crack Users: How many are there?

Why it's important: Methamphetamine and crack users are at high risk for HIV infection.

How it's measured: Number of persons having a history in the past 12 months of using methamphetamines, cocaine or crack, but no illicit needle use, who entered treatment at publicly funded or licensed alcohol and drug treatment programs.

Findings: For each group except for African Americans, the number of non-IDU methamphetamine, cocaine or crack users entering treatment increased substantially from 1992 to 2003.



Strengths/Limitations: The numbers omit users who did not enter treatment during the year, and counts of those who entered treatment may reflect availability of services and propensity to enter treatment. Nevertheless, the increased counts over time are interesting when compared with data on declining counts of IDU entering treatment over the same time period.

Additional measures: As a percent of all persons in the respective group who entered treatment, the number of non-injection methamphetamine, cocaine or crack users increased over the study period for each group, except among African Americans. The HIV Counseling and Testing Program reports substantial increases from 1998 to 2002 within the Hispanic and Native American groups in the percent of clients in the group who report non-injection crack or amphetamine use.

Sources: (1) California Alcohol and Drug Data System (CADDs), California Department of Alcohol and Drug Programs. (2) Counseling and Testing Program Data, Office of AIDS, California Department of Health Services.

Acknowledgment: Sally Jew

Indicator 2-2-2: HIV Prevalence among Respondents in a San Francisco Street Survey

Category: Populations

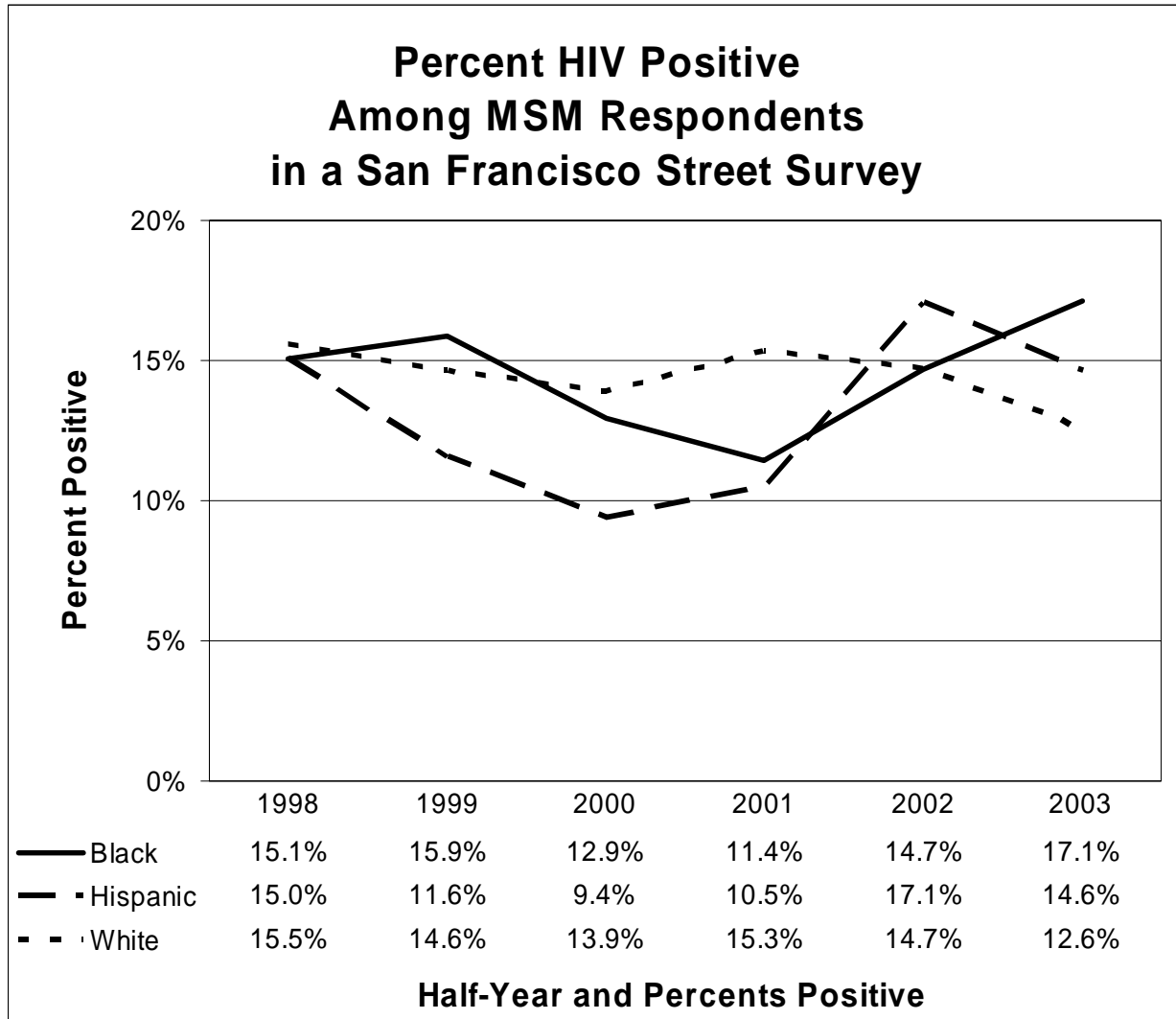
Domain: Prevalence of HIV Infection

Question: How common is HIV infection among MSM populations?

Why it's important: The extent to which HIV is present in the community represents increased potential for new infections.

How it's measured: Persons who indicate they are HIV positive as a proportion of those who indicate HIV status in an ongoing street survey in San Francisco. Analysis is limited to those who reported African American, Hispanic/Latino or White Non-Hispanic race/ethnic status.

Findings: The percentage who stated that they were HIV positive has changed little since 1998.



Sample Size: Findings are based on 210-768 individuals who said they were HIV positive during any period.

Strengths/Limitations: The sampled method is based on a convenience of subjects. Findings are limited to persons who frequent survey locations, and the percentages cannot be interpreted as representing HIV prevalence within the MSM community.

Source: Stop AIDS Project, San Francisco

Acknowledgment: Roop Prabhu, San Francisco Department of Public Health

Indicator 2-2-3: HIV Prevalence among HIV Counseling and Testing Program Clients

Category: Populations

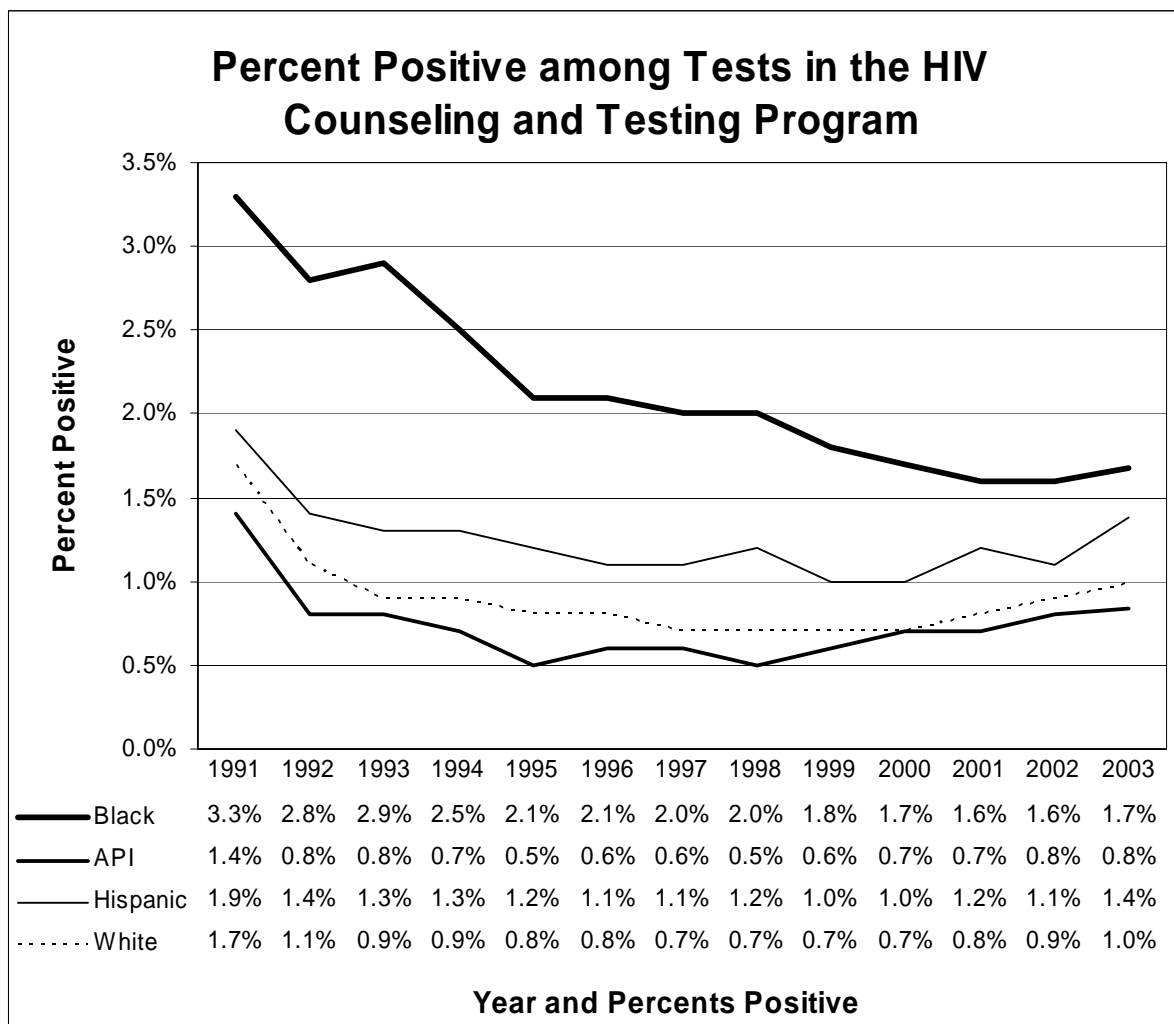
Domain: Prevalence of HIV Infection

Question: How common is HIV infection among testing populations?

Why it's important: The extent to which HIV is present in the community represents increased potential for new infections.

How it's measured: Positive HIV tests as a proportion of tests in the HIV Counseling and Testing Program. Analysis excludes repeated positive tests for the same individual.

Findings: Throughout the study period, African Americans had the highest percentage of tests that were positive. Within each group, the percentage of tests that were positive fell rapidly in the early 1990s. Over the most recent three years, percentages increased for each group except among African Americans.



Sample Size: For the smallest group (API), findings are based on 53-132 positive tests in any given year.

Strengths/Limitations: This indicator is useful for monitoring change in number of new infection, rather than for estimating the absolute number of new infections. Findings may reflect changes in client composition, such as an increased focus on high risk populations.

Source: Counseling and Testing Program Data, California State Office of AIDS

Acknowledgment: Nancy Berman Lees, Christine Dahlgren

Indicator 3-1-1: Adults Who Ever Tested for HIV

Category: Interventions

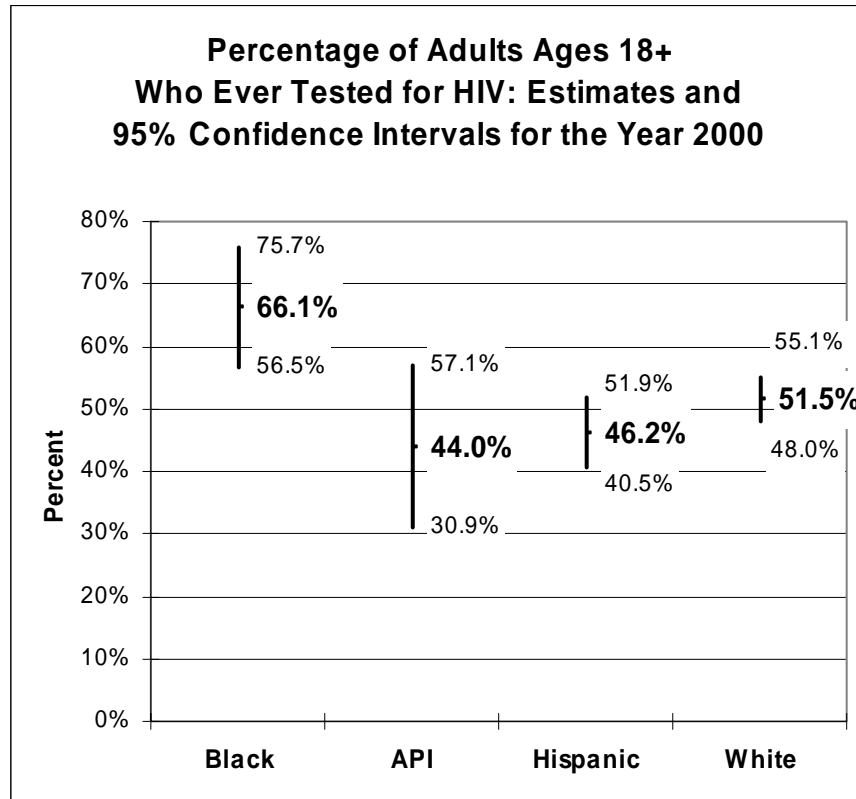
Domain: Availability and Utilization

Question: How many people access HIV testing services?

Why it's important: When people are aware of their HIV status, they are more likely to modify their behavior to protect themselves or others from infection.

How it's measured: Proportion of adult telephone survey respondents ages 18-64 who indicate that they ever tested for HIV.

Findings: A substantial proportion of adult have tested for HIV during their lifetimes. Percentages are particularly high among African Americans.



Strengths/Limitations: Telephone surveys have a number of limitations, particularly in connection with sensitive questions. Confidence intervals are reasonably narrow. A question about having “ever tested” tells us little about recent testing and behaviors since most recent HIV test. While the question was asked of all adults ages 18-64, we should recognize that many people have no need to test for HIV, and it would be useful to have data that focus on those who may be at risk for HIV infection.

Source: Centers for Disease Control. Behavioral Risk Factor Surveillance System <http://apps.nccd.cdc.gov/brfss/> accessed 1-29-03 and 12-9-03.

Indicator 3-1-2: Annual Volume of HIV Testing Services

Category: Interventions

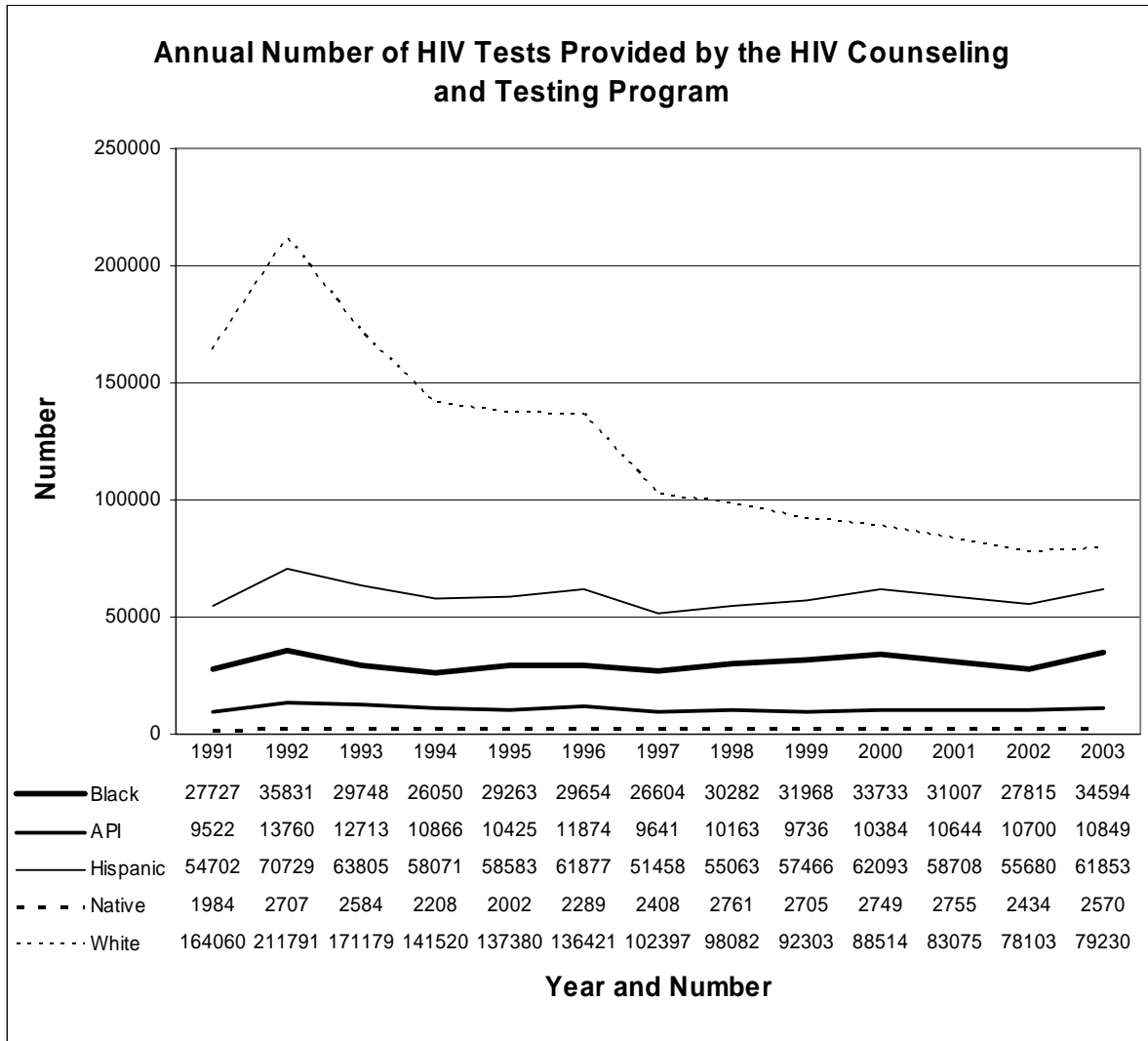
Domain: Availability and Utilization

Question: To what extent are publicly funded HIV testing services available and utilized?

Why it's important: HIV prevention services effectively reduce the number of new HIV infections.

How it's measured: Annual number of HIV tests provided under the HIV Counseling and Testing Program.

Findings: Whites have accounted for the largest number of HIV tests, although annual counts for Whites have declined substantially over the study years. Counts for other groups have increased.



Strengths/Limitations: The decline in testing volume is likely appropriate over a period in which the annual number of new HIV cases decreased. The numbers shown do not include services provided by other prevention programs, nor testing in private medical care.

Source: Office of AIDS, California Department of Health Services

Acknowledgment: Nancy Berman Lees, Christine Dahlgren

Indicator 3-2-1: HIV Tests Where Clients Do Not Return for Results

Category: Interventions

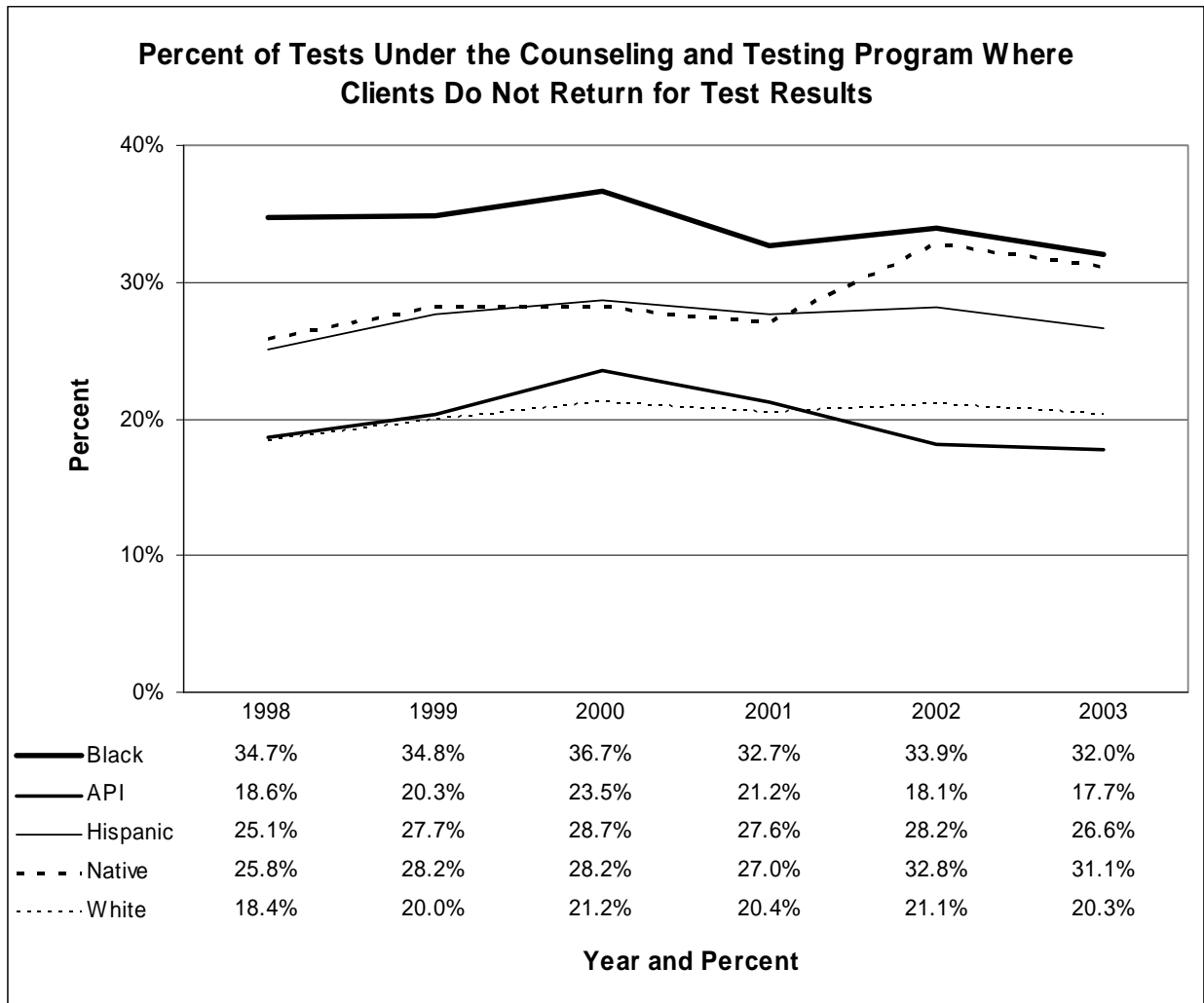
Domain: Timeliness and Continuity

Question: To what extent are high risk populations aware of their HIV status?

Why it's important: The effectiveness of HIV counseling and testing services is improved when clients return for test results.

How it's measured: Percent of HIV tests under the HIV Counseling and Testing Program where the clients do not return for test results.

Findings: Almost one-third of African Americans have not returned for test results. Proportions have been higher than 25% for Hispanic and Native American clients.



Sample Size: Findings for the smallest group (Native American) are based on 711-799 persons who did not obtain test results in any given year.

Strengths/Limitations: Findings may reflect a change in the composition of program clients.

Source: Office of AIDS, California Department of Health Services

Acknowledgment: Nancy Berman Lees, Christine Dahlgren

Indicator 3-2-2: Positive HIV Tests Where Clients Do Not Return for Results

Category: Interventions

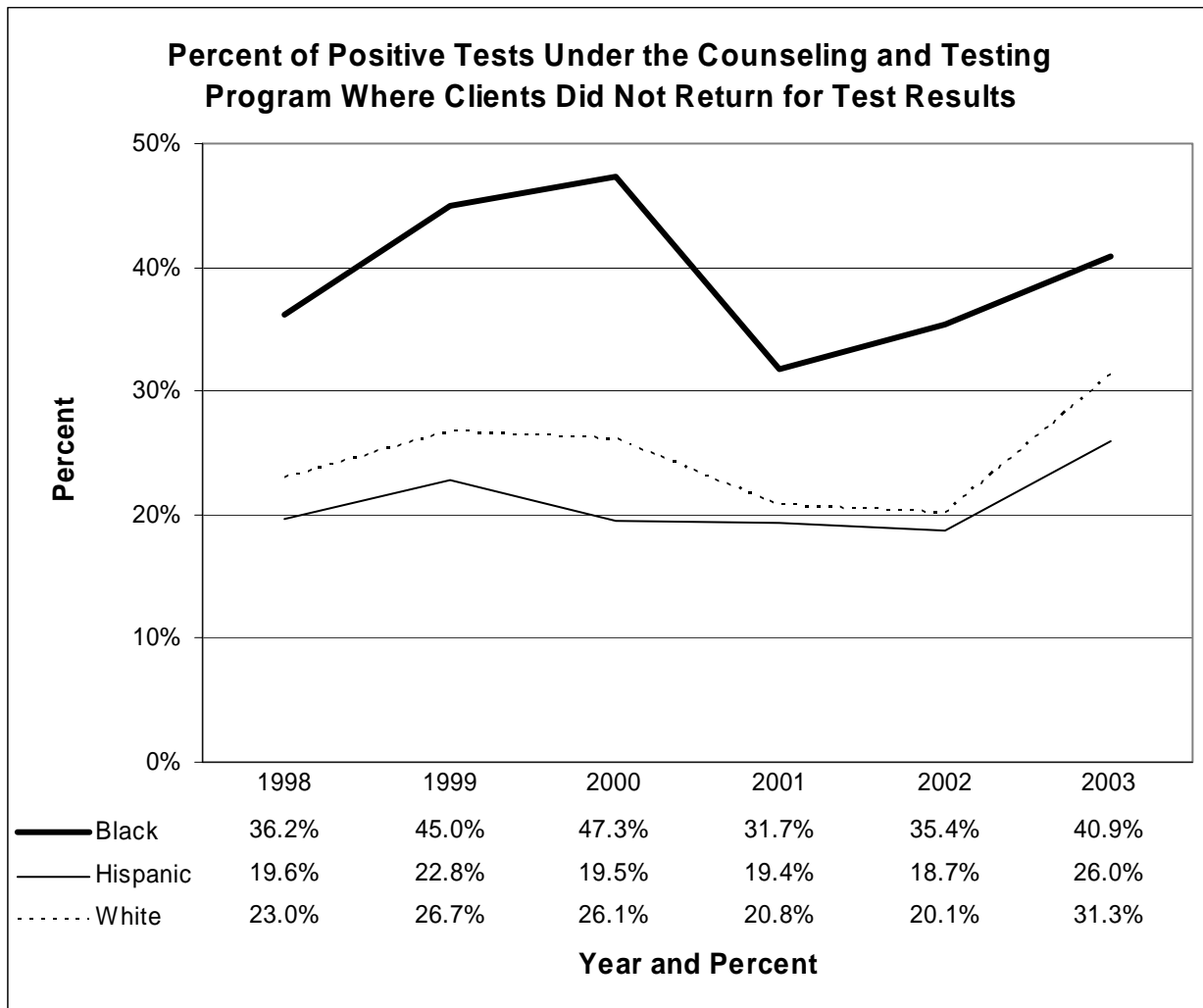
Domain: Timeliness and Continuity

Question: To what extent are persons with HIV aware of their HIV status?

Why it's important: The effectiveness of HIV counseling and testing services is improved when clients with HIV return for test results.

How it's measured: Percentage of positive HIV tests under the HIV Counseling and Testing Program where the clients do not return for test results.

Findings: A very large percentage of African Americans who test positive have not returned for test results. Percentages for other groups, while lower, have still been in the 19%-31% range.



Sample Size: Findings for the smallest group (Hispanic/Latino) are based on 119-222 individuals who did not obtain test results in any given year.

Strengths/Limitations: Findings may reflect a change in the composition of program clients.

Source: Office of AIDS, California Department of Health Services

Acknowledgment: Nancy Berman Lees, Christine Dahlgren

Indicator 3-2-3: Earliest Positive HIV Test Was Less than or Equal to Six Months before AIDS Diagnosis

Category: Interventions

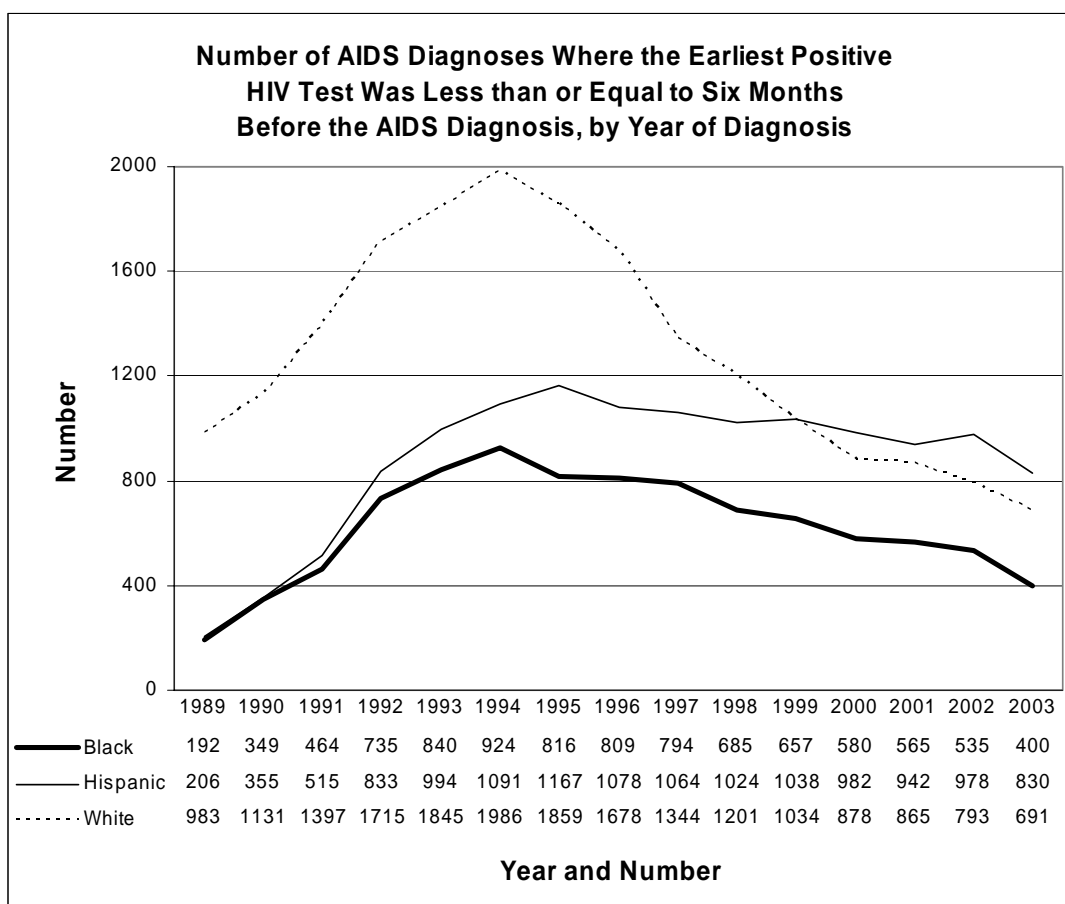
Domain: Timeliness and Continuity

Question: To what extent are people with HIV aware of their status?

Why it's important: When individuals with HIV are unaware of their HIV status, they are more likely to engage in behaviors that infect others.

How it's measured: Number of AIDS diagnoses where the earliest positive HIV test was less than or equal to six months before the AIDS diagnosis, by year of AIDS diagnosis. Cases where earliest positive HIV test are unknown are excluded.

Findings: Until the mid-1990s, the counts for each group increased, and have since decreased. The decline has been most evident among the White population. The decline among the Hispanic population has lagged and now exceeds the number for non-Hispanic Whites.



Strengths/Limitations: The numbers in the earlier years should probably be disregarded, as those times were relatively chaotic and chances for error are great. For example, many people were diagnosed with AIDS and never had an HIV test and, thus, were not counted in this study. Numbers in more recent years seem more accurate. We would like to present these numbers as a percentage of AIDS diagnoses for each group. However, such an approach would be misleading because many individuals who forestall onset of AIDS with anti-retroviral therapy would not appear in the database until some future year.

Source: Office of AIDS, California Department of Health Services

Acknowledgment: A. Nakamura

Indicator 3-2-4: Persons Successfully Referred by Outreach to HIV Counseling and Testing Program

Category: Interventions

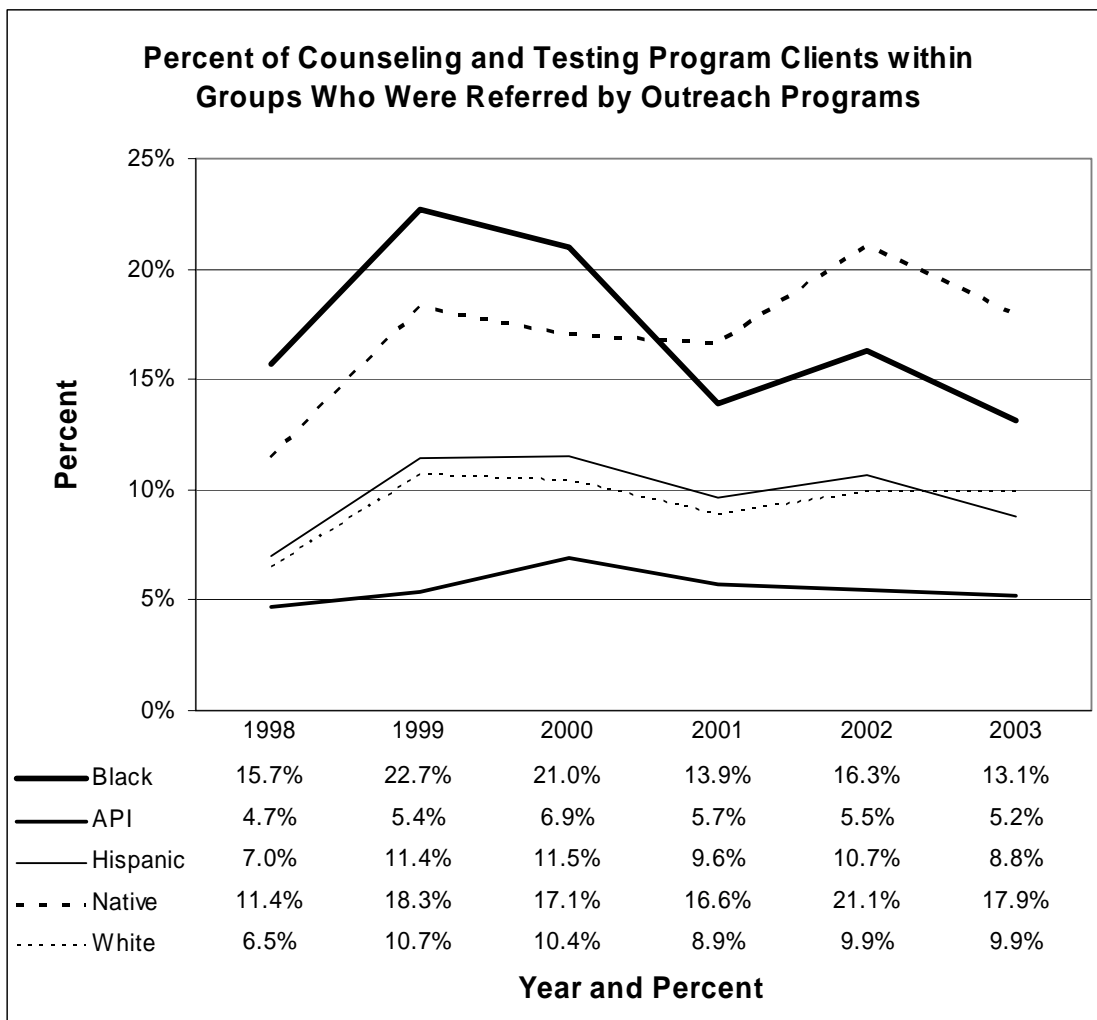
Domain: Timeliness and Continuity

Question: To what extent does outreach encourage high risk populations to enter prevention services?

Why it's important: Successful outreach with high risk populations helps the HIV Counseling and Testing program direct services toward those most in need.

How it's measured: Proportion of HIV tests in the Counseling and Testing program where the client indicates referral from outreach. Findings displayed for each race/ethnic group.

Findings: A relatively large share of African American and Native American clients came to the program because of outreach services.



Sample Size: Findings for the smallest group (Native American) are based on 316-513 successful referrals in any given year.

Strengths/Limitations: Findings may be influenced by overall change over time in program utilization.

Source: Office of AIDS, California Department of Health Services

Acknowledgment: Nancy Berman Lees

Indicator 4-1-1: Counseling and Testing Program Clients with More than Five Sex Partners in Past Year

Category: Risk-Taking and Protective Behaviors

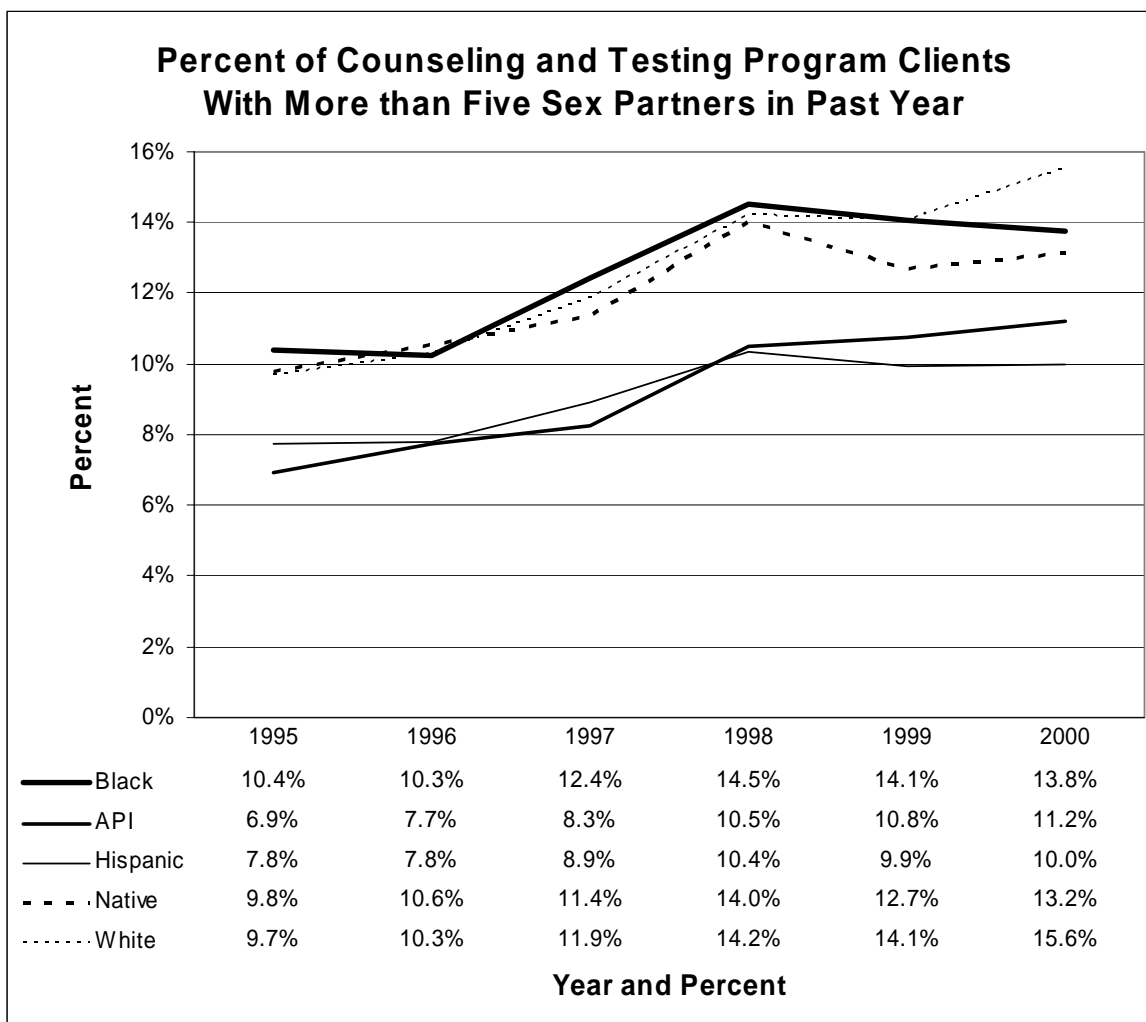
Domain: High Risk Sex

Question: To what extent do adult populations have multiple sex partners?

Why it's important: Having multiple sex partners increases the potential for HIV transmission.

How it's measured: Percent of Counseling and Testing Program clients with more than five sex partners in past twelve months.

Findings: From 1991 through the year 2000, increasingly larger percentages of clients in each group had more than five sex partners in the prior year. Beginning 2001, the measure changed to number of sex partners in the shorter of past two years or since HIV test; and, from 2001 to 2003, the percentages increased for each group.



Sample Size: Findings for the smallest group (Native American) are based on 196-387 persons in any year who reported a recent history of more than five partners.

Strengths/Limitations: Findings may reflect a change in the composition of program clients, for example, a trend toward increased focus on high risk populations.

Source: Counseling and Testing Program Data, California State Office of AIDS

Acknowledgment: Nancy Berman Lees, Christine Dahlgren

Indicator 4-1-2: Counseling and Testing Program Clients with Sex Partners who are Positive for HIV

Category: Risk-Taking and Protective Behaviors

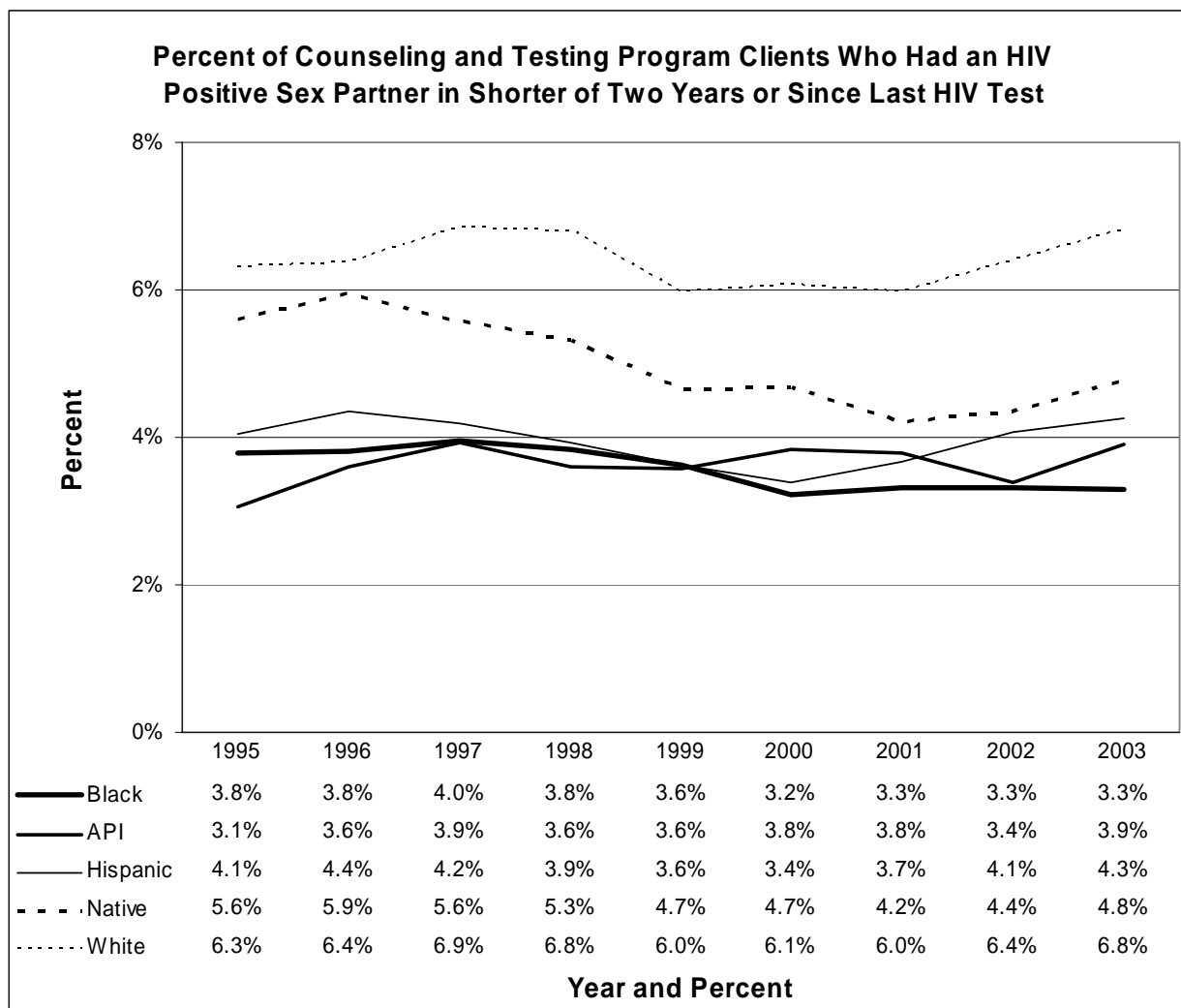
Domain: High Risk Sex

Question: To what extent do adults have sex partners who are infected with HIV?

Why it's important: Having sex partners with HIV increases the potential for HIV transmission.

How it's measured: Of Counseling and Testing Program clients, percent with HIV positive sex partners in the shorter of past two years or since last HIV test.

Findings: Percentages have been highest among the non-Hispanic White clients. Percents appear to have decreased among Native Americans



Sample Size: The smallest numbers are among Native American clients where, in any given year, 106-147 reported having an HIV positive partner in any given year.

Strengths/Limitations: Findings may reflect a change in the composition of program clients.

Source: Counseling and Testing Program Data, California State Office of AIDS

Acknowledgment: Nancy Berman Lees, Christine Dahlgren

Indicator 4-1-4: Unprotected Anal Intercourse among MSM Respondents in a San Francisco Street Survey

Category: Populations

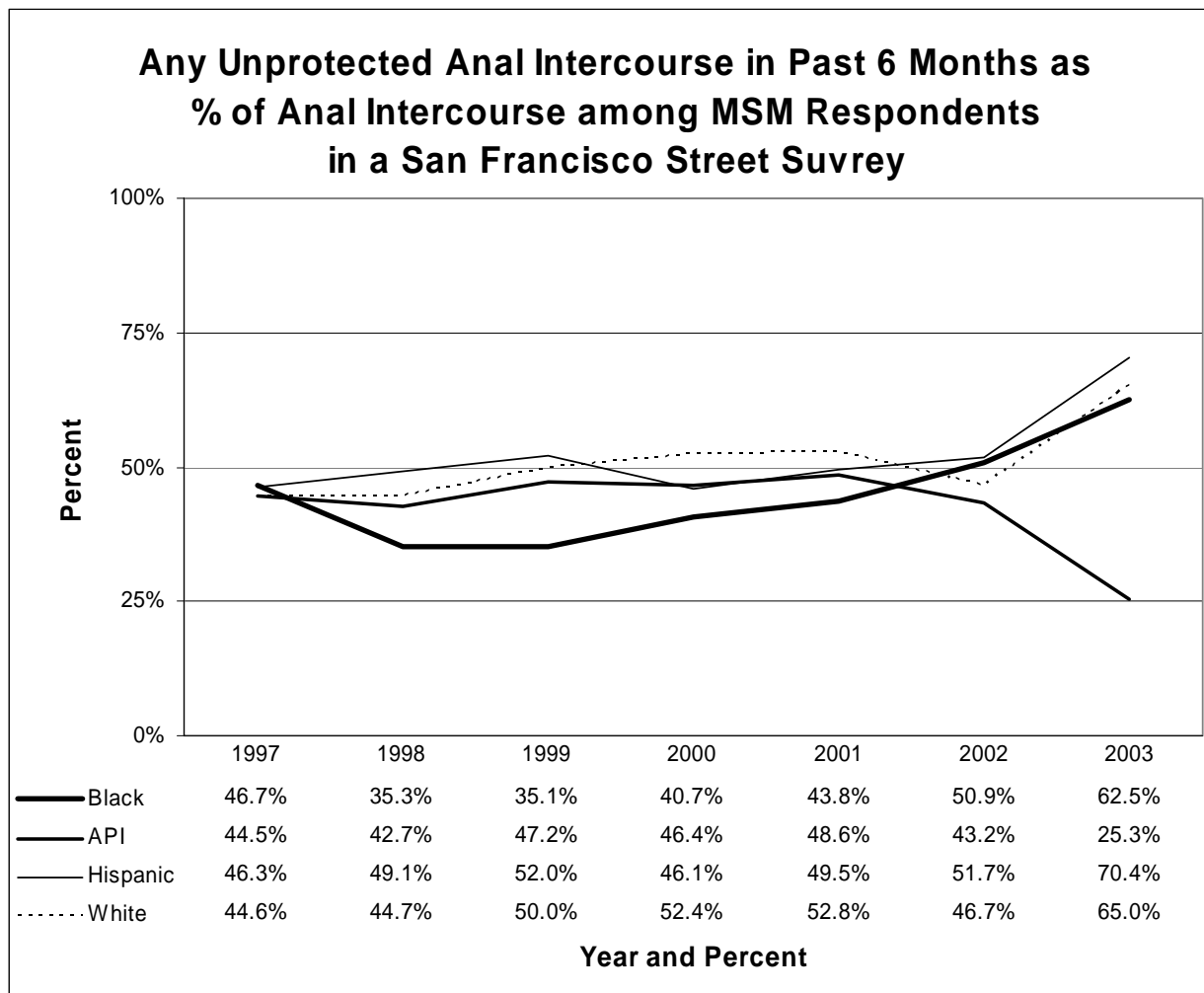
Domain: Values

Question: To what extent do MSM engage in unprotected anal intercourse?

Why it's important: Unprotected anal intercourse is a common route for HIV infection.

How it's measured: Among MSM who indicate that they practiced anal intercourse in the past six months, the proportion who did not always use a condom.

Findings: Percentages have substantially increased over the years, except among the API population.



Sample Size: Findings are based on 600-2500 individuals in any given year who reported unprotected anal intercourse.

Strengths/Limitations: Findings from the convenience sample are limited to persons who frequent survey locations, and the percentages cannot be interpreted as representing condom usage within the MSM community.

Details Available: See reports on Race/Ethnicity.

Source: Stop AIDS Project, San Francisco

Acknowledgment: Roop Prabhu, San Francisco Department of Public Health

Indicator 4-1-5: Unprotected Receptive Anal Intercourse

Category: Risk-Taking and Protective Behaviors

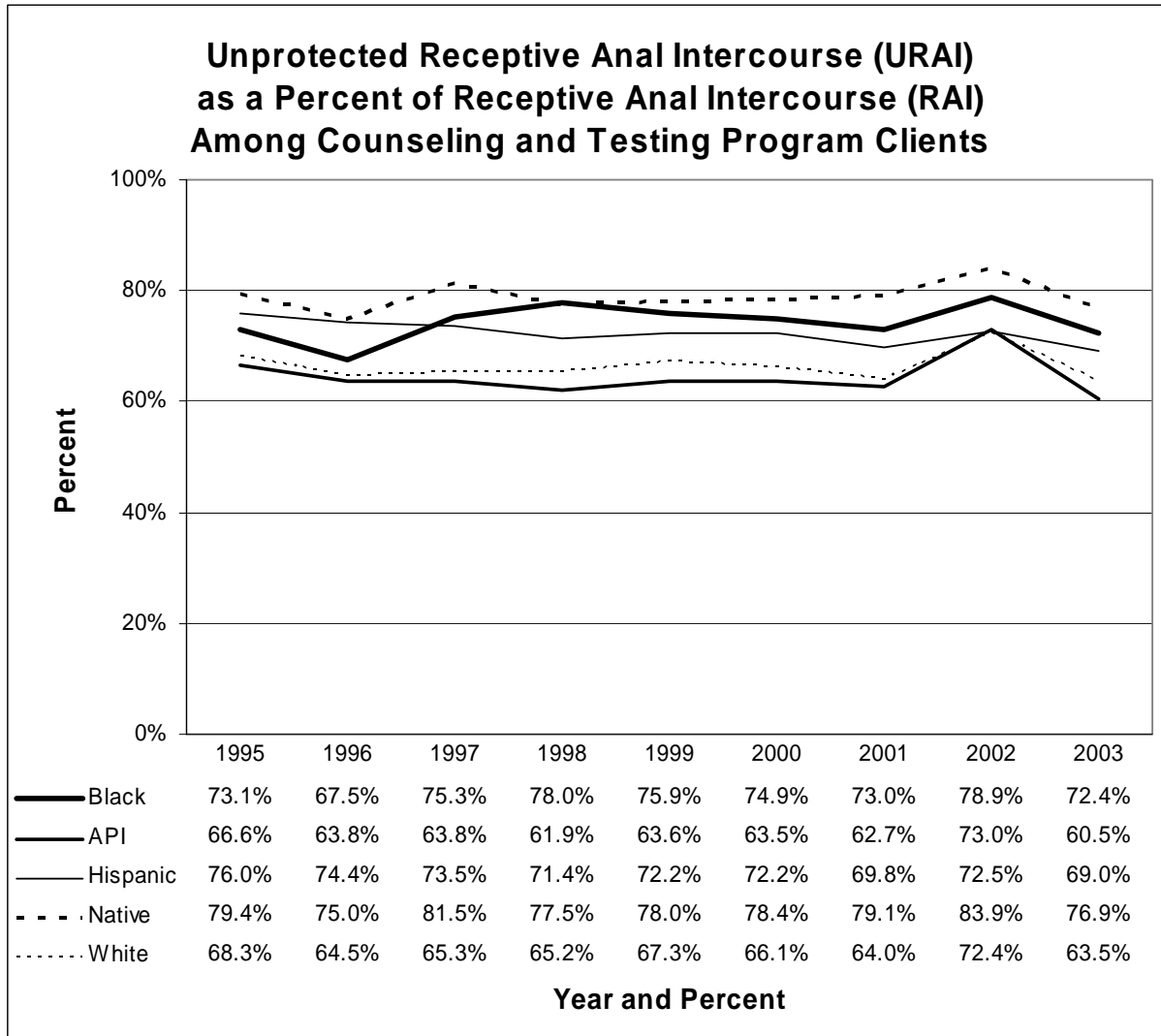
Domain: High Risk Sex

Question: To what extent do those who engage in receptive anal intercourse neglect to use condoms?

Why it's important: Failure to use a condom during anal intercourse substantially increases the risk of HIV transmission.

How it's measured: Among Counseling and Testing Program clients who report receptive anal intercourse (RAI) in the shorter of the past two years or since last HIV test, percent who report not using a condom.

Findings: Overall percentages are high with no clear trend.



Sample Size: The smallest numbers are among the Native American group where, in any given year, 227-335 clients reported URAI.

Strengths/Limitations: Findings may reflect a change in the composition of program clients, for example, a trend toward increased focus on high risk populations. The data do not consider whether URAI was within monogamous relationships or with casual partners.

Source: Counseling and Testing Program Data, California State Office of AIDS

Acknowledgment: Nancy Berman Lees

Indicator 4-2-1: Needle Sharing among Injection Drug Users

Category: Risk-Taking and Protective Behaviors

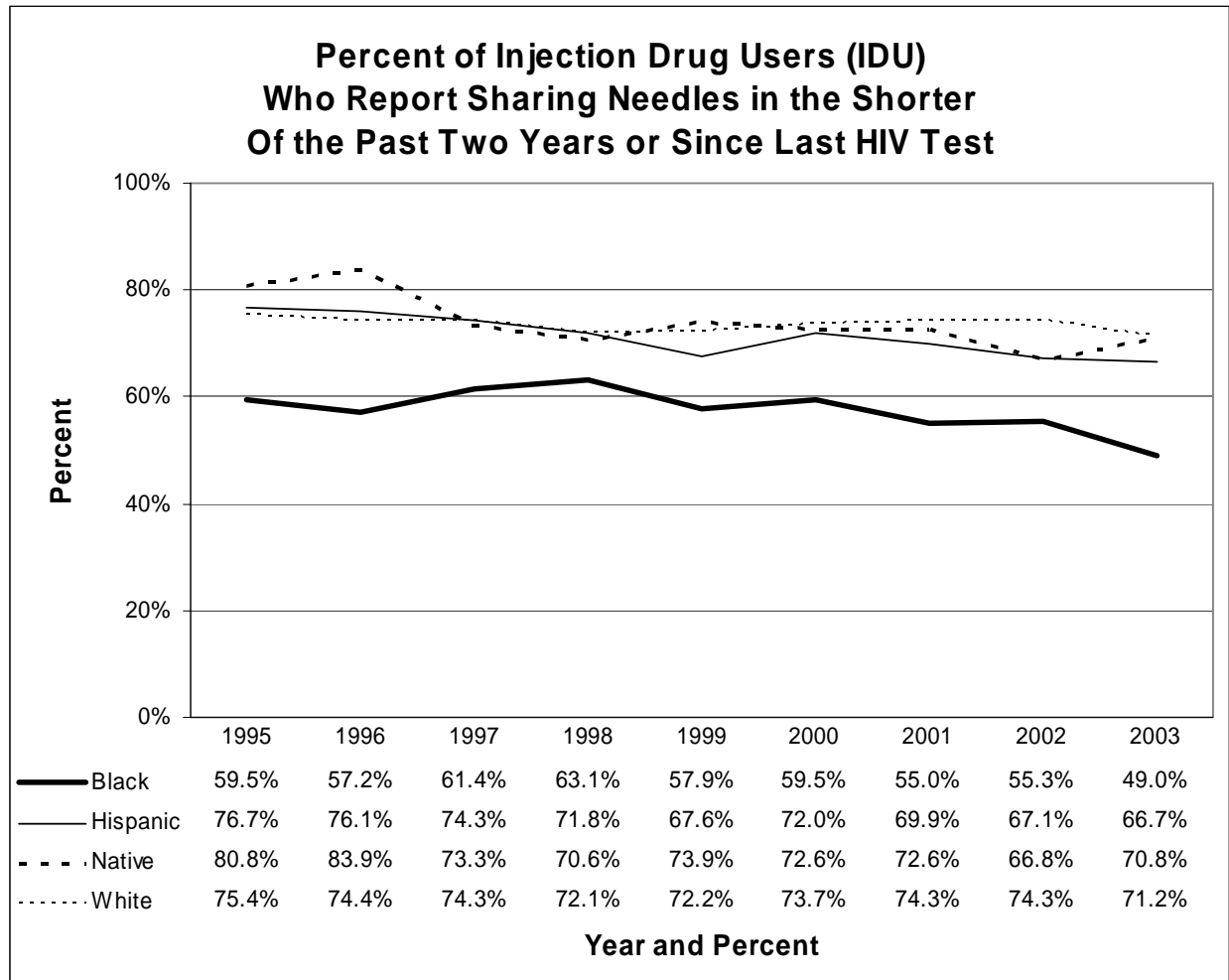
Domain: Needle Sharing

Question: To what extent do injection drug users share needles?

Why it's important: Needle sharing among injection drug users carries a risk of HIV transmission.

How it's measured: Among Counseling and Testing Program clients who report injection drug use (IDU) in the shorter of the past two years or since last HIV test, percent who report sharing needles.

Findings: Overall percentages are high, with a generally declining trend for each group. Needle sharing is less often reported by African American IDU.



Sample Size: Findings for the smallest group (Native American) are based on 236-425 persons reporting a recent history of needle sharing.

Strengths/Limitations: Findings may reflect a change in the composition of program clients. The data do not consider whether needle sharing included bleaching of apparatus or sharing with exclusive partners.

Source: Counseling and Testing Program Data, California State Office of AIDS

Acknowledgment: Nancy Berman Lees

Indicator 5-1-1: Number of New HIV Infections

Category: Disease Impacts

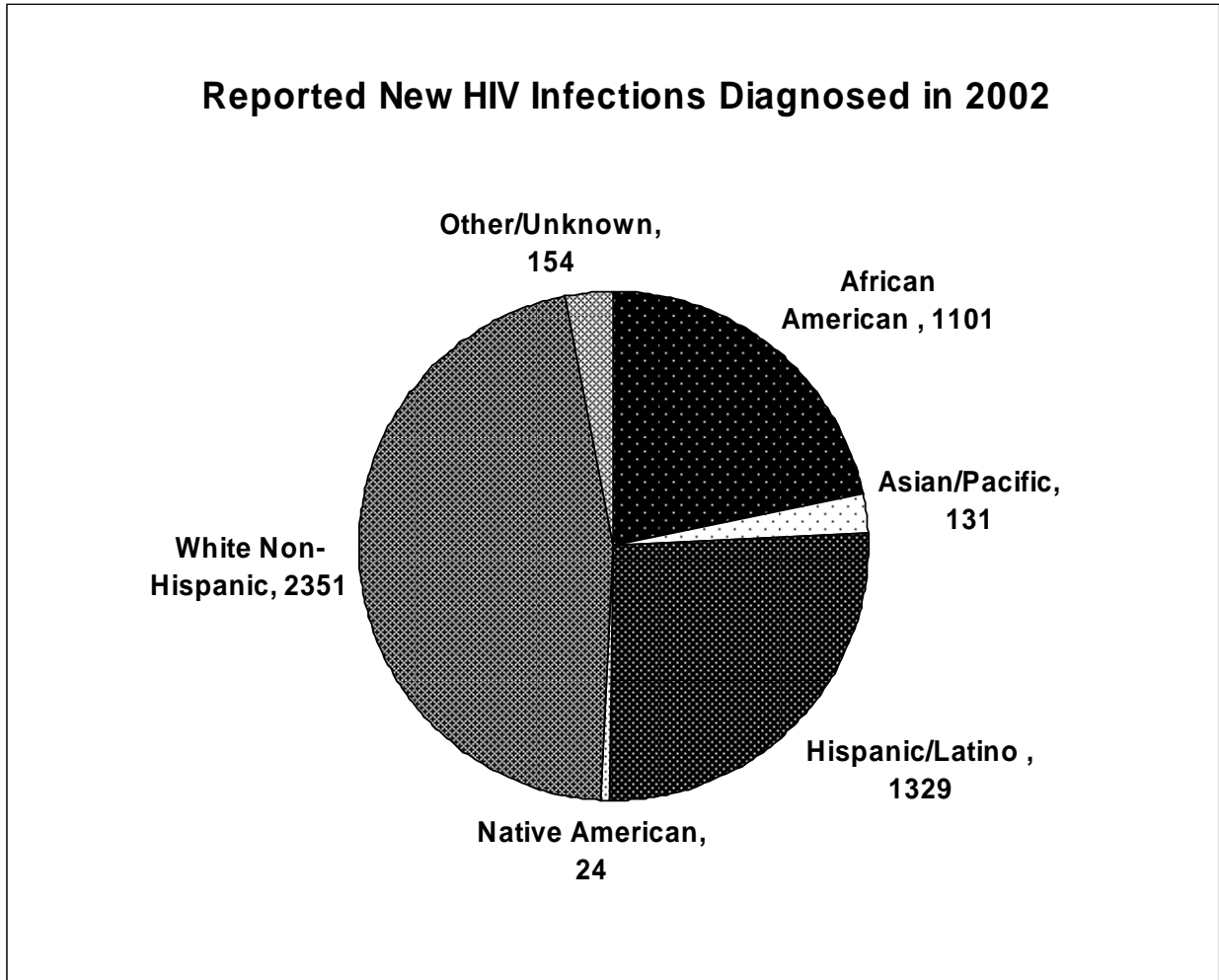
Domain: New Infections

Question: To what extent has number of new HIV infections changed over time?

Why it's important: Successful HIV prevention reduces the rate of new HIV infections.

How it's measured: Number of new HIV infections reported to the Non-Names HIV Reporting System by year of diagnosis.

Findings: 5,090 new cases were reported for the year 2002. 46% were among the White non-Hispanic populations, 26% among Hispanics, 22% among African Americans.



Strengths/Limitations: Because the HIV reporting system is new, the extent of under-reporting is unknown.

Source: California State Office of AIDS, Non-Names HIV Reporting System

Acknowledgment: A. Nakamura

Indicator 5-1-2: New HIV Cases Identified in the Counseling and Testing Program

Category: Disease Impacts

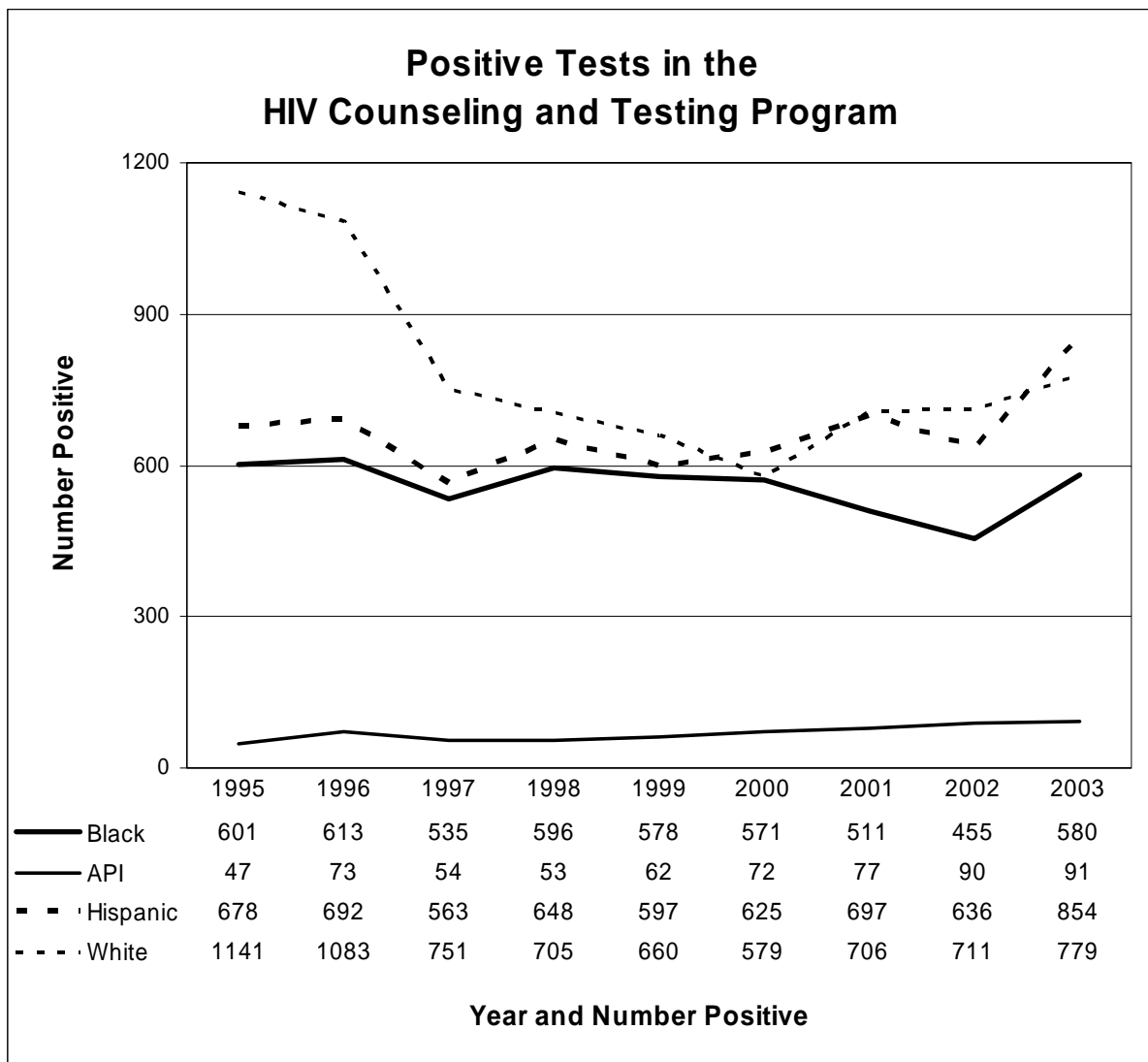
Domain: New Infections

Question: To what extent has the number of new HIV infections changed over time?

Why it's important: Successful HIV prevention reduces the rate of new HIV infections.

How it's measured: Number of positive HIV tests annually in the HIV Counseling and Testing Program among clients who have not previously tested positive.

Findings: The number of newly detected cases declined over the longer term among non-Hispanic Whites. Among the Asian/Pacific populations, counts have steadily increased. Recent increases are evident among all groups except the Asian/Pacific group.



Strengths/Limitations: Recent increases may reflect improved outreach to higher risk populations.

Source: Counseling and Testing Program Data, California State Office of AIDS

Acknowledgment: Nancy Berman Lees, Christine Dahlgren

Indicator 5-1-3: New HIV Infections per 100 Person-Years at Risk

Category: Disease Impacts

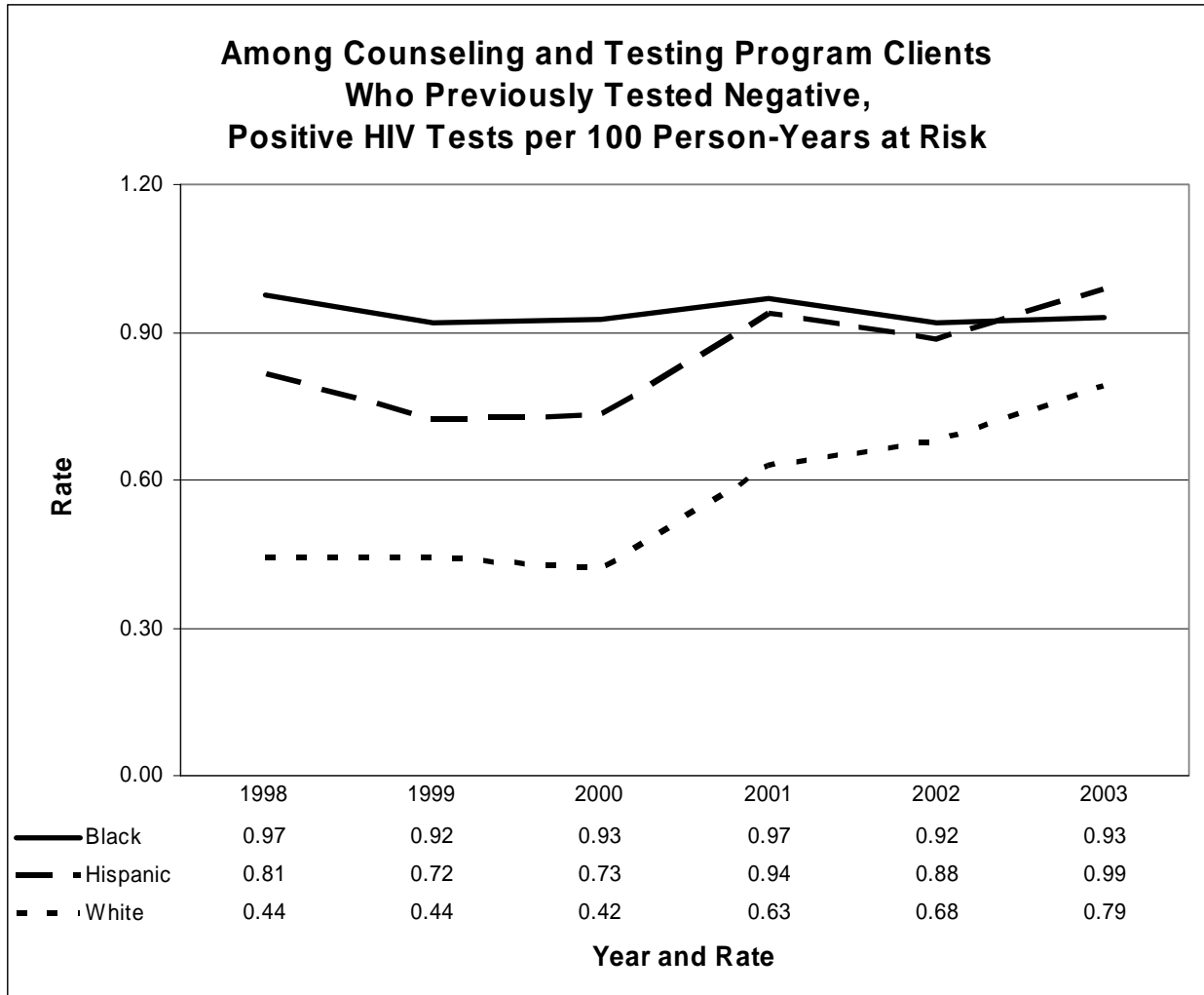
Domain: New Infections

Question: To what extent has incidence of new HIV infection changed over time?

Why it's important: Successful HIV prevention reduces the rate of new HIV infections.

How it's measured: Number of positive tests per 100 person-years at risk among Counseling and Testing Program clients who state that they had a prior negative test and give the date of that test as at least two months ago and not more than 5 years ago.

Findings: Over the study period, rates have been higher among African American and Hispanic clients. Recent increases are evident among Hispanic and non-Hispanic White clients



Sample Size: Findings for the smallest group (African American) are based on 191-264 positive HIV tests in any given year.

Strengths/Limitations: Findings may reflect a change in the composition of program clients, for example, a trend toward increased focus on high risk populations. Measurement is limited to repeat testers, who are assumed to be at higher risk.

Sources: Counseling and Testing Program Data, California State Office of AIDS

Acknowledgment: Nancy Berman Lees, Christine Dahlgren

Indicator 5-1-4: Primary and Secondary Syphilis

Category: Disease Impacts

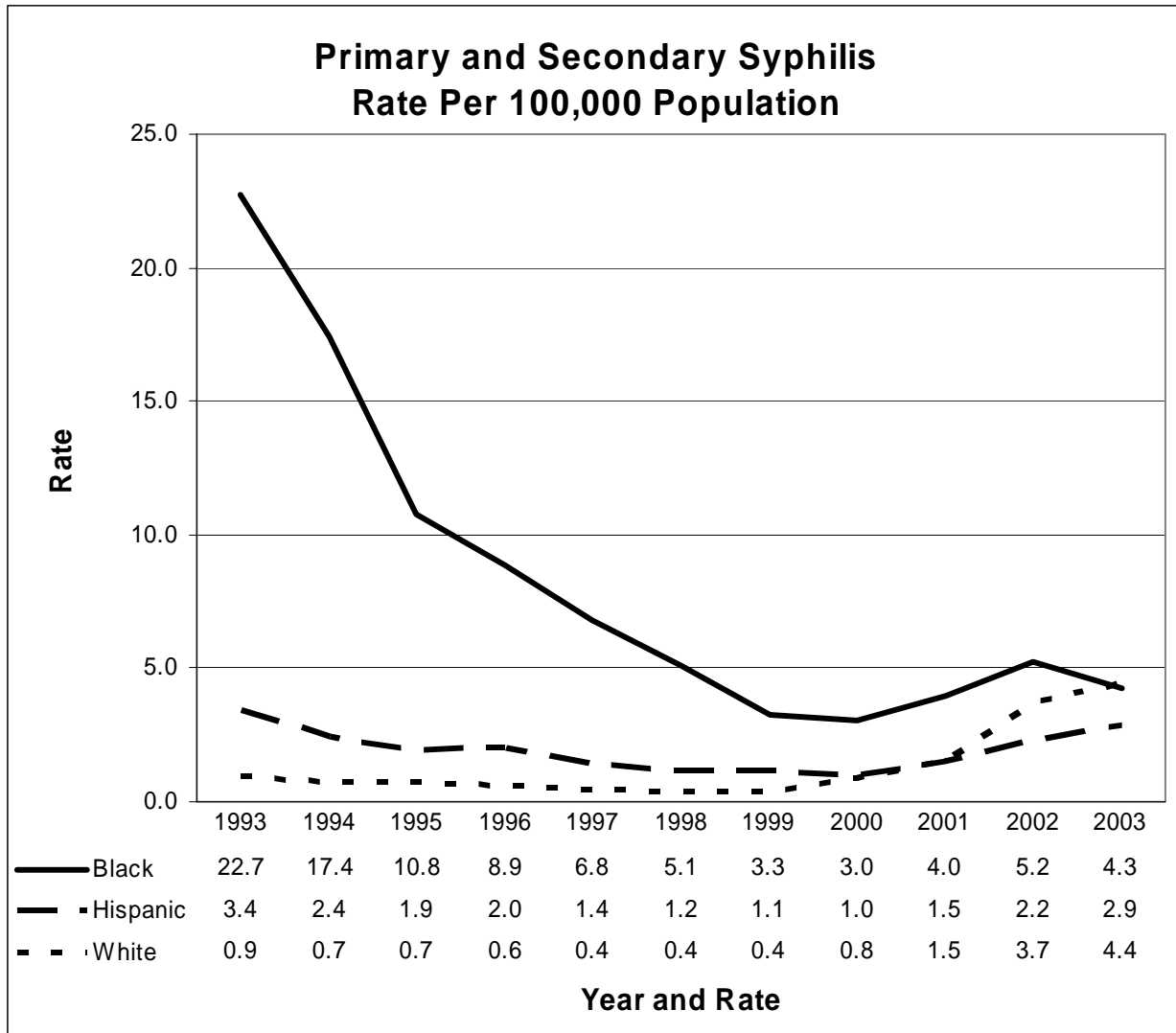
Domain: New Infections

Question: To what extent has incidence of syphilis infections changed over time?

Why it's important: Changes in the rate of new syphilis infections are believed to parallel changes in the rate of new HIV infections.

How it's measured: Number of newly detected cases of primary and secondary syphilis per 100,000 population.

Findings: Rates for African American have been higher than rates for other groups. For each group, rates declined up to the years 1999-2000, and have since increased.



Sample Size: The lowest rate (non-Hispanic White) in the study period is based on 67 cases.

Strengths/Limitations: Measurement does not include cases that elude detection in the early stages.

Sources: Data compiled from various publications of the California Department of Health Services STD Control Branch. Rates are based on California Department of Finance population estimates issued in 2003.

Indicator 5-2-1: New Diagnoses of AIDS

Category: Disease Impacts

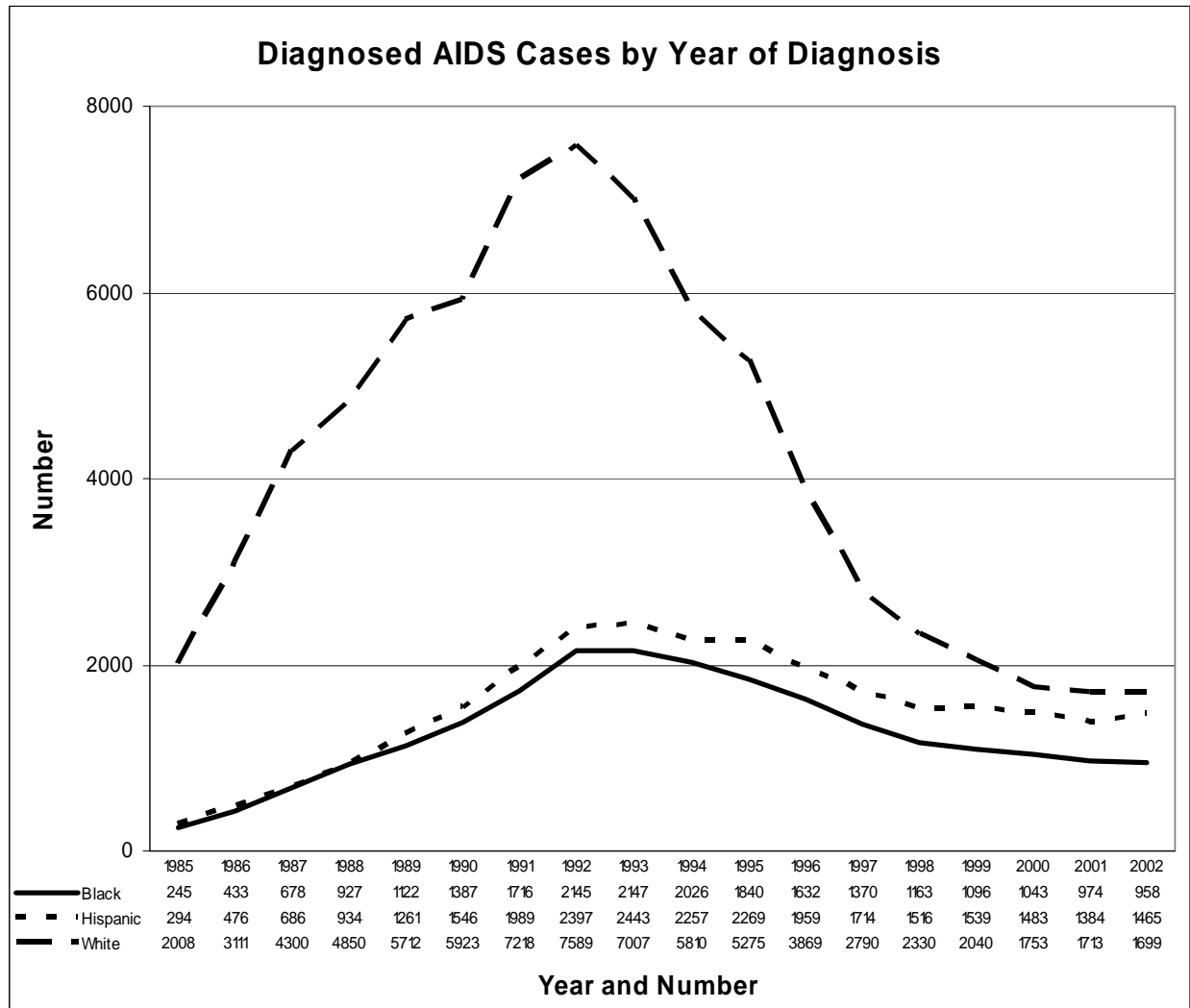
Domain: AIDS

Question: How many new cases of AIDS are diagnosed annually?

Why it's important: Over the longer term, HIV prevention reduces the number of new AIDS cases.

How it's measured: Number of newly diagnosed AIDS cases by year of diagnosis.

Findings: Following rapid increases for each group up through early 1990s, the annual number of new AIDS cases substantially declined. The number of new cases among Whites peaked from 1-3 years earlier than among other groups and appears to have declined more rapidly. The annual number of new cases appears to have leveled off for each group.



Strengths/Limitations: The decline in the number of new AIDS cases since 1992-93 results from widespread use of anti-viral medications and tells us little about the current spread of HIV.

Sources: California Department of Health Services, Office of AIDS-HIV/AIDS Case Registry, August 31, 2004. Run Date: October, 2004

Acknowledgment: A. Nakamura

Indicator 5-2-2: Number of Persons Living with AIDS

Category: Disease Impacts

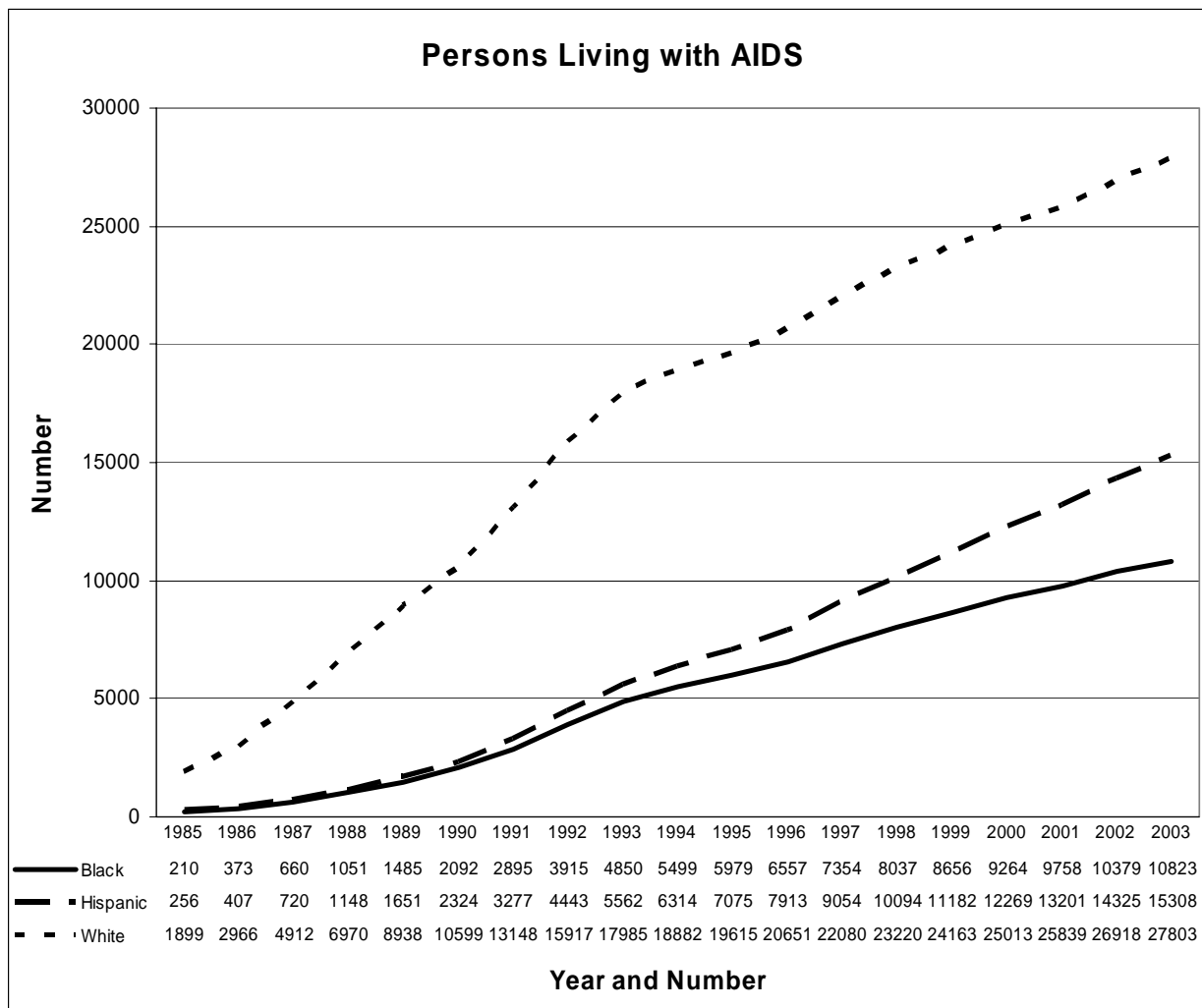
Domain: AIDS

Question: How many people are living with AIDS?

Why it's important: The number of persons living with AIDS presents difficult public policy choices, particularly in regard to financing of AIDS-related services.

How it's measured: Number of persons living with AIDS at end of year.

Findings: The number of persons living with AIDS is increasing at a regular pace for each group. While non-Hispanic Whites accounted for more than 2/3 of cases in 1990, they accounted for about half of the cases in 2003.



Strengths/Limitations: The estimated number of persons living with AIDS relies on the AIDS Case Registry and is calculated from annual new cases and annual reported deaths. The measure tells us little about the current spread of HIV.

Details Available: See reports on MSM and IDU, Race/Ethnicity, Regions, and Selected Counties.

Sources: California Department of Health Services, Office of AIDS-HIV/AIDS Case Registry, August 31, 2004. Run Date: October, 2004.

Acknowledgment: A. Nakamura

Indicator 5-2-3: Deaths of Persons with AIDS

Category: Disease Impacts

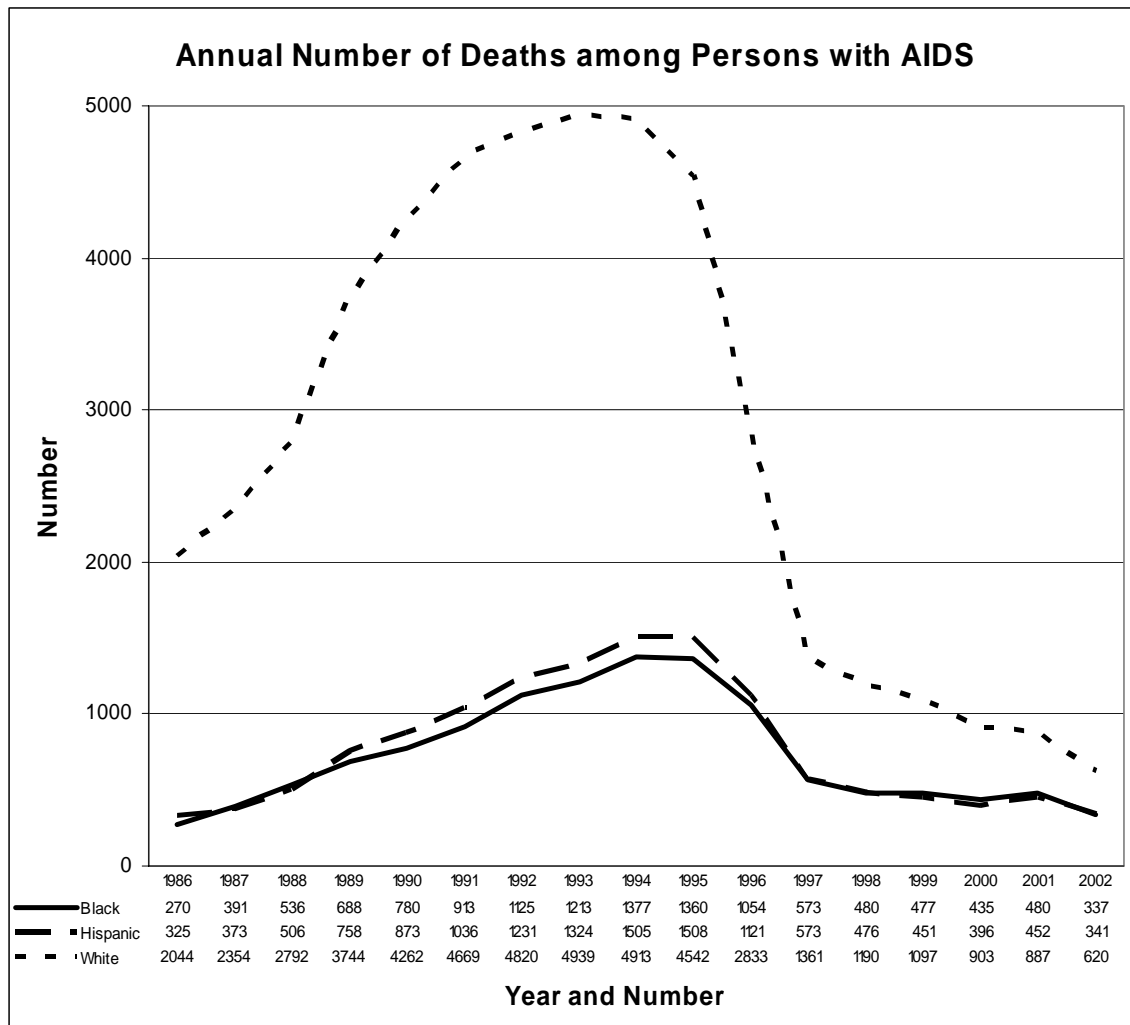
Domain: AIDS

Question: How many people with AIDS die each year?

Why it's important: Over the longer term, HIV prevention reduces the number of deaths associated with AIDS.

How it's measured: Annual number of deaths among people with AIDS.

Findings: Following rapid increases up through 1994-95, the annual number of deaths dropped precipitously for each group. In 1993, about 3/4 of deaths were among non-Hispanic Whites. In 2003, the accounted for about half of the deaths.



Strengths/Limitations: The measure includes all deaths of persons with AIDS, and does not restrict to deaths as a consequence of AIDS. The rapid decline in the number of deaths after 1994 results from widespread use of anti-viral medications and, thus, tells us little about the current spread of HIV.

Sources: California Department of Health Services, Office of AIDS-HIV/AIDS Case Registry, August 31, 2004. Run Date: October, 2004.

Acknowledgment: A. Nakamura