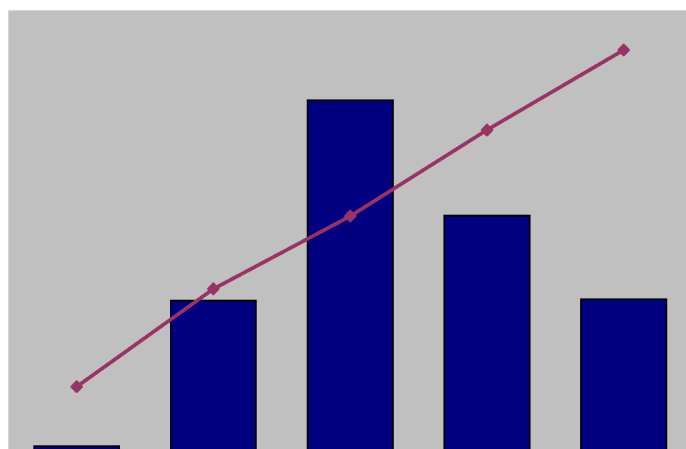


HIV/AIDS Epidemiology Report

2005



County of San Diego

Health and Human
Services Agency



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Health and Human Services Agency
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I. Executive Summary

Overall, the state of California has the second highest number of Acquired Immunodeficiency Syndrome (AIDS) cases in the United States and San Diego County has the third highest number of AIDS cases in the state of California. There have been 12,201 cumulative AIDS cases reported in San Diego County as of December 31, 2004. Highlights of this report are summarized below.

AIDS Cases

Over time the number of cases has declined most among white men, resulting in an increased proportion of cases among people of color. In the most recent 5 year time period, 55% of AIDS cases have been among persons of Hispanic, black, Asian/Pacific Islander, and Native American heritage.

Since 1986, the highest rate of AIDS has been in the black community. The second highest rate of AIDS is in the Hispanic community.

Women constitute 8% of total cases and 11% of cases diagnosed since 2000. In 2004, the number of women diagnosed decreased from the previous year while the percent of cases attributed to women was 12%.

Among men, "Men who have Sex with Men" (MSM) continues to be the primary mode of transmission for male AIDS cases. Over the span of the epidemic, there has been an increase in injection drug use (IDU) and heterosexual transmission.

For women, the primary mode of transmission is heterosexual contact, followed by IDU.

The Centers for Disease Control and Prevention Interstate Duplication Project (IDEP) required adjustments to the local HIV/AIDS database in November 2004; 236 previously reported AIDS cases were identified as dupli-

cates with other states and were deleted.

HIV Cases

4,647 cases of HIV have been reported in San Diego County since the inception of HIV reporting statewide in July 2002.

HIV and Local Data

The HIV infection rate among HIV Counseling and Testing (HCT) site testers has increased each year 2001-2004, from 1.3% to 2.4%.

Male HCT testers have had an increase in HIV infection rates each year 2001-2004, from 1.6% to 2.9%. Women's rates increased in 2002-2003 (0.2% to 1.1%), leveling off at 1.0% in 2004.

Black and Hispanic HCT testers have had the highest HIV infection rates. Since 2002 rates have remained about the same for blacks (1.9% in 2004), while increasing from 1.7% to 4.2% for Hispanics. Rates for whites increased from 1.2% in 2001 to 2.0% in 2002 and have declined to 1.6% in 2004.

Compared to the year 2000, rates of HIV infection have increased for each age group except those under 20, with the highest rates being among 25-34 and 35-49 (2.6% and 2.8% in 2004 respectively) year olds.

Historically, HCT testers from the Central Region of San Diego County have the highest HIV infection rates by region; however, the South Region has experienced an increase and has had the highest rate for the last two years (4.5% in 2004).

Among HCT testers, men who have male sexual partners (the MSM group) continue to have higher HIV infection rates than other risk groups. Rates increased for this group from 2001-2003 and decreased slightly in 2004, from 5.0% to 4.6%.

II. AIDS Cases

1.0 Overall AIDS Case Data

As of December 31, 2004, California has the second highest number of AIDS cases reported in the United States. By December 31, 2004 there were 135,975 AIDS cases reported in California. A total of 12,201 of those cases were reported among San Diego County residents, making San Diego County the third largest contributor of AIDS cases in California, following Los Angeles and San Francisco counties. Four hundred eighty-one (481) of the 12,201 cases were reported in 2004, of which three hundred thirty-two (332) were also diagnosed in 2004. The additional 149 cases reported in 2004 were diagnosed years earlier but due to delays in reporting were not included in the database until 2004. Additional AIDS cases diagnosed in 2004 are expected to be reported throughout 2005 and into 2006.

The Centers for Disease Control and Prevention Interstate Duplication Project (IDEP) required adjustments to our local database in November 2004; 236 previously reported AIDS cases were identified as duplicates (with other states) and were deleted. Refer to *Appendix 2* for more information on data sources, reliability and limitations as well as *Appendix 3* for an AIDS case definition, how they are

reported, and delays in reporting.

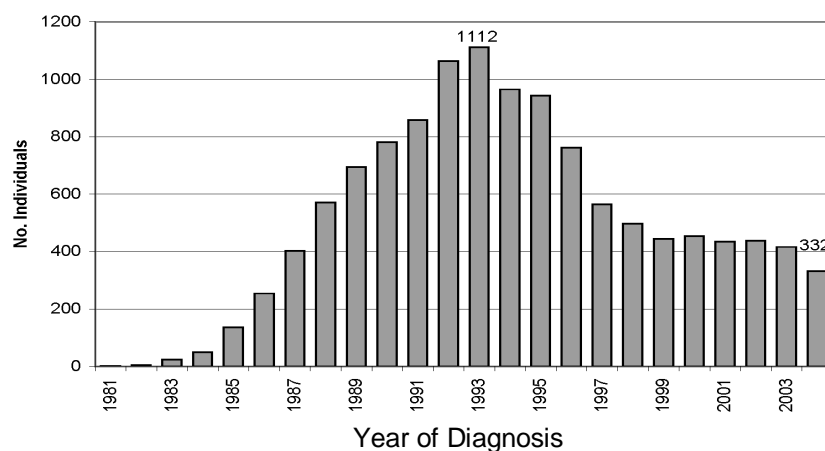
The first cases of AIDS in residents of San Diego County (2) were diagnosed in 1981. During 1993, 1,112 cases were diagnosed among residents of the County (*Figure 1*). With the implementation of the expanded AIDS Surveillance Case Definition in 1993, reported cases now reflect conditions that occur earlier in Human Immunodeficiency Virus (HIV) infection. The peak in AIDS cases during 1993 is likely the result of changes in the case definition.

2.0 Demographic Variables

White men between 30 and 39 years of age who were living in the Central Region at the time of diagnosis continue to be most frequently diagnosed group with AIDS in San Diego County. The demographics of AIDS in San Diego County are changing slowly. The breakdown of new cases by racial/ethnic group show that while the number of new cases in each racial/ethnic group continues to decrease, that decrease is most notable among whites. Because these decreases are most pronounced in whites, an increasingly larger percentage of new cases are being diagnosed in persons of color (Asian/Pacific Islander, black, Hispanic, and Native American). Women are starting to make up larger percent-

FIGURE 1:

**AIDS CASES BY YEAR OF DIAGNOSIS,
SAN DIEGO COUNTY**



ages of the yearly cases, but the numbers are still small for this group. There has been a smaller shift in place of residence at time of diagnosis with the second most frequent region of residence at time of diagnosis moving from the north to the south. While there has been a gradual increase in average age at time of diagnosis, the 30-39 year age group remains most common.

2.1 Gender

The first adult woman with AIDS in San Diego County was diagnosed in 1985 and the first girl was diagnosed in 1984. Females constitute about 8% of the cumulative cases. There have been 11,281 (92%) male cases and 920 (8%) female cases as of December 31, 2004. Of recent cases (years 2002 to 2003), females made up 11% of the total cases reported. The percent of cases diagnosed in females steadily climbed from 1984 to 1996. Between 1997 and 2002, the percent of diagnoses per year stabilized at about 10%, fluctuating from 9% to 11%. In 2004, women made up the largest percent of cases in any year at about 12%.

There seems to be an increase in the proportion of female cases nationwide, and a more gradual increase statewide; however, the number of female cases in San Diego County is too small to distinguish a trend (Table 1).

2.2 Racial/Ethnic Group

Cumulatively (as of 12/31/03), whites made up 41% of all cases in the United States. In California, this group makes up 57% of the cumulative cases and locally, 63% (as of 12/31/04). Twenty-two percent of all San Diego County AIDS cases were Hispanic, the same proportion as statewide and close to that seen nationally (19%). The proportion of black cases in San Diego County is 12%, which is lower than the state and national levels. At the state level blacks constitute 16% of AIDS cases (through 12/31/04) and at the national level 40% (through 12/31/03) (Figure 2). During the most recent year (2004), persons of color comprised 53% of San Diego County's AIDS cases. Nationally, persons of color accounted for 71% of cases in the most recent year (2003).

For a more complete breakdown of Hispanic and Asian/Pacific Islander cases, please see Appendix 5.

In contrast to what is seen at the national level, whites continue to make up the largest proportion of cumulative local cases. Gradually, however, persons of color (Hispanic and blacks in particular), are making up increasingly larger proportions of the new cases diagnosed with AIDS (Figure 3). The breakdown by racial/ethnic group for recent cases (2000-2004) looks much more similar to the national breakdown with the exception that the second

TABLE 1: AIDS DIAGNOSIS AMONG AGES 13 AND OLDER BY GENDER AND AREA OF RESIDENCE

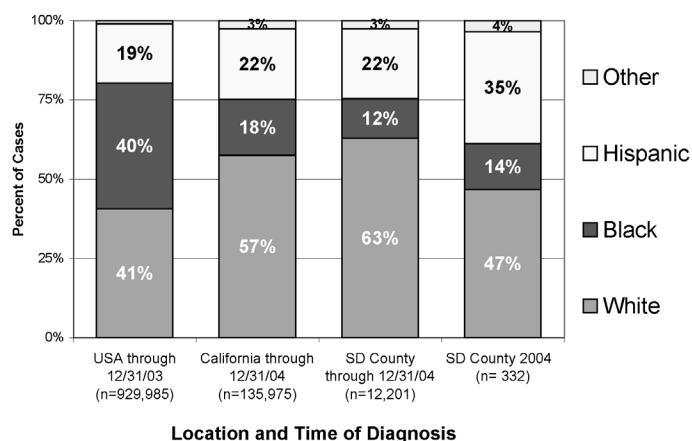
Gender	United States*		California		San Diego		San Diego	
	Through 12/31/03		Through 12/31/04		Through 12/31/04		2001-2003	
	#	%	#	%	#	%	#	%
Male	749,887	81%	123,725	92%	11,241	93%	1,149	89%
Female	170,679	19%	10,952	8%	890	7%	138	11%
Total	920,566		134,677		12,131		1,287	

* 2003 is the most recent year for national data.

FIGURE 2:**COMPARISON OF AIDS CASES BY RACIAL/ETHNIC GROUP, LOCATION AND TIME PERIOD OF DIAGNOSIS**

Note: 2003 is the most recent year available for national data.

Other includes Asian, Pacific Islander, Native American, and unknown.



and third most frequent groups are reversed. At a national level, blacks make up the second most frequent group followed by Hispanics. Locally, Hispanics make up the second most frequent group followed by blacks.

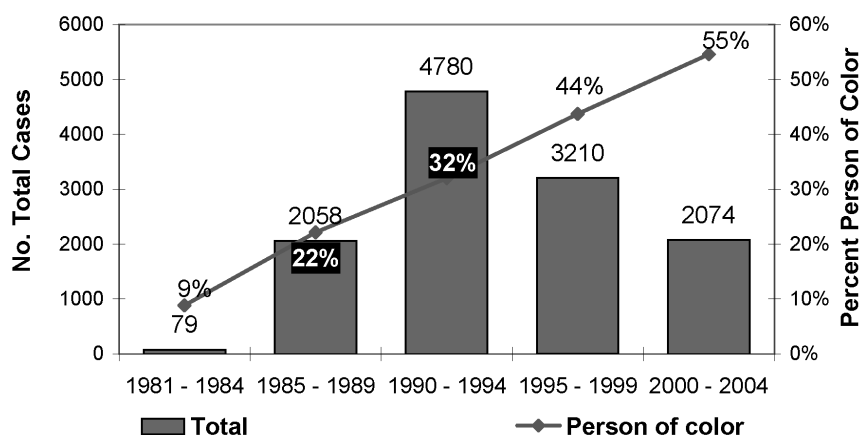
To understand the impact AIDS has on different racial/ethnic communities in San Diego, the rates of AIDS in those communities should be compared. In year 2004, San Diego County had a rate of 11 newly diagnosed AIDS cases per 100,000 persons living in the county. Because the number of new cases diagnosed in year 2004 is expected to increase as those cases are reported through 2005 and into 2006, the rate for that year is also expected to increase. In 2003, the rate of AIDS in San Diego County was 14 per 100,000 people. Healthy People 2010 estimated that there were 19.5 AIDS cases per

100,000 adolescents and adults in the United States in 1998 and set a goal of no more than 1 new case per 100,000 persons.

Not all communities in San Diego are the same size, so when rates by racial/ethnic group are compared, the picture of AIDS in San Diego looks quite different than when examining the raw numbers of those same racial/ethnic groups. Since the mid-1980s, blacks have had the highest rate of AIDS in San Diego County. In year 2004, the rate for AIDS in the black community was estimated at 30 per 100,000 black residents of San Diego County. The year before, 2003, the rate was 48 per 100,000. Again, as new cases diagnosed in year 2004 are reported, the rate of AIDS in this community is likely to increase. The rate in Hispanics surpassed that of whites in the mid-1990s and has remained the second

FIGURE 3:**NUMBER OF NEW AIDS CASES IN A TIME PERIOD AND PERCENTAGE ATTRIBUTED TO PERSONS OF COLOR*, SAN DIEGO COUNTY**

* 'Persons of Color' includes black, Hispanic, Asian/Pacific Islander and Native American.



highest rate. Figure 4 displays the rate of AIDS in various racial/ethnic groups in San Diego County from 1999 to 2003. Year 2004 data is not included because not all cases diagnosed in 2004 have been reported, resulting in a spurious decrease in rates. Asian/Pacific Islanders and Native Americans have been grouped into the “other” category due to limitations with the population data (until recently population data was combined for Asian, Pacific Islanders and Native Americans) and the number of cases was often too small to calculate a rate individually. For more discussion on calculating rates and more specific rates by year and racial/ethnic group, please see Appendix 4.

2.3 Age

At the national, state, and local level, the age group most frequently diagnosed with AIDS is the 30s. Nationally, 39% of cumulative cases (929,985) are in the 35 - 44 year age group and 33% are in the 25-34 age group. The 30-39 year age group makes up 44% of cases at the state level, and 46% in San Diego County. The second largest group for the state and local area is the 40-49 years followed

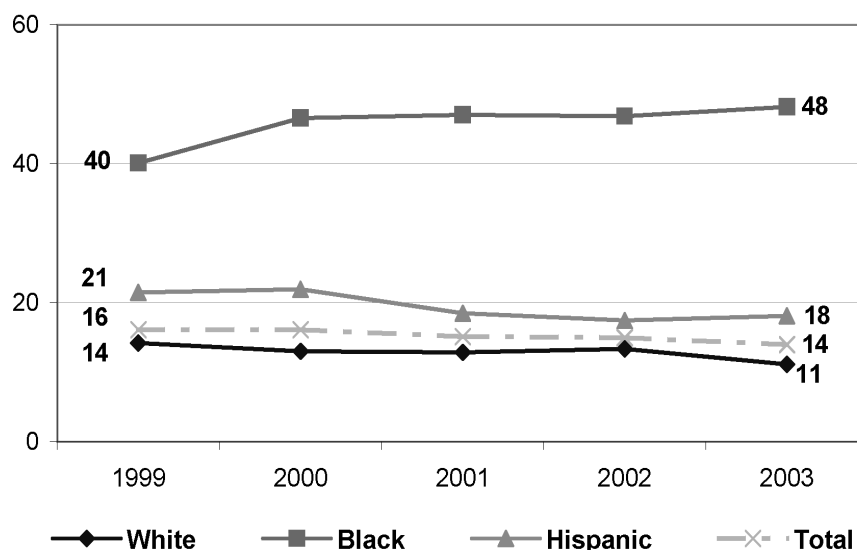
by 20-29 years.

The age group 30-39 years has consistently been the most frequent age group since the beginning of the epidemic. In the time period 1984-1988, the second most frequent age group was 20-29 years and the third most frequent was 40-49 years. Since then, the age group 40-49 years has become the second most frequent and 20-29 years the third most frequent. The percentage of cases diagnosed between 20-29 years of age has continued to decrease since 1988 while the percentage of cases diagnosed between 40-49 years of age has continued to increase. The “less than 20 years” age group consistently represents 1% or less of all cases diagnosed in each time period (Figure 5).

The average age at the time of AIDS diagnosis is 38 years. When age at time of diagnosis is analyzed by race, Hispanics have had a lower mean age at diagnosis than that of the other racial/ethnic groups (Table 2).

FIGURE 4:

**RATE OF AIDS CASES BY RACIAL/
ETHNIC GROUP,
SAN DIEGO COUNTY**



Note: Total includes the three groups shown on the chart as well as Asian/Pacific Islander and Native American.

FIGURE 5:

AIDS CASES BY AGE GROUP AT TIME
OF DIAGNOSIS,
SAN DIEGO COUNTY

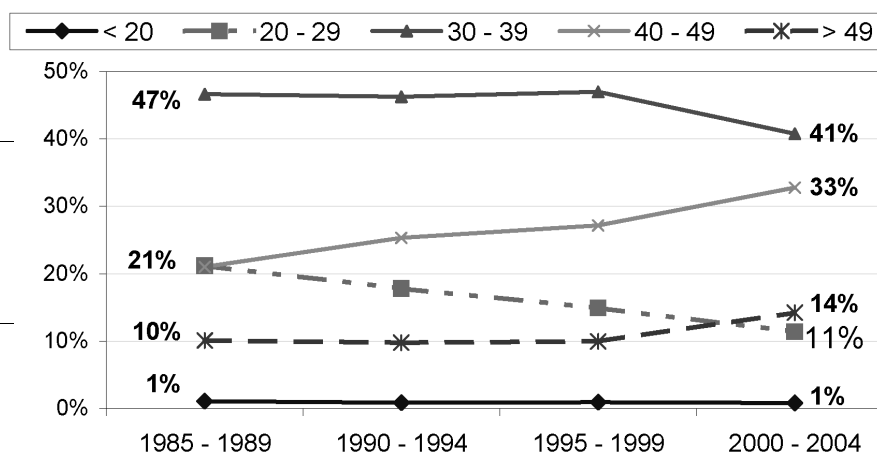


TABLE 2: AIDS CASES BY AGE-RELATED MEASUREMENTS AND RACIAL/ETHNIC GROUP OVER TIME, SAN DIEGO COUNTY

Time Period	Age Related Measurement	Racial / Ethnic Group			
		White	Black	Hispanic	Other*
1985 – 1989	Mean Age	38	33	34	35
	Range in years	88	58	72	27
	Youngest Case	Birth	Birth	Birth	23
	N	1,602	186	239	31
1990 – 1994	Mean Age	38	36	34	36
	Range in years	70	71	75	69
	Youngest Case	9	Birth	Birth	Birth
	N	3,249	547	863	121
1995 - 1999	Mean Age	39	38	36	36
	Range in years	76	71	75	46
	Youngest Case	1	Birth	Birth	20
	N	1,806	444	864	96
2000 - 2004	Mean Age	42	39	36	37
	Range in years	88	55	75	55
	Youngest Case	4	13	Birth	18
	N	941	344	718	71
Cumulative**	Mean Age	38	37	36	36
	Range in years	92	71	78	73
	Youngest Case	Birth	Birth	Birth	Birth
	N	7,670	1,522	2,690	319

* "Other" includes Asian/Pacific Islander, and Native American.

** Includes 79 cases diagnosed between 1981 and 1984

2.4 Pediatric AIDS Cases

A pediatric case is one in which the individual was 12 years old or younger at the time they met the case definition and were diagnosed with AIDS. As of 12/31/03, there have been 9,419 pediatric cases in the nation. This constitutes 1% of all AIDS cases diagnosed nationwide. In the state of California, a smaller percent are pediatric, 0.4% (645) of the 135,975 cases diagnosed as of 12/31/04. At the local level, the percent of cases diagnosed in this age group as of 12/31/04 is also very small. There have been 60 pediatric cases, or about 0.5% of total San Diego County cases. In recent years, the number of cases in children has been even lower. No one in this age group was diagnosed in 2003 and only 2 were diagnosed in 2004; only 3 children in the last 5 years have been diagnosed with AIDS.

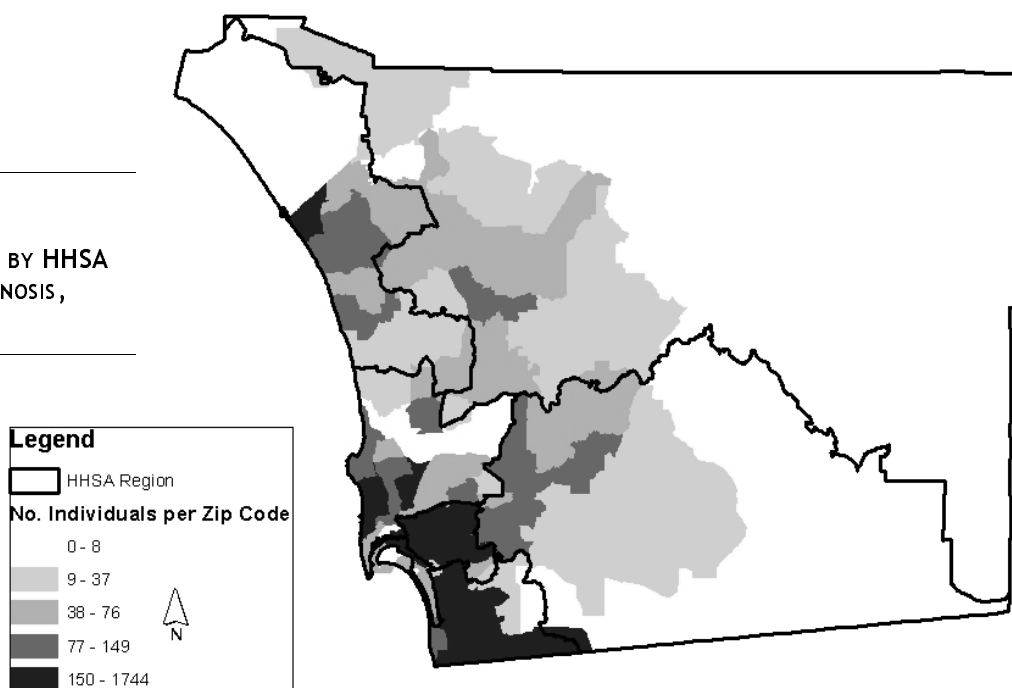
2.5 Place of Residence

Because individuals move, place of residence at the time of AIDS diagnosis is not necessarily the same as the place of residence at the time of HIV diagnosis. The Health and Human Services Agency (HHSA) geographically divides the County of San Diego into 6 HHSA regions. For more information about the Health Service Areas, please see Appendix 6.

While AIDS cases have been diagnosed in all parts of the county, 58% of individuals diagnosed with AIDS were living in the Central Region at the time of their diagnosis (*Figure 6*). Sixty percent of men and 41% of women diagnosed with AIDS were living in the Central Region at the time of their diagnosis. By racial/ethnic group, 60% of white cases, 70% of black cases, 49% of Hispanic cases, 43% of Asian/Pacific Islander cases, and 64% of Native American cases were living in this region at the time of their AIDS diagnosis.

FIGURE 6:

AIDS CASE DISTRIBUTION BY HHSA
REGION AT TIME OF DIAGNOSIS,
SAN DIEGO COUNTY



Note: The six HHSA regions are based on zip code.

TABLE 3: AIDS CASE DISTRIBUTION BY RACIAL/ETHNIC GROUP AND HHSA REGION, SAN DIEGO COUNTY

Racial/ Ethnic Group	HHSA Region					
	Central	South	North Central	North Coastal	East	North Inland
White	64%	28%	75%	66%	67%	68%
Black	15%	10%	8%	10%	11%	5%
Hispanic	19%	58%	14%	21%	18%	22%
Asian/PI	1%	3%	3%	2%	2%	4%
Native American	1%	0%	1%	1%	1%	1%
Total in Region	7114	1163	1600	908	866	550

Note: Percentages may not add up to 100% due to rounding.

The percentage breakdown of racial/ethnic group by region of residence at the time of AIDS diagnosis shows that the largest proportion of cases in most regions is white with the exception of the South HHSA Region where the largest proportion of cases is Hispanic (Table 3). As well, the vast majority of cases in each region are male (85% - 95%).

There has not been a dramatic shift in where individuals diagnosed with AIDS are living at the time of their diagnosis. The

East, North Coastal, and North Inland Regions have been relatively stable over time. The biggest changes have been a decrease in percent of cases diagnosed in the Central and North Central Regions and an increase in percent of cases diagnosed in the South Region. (Table 4).

Over time, reported AIDS cases in all of the HHSA regions have become more diverse in their racial/ethnic group make up. This diversity results primarily from a proportional

TABLE 4: AIDS CASE DISTRIBUTION BY HHSA REGION OVER TIME, SAN DIEGO COUNTY

HHSA Region	Time Period of Diagnosis				Cumulative*
	1985 - 1989	1990 - 1994	1995 - 1999	2000 - 2004	
Central	62%	59%	58%	53%	58%
East	7%	7%	7%	8%	7%
South	6%	7%	11%	17%	10%
North Coastal	6%	8%	8%	7%	7%
North Inland	4%	5%	5%	4%	5%
North Central	16%	14%	11%	11%	13%
Total	2,058	4,780	3,210	2,074	12,201

*Includes 79 individuals diagnosed between 1981 and 1984

Note: Percentages may not add up to 100% due to rounding.

TABLE 5: AIDS CASE DISTRIBUTION BY RACIAL/ETHNIC GROUP AND HHSA REGION OVER TIME, SAN DIEGO COUNTY

HHSA Region	Time Period	Racial/Ethnic Group				Number in Time Period
		White	Black	Hispanic	Other*	
Central	1985 - 1989	78%	11%	10%	1%	1277
	2000 - 2004	49%	21%	27%	3%	1109
East	1985 - 1989	82%	6%	8%	3%	148
	2000 - 2004	52%	15%	29%	3%	162
South	1985 - 1989	43%	10%	44%	3%	120
	2000 - 2004	16%	9%	73%	1%	344
North Coastal	1985 - 1989	79%	9%	10%	2%	116
	2000 - 2004	50%	16%	31%	3%	147
North Inland	1985 - 1989	88%	<1%	12%	<1%	78
	2000 - 2004	51%	10%	34%	5%	93
North Central	1985 - 1989	85%	4%	9%	2%	319
	2000 - 2004	65%	12%	19%	3%	219

* Other includes Asian/Pacific Islander and Native American.

Note: Percentages may not add up to 100% due to rounding.

decrease in white cases and subsequent increases in black and Hispanic cases. The above table (5) breaks down the six regions by racial/ethnic group and compares an early time in the epidemic (1985 - 1989) with the most recent 5 years of the epidemic (2000 - 2004).

While females tend to be more evenly distributed throughout San Diego County than males, there is an increased concentration of females in the Central Region. In the time period 1985-1989, 35% of the 88 females diagnosed were residing in the Central Re-

gion. In the most recent 5-year period (2000-2004), 46% of the 227 females diagnosed were living in this region.

In total, females make up 8% of all cases diagnosed in San Diego County. This proportion changes by year of diagnosis and also by region of San Diego County. Table 6 shows the percent of cases diagnosed in females per time period and region. The proportion of females diagnosed has increased in each region over time. In the Central Region, where the bulk of the female cases were living at the time of their diagnosis, females constituted

TABLE 6: FEMALE AIDS CASE DISTRIBUTION BY HHSA REGION OVER TIME, SAN DIEGO COUNTY

HHSA Region	Time Period of Diagnosis								Cumulative*	
	1985 - 1989		1990 - 1994		1995 - 1999		2000 - 2004			
	% Female	No.	% Female	No.	% Female	No.	% Female	No.	% Female	No.
Central	2%	1277	4%	2836	7%	1856	9%	1109	5%	7114
East	10%	148	9%	337	12%	214	17%	162	11%	866
South	7%	120	15%	330	10%	365	12%	344	12%	1163
North Coastal	9%	116	11%	371	16%	264	13%	147	12%	908
North Inland	10%	78	16%	224	15%	151	16%	93	15%	550
North Central	5%	319	7%	682	10%	360	9%	219	7%	1600
Total in Time Period	4%	2058	7%	4780	9%	3210	11%	2074	8%	12201

Note: Percentages may not add up to 100% due to rounding.

* Includes 1 female diagnosed between 1981 and 1984

about 5% of the cases diagnosed in this region. The proportion was as low as 2% in the 1985-1989 time period and increased to 9% of cases in this region in the 2000-2004 time period. In the last 5 years (2000-2004), the region with the largest proportion of females is the East Region (17%) followed by North Inland (16%) and North Coastal (13%).

Place of residence can be examined by community of residence within San Diego County. Cumulative cases by the community of residence in San Diego County at the time of diagnosis are displayed in Appendix 7.

2.6 Place of Origin

The majority of AIDS cases diagnosed in San Diego County were among individuals born in the United States. Of the 12,201 cases diagnosed in San Diego County, 15% were born in foreign countries, and 1% were born in a United States Dependency (such as Puerto Rico or Guam).

Those born outside of the United States in either a US Dependency or a foreign country account for 60% of the 246 Asian/Pacific Islander cases and 59% of the 2690 Hispanic

cases. About 3% of the 73 Native Americans, 2% of the 7670 whites and 4% of the 1522 black cases were born outside of the United States. While country of birth is recorded, the length of time a person has resided in the United States is not. Those who arrived in the United States shortly after birth cannot be differentiated in analysis from those who are newly arrived.

When the 1975 individuals with AIDS who were born outside the United States (US Dependency or other country) are examined by race, the most frequent group is Hispanic, constituting 80% of all foreign and US Dependency born persons. While more than half of Asian/Pacific Islanders were born outside of the United States, this group makes up only 7% of the 'foreign born' group. White individuals make up 9% and blacks constitute 3% of those born in either a US Dependency or foreign country.

An analysis of Hispanic cases by time period, place of birth, and gender shows that an increasing proportion of all Hispanics are foreign-born and that a slightly larger proportion of females are foreign-born than males (*Table 7*). Male and female Hispanic cases show a similar pattern for place of birth over time.

TABLE 7: HISPANIC AIDS CASES BY GENDER, PLACE OF BIRTH, AND TIME PERIOD, SAN DIEGO COUNTY

Gender	Place of Birth	Time Period of Diagnosis				Cumulative*
		1985 – 1989	1990 – 1994	1995 - 1999	2000 - 2004	
Male	US born	52%	52%	42%	26%	42%
	US Dependency born	6%	2%	2%	1%	2%
	Foreign Born	42%	46%	57%	72%	56%
	Unknown	<1%	<1%	<1%	<1%	<1%
	No. in Time Period	222	789	782	621	2420
Female	US born	59%	38%	41%	23%	35%
	US Dependency born	12%	5%	1%	2%	3%
	Foreign Born	29%	57%	57%	75%	62%
	No. in Time Period	17	74	82	97	270

* Includes six males from the 1981 - 1984 time period

Note: Percentages may not add up to 100% due to rounding. No Hispanic AIDS cases were diagnosed prior to 1983.

Asian/Pacific Islander cases show a larger percent of female AIDS cases (79%) than male cases (57%) being foreign- or US Dependency-born. Due to small numbers, the percentages shown for Asian/Pacific Islander cases should be interpreted with caution. Most of the foreign-born Hispanics (88%) were born in Mexico, and the majority of foreign-born Asian/Pacific Islanders (60%) were born in the Philippines.

3.0 Mode of Transmission

Mode of transmission has remained relatively stable over time with “Men who have Sex with Men” (MSM) consistently contributing the largest number of cases (74% of all cases). Since the mid-1990s, the proportion of cases attributed to injection drug use (IDU) and heterosexual contact has been growing. In the following figure (7), the distribution of transmission mode is presented by year of diagnosis.

Cumulatively, MSM constitutes 74% of the AIDS cases, followed by both IDU and the combined category, MSM+IDU at 9% and 10%

respectively. About 5% of all cases are attributed to heterosexual contact. Over time, there has been a slow decrease in percentage of cases attributed to MSM and a gradual increase of IDU and MSM+IDU. The percentage of cases attributed to heterosexual transmission is proportionally highest in 2004 at 16% of all cases diagnosed.

When the genders are separated, the percent distribution for mode of transmission changes (*Figure 8 and 9*). In males, the primary mode of transmission is MSM (80%) with much smaller proportions attributed to heterosexual contact and IDU (1% and 7%, respectively). After MSM, MSM+IDU is the second most frequent risk factor among males (10%). In females, a different picture is seen. About 88% of all females attribute their infection to either heterosexual contact (51%) or IDU (37%). The proportion of cases attributable to IDU (37%) is higher than what is seen in males (7%).

Pediatric AIDS cases (individuals less than 13 years of age) constitute less than 1% of all cases with the majority being diagnosed in individuals who were infected via vertical trans-

FIGURE 7: AIDS CASE DISTRIBUTION BY MODE OF TRANSMISSION, SAN DIEGO COUNTY

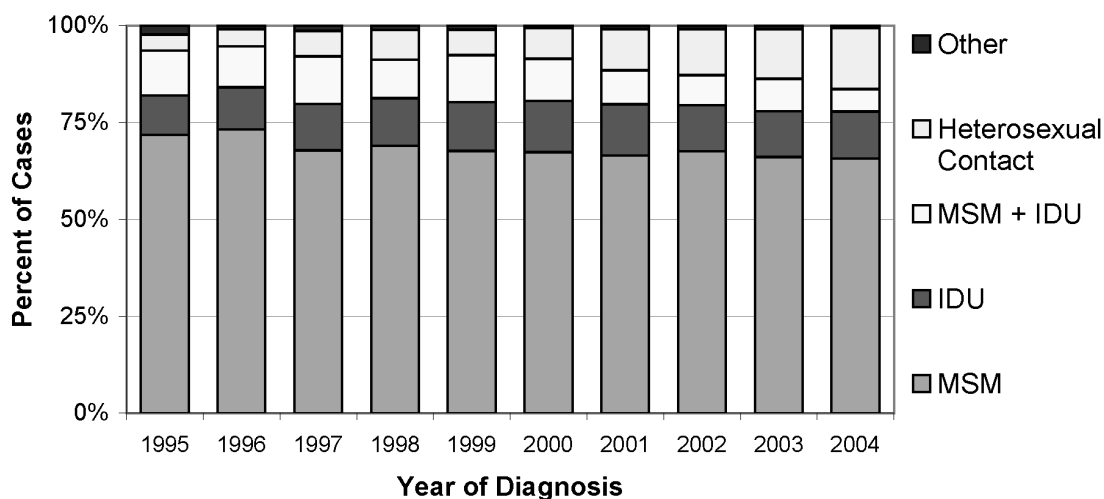
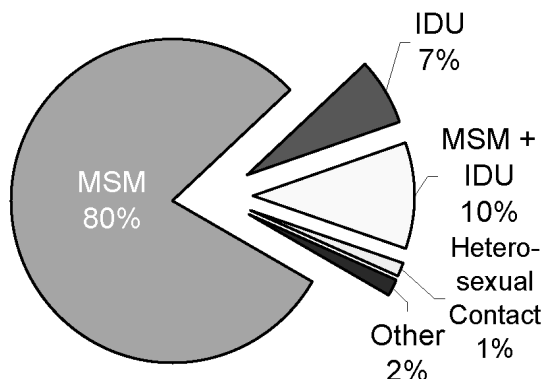
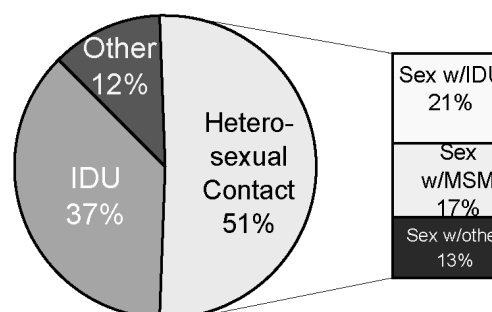


FIGURE 8: MODE OF TRANSMISSION FOR MALE AIDS CASES, SAN DIEGO COUNTY (N=11,281)**FIGURE 9: MODE OF TRANSMISSION FOR FEMALE AIDS CASES, SAN DIEGO COUNTY (N=920)**

mission from an HIV positive mother. There have been 60 pediatric cases reported. Of these, 25 boys and 26 girls were diagnosed with AIDS due to maternally transmitted HIV. Some individuals (10 additional cases) were infected with HIV via vertical transmission (an HIV+ mother) or exposure to contaminated blood while less than 13 years of age and did not get diagnosed with AIDS until aged 13 or older. For most areas of this report those individuals are considered to be adolescent/adult cases but for the purposes of describing mode of transmission, they are counted as pediatric.

When Mode of Transmission is examined by 5-year time periods and gender (Table 8), a decrease in percentage of male cases attributed to MSM can be seen (84% to 74%). The decrease from the time period 1985 - 1989 to 2000 - 2004 is statistically significant ($p < .05$). There has also been a gradual increase of IDU transmission modes for men. Heterosexual contact still makes up a very small percentage of HIV transmission in men each year.

TABLE 8: AIDS CASES BY GENDER, MODE OF TRANSMISSION AND TIME PERIOD, SAN DIEGO COUNTY

Gender	Mode of Transmission	Time period of Diagnosis				Cumulative*
		1985 - 1989	1990 - 1994	1995 - 1999	2000 - 2004	
Male	Adolescent/Adult:					
	Homosexual / Bisexual (MSM)	84%	82%	77%	74%	80%
	Injection Drug Use (IDU)	3%	6%	8%	10%	7%
	MSM + IDU	10%	10%	12%	9%	10%
	Heterosexual	1%	1%	1%	5%	1%
	Contact with contaminated blood/ blood product	2%	1%	1%	1%	1%
	Risk Not Specified/Other	<1%	<1%	<1%	<1%	<1%
	Pediatric (0 - 12 years):					
	All modes of transmission	<1%	<1%	<1%	<1%	<1%
	Number in Group	1970	4469	2917	1847	11281
Female	Adolescent/Adult:					
	Injection Drug Use (IDU)	28%	37%	43%	32%	37%
	Heterosexual	35%	47%	49%	65%	51%
	Contact with contaminated blood/ blood product	26%	12%	3%	0%	8%
	Risk Not Specified/Other	<1%	1%	1%	2%	1%
	Pediatric (0 - 12 years):					
	All modes of transmission	10%	3%	3%	1%	3%
	Number in Group	88	311	293	227	920

Note: * Includes 78 males and 1 female that were diagnosed between 1981 and 1984.

Percentages may not add up to 100% due to rounding.

* Includes 78 males and 1 female that were diagnosed between 1981 and 1984.
Note: Percentages may not add up to 100% due to rounding.

For women, heterosexual transmission continues to be the most frequent risk factor for HIV infection. The proportion of cases attributed to heterosexual transmission per time period of diagnosis seems to be increasing; these increases are not statistically significant ($p > .05$). When IDU as a risk factor for women is examined, the proportion of cases seems to fluctuate from 28% to 43% to 32% between 1985-1989 and 1995-1999.

Mode of transmission for adult/adolescent male cases by racial/ethnic group and time period of diagnosis show a similar trend among groups (Table 9). MSM is the biggest risk factor in all racial/ethnic groups and in all time periods. In Hispanic men, the proportion of cases attributed to MSM between the two time periods (1990-1994 and 2000-2004) is almost the same while it decreased in white, and "all racial/ethnic groups". In blacks, the proportion is slightly increased. The black community has a smaller proportion of cases attributed to MSM and a larger proportion attributed to IDU than in any other male racial/ethnic group.

Injection drug use (IDU) is the second most frequent transmission mode among adult/adolescent males. In the earlier time period

(1990-1994), IDU among gay/bisexual men (MSM+IDU) was more frequent than IDU in heterosexual men (IDU alone) but in the most recent time period (2000-2004) they switched and a slightly higher proportion of the cases are attributed to IDU than IDU+MSM. Unlike Hispanic and black men, white men are more likely to be MSM+IDU than heterosexual IDU in both time periods. In black and Hispanic men, a larger proportion of cases are among heterosexual IDUs and fewer among MSM+IDU. When comparing the two time periods in the table, the proportion of cases attributed to heterosexual IDU in the later time period is increased significantly ($p < .05$) among both combined racial/ethnic groups (total of all racial/ethnic groups) and whites. Among Hispanic men, the proportion has slightly decreased. The proportion of MSM+IDU has decreased for Hispanic and black men and the total group, but not for white men.

Heterosexual transmission occurs in about 5% of all recent adult/adolescent male cases, up from 1% in the earlier time period. This varies widely by racial/ethnic group. The smallest increase is in white men where heterosexual contact has gone from less than 1% to 3%. The largest percent increase is in

TABLE 9: ADULT/ADOLESCENT MALE AIDS CASES BY MODE OF TRANSMISSION, RACIAL/ETHNIC GROUP AND TIME PERIOD, SAN DIEGO COUNTY

Mode of Transmission	Racial / Ethnic Group						All Racial / Ethnic Groups	
	White		Black		Hispanic		1990 - 1994	2000 - 2004
	1990 - 1994	2000 - 2004	1990 - 1994	2000 - 2004	1990 - 1994	2000 - 2004		
MSM	85%	75%	64%	67%	77%	78%	82%	75%
IDU	3%	9%	17%	17%	11%	10%	6%	10%
MSM +IDU	9%	13%	15%	8%	10%	6%	10%	9%
Heterosexual	0%	3%	2%	8%	1%	6%	1%	5%
Not Specified / Other	2%	1%	1%	1%	2%	1%	2%	1%
Number in Group and Time Period	3096	871	470	288	784	620	4456	1845

Note: Percentages may not add up to 100% due to rounding.

black men, 2% to 8%, followed by Hispanic men, from 1% to 6%.

While MSM is the most common mode of transmission in males, heterosexual contact is the primary mode of transmission for adult/adolescent women in general, followed by IDU. When mode of transmission is examined for each racial/ethnic group, heterosexual contact remains the primary mode of transmission in recent years in all groups (Table 10). The proportion of cases attributed to heterosexual contact between 1990-1994 and 2000-2004 has increased in all racial/ethnic groups. The most dramatic increase is seen in black females, 44% to 71%, followed by Hispanic women, 58% to 73%. The proportion of cases attributed to IDU has also been decreasing among all race/ethnicities except white women. The decrease amounts to a percent change of -8% among Hispanic women and -43% among black women.

4.0 Health Outcomes

HIV infection alone does not meet the criteria for an AIDS diagnosis. An HIV-infected person must also have one of a number of conditions defined by the Centers for Disease Control and Prevention (CDC) to be considered an AIDS case. (Refer to Appendix 3, Reporting AIDS Cases, for more information about the CDC's case definition of AIDS and how cases are reported.) Individuals with AIDS in San Diego have experienced a number of different infections. The most common AIDS-defining infection reported for adolescent and adult cases is *Pneumocystis carinii* pneumonia, which was one of the original AIDS defining conditions.

In recent years, individuals with AIDS are living both healthier and longer lives. With the introduction of new medications, many opportunistic infections that were commonplace at the beginning of the epidemic are now less frequent. The case fatality rate, computed by dividing the number of people with AIDS who have died by the total number of people with AIDS, has also been decreasing over time.

TABLE 10: ADULT/ADOLESCENT FEMALE AIDS CASES BY MODE OF TRANSMISSION, RACIAL/ETHNIC GROUP AND TIME PERIOD, SAN DIEGO COUNTY

Mode of Transmission	Racial / Ethnic Group						All Racial / Ethnic Groups	
	White		Black		Hispanic		1990 - 1994	2000-2004
	1990 - 1994	2000-2004	1990 - 1994	2000-2004	1990 - 1994	2000-2004		
IDU	42%	48%	51%	29%	24%	22%	38%	32%
Heterosexual	44%	49%	44%	71%	58%	73%	49%	65%
Contaminated blood	13%	0%	6%	0%	16%	1%	12%	0%
Not Specified/ Other	1%	3%			1%	4%	1%	3%
Number in Group and Time Period	151	69	71	56	67	96	303	226

Note: Percentages may not add up to 100% due to rounding.

4.1 Indicator Diseases

The following two tables show the different indicator diseases experienced by San Diego residents who met the AIDS case definition, as defined by the CDC. There are some differences in pediatric case (*Table 11*) or adolescent and adult case (*Table 12*) definitions.

Since one individual can have multiple health events, the total exceeds the number of cases.

4.2 Mortality Status

In 1993, a change in the definition of AIDS created a spike in the number of AIDS cases reported. Since this time, the number of new cases per year has been steadily dropping. At the same time the number of individuals who are currently living with AIDS has been on the rise. About 37% of those diagnosed in 1993 are currently living while 68% of those diagnosed just 2 years later are currently living. In each year after 1996, the proportion

TABLE 11: FREQUENCY OF INDICATOR DISEASES* AMONG REPORTED PEDIATRIC AIDS CASES**, SAN DIEGO COUNTY

Indicator Disease	Frequency	Percent
Wasting syndrome	35	58%
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	21	35%
HIV encephalopathy	18	30%
<i>Pneumocystis carinii</i> pneumonia	18	30%
Esophageal candidiasis	14	23%
Cytomegalovirus	11	18%
<i>Mycobacterium avium</i> complex or <i>M. kansasii</i>	11	18%
Recurrent/multiple bacterial infections	8	13%
Pulmonary candidiasis	6	10%
Cryptosporidiosis	4	7%
Cytomegalovirus retinitis	4	7%
Immunoblastic lymphoma	4	7%
<i>M. tuberculosis</i> , disseminated or extrapulmonary	3	5%
Progressive multifocal leukoencephalopathy	2	3%
Cryptococcosis	1	2%
Herpes simplex, invasive or chronic	1	2%
Lymphoma, primary in brain	1	2%
<i>Mycobacterium</i> , of other species or unidentified species	1	2%

* This list may not be a complete accounting of all the indicator conditions experienced as there is limited time to track additional opportunistic infections as disease progresses.

** The sum of percentages is greater than 100 because some patients are reported with more than one AIDS indicator disease or condition.

Note. A CD4+ T-lymphocyte of less than 200 mL/mm^3 or a percentage less than 14% in a pediatric patient does not meet the CDC AIDS case definition.

TABLE 12: FREQUENCY OF INDICATOR DISEASES* AMONG REPORTED ADULT/ADOLESCENT AIDS CASES, SAN DIEGO COUNTY**

Indicator Disease	Frequency	Percent
CD4 count <200 mL/mm ³ or <14%***	3775	31%
<i>Pneumocystis carinii</i> pneumonia	3413	28%
Wasting syndrome	1951	16%
Kaposi's Sarcoma	1533	13%
<i>Mycobacterium avium</i> complex or <i>M. kansasii</i>	1063	9%
Esophageal candidiasis	954	8%
HIV encephalopathy	785	6%
Cytomegalovirus	719	6%
Cryptococcosis	611	5%
Cytomegalovirus retinitis	597	5%
Cryptosporidiosis	468	4%
Immunoblastic lymphoma	419	3%
<i>M. tuberculosis</i> , pulmonary	389	3%
Herpes simplex, invasive or chronic	293	2%
Toxoplasmosis of the brain	288	2%
<i>M. tuberculosis</i> , disseminated or extrapulmonary	245	2%
Lymphoma, primary in brain	180	1%
Progressive multifocal leukoencephalopathy	171	1%
Pneumonia, recurrent in 12-month period	112	1%
Pulmonary candidiasis	73	1%
<i>Mycobacterium</i> , of other species or unidentified species	61	1%
Coccidioidomycosis	57	0%
Burkitt's lymphoma	52	0%
Histoplasmosis	52	0%
Isosporiasis	26	0%
Salmonella septicemia, recurrent	25	0%
Carcinoma, invasive cervical	2	0%

* This list may not be a complete accounting of all the indicator conditions experienced as there is limited time to track additional opportunistic infections as disease progresses.

** The sum of percentages is greater than 100 because some patients are reported with more than one AIDS indicator disease or condition.

*** Defined as a CD4+ T-lymphocyte of less than 200 mL/mm³ or a percentage less than 14% in adult/adolescents who meet the AIDS surveillance case definition.

of living cases ranges from 74% to 93% per year (Figure 10).

The number of individuals living with AIDS at the end of each year has been increasing dramatically since about 1993 (Figure 11). Through the 1990s there was an average of 13% more individuals living with AIDS per year. Partly this is due to the sharp increase in number of AIDS cases around 1993 but this increase can also be attributed to the new medications that allowed individuals to live longer, healthier lives post-AIDS diagnosis. Over the last five years the increase has been about 5% per year.

The annual number of deaths to individuals with AIDS also has been dropping, thus the case fatality rate has decreased or remained steady year to year (Table 13). As of December 31, 2004, a total of 6,575 deaths have been reported for an overall case fatality rate of 54%.

As people with AIDS begin to live longer lives, their age also increases. The mean age

at AIDS diagnosis is 38 years. The average age at the end of 2004 of the 5,626 individuals currently living with a diagnosis of AIDS was 44 years. While it's easy to imagine persons with HIV or AIDS as being middle aged or slightly younger, 25 individuals living with AIDS are less than 18 years old and 281 individuals living with AIDS are 60 years of age or older. As well, 29 of the 60 individuals diagnosed before the age of 13 are still living. Fifteen of them are still less than 13 years old - and 14 individuals are growing out of childhood into the teen and young adult years (Table 14).

FIGURE 10: AIDS CASES BY YEAR OF DIAGNOSIS AND STATUS, SAN DIEGO

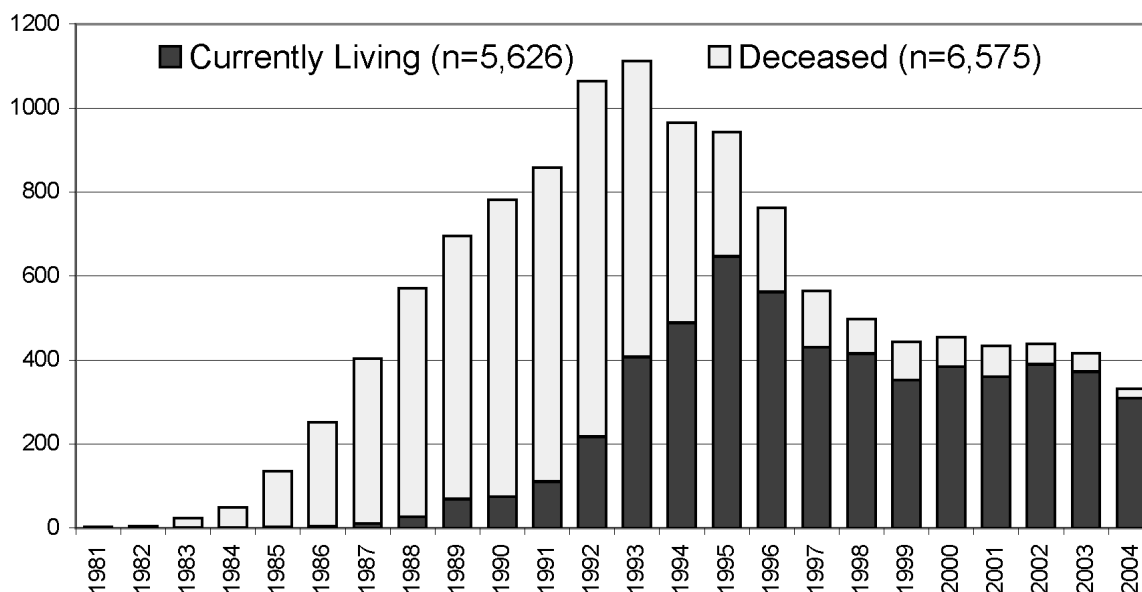


FIGURE 11:

NUMBER OF PERSONS DIAGNOSED
AND LIVING WITH AIDS,
SAN DIEGO COUNTY

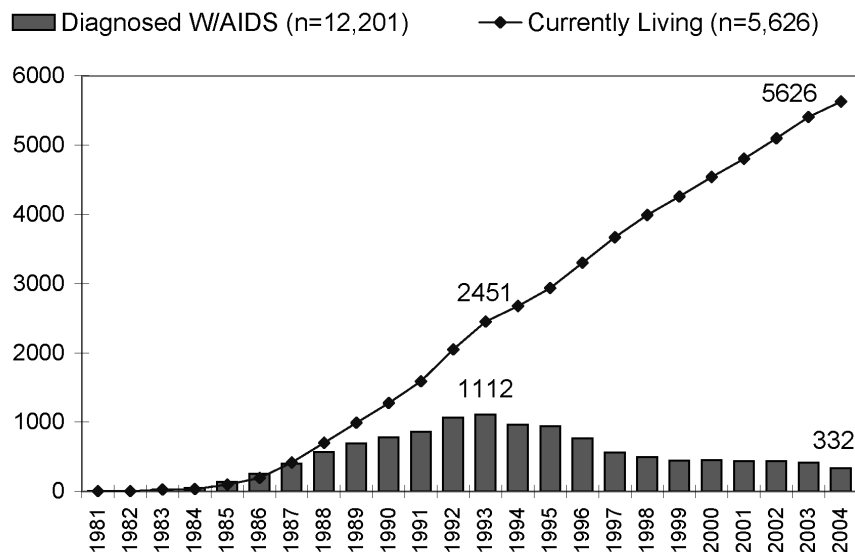


TABLE 13: AIDS CASES, DEATHS AND FATALITY RATE OVER TIME, SAN DIEGO COUNTY

Measure	Time Period				
	Prior to 2000	2000	2001	2002	2003
New Cases	10127	454	434	438	416
Percent Change	*	2%	-5%	1%	-5%
Number of Deaths	5870	172	170	143	111
Percent Change	*	-2%	-1%	-19%	-29%
Case Fatality Rate	58%	38%	39%	33%	27%

Note: Year 2004 data is still considered preliminary.

* Cumulative Data

TABLE 14: CURRENT AGE OF INDIVIDUALS LIVING WITH AIDS, SAN DIEGO COUNTY

Age Group in Years	Frequency	Percent	Cumulative Percent
Less than 13	15	0.3%	0.3%
13-19	18	0.3%	1%
20-29	200	3.6%	4%
30-39	1505	26.8%	31%
40-49	2521	44.8%	76%
More than 49	1367	24.3%	100%
Total	5626	100.0%	

5.0 AIDS Summary

There have been 12,201 individuals diagnosed with AIDS in San Diego County since the beginning of the epidemic. The number of new cases per year has been decreasing since 1993, leveling off to 400 to 450 per year between 1998 and 2003. It is expected that some cases diagnosed in 2004 will be reported in 2005 and will bring the number of 2004 cases also into the 400s.

Individuals diagnosed with AIDS in San Diego County are most commonly white, male, 30 to 39 years of age, and have male sexual partners. Over the years, this has been slowly changing with larger proportion of people diagnosed being black or Hispanic, women, in their 40s or older, and having used injection drugs.

While the number of AIDS cases has decreased, this decrease has not been uniform across all racial/ethnic groups. The largest decrease has been in the white community shifting the proportional burden from whites to persons of color. The black community has had the third highest number of cases per year and the highest rate of AIDS since the mid-1980s. The annual rate of AIDS among blacks is two to three times the rate in the white community. Hispanics have the second highest number and rate of AIDS, about 1½ times the rate of AIDS in whites and less than half the rate of blacks.

The average age at the time of diagnosis has been slowly increasing over the years across all racial/ethnic groups. The average age at the time of diagnosis from 1999 to 2004 was 40 years of age with Hispanics being slightly younger (37 years of age). Examining AIDS data alone cannot tell us if this age increase is due to later age at HIV infection or successful medications which allow an HIV infected individual to be healthy longer with increased time before they meet the case definition for

AIDS.

The most frequent place of residence at the time of AIDS diagnosis is the Central HHS Region. Sixty percent of the men and 41% of the women diagnosed with AIDS were living in the Central Region at the time of their diagnosis. The majority of cases diagnosed in the Central Region occur among whites (64%), with 19% of cases among Hispanics and 15% among blacks. The second most frequent place of residence since 1995 is the South Region. The cases diagnosed in the South are predominately Hispanic (58%) and white (28%).

For men, the predominant mode of transmission is MSM (80%) followed by MSM+IDU (11%). Over the years, IDU has become a more frequent mode of transmission in men. In women, heterosexual contact is the primary mode of transmission (51%) followed by IDU (37%). These modes do have some overlap because women whose transmission route was heterosexual contact often have had a sexual partner who was an IDU. Sexual partner to an IDU accounts for 21% of all female cases.

While AIDS was once considered a fatal illness, the advances in medicine and medical treatment have enabled individuals with AIDS to live longer, healthier lives. As the number of individuals newly diagnosed with AIDS has been decreasing, the number of individuals living with an AIDS diagnosis continues to increase. To date, approximately 5626 of the individuals diagnosed with AIDS in San Diego County are currently alive.

III. HIV Cases

1.0 Overall HIV Case Data

Advances in medical treatment of HIV have dramatically improved the lives of those infected and increased the time from infection to the point at which an individual meets the criteria for an AIDS diagnosis. Until recently all of the information on trends, demographics and risk behavior of HIV-infected individuals in California was based on AIDS data. The expanded time from infection to AIDS diagnosis makes AIDS data a poor descriptor of the newly HIV positive population.

To increase our understanding of HIV in California, in July 2002, the State of California initiated mandated HIV reporting along with the current practice of AIDS reporting. Unlike in AIDS surveillance, no patient name or address is reported. Instead, the regulations require health care providers and laboratories to report using a non-name code. The non-name code is composed of the Soundex (a laboratory generated alphanumeric representation of the last name), date of birth, numerically coded gender, and last 4 digits of the social security number. As with other communicable diseases, this is a dual reporting process in which both health care providers and laboratories provide data. See Appendix 3 for more information about HIV reporting procedures.

As a cautionary note, there are some known factors that affect HIV reporting data. Although HIV reporting began 3 years ago, the system is both new and different from AIDS reporting; facilities involved in reporting are still adjusting to the new requirements. In some cases HIV reporting may necessitate new or modified electronic systems; other facilities may need to re-organize internal systems to efficiently accommodate reporting. Thus, some facilities are at full reporting capacity while others are not; this affects the ability to

accurately describe the population with HIV in San Diego County.

The present HIV reporting system is designed to capture prevalent cases (cases in care) through viral load reporting. As the system 'matures' the proportion of prevalent cases should decrease as incident (new) cases increase, until most of the cases are new cases. Through 12/31/2004, most of the cases in San Diego County are still prevalent cases. The HIV reporting system does not capture those HIV positive individuals who have tested anonymously (only confidential tests are reported). Also, those individuals who are HIV infected but have not tested are also not represented in these data.

Because the HIV reporting system is relatively new, analysis of reported HIV cases will be limited to the distribution of demographic and geographic variables within the cumulative data. No rates will be computed nor will trends be examined at this time. National and state data, when comparable, will be discussed. Nationally, published HIV reporting data are limited to the 36 states that have confidential names-based reporting. Data from the states that have code-based HIV reporting, like California, are not included.

2.0 Demographic Variables

All HIV reporting data presented here are inclusive of the period July 1, 2002 through December 31, 2004 for a total of 4647 HIV case reports. In general, the distribution of demographic variables for those HIV cases reported is similar to that of cumulative AIDS cases in San Diego County. White men between the ages of 30-39 living in the Central Region of the county are most often diagnosed as HIV positive. Women represent about 10% of all HIV cases and the relationship between race and region is less clear in women, perhaps in part due to the smaller numbers. Although white women do have a larger share of female cases than other racial or ethnic groups, the difference by race is not as pronounced as among men.

2.1 Gender

The distribution of HIV cases by gender appears to be different for San Diego and California, when compared to the United States (Table 15). A smaller proportion of female cases of HIV have been reported in San Diego (10%) and California (14%) than in the United States (29%). The distribution by gender in San Diego County is about the same for HIV (90% male; 10% female) and recent AIDS cases (89% male; 11% female).

2.2 Race/Ethnicity Group

Through the end of 2004, 62% of reported HIV cases in San Diego County were white, 13% black, and 22% Hispanic. The remaining 3% represented Asian/Pacific Islander and Native American cases. When compared to the United States, California and San Diego have fewer black cases, and more white and Hispanic cases of HIV (Figure 12). In fact, although San Diego 'looks' more like California than the United States, San Diego has a considerably higher proportion of white HIV cases (62% vs. 49%) than the state as a whole.

Cumulative AIDS case data by racial/ethnic group in San Diego County are similar to HIV reporting data. However, recent AIDS case data (2004) have a smaller proportion of white (47% versus 62%), and a greater proportion of Hispanic (35% versus 22%) compared to HIV cases. In general, states that have recently initiated HIV reporting have found that the HIV data resembled national trends in HIV data; that is, a higher proportion of cases were female, younger, more likely to be person of color and more likely to report risk of heterosexual transmission. To date, this has not been true for HIV cases reported in San Diego County. The high proportion of long standing (prevalent) cases in San Diego County HIV reporting data may be a reason for a distribution that is more like cumulative AIDS

TABLE 15: HIV CASES, AGES 13 AND OLDER BY GENDER AND AREA OF RESIDENCE

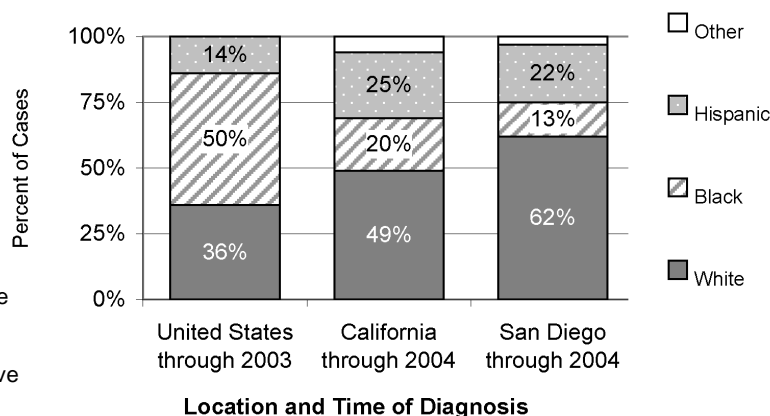
Gender	United States Through 12/31/03		California Through 12/31/04		San Diego Through 12/31/04	
	#	%	#	%	#	%
Male	152,739	71%	29,992	85%	4,152	90%
Female	63,740	29%	4,891	14%	464	10%
Transgendered	*	*	322	1%	*	*
Unknown	7	<1%	4	<1%	0	0%
Total	216,479		35,209		4,616	

* Not collected or not reported

FIGURE 12:**COMPARISON OF HIV CASES BY RACIAL/ETHNIC GROUP, LOCATION AND TIME PERIOD OF DIAGNOSIS**

Note: 2003 is the most recent year available for national data.

Other includes Asian, Pacific Islander, Native American, and unknown.



case data.

For more information on expanded racial/ethnic groups among Hispanic or Asian/Pacific Islander HIV cases, see Appendix 5.

2.3 Age

Those in the age group 30-39 are most frequently diagnosed with HIV in both the state and county, similar to AIDS case data. At the state and local level, a greater proportion of HIV cases are in the 20-29 year age group at the time of diagnosis compared to AIDS cases (25% vs. 15% California; 32% vs. 17% San Diego). This is expected given the natural history of the disease and current medical treatments. National data of reported HIV cases by age group is not available.

The age groups 20-29 and 30-39, when combined represent 75% of HIV cases (Table 16). The next highest proportion, 17%, is among the 40-49 year old age group. Those under age 20 or 50 and over represent very few cases, 3% and 5% respectively.

Table 16 presents the number of HIV cases by age at date of diagnosis and current age of living cases. One hundred and twenty-seven cases of HIV were diagnosed in children and youth ages 0-19, while 248 cases were age 50 and older at diagnosis. Of the cases, the oldest age at HIV diagnosis was 85; the youngest were infants under one year of age. Age at diagnosis does not change; however, individuals continue to age. The current age (as of 2004) of living cases presents a shift in age groups toward older ages: only 30 cases of children and youth are under 20, while 650 cases are 50 or older, compared to 248 at diagnosis.

TABLE 16: HIV CASES BY AGE OF DIAGNOSIS AND CURRENT AGE, SAN DIEGO COUNTY

Age Group in Years	Age by Date of Diagnosis		Current Age of Living Cases	
	Frequency	Percent	Frequency	Percent
Less than 20	127	2.7%	30	0.6%
20-29	1486	32.0%	501	10.8%
30-39	1989	42.8%	1610	34.6%
40-49	797	17.2%	1762	37.9%
50+	248	5.3%	650	14.0%
Total	4647	100%	4553	100%

Note: Percentages may not add up to 100% due to rounding.

2.4 Pediatric HIV Cases

As with AIDS cases, a pediatric HIV case is one in which the age at diagnosis is 12 years or younger. Through 12/31/2004, there have been a total of 31 pediatric HIV cases, representing less than 1% of all cases. At the state level, just over 1% of all cases are pediatric. Of the 31 cases reported in San Diego County, 22 are under 5 years of age at the time of diagnosis and 9 are between the ages of 5 and 12 at diagnosis.

2.5 Place of Residence

The zip code of residence at the time of HIV diagnosis is used to examine geographic differences in case distribution. Please note that place of residence at diagnosis may be different than current residence. The County of San Diego Health and Human Services Agency (HHSA) divides the county into 6 regions for planning purposes: Central, North Central, South, North Coastal, East and North Inland. These regions are based on the county zip codes. See Appendix 6 for more information.

Most of the county's HIV cases, 63%, were residing in the Central Region at the time of diagnosis, with the North Central and South

Regions having the next highest proportion of cases (12% and 10% respectively). North Coastal, North Inland, and East Regions shared the remaining 15% of cases.

Whites constitute the majority of reported HIV cases in all regions except the South Region, where the majority of cases are Hispanic (Table 17). When examining race by region, all races have the greatest number of cases within the Central Region; however, proportions by racial/ethnic group within regions can vary. For example, whites have the greatest number of cases in the Central Region but the region in which they represent the highest proportion (76%) is North Central. The greatest proportion of blacks is seen in the Central Region (15%); Hispanics in the South Region (57%); Asian/Pacific Islanders in the North Coastal Region (4%); Native Americans in both the East and Central Regions (1%).

2.6 Place of Origin

Most of the HIV cases reported to date are among individuals born in the United States. Approximately 87% of the 4647 cases are US born. This differs slightly by gender; more women than men are foreign born, 24% versus 12%. Of those who are foreign born, about 75% were born in Mexico, and 4% in the Phil-

TABLE 17: HIV CASE DISTRIBUTION BY RACIAL/ETHNIC GROUP AND HHSA REGION, SAN DIEGO COUNTY

Racial/Ethnic Group	HHSA Region					
	Central	North Central	South	North Coastal	East	North Inland
White	63%	76%	28%	66%	65%	64%
Black	15%	10%	11%	13%	11%	7%
Hispanic	19%	11%	57%	16%	20%	27%
Asian/PI	2%	3%	3%	4%	3%	3%
Native American	1%	<1%	<1%	<1%	1%	<1%
Total in Region	2912	542	457	288	276	170

Note: Two cases had invalid zip codes and could not be assigned to a region. Percentages may not add up to 100 due to rounding.

TABLE 18: HIV CASES BY GENDER AND MODE OF TRANSMISSION, SAN DIEGO COUNTY

Gender	Mode of Transmission	Cumulative	Percent
Male	Adolescent/Adult:		
	Homosexual / Bisexual (MSM)	3315	79%
	Injection Drug Use (IDU)	182	4%
	MSM + IDU	312	7%
	Heterosexual	171	4%
	Transfusion/Transplant/Hemophiliac	10	0%
	Risk Not Specified/Other	162	4%
	Pediatric (0 – 12 years):		
	All modes of transmission	18	<1%
	Number in Group	4170	100%
Female	Adolescent/Adult:		
	Injection Drug Use (IDU)	95	20%
	Heterosexual	306	64%
	Transfusion/Transplant/Hemophiliac	1	<1%
	Risk Not Specified/Other	62	13%
	Pediatric (0 – 12 years):		
	All modes of transmission	13	3%
	Number in Group	477	100%

Note: Percentages may not add up to 100 due to rounding.

ippines. The remaining 18% were born in one of another 50 countries, and in 3% of cases the country of birth was unknown.

drugs, 7%), and IDU (injection drug users, 6%). Table 18 presents the number of cases by gender, and mode of transmission among adult or pediatric cases.

3.0 Mode of Transmission

“Men who have Sex with Men” (MSM) represents the likely mode of transmission for 71% of the 4647 cumulative cases of HIV. The mode of transmission for the remaining cases are heterosexual transmission (10%), MSM + IDU (men who have sex with men and inject

The distribution of cases by gender and transmission are quite different. For males, 79% of cases are attributed to MSM, while for females, the majority of cases, 64% are due to heterosexual contact (*Figure 13 and 14*). For males, the other modes of transmission are MSM+IDU, 7%, IDU, 4%, heterosexual con-

FIGURE 13: MODE OF TRANSMISSION FOR MALE HIV CASES, SAN DIEGO COUNTY (N=4170)

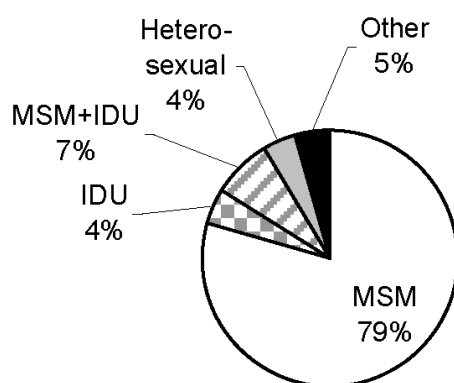
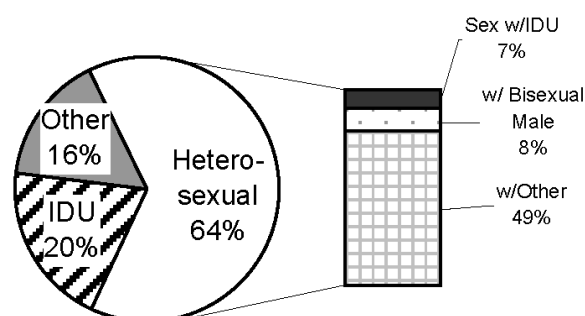


FIGURE 14: MODE OF TRANSMISSION FOR FEMALE HIV CASES, SAN DIEGO COUNTY (N=477)



tact, 4%, and 4% not specified/other, while for females, the other modes of transmission are IDU, 20%, and 16% not specified/other. 'Other' can include hemophilia, transfusion/transplant, pediatric, and unknown transmission. Notably, females have a higher proportion of transmission due to IDU (20% versus the 11% of IDU and MSM+IDU combined), as well as a higher percentage of cases in which mode of transmission is unknown (13% versus 4%). The CDC transmission categories require knowledge about the behaviors of a female's sexual partner; this information is not always known or available at the time of diagnosis.

Compared to the nation, San Diego has a larger proportion of MSM among adult male cases (80% versus 48%), and a lower proportion of IDU and not specified/other (4% versus 13% and 4% versus 25%). Among adult females, San Diego has a larger proportion of heterosexual transmission (66% versus 45%) and a lower proportion of not specified/other (13% versus 36%) than the Nation. In general, the differences in mode of transmission between San Diego and California are similar to those with the nation, but are less pronounced.

Pediatric cases among boys include 5 with HIV transmission due to hemophilia, 1 due to a transfusion/transplant, and 12 due to maternal transmission. All of the 13 female pediatric cases were due to maternal transmission. Maternal transmission in pediatric cases is similar by gender after accounting for hemophilia, a sex-linked disorder.

When examining racial/ethnic group and mode of transmission for males, a greater proportion of white, Hispanic and Asian/Pacific Islander HIV cases fall into the MSM category than black or Native American (*Table 19*). Although the most frequent mode of transmission among women of all racial/ethnic groups is heterosexual, white women and black women have a greater proportion of cases due to IDU transmission than Hispanic, Asian/Pacific Islander or Native American women (*Table 20*).

4.0 Mortality Status

Of the 4647 cases of HIV reported through 12/31/04, 94 individuals have died. The deceased did not have an AIDS diagnosis and the cause of death may be unrelated to their HIV disease. Most of the deceased were be-

TABLE 19: ADULT/ADOLESCENT MALE HIV CASES BY MODE OF TRANSMISSION AND RACIAL/ETHNIC GROUP, SAN DIEGO COUNTY

Mode of Transmission	Racial / Ethnic Group										All Racial / Ethnic Groups
	White		Black		Hispanic		Asian/PI		Native American		
	No.	%	No.	%	No.	%	No.	%	No.	%	
MSM	2178	82%	315	64%	729	84%	70	82%	23	66%	3315
IDU	100	4%	48	10%	29	3%	1	1%	4	11%	182
MSM +IDU	232	9%	34	7%	37	4%	5	6%	4	11%	312
Heterosexual	78	3%	56	11%	32	4%	3	4%	2	6%	171
Not Specified / Other	80	3%	40	8%	44	5%	6	7%	2	6%	172
Number in Group	2668	100%	493	100%	871	100%	85	100%	35	100%	4152

Note: Percentages may not add up to 100 due to rounding.

TABLE 20: ADULT/ADOLESCENT FEMALE HIV CASES BY MODE OF TRANSMISSION AND RACIAL/ETHNIC GROUP, SAN DIEGO COUNTY

Mode of Transmission	Racial / Ethnic Group										All Racial / Ethnic Groups
	White		Black		Hispanic		Asian/PI		Native American		
	No.	%	No.	%	No.	%	No.	%	No.	%	
IDU	60	32%	24	21%	10	7%	1	5%	0	0%	95
Heterosexual	111	59%	71	62%	103	76%	17	85%	4	80%	306
Not Specified/ Other	18	10%	19	17%	23	17%	2	10%	1	20%	63
Number in Group	189	100%	114	100%	136	100%	20	100%	5	100%	464

Note: Percentages may not add up to 100 due to rounding.

tween the ages of 30-49 (60%) when they died (Table 21).

5.0 HIV Summary

HIV reporting began statewide on July 1, 2002; 4647 cases have been reported through December 31, 2004. About 90% of HIV cases are male and 10% are female. By racial/ethnic group, 62% of HIV cases are white, 22% Hispanic, 13% black and 3% other (Asian/Pacific Islander, or Native American). Most HIV cases are 30-39 years old, with about 1% being pediatric cases. By HHSA region within the County, most cases were living in the Central Region at the time of diagnosis. The majority of adult HIV cases have a MSM mode of transmission (72%), followed by heterosexual transmission (10%).

Trends cannot be examined at this time because the system is new and has not yet been evaluated. The demographic distribution of HIV cases by racial/ethnic group are very similar to cumulative AIDS cases, but different from recent AIDS cases. HIV reports collected to date may represent the population of HIV infected individuals seeking testing and care, or it may reflect the HIV positive clients of facilities that have more rapidly adopted the new HIV reporting system.

TABLE 21: AGE AT DEATH OF HIV CASES, SAN DIEGO COUNTY

Age Group in Years	Frequency	Percent	Cumulative Percent
Less than 20	1	1%	1%
20-29	16	17%	18%
30-39	32	34%	52%
40-49	24	26%	78%
50+	21	22%	100%
Total	94	100%	

IV. HIV and Local Data

Given the newness of the HIV reporting system, several other sources of data can provide information about the basic demographics of the HIV-positive community. Each source has limitations. For example, most of the data sources described here do not contain an identifier, such as a name or social security number. The system is designed to protect confidentiality and thus may contain duplicate records.

Anonymous HIV Counseling and Testing

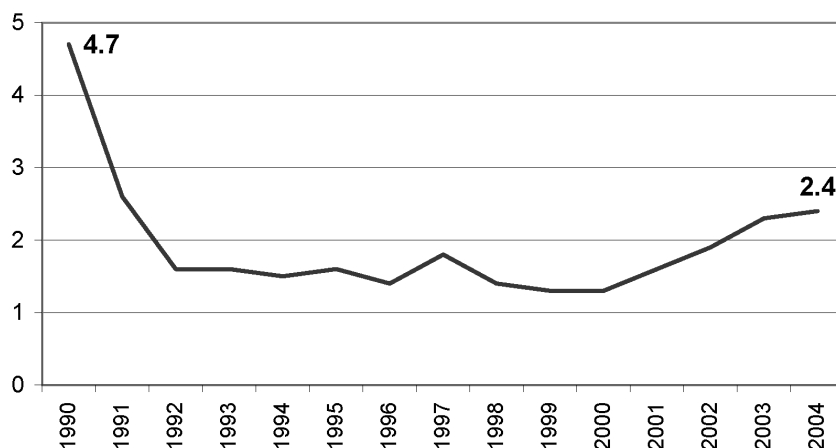
Local HIV counseling and testing data (HCT), most of which is conducted by the California Department of Health Services through contracts with the County of San Diego, can give us some information about those aged 12 and older who voluntarily seek HIV testing. In the last five years, the County has provided between 12,000 and 18,000 counseling and testing services each year, with fewer tests in recent years. These tests have been provided at no cost, either anonymously (no name is given) or confidentially (a name is given). At the inception of the program in 1985, when the data did not distinguish between anonymous and confidential tests, the rate of HIV infection among the testers was 18.6%, decreasing sharply to 1.1% by 1992.

One limitation of the HCT data is that each case may not be unique as some individuals may test repeatedly within a year. Therefore, when discussing this data we refer to 'testers' not individuals - and it is assumed that some of the 'testers' are the same person. Also, those who voluntarily seek testing probably differ in important ways from those who don't. HIV tests performed at private clinics or hospitals are not included in this database. Analysis of HCT data in this report has been limited to anonymous tests since it is likely to be more representative of those who seek publicly-funded HIV testing. Most confidential tests are offered at STD (sexually transmitted disease) clinics in which the client comes in for an STD other than HIV. Thus, testers at confidential sites don't come in specifically for an HIV test and many choose not to test. Like the trend among all tests, the HIV infection rate among anonymous tests declined between 1990 and 1992, with a recent increase from 1.3% in 2000 to 2.4% in 2004 (Figure 15). Data entry for 2004 was not yet completed as of this writing and should be considered preliminary.

Beginning in September 2003, the HCT program began offering the rapid HIV (OraQuick) antibody test as a pilot site for the State Office of AIDS. The HIV rapid test result is available in approximately 20 minutes

FIGURE 15:

RATE PER 100 TESTING HIV+,
ANONYMOUS HCT,
SAN DIEGO COUNTY,
1990-2004



with either a negative or preliminary positive result. With a conventional serum test, clients must return after one week for results. Unless the result is preliminary positive, clients who choose a rapid HIV test do not need to return for results. The test has been very popular and by 2004 rapid tests accounted for more than a third of all anonymous tests. Not only are the rapid tests convenient for clients, but they also increase the likelihood that the client will receive his or her test result. Since the rapid test counseling session incorporates the risk assessment and the disclosure counseling into one visit to the test site, fewer rapid tests can be completed in the same time period when compared to conventional serum tests. This combined with the closure of selected low yielding testing sites has resulted in a significant decrease in the number of tests in 2004 (from 9265 in 2003 to 6653 in 2004).

The growing awareness of the availability of rapid testing may have an effect on the demographics of the client population. In 2004, more high risk clients (defined by specific behaviors- see *Appendix 10*) tested compared to recent years. Although the rapid test has decreased the number of tests, it has increased the number of clients who receive their results and it may be more attractive to high risk clients.

Seroprevalence

Seroprevalence data may be gathered from studies or institutions that have access to populations of particular interest. After tests are conducted for purposes of the original study or institution, samples are stripped of all identifying information and residual serum is tested for HIV. Seroprevalence data has a number of limitations. Some seroprevalence studies examine data in populations at higher risk for HIV, such as an STD (sexually transmitted disease) clinic, while other seroprevalence populations are likely to have lower risk. For example, blood and plasma centers employ a protocol intended to screen out indi-

viduals thought to be at high risk for HIV. All of the participants in these programs are self-selected and are likely to be different from the population as a whole. Much of this data is not currently available at the county level by gender, racial/ethnic group, or age.

1.0 HIV Data and Demographics

While mandatory reporting has expanded what we know about HIV infected individuals locally, the picture is not entirely clear and thus other data are explored. Unfortunately, these sources do not always contain information about certain subgroups such as women, youth, children and some racial/ethnic groups. Even when such demographic data are collected, the numbers are often small. Small numbers make it difficult to distinguish between random variation and real differences between groups or over time. Also, small numbers can mean some groups may not be represented in the data at all. This is especially true for some racial/ethnic groups, age groups, and transgender populations.

Demographic data is a reflection of the collection categories, methods and tools used for capture and these tend to vary. Some demographic elements are captured through self-report while others may be assessed by a health care provider or counselor. For example, individuals are usually asked for date of birth (or age) but gender or race may be assessed and never asked.

2.0 Gender

Anonymous HIV Counseling and Testing

The majority of individuals seeking anonymous HIV counseling and testing services in San Diego County are men: about 74% male and 26% female in the year 2004. Men test positive at a much higher rate than women (2.9% versus 1.0% in 2004). Up until 2001,

the rate for men appeared to be decreasing (Figure 16). In general, men coming in for services are less racially diverse and older than women in any particular year. Compared to the year 2000, a smaller percentage of testers were black and a slightly greater percentage were white or Hispanic in 2004. Proportions of testers by age remained about the same between 2000 and 2004.

Of all the men coming in for anonymous HIV testing services, 84% had tested at least once before according to year 2004 data. In year 2004, 159 anonymous tests were confirmed HIV positive; 143 (90%) of these were men. Most of these positive tests were among men who had tested at least one other time. Of the repeat male testers, 3.1% were HIV infected, while 2.0% of the first-time male testers were positive.

Like men, the majority of female testers were repeat testers: 75% of women in 2004 had tested at least once before. Of the 159 HIV positive tests in 2002, 16 were women (10%). Rates for first time and repeat tests to females could not be calculated due to small numbers.

In recent years the number of pregnant women testing (self-reported) has decreased from 68 in 2000 to 21 in 2004. These num-

bers are too small to reliably examine by race or age. Between 1995 and 2004, only 2 pregnant women have tested positive for HIV. Also, in that same time period, fewer pregnant testers are first-time testers. In 1995, 55% of the pregnant women were first-time testers, but in 2004 only 19% were first-time testers.

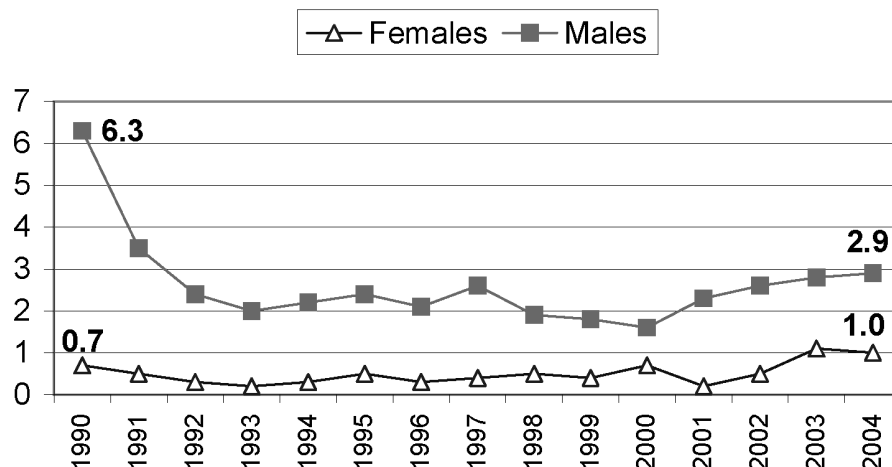
Seroprevalence

The California Department of Health Service's Survey of Childbearing Women (SCBW) began in 1988, was discontinued in 1996, and then replicated in 1998. During those years, unlinked testing was conducted on blood samples taken from hospital live births for the third quarter of each year capturing between 9,000 and 12,000 births per year in San Diego County. The rate of HIV seropositivity in the county ranged from 0.3 to 0.9 per 1,000 births (or .03% to .09%), about the same rate seen at the state level. For the county, this rate translates to between 4 and 11 HIV infected mothers, numbers too small to further analyze by racial/ethnic group or age.

A survey of adults attending STD clinics was conducted at 12 California health departments, including San Diego County, from 1989 through 2004. To be included, a client must be visiting for a STD (other than HIV) that requires a blood sample. Eligible clients were consecutively sampled during one month,

FIGURE 16:

RATE PER 100 TESTING HIV+
BY GENDER, ANONYMOUS HCT,
SAN DIEGO COUNTY,
1990-2004



up to 500 samples. Samples were stripped of identifiers and tested for HIV to examine seroprevalence among a high-risk group attending an STD clinic.

The seroprevalence for women attending STD clinics in San Diego County during 2004 was 0.9% (1 HIV infected woman out of 112 tested), but over time it has ranged from no positives to 0.9%. Seroprevalence for men in 2004 was 5.3% (21 men out of 399 tested), with a range of 3.0% to 10.6% over time. From 1990 to 2003, the trend had been an increase for men, with a decrease in 2004 (Figure 17). The difference between the 3.0% in 1996 for men and the 10.6% in 2003 is statistically significant ($p < .05$).

Blood and plasma donation data does not consistently include gender at the county level. The number that are HIV infected is very small: 1 out of 58,765 (.002%) units of blood tested in the first half of 2003, and 1 out of 75,681 (.001%) units of plasma tested in the last half of 2002. Military applicant screening does include data on gender but the numbers are too small for analysis. In year 2003, 3,682 civilians applied for military service in San Diego and were screened for HIV. Of that number 2 persons tested positive for HIV, resulting in a prevalence rate of .05% overall. Job Corps also tests applicants for

HIV, however, there are concerns about the quality of the data for recent years so it is not included here.

2.1 Racial/Ethnic Group

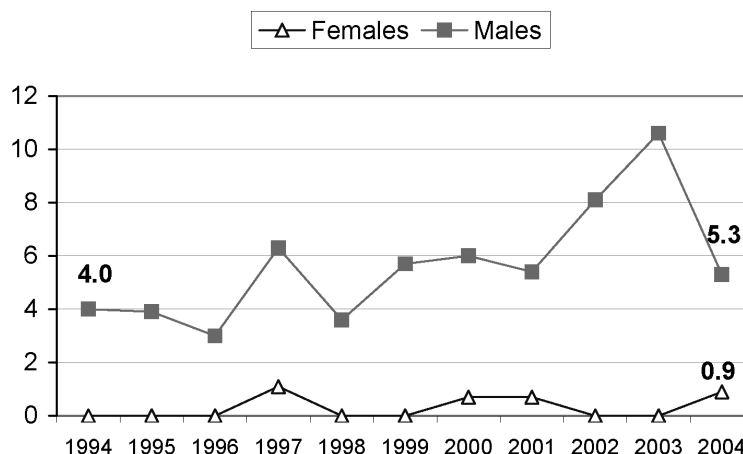
Anonymous HIV Counseling and Testing

Through the last half of 1997, clients of HIV counseling and testing services had 6 mutually exclusive racial/ethnic categories to choose from: American Indian/Alaskan Native, Asian/Pacific Islander, black, Hispanic, white, and other. Beginning in fiscal year 97/98, clients had the same categories but could choose two different racial/ethnic groups if they desired. Since then, between 2% and 3% of testers have chosen more than one racial/ethnic group. For purposes of analysis, only the first racial/ethnic group chosen is used to assign race/ethnicity. Whites constituted the largest proportion of testers, about 51% in 2003. In recent years there have been proportionately more tests by persons of color each year; however, in 2004 the proportion of white testers increased.

In 2004, the largest proportion of positive tests were among Hispanic testers (48%) compared to 34% for whites and 9% for blacks. Up until 2001, the largest proportion of positive tests had always been among whites and

FIGURE 17:

HIV-1 SEROPREVALENCE BY GENDER IN A SAMPLE OF STD CLINIC ATTENDEES, RATE PER 100 TESTING HIV+, SAN DIEGO COUNTY, 1994-2004



this was also the case in 2002, when whites accounted for 50% of positive tests, Hispanics 31%, blacks 13% and Asian/PI 4%. The division of the relatively small number of HIV positive tests (159 in 2004) by racial/ethnic group may account for the year-to-year variation.

Simple proportions of the number of positive tests from each subgroup (i.e., Hispanics accounting for 48% of positive tests) do not take into account the size of the specific group coming in for testing, and therefore do not allow for direct comparisons between subgroups. Rates do take into consideration the size of the subpopulations, providing a measure of the extent of the positive tests within subgroups (see *Appendix 4* for more information about rates). Blacks and Hispanics historically have the highest rates; 1.9% and 4.2% respectively in 2004 (*Figure 18*). Hispanics not only had the highest rate in 2004 at 4.2%, it was statistically different from rates for other racial/ethnic groups ($p < .05$). In 2002, rates for whites increased significantly ($p < .05$) from 1.2% to 2.0%, with a decrease to 1.6% in 2004. Rates for Native American/Alaskan Natives generally cannot be calculated due to fewer than 5 HIV positive tests per year.

2.2 Age

Anonymous HIV Counseling and Testing

Since 2000, the distribution of testers by age group has changed slightly. In general, more testers age 50+ are testing, slightly more of those age 25-34, and fewer of those under age 20. Although those age 12 and up may test at HIV Counseling and Testing sites, only about 4% of testers are under 20, and rarely are there enough HIV positive tests (5 or more) in that age group to calculate a rate.

Historically, the 25-34 age group has had the highest HIV infection rates, with the next highest rate in 35-49 year olds. Rates have increased for all age groups (not including the under 20 age group) since the year 2000, with statistically significant ($p < .05$) increases among the 25-34 and 35-49 year olds (see *Figure 19*). In 2004, the 35-44 age group had the highest HIV infection rate at 3.0%, with the 25-34 age group close behind at 2.9%.

2.3 Youth

Anonymous HIV Counseling and Testing

Each year 1200-3000 youth aged 12-24 present for anonymous HIV testing, with fewer youth testing in 2004 than previous years. Of those aged 12-24 who tested in 2004, about

FIGURE 18:

**RATE PER 100 TESTING HIV+
BY RACIAL/ETHNIC GROUP,
ANONYMOUS HCT,
SAN DIEGO COUNTY,
1999-2004**

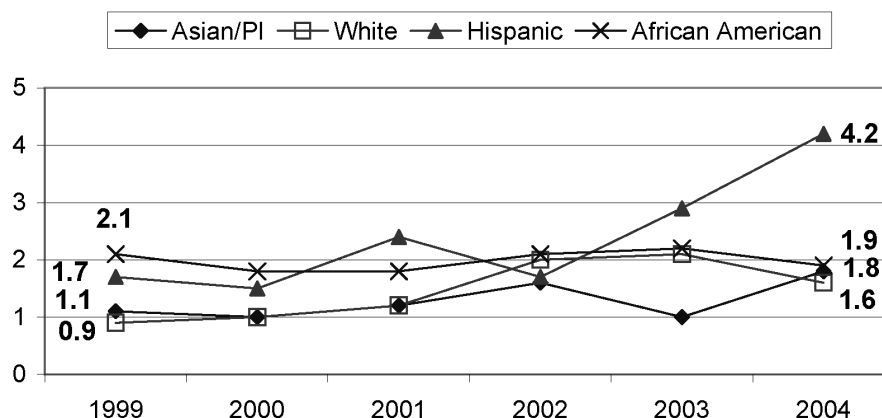
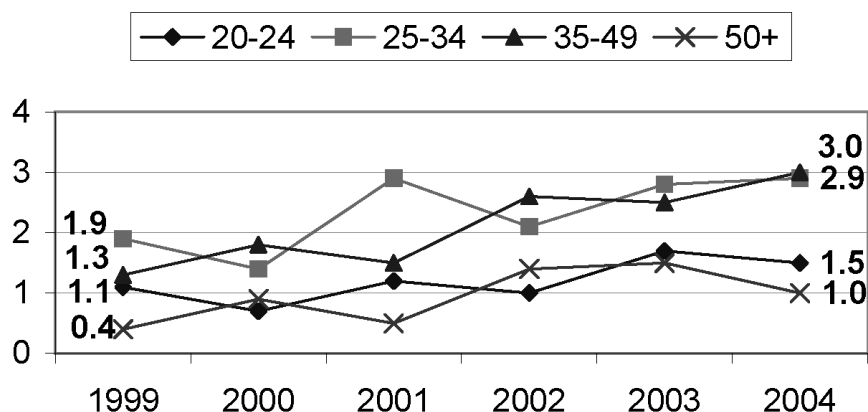


FIGURE 19:

RATE PER 100 TESTING HIV+ BY
AGE GROUP, ANONYMOUS HCT,
SAN DIEGO COUNTY,
1999-2004



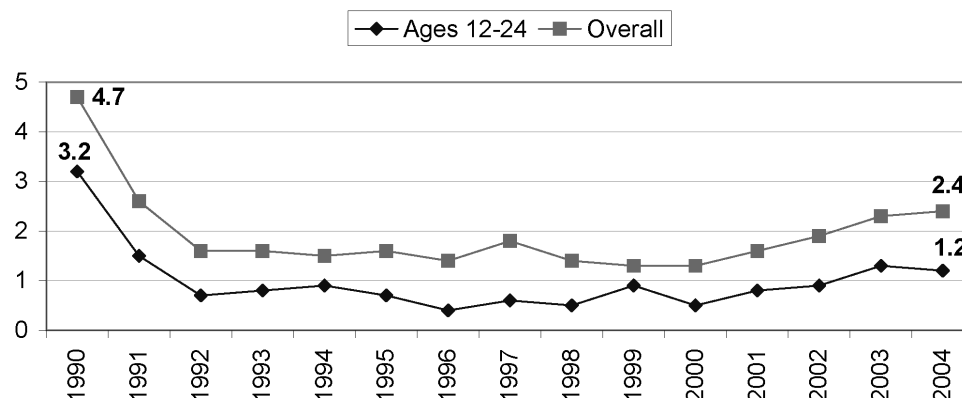
66% were male and 34% were female. This appears to be a gradual change from 1997 when the majority of youth testers were female. When compared by racial/ethnic group, more Hispanics and fewer whites seek HIV testing than those age 25 and older.

The rate of HIV infection in testers 12-24 years of age is much lower than the overall rate, about 1.2% or 14 HIV positive tests out of 1200 in 2004. Since 1990, the percent of youth testers who are HIV infected has fluctuated from a high of 3.2% to a low of 0.4% (Figure 20). This is statistically different, but fluctuations in the rate since 1992 are a result of small numbers and random variation rather than actual differences between years. Similarly, the small number of youth testing positive each year precludes further analysis by racial/ethnic group.

Like adults who test, youth are asked about risk behaviors for assignment to a risk group. For more information on this process, see section 2.5 Risk Groups or Appendix 10. In previous years, the vast majority of youth seeking HIV testing fell into the Multiple Partners risk group, although few in this risk group test positive for HIV (2 in 2004). However in 2004, the most frequent risk group was MSM (7 HIV positive in 2004) followed by Multiple Partners, and No Reported Risk (2 HIV positives each in 2004). Prior to 2004, MSM was either the 3rd or 4th most common risk group seeking testing among youth, and had the largest share of HIV positives (7 of the 14 positives). With that in mind, the rate of HIV infection for MSM youth in 2004 was 2.0%, a decrease from 3.0% in 2003. In 2004, Unknown (client refuses to discuss behaviors) was the 4th most frequent risk group, Bisexual

FIGURE 20:

RATE PER 100 TESTING
HIV+, AGES 12-24,
ANONYMOUS HCT,
SAN DIEGO COUNTY,
1999-2004



5th and IDU 6th. The number of youth who are first time testers decreased from 51% in 2003 to 37% in 2004.

2.4 Place of Residence

Anonymous HIV Counseling and Testing

Using zip code of residence at the time of testing, rates of HIV infection can be examined for the six HHSA (Health and Human Services Agency) geographic regions: North Coastal, North Inland, North Central, Central, East and South (see *Appendix 6* for more information about the regions). HCT data clearly show that the largest share of clients live in the Central Region, 47% in 2004. The Central Region also shows the highest HIV infection rate as well as the largest share of HIV positive tests through 2002 (*Figure 21*). Notably, since 2003 the South Region has had the highest rate (4.5% in 2004), although the Central Region maintained the largest share of HIV positive tests (47%). In recent years, North Inland has had so few HIV positives tests that a rate cannot be calculated; however in 2004 it had the 2nd highest rate, 4.2%. The increase in the rate for North Inland is not statistically significant; however, the increase for the South region from 2.2% in 2002 to 4.5% in 2004 was statistically significant ($p<.05$). Geographic data may reflect a higher

risk by region, or it may be the result of testing locations, outreach programs or access to healthcare. Some regions had fewer than 5 HIV positive tests; therefore, no rates were calculated.

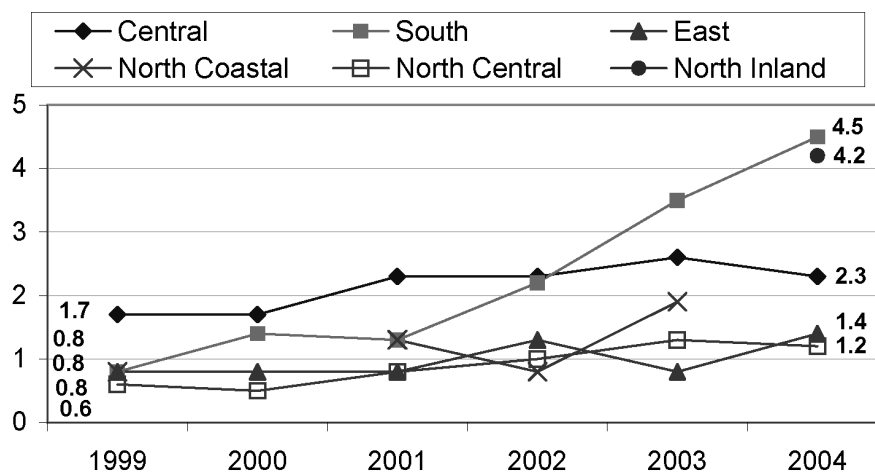
2.5 Risk Groups

Anonymous HIV Counseling and Testing

When a client comes in for HIV testing, a counselor asks about specific risk behaviors. The State Office of AIDS has calculated a hierarchy of risk based on those behaviors and on the risk of HIV transmission. This hierarchy is used in a computer program to automatically assign a client to one of fourteen mutually exclusive risk categories. The 14 risk groups are: Men who have Sex with Men (MSM), Bisexual, Intravenous Drug Users (IDU), Gay/Bi IDU (men only), HIV+ Partner, Partner Bisexual (women only), IDU Partner, Sex for Drugs/Money, Blood Transfusion prior to 1985, Multiple Partners, Occupational Exposure, Child at Risk (maternal transmission), No Reported Risk, and Unknown. Heterosexual risk categories include IDU, HIV+ Partner, IDU Partner, Sex for Drugs/Money, Multiple Partners and Partners with Multiple Partners. For a more in-depth description of this hierarchy, please see *Appendix 10*.

FIGURE 21:

RATE PER 100 TESTING HIV+ BY
HHSA REGION, ANONYMOUS HCT,
SAN DIEGO COUNTY,
1999-2004



During 2004, the largest share of testers was MSM (35%). This is a change from recent years when the largest share was Multiple Partners (30% in 2003; 17% in 2004). Partners with Multiple Partners is no longer calculated as a risk group. A few of the notable changes since 2000 include an increase in the number and proportion of testers who fall into the MSM risk group, and No Reported Risk, and a large decrease in the number and proportion in IDU and Gay/Bi IDU. The distribution of testers by other risk groups has stayed relatively stable over the last 4 years.

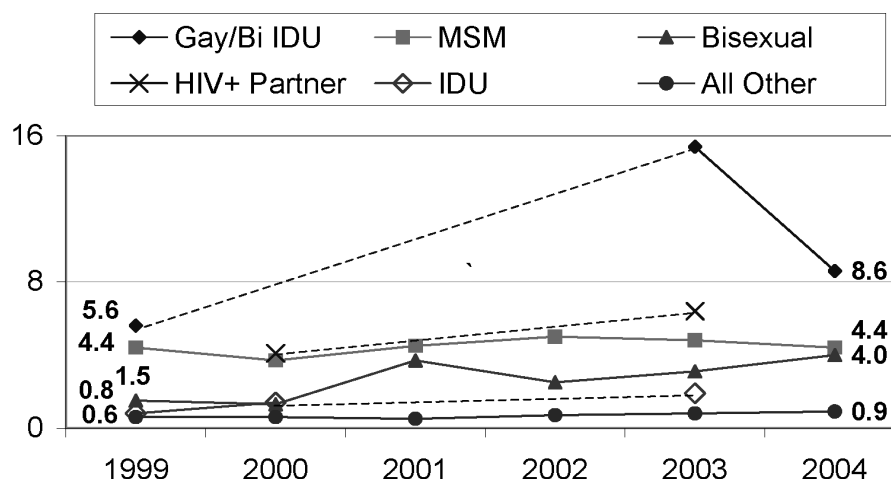
Of the HIV positive tests in 2004, 87% fell into one of 4 groups: MSM (64%), Bisexual (9%), Multiple Partners (5%), and No Reported Risk (9%). The distribution of HIV positive tests has changed since the year 2000. MSM has the largest share and an increasing share of HIV positive tests. The number of HIV positive tests in 'Multiple Partners' increased through 2003, decreasing in 2004. In 2001 the counselor information form changed and clients were asked if they had injected nonprescription drugs since their last test or in the last two years rather than if they had ever injected nonprescription drugs. Thus, if a client with a history of IDU reported no recent IV drug use, and had no other identifiable risks, he or she would be categorized in No Reported Risk (this would also affect Gay/Bi IDU). The objective of the change was to

identify recent risks related to the presumed recent HIV infection. These changes to the form have resulted in a decrease in the number and proportion of HIV positive tests each year since 2001 for the risk groups IDU and Gay/Bi IDU, while the number and proportion has increased for No Reported Risk.

When rates can be calculated (5 or more positives), the highest rate of HIV infection has been among Gay/Bi IDU in 1999, 2003 and 2004 (5.6%, 15.4% and 8.6% respectively) (Figure 22). Rates for Gay/Bi IDU fluctuate greatly between years due to small numbers, and thus, the increase in rates for Gay/Bi IDU since 1999 have not been statistically significant. MSM and Bisexual have the next highest rates, 4.4% and 4.0% respectively in 2004. Rates increased slightly for MSM in both 2001 and 2002 (4.5%, 5.0%) decreasing to 4.4% in 2004 while rates for Bisexual fluctuated up and down over the last several years (no statistically significant changes). Like rates for Gay/Bi IDU, rates for HIV+ Partner are based on small numbers, resulting in considerable fluctuation and years where a rate cannot be calculated. As mentioned previously, IDU has had a decrease in number testing HIV positive as well as a corresponding drop in the number coming in for HIV testing and counseling services, likely due to changes in the HCT form in 2001. The other groups

FIGURE 22:
RATE PER 100 TESTING HIV+ BY RISK GROUP, ANONYMOUS HCT, SAN DIEGO COUNTY, 1999-2004

Note: Dotted lines are used when too few events exist to calculate a rate for a year(s).



have remained fairly stable or have such small numbers that trends aren't clear.

Among men seeking anonymous HIV testing services in 2004, 79% fell into one of three risk groups: MSM (48%), Multiple Partners (15%), and No Reported Risk (16%). For men, the highest rate of HIV infection was among Gay/Bi IDU, Bisexual and MSM (8.6%, 4.7% and 4.4% respectively). Other risk groups for men had rates of infection at or below the average for 2004 (2.4%) or had too few positives to calculate a rate.

During 2004, 40% of women seeking testing had No Reported Risk, and 23% were categorized as having Multiple Partners. Between 1997 and 2000, Partners with Multiple Partners constituted the second largest proportion of female testers. When the category Partners with Multiple Partners was dropped in 2001, females who would have been in that category were reassigned to No Reported Risk. Of women seeking testing in 2004, 5% were IDU and 4% reported an IDU Partner. Bisexual women represented 5% of those seeking testing, and about 2% reported having a bisexual partner in 2004. Women had too few HIV positive tests to calculate rates by risk group.

The percent of all tests attributed to No Reportable Risk increased dramatically in 2001 and has remained high since that time. Re-

sponses to counselor's questions are voluntary and those who opt not to divulge risk behavior information are categorized with those who do not appear to have a traditional high-risk behavior. Recent changes in the form have had an impact on the increase in No Reported Risk. Partner with Multiple Partners, no longer one of the calculated risk factors, is now reclassified into the No Reported Risk category, as would IDU with no recent injection drug use.

3.0 MSM Group, Anonymous Counseling and Testing

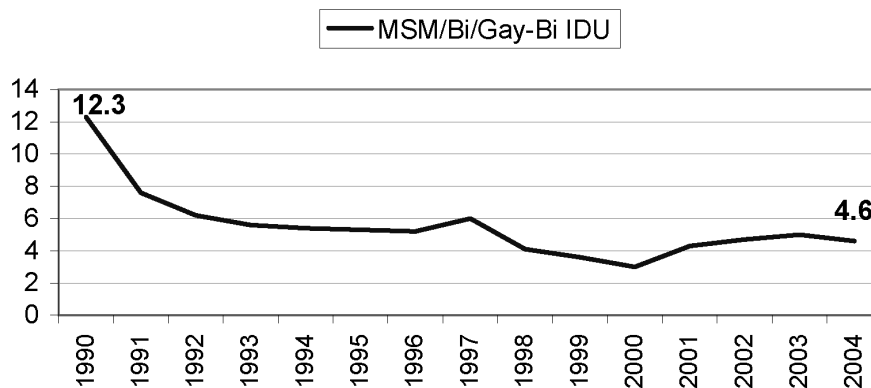
High Risk Groups

Certain risk groups have historically had much higher rates of HIV infection than others in San Diego County. Three HCT risk groups, having in common both the highest rates and the behavior of men who have had sex with men, were combined to form the MSM group: Gay/Bi IDU, MSM, and Bisexual men. MSM made up the largest proportion of testers in the MSM group (85%), with Bisexual next (11%), and Gay/Bi IDU (4%). In 2004, the MSM group had 2656 tests, 121 (4.6%) of which were HIV positive.

Overall, rates of HIV infection have fallen for the MSM group from 12.3% in 1990 to 3.3% in 2000 (*Figure 23*). Of concern is the

FIGURE 23:

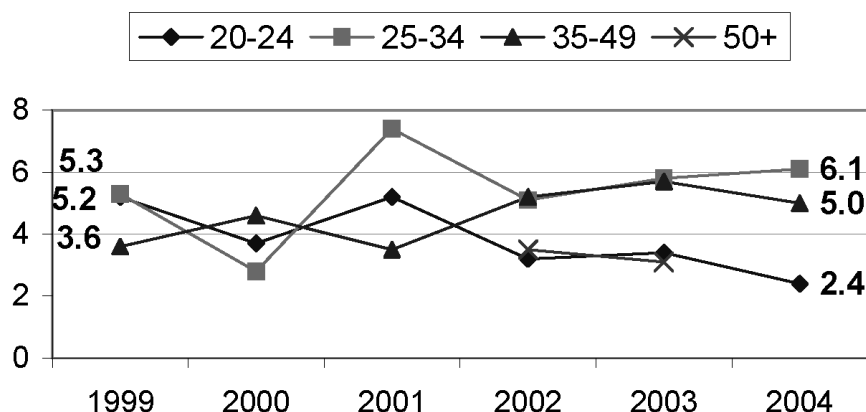
RATE PER 100 TESTING HIV+,
MSM GROUP*, ANONYMOUS HCT,
SAN DIEGO COUNTY,
1990-2004



*MSM Group= MSM, Gay/Bi IDU and Bisexual men.

FIGURE 24:

RATE PER 100 TESTING HIV+,
MSM GROUP BY AGE GROUP,
ANONYMOUS HCT,
SAN DIEGO COUNTY,
1999-2004



*MSM Group= MSM, Gay/Bi IDU
and Bisexual men.

statistically significant ($p < .05$) increase in the HIV infection rate from 3.3% in 2000 to 5.0% in 2003, with a slight decrease (not statistically significant) to 4.6% in 2004.

Age Group

When a rate could be calculated by age for the MSM group in 2004, the age groups with the highest HIV infection rates are 25-34 and 35-49, 6.1% and 5.0% respectively (Figure 24). Youth under the age of 15 and teens aged 15-19 had no positive tests during this time period. The age group 50+ had 3 HIV positive tests in 2004, too few to calculate a rate.

Racial/Ethnic Group

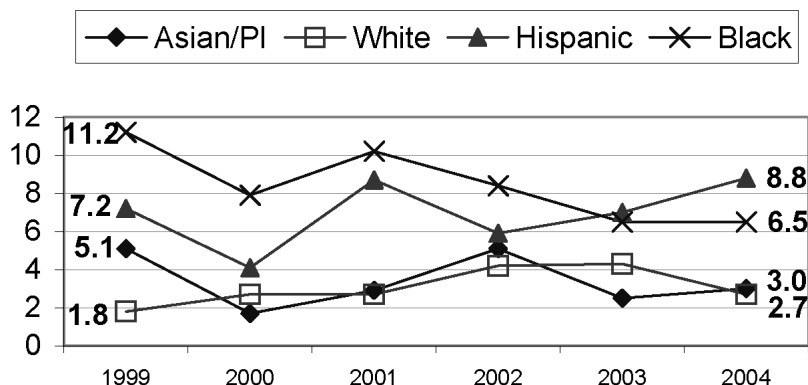
Between 2000 and 2002, blacks in the MSM group had the highest HIV infection rate until 2003 when Hispanics had the highest rate (Figure 25). Again in 2004, Hispanics had the highest rate at 8.8%, with blacks following at 6.5%. Asian/Pacific Islanders had a rate of 3.0% and whites 2.7% in 2004. Native American/Alaskan Natives had too few HIV positive tests to calculate a rate in 2004.

Place of Residence

Since 2002 the South Region of San Diego County has had the highest HIV infection rates, although the increase in the rate for South Region has not been statistically signifi-

FIGURE 25:

RATE PER 100 TESTING HIV+,
MSM GROUP* BY RACIAL/ETHNIC GROUP,
ANONYMOUS HCT,
SAN DIEGO COUNTY,
1999-2004



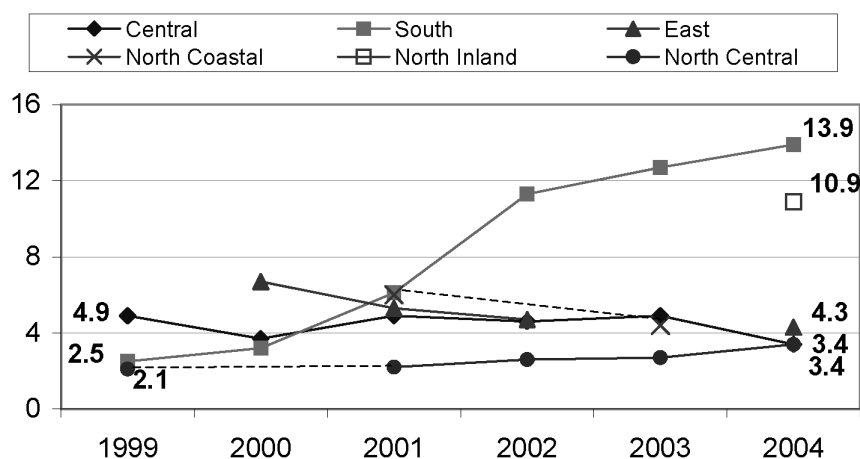
*MSM Group= MSM, Gay/Bi IDU
and Bisexual men.

FIGURE 26:

**RATE PER 100 TESTING HIV+,
MSM GROUP* BY HHSA REGION,
ANONYMOUS HCT,
SAN DIEGO COUNTY,
1999-2004**

*MSM Group= MSM, Gay/Bi IDU
and Bisexual men.

Note: Dotted lines are used when
too few events exist to calculate a
rate for a year(s).



cant (Figure 26). Since about 46% of HIV positive tests come from testers who reside in the Central Region, numbers are small in the remaining regions, resulting in years in which rates cannot be calculated or unstable rates. In 2004, the rate for the South Region was 13.9% followed by North Inland at 10.9%, East at 4.3%, North Central and Central at 3.4%, and North Coastal at 3.2%.

4.0 Young MSM, Anonymous HIV Counseling and Testing

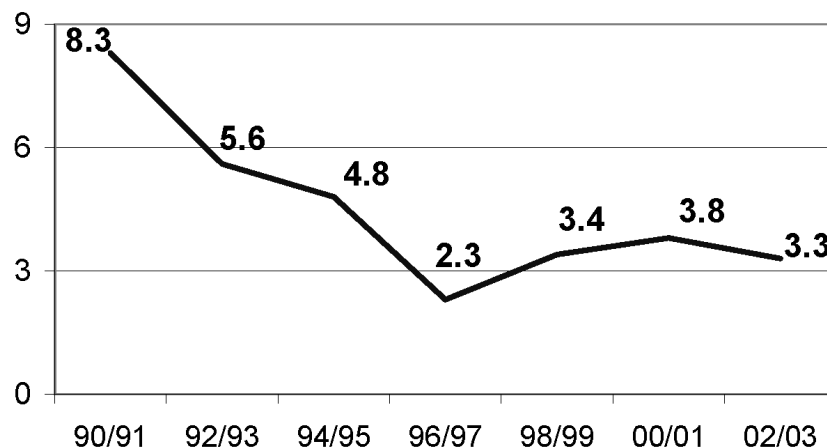
Increases in HIV infection rates for young MSM have been noted recently in some large metropolitan areas of the U.S. Each year in

San Diego, approximately 400 young MSM (including Gay/Bi IDU and bisexual) ages 12-24 test through HCT, of which about 8-20 are HIV positive. Because of the small numbers, rates are calculated in two-year averages.

The trend for young MSM in San Diego County who tested is a decline from 1990/1991 to 1996/1997, with a slight increase since then (Figure 27). Although two-year averages were used to calculate rates, the number of positives are small, resulting in considerable annual variation in rate. The change in rate from 2.3% in 1996/1997 to 3.8% in 2000/2001 is not statistically significant ($p > .05$).

FIGURE 27:

**RATE PER 100 TESTING HIV+,
MSM AGES 12-24, ANONYMOUS HCT,
TWO-YEAR AVERAGES,
SAN DIEGO COUNTY,
1990/91-2002/03**



5.0 HIV and Local Data Summary

HCT data in San Diego County suggest a decline in HIV infection rates among diverse groups of voluntary testers from 1985 to 1992, fairly level rates to 2000 and an increase in 2001-2004. While the slight overall increase in HIV infection rate from 1.3% in 2000 to 1.6% in 2001 was not statistically significant, the increase from 1.3% to 1.9% in 2002 was statistically significant ($p < .05$). Although there have been no statistically significant changes since 2002, slight increases were seen in rates for 2003 and 2004: 2.3% and 2.4% respectively.

Significant increases in HIV infection rates were seen for some subgroups in the last several years. For example in 2001, the change in rates for men, from 1.6% in 2000 to 2.3% in 2001 was statistically significant ($p < .05$). Women, on the other hand, showed a statistically significant decline in their HIV infection rate, from 0.7% in 2000 to 0.2% in 2001 and then a statistically significant increase from 0.5% in 2002 to 1.1% in 2003 ($p < .05$). Rates did not change significantly by gender between 2003 and 2004.

With the exception of 2002, black and Hispanic testers have higher HIV infection rates than other racial/ethnic groups although the gap has decreased over time. Generally, these are statistically significant differences. From 2001 to 2002, rates for whites increased (statistically significant; $p < .05$) from 1.2% to 2.0%, surpassing the rate for Hispanics, then decreasing to 1.6% in 2004. Between 2002 and 2004 rates for Hispanics increased from 1.7% to 4.2%, and this was a statistically significant difference each year ($p < .05$).

Testers ages 25-34 have historically had the highest HIV infection rates, although in recent years the 35-49 age group has occasionally had higher rates. Since the year 2000, there has been an increase in the rates for all

age groups (not including those under 20); however, only the increases for the 25-34 and the 35-49 age groups reached statistical significance ($p < .05$).

HIV infection rates for other subgroups had numbers too small to detect significant differences. Youth ages 12-24 showed an increase from 0.5% in 2000 to 1.2% in their HIV infection rate and the rate of HIV infection for young MSM (ages 12-24) increased from 2.3% in 1996/1997 to 3.8% in 2000/2001 but these differences were not statistically significant. Similarly, although the rates increased for ages 50+ from 1999 to 2003, the differences were not statistically significant.

Until 2003, testers who reside in the Central Region of San Diego County had higher HIV infection rates than those from other regions. The rate for the South Region from 2002 through 2004, while not statistically significant, has increased in each of the last three years. The rate of HIV infection for the Central Region increased from 1.7% in 2000 to 2.3% in 2001 (statistically significant), and the rate has remained near the current rate, 2.3% in 2004, since that time.

Although Gay/Bi IDU had the highest HIV infection rate in 2003 and 2004, the numbers have been small and often a rate could not be calculated, thus the risk groups MSM and Bisexual usually have the highest calculable rates. The MSM group (MSM, Gay/Bi IDU and Bisexual men combined), has shown a decline in rates over time, until 2001. The increase in the HIV infection rate for the MSM group from 3.3% in 2000 to 5.0% in 2003 was statistically significant. In 2004, the rate decreased slightly for the MSM group to 4.6% (not statistically significant). Young MSM testers have shown an increase in HIV infection rates since 1997, yet small numbers result in no statistical difference in the rates over time.

HIV Data Sources:

San Diego County HIV Counseling and Testing Data, State of California, Department of Health Services, Office of AIDS

Epidemiology Profile and Projections of HIV/AIDS in San Diego County, 2002, County of San Diego, HHSA, Community Epidemiology

California HIV Counseling and Testing Annual Reports, State of California, Department of Health Services, Office of AIDS, HIV Prevention Research and Evaluation

California HIV Seroprevalence Annual Reports, State of California, Department of Health Services, Office of AIDS, HIV/AIDS Epidemiology Branch

Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention (Military and Job Corps data)

Results of HIV-1 and HIV-2 Testing in California Blood Banks and Plasma Centers, Semi-annual reports, State of California, Department of Health Services, Office of AIDS, HIV/AIDS Epidemiology Branch

V. Appendices

Appendix 1. Glossary

Acquired Immune Deficiency Syndrome (AIDS) - End stage HIV disease where the immunological system is severely disabled by HIV, resulting in an increased susceptibility to opportunistic infections and rare cancers. To be considered an AIDS case, one must meet the CDC case definition (see *Appendix 3* for more information).

Adult/Adolescent Cases - AIDS cases who were at least 13 years of age at time of diagnosis.

Bisexual - HIV risk group used in HIV Counseling and Testing but not for AIDS data. Used to describe men and women who report having both a male and female partner. See *Appendix 10* for details.

Case Definition - A set of standard criteria for deciding whether a person has a particular disease or health-related condition. In the case of AIDS, the Centers for Disease Control lists specific conditions (opportunistic infection or a level of immunosuppression) a person must have in order to be classified as an AIDS case.

Case Fatality Rate - The number of deaths due to a disease within a specified time period divided by the number with that disease in the same time period, multiplied by 100.

Centers for Disease Control and Prevention (CDC) - The lead federal agency for protecting the health and safety of people - at home and abroad - providing credible information to enhance health decisions, and promoting health through strong partnerships.

Epidemic - The occurrence of an infectious disease through a community or region that is clearly in excess of what would be expected within that specific time and place.

Epidemiology - The study of factors associated with health and disease and their distribution in the population.

Health and Human Services Agency (HHSA) Regional Services Areas - Service areas defined by zip codes. See *Appendix 6* for a list of the zip codes for the 6 areas.

Heterosexual Transmission - Transmission of HIV via sexual contact sex with any member of the opposite sex. This category can be further analyzed to investigate other risks of the sexual partner, such as sex with an intravenous/injection drug user, bisexual male (for females only), person with hemophilia/coagulation disorder, transfusion/transplant recipient with documented HIV infection, or a person with AIDS or documented HIV infection.

Human Immunodeficiency Virus (HIV) - A retrovirus that destroys the immune system eventually causing AIDS.

Injection Drug User (IDU) - Someone who at some time has injected non-prescription drugs.

Incidence - The total number of new cases of a disease occurring within a specified period of time.

Incidence Rate - The number of cases of a disease per specified time period divided by the population at risk, often expressed per 100,000. Incidence rates are useful for comparison of selected factors to demonstrate the severity of the epidemic among individuals of different ages, gender and racial/ethnic group.

Maternal Transmission - The transmission of a disease from mother to child. HIV can be transmitted from mother to child in the womb, during delivery or during breastfeeding. Sometimes referred to as vertical or perinatal transmission.

Mode of Transmission - The way in which a disease was passed from one person to another. In describing HIV/AIDS cases, identifies how an individual may have been exposed to HIV, such as having injected drugs, or homosexual or heterosexual contact. (Also known as exposure categories)

Men having Sex with Men (MSM) - In AIDS case data, MSM is the mode of HIV transmission, men who have same sex contact (bisexual or homosexual). For HIV Counseling and Testing purposes, MSM are those men who only have sex with men and are not bisexual. See Appendix 10 for details.

Pediatric Cases - HIV or AIDS cases 12 years of age or less at time of diagnosis.

Prevalence - The number of all cases (new and old) of a disease occurring within a specified period of time.

Prevalence Rate - The number of all cases (new and old) of a disease occurring within a specified period of time divided by the population at risk, often expressed per 100,000. Prevalence rates are useful for comparison of selected factors to demonstrate the severity of the epidemic among individuals of different ages, gender and racial/ethnic group

Public Health Surveillance - An ongoing, systematic collection, analysis, and use of data regarding specific health conditions and diseases, in order to monitor these health problems, such as the Centers for Disease Control and Prevention surveillance system for AIDS cases.

Risk Group - Used in HIV Counseling and Testing to assign clients risk of HIV transmission based on their behavior. See Appendix 10 for detail.

Year of Diagnosis - The year in which an individual met the CDC case definition for HIV/AIDS.

Year of Report - The year in which an HIV/AIDS case is reported to the Department of Health Services.

Appendix 2. HIV/AIDS Reporting- Reliability and Limitations

Individuals with HIV or AIDS are required to be reported to the HHSA pursuant to California Code of Regulations, Health & Safety Statutes, Title 17, Section 2643.5 and 2500. Reports come from physicians, other health care providers, hospitals, and clinics via HIV/AIDS Case Report forms; individuals with AIDS are reported by name and those with HIV (not AIDS) are reported by a non-name code. A San Diego County case is an individual diagnosed with HIV or AIDS, while residing in San Diego County.

Active verification of cases and internal tests of the data increase the reliability of the data.

The HIV and AIDS case data used to generate reports may have several limitations as listed below:

1. ***Under-reporting of cases*** - The number of diagnosed HIV and AIDS cases for which notification to Community Epidemiology does not occur is called "under-reporting". Delays in reporting are graphically obvious in recent (2003 and 2004) years. It is likely that cases diagnosed in 2004 will continue to be reported in 2005.
2. ***Diagnosis date versus report date*** - Reporting delays impact the available data. Those cases diagnosed in 2004, for example, may not have been reported to the Health and Human Services Agency until 2005 or later. It is likely that cases diagnosed in 2004 will continue to be reported in 2005. See *Appendix 1, Glossary* for the definition of Year of Diagnosis and Year of Report.
3. ***Collection tools*** - While information on a variety of variables is collected, it is still limited. Data on an individual income or specific drug of choice is not collected, for example. The data collected is limited and reflects the quality of data submitted by the reporting facility.
4. ***Non-resident cases*** - Persons with HIV or AIDS diagnosed elsewhere and relocating to San Diego County after diagnosis, are not represented in data for the county. Persons receiving medical care or other services in San Diego County while residing outside the county, are also not reflected in this data.
5. ***Asian/Other Category*** - Available population estimates combines Asian/Pacific Islander and Native American racial/ethnic groups into one category: Asian/Other.
6. ***Confidentiality*** - Charts and graphics with small cell sizes (under 5) may not be described in detail where identification of persons may occur.
7. ***Changes in CDC Criteria for AIDS Case Definition*** - Since 1981, the CDC has changed the AIDS Case definition multiple times to include more diagnostic criteria. These changes in definition distort observed trends. The peak in AIDS cases is likely the result of the 1993 change in the case definition.
8. ***Limited Time Collecting Data***. HIV infection, without an AIDS defining condition, has only been reportable in California since July 2002. Because of the relatively short time it has been mandated to be reported and the different way it is required to be reported (non-name code), some facilities have not yet institutionalized HIV reporting. HIV data may be skewed to primarily represent the patients of those facilities that have been able to more easily adopt HIV reporting.

Appendix 3. Reporting HIV and AIDS Cases for Health Care Providers

Who is responsible for reporting HIV and AIDS cases?

HIV and AIDS are conditions listed in California's disease reporting regulations. (California Code of Regulations, Health & Safety Statutes, Title 17, Section 2643.5 and Section 2500). Every health care provider knowing of or in attendance on a case or suspected case of a HIV or AIDS is required to make a report.

When is HIV Reported?

Report a case when a patient has a test result indicative of HIV infection. This includes:

- Confirmed positive HIV antibody test
- Any viral load test
- P24 antigen test
- Viral isolation test

Providers should report an individual who newly tests positive for HIV as well as those the health care provider (ordering the test) has never reported and has no verification that the individual has already been reported with HIV. If an individual meets the case definition for AIDS, they are reported again.

To unduplicate reporting and provide a way to get missing information, health care providers are required to keep a log of patients that have been reported. Always report a case even if you think the patient may have been reported by another provider. This helps ensure complete case capture, which is critical for local prevention and treatment funding. Health care providers are required to complete a report within 7 days of learning of the HIV test.

When is AIDS Reported?

When an individual is diagnosed with one or more of the AIDS defining conditions listed

below, their care provider is required to report the case to the local health department within 7 days of the diagnosis: (For HIV infected individuals, definitive or presumptive)

- * CD4+ T-lymphocyte count $<200 \mu\text{L}/\text{mm}^3$ or $<14\%$ of total T-lymphocytes
- * Candidiasis of the bronchi, trachea, or lungs
- * Candidiasis, esophageal
- * Cervical cancer, invasive
- * Coccidioidomycosis, disseminated or extra-pulmonary
- * Cryptococcosis, extra-pulmonary
- * Cryptosporidiosis, chronic intestinal
- * Cytomegalovirus disease
- * Cytomegalovirus retinitis
- * Encephalopathy, HIV-related
- * Herpes simplex: chronic ulcers or bronchitis pneumonitis or esophagitis
- * Histoplasmosis, disseminated or extrapulmonary
- * Isosporiasis, chronic intestinal
- * Kaposi's Sarcoma
- * Lymphoma, Burkitt's
- * Lymphoma, immunoblastic
- * Lymphoma, primary in the brain
- * Mycobacterium avium complex or M kansasii, disseminated or extrapulmonary
- * Mycobacterium tuberculosis, any site
- * Pneumocystis carinii pneumonia
- * Pneumonia, recurrent
- * Progressive multifocal Leukoencephalopathy
- * Salmonella septicemia, recurrent
- * Toxoplasmosis of the brain
- * Wasting syndrome due to HIV

The pediatric AIDS case definition (HIV infected children 12 years of age and younger) includes all of the above mentioned indicator diseases with the exception of pulmonary Mycobacterium tuberculosis, cervical cancer and CD4+ T-lymphocyte counts $<200 \mu\text{L}/\text{mm}^3$ or $<14\%$ of total T-lymphocytes.

In addition, recurrent bacterial infections (at least two episodes within a two year period) and lymphoid interstitial pneumonia/

pulmonary lymphoid hyperplasia (LIP/PHL) are AIDS defining conditions for HIV infected children.

The original case definition of AIDS was established by the Centers for Disease Control (CDC) in 1981. Additional conditions and diseases were added in 1985, 1987 and 1993. All case definitions and revisions are published in the CDC's publication entitled 'Morbidity and Mortality Weekly Report' (MMWR).

What information is required to be reported?

Reports of HIV and AIDS cases to the local health department shall include, but are not limited to: racial/ethnic group, gender, date of birth, mode of transmission information, diagnosis and date of diagnosis and the name, address and phone number of the person or facility making the report.

In California, HIV infected individuals without a diagnosis of AIDS are required to be reported using a non-name code. The non-name code is composed of the Soundex (an alphanumeric representation of the last name generated by the laboratory), date of birth, gender, and last 4 digits of the social security number. As with other communicable diseases, HIV uses a dual reporting process in which both health care providers and laboratories report.

AIDS cases are reported with the same information as HIV but also include the name, address, telephone number, and full Social Security Number of the individual with AIDS.

Community Epidemiology is required by law to protect the privacy of any individual reported with AIDS.

How should a report be made?

Providers can submit a confidential case report form available from County of San

Diego, Health and Human Services Agency. Forms can be sent to:

Lyn Cardoza
Health and Human Services Agency
Community Epidemiology
P.O. Box 85222
San Diego, CA 92186-5222

Providers also have the option of reporting cases by phone. For a reporting kit or any additional information, call the Community Epidemiology Branch at (619) 515-6675.

Why is reporting necessary?

The law requires reporting of diagnosed HIV and AIDS cases. California's disease reporting regulations not only specify what, when, where and how to report cases, but also include descriptions of monetary penalties to be imposed for failure to comply with these laws.

Timely and accurate HIV/AIDS case reports provide this county with a better understanding of our local epidemic. Epidemiologists can monitor trends in populations being affected by HIV infection, project future numbers of AIDS cases and provide information to those responsible for planning for future health care needs and prevention activities.

Failure to report in a timely manner may have an impact on current and projected funding needs. Funding formulas using data which represents under-reporting of AIDS cases may translate into under funded programs and services for those with HIV infection.

A summary of legislation related to the case reporting, confidentiality, penalties and surveillance activities supported in the California Code of Regulations is available by calling the Community Epidemiology Branch at (619) 515-6675. For a copy of the regulations and more information on HIV/AIDS reporting go to: www.dhs.ca.gov/AIDS.

Appendix 4. Computing Rates, Rates by Racial/Ethnic Groups and Statistics.

Calculating a rate of AIDS is a better indication of the burden of disease for a given population than just looking at the raw numbers. Not all population sizes are the same so the same number of cases in different populations may not reflect the proportion of that population which experiences a given disease. A rate normalizes the number and allows populations with dissimilar sizes to be compared. Rates may be based on the population at large (for AIDS rates) or a subpopulation utilizing services (clients presenting for HIV Counseling and Testing for HCT rates) or individuals in a research study (STD seroprevalence study).

AIDS Rates

A rate is calculated by dividing the number of individuals with a disease/condition in a given time period in the by the population size. As is common for population-based rates, the proportion of AIDS cases in a given population is then multiplied by 100,000 to give the rate per 100,000. For example, in year 2001, there were 434 individuals diagnosed with AIDS. When the number of cases (434) is divided by the population size (2,868,873) and multiplied by 100,000, the result is:

$$(434/2,868,873)*100,000 = 15 \text{ AIDS cases per } 100,000 \text{ residents of San Diego County.}$$

Rates by racial/ethnic groups were computed by dividing the number of individuals with AIDS from a particular racial/ethnic group by the number of that same racial/ethnic group in the population at large (see Table 22). The following are considerations for comparison by racial/ethnic group. Rates calculated in this report are based on current estimates of population size published by San Diego Association of Governments (SANDAG), which is calculated from Census data. Race information was collected differently during the 2000 Census and does not match the way race is collected on the HIV/AIDS report forms. This change over time and mismatch could affect rates, particularly when analyzing groups with small numbers.

TABLE 22: RATE OF AIDS BY RACIAL/ETHNIC GROUP AND YEAR OF DIAGNOSIS, SAN DIEGO COUNTY

Racial/Ethnic Group	Description of Rows	Year of Diagnosis				
		2000	2001	2002	2003	2004*
White	No. of AIDS cases	202	200	209	175	155
	Population Size	1,548,833	1,554,334	1,563,906	1,570,801	1,572,114
	Rate per 100,000	13	13	13	11	10
Black	No. of AIDS cases	72	73	74	77	48
	Population Size	154,487	155,110	157,891	159,735	160,469
	Rate per 100,000	47	47	47	48	30
Hispanic	No. of AIDS cases	165	144	141	151	117
	Population Size	750,965	778,929	806,459	833,729	858,168
	Rate per 100,000	22	18	17	18	14
All Racial/Ethnic Groups	No. of AIDS cases	454	434	438	416	332
	Population Size	2,813,833	2,868,873	2,924,058	2,976,104	3,017,204
	Rate per 100,000	16	15	15	14	11

*Year 2004 AIDS case numbers are still preliminary numbers. As more individuals diagnosed with AIDS in 2004 are reported in 2005, the rate will increase.

Other Rates

HIV Counseling and Testing rates and the STD seroprevalence rates were calculated by dividing the number HIV positive by the number tested for HIV.

Statistics

Fluctuation in rates occurs over time and between groups. The smaller the number of events (AIDS/HIV cases or HIV infections), the greater the fluctuation. Statistical tests are often used to determine when one rate is different from another. One such test is used in this report, the 95% confidence interval. When rates are described here as 'statistically significant' or 'significant', the rates can be said to be different from each other with 95% confidence ($p < .05$).

Appendix 5. Expanded Ethnic Origin of Hispanic and Asian/Pacific Islander Cases

TABLE 23: EXPANDED ORIGIN OF HISPANIC AIDS CASES

Ethnic Origin	Frequency	Percent
Mexican	2207	82%
Hispanic, non-specific	218	8%
Puerto Rican	103	4%
Central American	49	2%
South American	47	2%
Spain / Portugal	31	1%
Cuban	30	1%
Dominican	5	0%
Total Hispanic Cases	2690	100%

TABLE 25: EXPANDED ORIGIN OF HISPANIC HIV CASES

Ethnic Origin	Frequency	Percent
Mexican	856	84%
Hispanic, non-specific	112	11%
South American	18	2%
Puerto Rican	14	1%
Central American	16	2%
Cuban	3	<1
Spain / Portugal	2	<1
Dominican	2	<1
Total Hispanic Cases	1023	100.0%

TABLE 24: EXPANDED ORIGIN OF ASIAN/PACIFIC ISLANDER AIDS CASES

Ethnic Origin	Frequency	Percent
Filipino	132	54%
Chinese	19	8%
Japanese	17	7%
Vietnamese	17	7%
Asian, non-specific	13	5%
Guamanian Islander	11	4%
Hawaiian	10	4%
Laotian	6	2%
Samoan	5	2%
Thai	3	1%
Cambodian	3	1%
Korean	2	1%
East Indian	2	1%
Other*	6	na
Total Asian/PI Cases	246	100%

TABLE 26: EXPANDED ORIGIN OF ASIAN/PACIFIC ISLANDER HIV CASES

Ethnic Origin	Frequency	Percent
Filipino	50	47%
Asian, non-specific	26	24%
Japanese	5	5%
Vietnamese	5	5%
Chinese	4	4%
Asian Indian	3	3%
Guamanian Islander	3	3%
Thai	3	3%
Cambodian	3	3%
Other*	5	na
Total Asian/PI Cases	107	100.0%

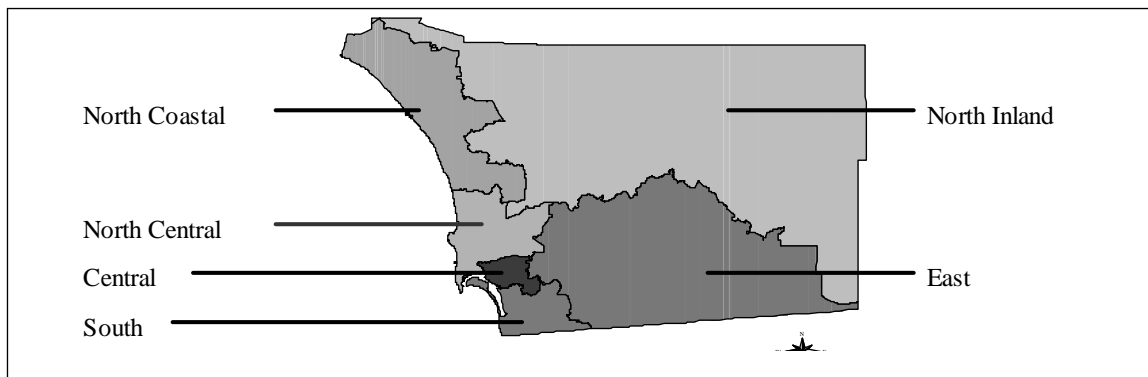
Other for AIDS cases includes Burmese, Fijian, Indonesian, Micronesian, Pacific Islander, and Tongan. *Other* for HIV cases includes Pakistani, Pacific Islander, Indonesian, Korean, and Hawaiian.

Note: Percentages may not add up to 100 due to rounding.

Appendix 6. Health and Human Services Agency (HHSA) Regions of San Diego

San Diego County is divided into 6 Health and Human Services Agency regions by zip code. The following list presents the regions and the zip codes contained therein.

FIGURE 28: HHSA REGIONS OF SAN DIEGO COUNTY



Central Area

Zip codes 92101, 92102, 92103, 92104, 92105, 92113, 92114, 92115, 92116, 92132, 92134, 92136, 92139, 92112, 92162, 92163, 92164, 92165, 92170, 92175, 92176, 92186, 92191, 92194, 92186, 92191, 92194, 92199, 92152, 92158, 92181, 92187, 92191, 92194, and 92195.

East Area

Zip codes 91901, 91905, 91906, 91916, 91917, 91931, 91934, 91935, 91941, 91942, 91945, 91948, 91962, 91963, 91977, 91978, 91980, 92019, 92020, 92021, 92040, 92071, 91944, 92090, 91946, and 92090.

South

Zip codes 91902, 91910, 91911, 91913, 91914, 91915, 91932, 91950, 92010, 92011, 92118, 91921, 91990, 92135, 92154, 92155, 92173, 92179, 91909, 91912, 92143, 91951, 91933, 92073, 92050, 92153, 92158, 91921, and 91990.

North Coastal

Zip codes 92007, 92008, 92009, 92013, 92014, 92024, 92051, 92052, 92054, 92055, 92056, 92057, 92067, 92013, 92058, 92068, 92075, 92077, 92081, 92083, 92084, 92672, 92092, 92093, 92169, 92161, 92038, 92137, 92078, 92091, 92199, 92096, 92013, 92078, 92091, 92077, 92081, 92008, 92058, and 92096.

North Inland

Zip codes 92003, 92004, 92025, 92026, 92027, 92028, 92029, 92036, 92059, 92060, 92061, 92064, 92065, 92066, 92069, 92070, 92082, 92086, 92127, 92128, 92129, 92259, 92390, 92536, 92592, 92046, 92198, 92190, and 92079.

North Central

Zip codes 92037, 92106, 92107, 92108, 92109, 92110, 92111, 92117, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92130, 92131, 92133, 92140, 92142, 92145, 92138, 92147, 92166, 92168, 92171, 92172, 91990, 92193, 92196, 92177, and 92147.

Appendix 7. Community of Residence at Time of Diagnosis

TABLE 27: COMMUNITY OF RESIDENCE AT TIME OF AIDS DIAGNOSIS

Community of Residence	Cases	Percent
San Diego	9010	74%
Chula Vista	406	3%
Oceanside	354	3%
El Cajon	240	2%
Escondido	232	2%
La Mesa	183	1%
Vista	180	1%
National City	173	1%
Spring Valley	167	1%
San Ysidro	151	1%
La Jolla	134	1%
Carlsbad	129	1%
Santee	91	1%
Lemon Grove	89	1%
Encinitas	86	1%
Imperial Beach	82	1%
San Marcos	73	1%
Lakeside	46	0%
Poway	42	0%
Coronado	38	0%
Del Mar	37	0%
Fallbrook	37	0%
Bonita	31	0%
Ramona	26	0%
Leudcadia	20	0%
Cardiff by the Sea	18	0%
Alpine	17	0%
Valley Center	16	0%
Solana Beach	15	0%
Rancho Santa Fe	14	0%
Jamul	10	0%
Other*	54	0%
Total	12201	

* The following communities had 9 or fewer cases: Bonsall, Boulevard, Borrego Springs, Camp Pendleton, Campo, Descanso, Dulzura, Guatay, Julian, Mount Laguna, Pauma Valley, Pine Valley, Ranchita, San Luis Rey, and Santa Ysabel
 Note: Percentages may not add up to 100 due to rounding.

TABLE 28: COMMUNITY OF RESIDENCE AT TIME OF HIV DIAGNOSIS

Community of Residence	Cases	Percent
San Diego	3554	76.5%
Chula Vista	164	3.5%
Oceanside	116	2.5%
El Cajon	101	2.2%
Vista	82	1.8%
Escondido	82	1.8%
San Ysidro	71	1.5%
National City	60	1.3%
La Mesa	53	1.1%
Imperial Beach	38	0.8%
La Jolla	36	0.8%
Spring Valley	35	0.8%
Carlsbad	34	0.7%
Lemon Grove	33	0.7%
Santee	28	0.6%
Encinitas	25	0.5%
Lakeside	19	0.4%
San Marcos	17	0.4%
Poway	14	0.3%
Bonita	11	0.2%
Del Mar	10	0.2%
Ramona	10	0.2%
Other*	54	1.2%
Total	4647	100%

* The following communities had 9 or fewer cases: Alpine, Bonsall, Borrego Springs, Campo, Cardiff By The Sea, Coronado, Fallbrook, Jamul, Julian, Pine Valley, Rancho Santa Fe, Santa Ysabel, Solana Beach, Valley Center.

Note: Percentages may not add up to 100 due to rounding.

Appendix 8. Cumulative AIDS Cases Reported through December 31, 2004

Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
San Diego County
Surveillance Report - 12/31/2004

1. Disease Category	Adult/Adolescent *		Pediatric *		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	3413 (28)	2724 (80)	18 (30)	12 (67)	3431 (28)	2736 (80)
Other Disease w/o PCP	4378 (36)	3095 (71)	42 (70)	19 (45)	4420 (36)	3114 (70)
KS Alone	575 (5)	388 (67)	0 (0)	0 (.)	575 (5)	388 (67)
No Diseases Listed	3775 (31)	337 (9)	0 (0)	0 (.)	3775 (31)	337 (9)
Total	12141 (100)	6544 (54)	60 (100)	31 (52)	12201 (100)	6575 (54)

2. Age *	Cases (%)	3. Race/Ethnicity	Adult/Adolescent *	Pediatric *	Total
			Cases (%)	Cases (%)	Cases (%)
Under 5	39 (0)	Hispanic - All Races	2657 (22)	33 (55)	2690 (22)
5-12	21 (0)	Not Hispanic - Am. Indian/Alaska Native	73 (1)	0 (0)	73 (1)
13-19	50 (0)	Asian	11 (0)	0 (0)	11 (0)
20-29	2011 (16)	Black or African American	1510 (12)	12 (20)	1522 (12)
30-39	5564 (46)	Native Hawaiian/Pacific Is.	13 (0)	0 (0)	13 (0)
40-49	3215 (26)	White	7656 (63)	14 (23)	7670 (63)
Over 49	1301 (11)	Legacy Asian/Pacific Is.	221 (2)	1 (2)	222 (2)
Unknown	0 (0)	Multi-race	0 (0)	0 (0)	0 (0)
Total	12201 (100)	Unknown	0 (0)	0 (0)	0 (0)
		Total	12141 (100)	60 (100)	12201 (100)

4. Exposure Category	Adult/Adolescent Transmission Modes**		
	Males (%)	Females (%)	Total (%)
Men who have sex with men	8984 (80)	0 (0)	8984 (74)
Injecting drug use	756 (7)	339 (38)	1095 (9)
Men who have sex with men and inject drugs	1182 (11)	0 (0)	1182 (10)
Hemophilia/coagulation disorder	54 (0)	3 (0)	57 (0)
Heterosexual contact	161 (1)	470 (53)	631 (5)
Receipt of blood, components, or tissue	85 (1)	66 (7)	151 (1)
Risk not reported/Other	19 (0)	12 (1)	31 (0)
Total	11241 (100)	890 (100)	12131 (100)

	Pediatric Transmission Modes		
	Males (%)	Females (%)	Total (%)
Hemophilia/coagulation disorder	10 (25)	0 (0)	10 (14)
Mother with/at risk for HIV infection	25 (63)	26 (87)	51 (73)
Receipt of blood, components, or tissue	5 (13)	4 (13)	9 (13)
Risk not reported/Other	0 (0)	0 (0)	0 (0)
Total	40 (100)	30 (100)	70 (100)

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

**10 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children. They are counted as adults/adolescent cases in tables 1, 2, and 3; and as pediatric cases in table 4.

Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
San Diego County
Surveillance Report - 12/31/2004

5. Reported Cases of AIDS and Case-Fatality Rates by Half-Year of Diagnosis.

Half-Year of Diagnosis -----	Number of Cases -----	Number of Deaths -----	Case-Fatality Rate -----
Before 1990	2137	2026	95%
1990 Jan -June	410	364	89%
July-Dec	371	343	92%
1991 Jan -June	391	337	86%
July-Dec	467	411	88%
1992 Jan -June	523	420	80%
July-Dec	541	427	79%
1993 Jan -June	618	405	66%
July-Dec	494	300	61%
1994 Jan -June	494	244	49%
July-Dec	471	233	49%
1995 Jan -June	501	161	32%
July-Dec	442	136	31%
1996 Jan -June	433	124	29%
July-Dec	329	76	23%
1997 Jan -June	317	73	23%
July-Dec	247	61	25%
1998 Jan -June	233	41	18%
July-Dec	264	41	16%
1999 Jan -June	226	52	23%
July-Dec	218	40	18%
2000 Jan -June	239	36	15%
July-Dec	215	34	16%
2001 Jan -June	214	35	16%
July-Dec	220	39	18%
2002 Jan -June	218	28	13%
July-Dec	220	21	10%
2003 Jan -June	189	17	9%
July-Dec	227	27	12%
2004 Jan -June	216	13	6%
July-Dec	116	10	9%
2005 Jan -Jan 10	0	0	----
-----	-----	-----	-----
Totals	12201	6575	54%

□

County of San Diego, HHSA, Community Epidemiology

Appendix 9. Cumulative HIV Cases Reported through December 31, 2004

Human Immunodeficiency Virus (HIV)
HIV Surveillance Report
San Diego County
Surveillance Report - 12/31/2004

1. Age *	Cases (%)	2. Race/Ethnicity	Adult/Adolescent *	Pediatric *	Total
-----	-----	-----	Cases (%)	Cases (%)	Cases (%)
Under 5	22 (0)	Hispanic - All Races	1007 (22)	16 (52)	1023 (22)
5-12	9 (0)	Not Hispanic - Am. Indian/Alaska Native	40 (1)	0 (0)	40 (1)
13-19	96 (2)	Asian	24 (1)	1 (3)	25 (1)
20-29	1486 (32)	Black or African American	607 (13)	6 (19)	613 (13)
30-39	1989 (43)	Native Hawaiian/Pacific Is.	17 (0)	1 (3)	18 (0)
40-49	797 (17)	White	2857 (62)	7 (23)	2864 (62)
Over 49	248 (5)	Legacy Asian/Pacific Is.	64 (1)	0 (0)	64 (1)
Unknown	0 (0)	Multi-race	0 (0)	0 (0)	0 (0)
-----	-----	Unknown	0 (0)	0 (0)	0 (0)
Total	4647 (100)	-----	-----	-----	-----
		Total	4616 (100)	31 (100)	4647 (100)

3. Exposure Category	Adult/Adolescent Transmission Modes		
-----	Males (%)	Females (%)	Total (%)
Men who have sex with men	3315 (80)	0 (0)	3315 (72)
Injecting drug use	182 (4)	95 (20)	277 (6)
Men who have sex with men and inject drugs	312 (8)	0 (0)	312 (7)
Hemophilia/coagulation disorder	7 (0)	0 (0)	7 (0)
Heterosexual contact	171 (4)	306 (66)	477 (10)
Receipt of blood, components, or tissue	3 (0)	1 (0)	4 (0)
Risk not reported/Other	162 (4)	62 (13)	224 (5)
-----	-----	-----	-----
Total	4152 (100)	464 (100)	4616 (100)

	Pediatric Transmission Modes		
-----	Males (%)	Females (%)	Total (%)
Hemophilia/coagulation disorder	5 (28)	0 (0)	5 (16)
Mother with/at risk for HIV infection	12 (67)	13 (100)	25 (81)
Receipt of blood, components, or tissue	1 (6)	0 (0)	1 (3)
Risk not reported/Other	0 (0)	0 (0)	0 (0)
-----	-----	-----	-----
Total	18 (100)	13 (100)	31 (100)

- Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

Non-names HIV reporting began on July 1, 2002. Prevalent cases, those under care and treatment prior to that time, will continue to be reported; reporting of incident cases, newly testing positive, will be ongoing. Caution should be taken in interpreting these data at this time.

County of San Diego, HHSA, Community Epidemiology

Appendix 10. Office of AIDS HIV Counseling and Testing Risk Group Hierarchy

After risk behavior information is entered into the database for a client, a computer program ranks the risks and assigns the client to the risk group with the *highest risk*. The following risk groups are mutually exclusive and are presented in order of estimated risk from highest risk to lower risk. As of 2001, behaviors have to have occurred within the last 2 years or since the last test result (whichever is less) to be recorded. Also, some categories may seem to include all of a particular risk group when they do not. For example, Gay/Bi IDU includes some men who have sex with men (MSM) who are also injection drug users (IDU). Below are the current definitions (there have been changes over the years):

Gay Men/Bisexual Men who are Injection Drug Users (Gay/Bi IDU): Men who report having sex with a male, or male and female partner and using injection drugs.

Men who have Sex with Men (MSM): men who report having a male sex partner, no female sex partners, and no injection drug use.

Bisexual: men and women who report having both a male and female partner.

Injection Drug Users (IDU): clients who report having injected drugs, except men who have had sex with men but no women (they are placed in Gay/Bi IDU).

HIV+ Partner: heterosexual client reports having a partner who is HIV positive.

Partner Bisexual: heterosexual women only who report having a male partner who has sex with men.

IDU Partner: heterosexual client reports having a partner who uses injection drugs.

Sex for Drugs/Money: heterosexual client reports trading sex for drugs or money.

Blood Transfusion <1985: client reports having a blood transfusion prior to 1985 or in a country where the blood is not tested for HIV.

Multiple Partners: heterosexual men who report more than one female partner and no male partners in that time; heterosexual women who report more than one male partner and no female partners in that time.

Partners with Multiple Partners: heterosexual client reports having a partner who has had multiple partners. Dropped as a risk group in 2001 (by default absorbed into No Reported Risk).

Occupational Exposure: client reports on the job blood exposure (either blood to blood exposure or any exposure to known HIV positive blood).

Child at Risk: clients less than 12 years of age and report having an HIV positive mother.

No Reported Risk: client does not fall into one of the above risk categories and reports one or no sexual partners.

Unknown: client refuses to discuss risk factors.

Appendix 11. World Wide Web Addresses for HIV/AIDS Related Information

International

International AIDS Economic Network

www.iaen.org

Comprehensive information on economic and cost-effectiveness aspects of HIV/AIDS therapy.

WHO Global HIV/STD Surveillance Fact Sheet

www.who.int/emc-hiv/

Contains the most recent country-specific data on HIV/AIDS prevalence and incidence

National

AIDS.ORG

www.aids.org

General information on HIV and AIDS.

ADAP Monitoring Project

www.atdn.org/access/adap

Up-to-date information on AIDS Drug Assistance Programs (ADAP) providing medications to low income, uninsured or underinsured people with HIV in 52 States and Territories.

AEGIS

www.aegis.com

Extensive databases of newspaper and wire reports, community group publications, legal documents, statistics, and patient forums.

AIDS Information

www.aidsinfo.nih.gov

US. Department of Health and Human Services site provides HIV/AIDS prevention, treatment and research information.

AIDSmeds.com

www.aidsmeds.com

Consumer owned and operated, this site contains easy-to-read information on treating HIV and AIDS, including guided treatment lessons, information on drugs, recent news, community forums, links, and more.

American Foundation for AIDS Research

www.amfar.org

HIV/AIDS research, AIDS prevention and treatment education.

CDC National Prevention Information Network

www.cdcnpin.org

Resources and information about education, prevention, published materials, research funding and related to HIV, TB and STDs.

CDC, Division of AIDS Prevention

www.cdc.gov/nchstp/od/nchstp.html

National Centers for HIV, STD and TB prevention.

Gay Men's Health Crisis

www.gmhc.org

New York based, non-profit organization offering support services.

National Institute of Health, Office of AIDS Research

www.nih.gov/od/oar/index.htm

Project Informwww.projinf.org

Contains information about HIV prevention, treatment, research and legislation.

Whatudo.orgwhatudo.org

University of California, San Francisco youth-oriented website about HIV and AIDS.

California*AIDS Project Los Angeles*www.apla.org*California AIDS Clearinghouse*www.hivinfo.org

HIV prevention, community planning, educational materials, directory & calendar.

State Office of AIDSwww.dhs.ca.gov/AIDS

The Office of AIDS has lead responsibility for coordinating state programs, services, and activities relating to HIV/AIDS. Current state statistics are available online.

The Body: California AIDS Services Organizationwww.thebody.com

An AIDS and HIV information resource.

San Diego County*Being Alive San Diego*www.beingalive.org

Non-profit organization delivering services to people affected by HIV/AIDS

The Centerwww.thecentersd.org/

A non-profit organization serving the gay, lesbian, bisexual, and transgender community in San Diego. Provides HIV testing information, prevention/education, HIV+ support groups and counseling services.

County of San Diego, Community Epidemiologywww.sdhivaid.org

Reports and statistics about HIV and AIDS in San Diego County.

County of San Diego, HIV, STD and Hepatitis Branch (formerly Office of AIDS Coordination)www2.sdcountry.ca.gov/hhsa/ServiceCategoryDetails.asp?ServiceAreaID=27

Assure the development and delivery of quality HIV services and coordinate programs for HIV prevention, medical care, and supportive services in San Diego County.

AIDS Research Institutewww.ari.ucsd.edu

University of California, San Diego; dedicated to education, outreach and patient care.

HIV Consumer Councilwww.hivconsumercouncil.org

Provides information regarding events that involve HIV+ people and to encourage participation of the HIV community of San Diego County in the decision making processes that affect them.

SANDAG - San Diego's Regional Planning Agencywww.sandag.org

Population and other data for San Diego County.

Appendix 12. County of San Diego HIV/AIDS Telephone Numbers

AIDS Drug Assistance Program (ADAP)	(619) 293-4712
Provides assistance to eligible individuals in obtaining prescription drugs for the treatment of HIV/AIDS.	
HIV Testing Clinics	(619) 293-4732
Free anonymous and confidential testing to anyone ages 12 or older. Available at over 10 sites.	
HIV, STD and Hepatitis Branch	(619) 293-4700
Formerly the Office of AIDS Coordination. Provides planning, and administration of HIV prevention funding and Ryan White Care Act funds for San Diego County, as well as AIDS case management and HIV testing.	
California Disclosure Assistance and Partner Services (C-DAPS)	(619) 293-4700
Formerly Partner Counseling and Referral Services. Provides assistance to those who want to notify partners of possible exposure to HIV. A free, voluntary and confidential service.	
Sexually Transmitted Disease Clinics (STD Clinics)	(619) 692-8550
Low cost/free confidential testing of STDs for anyone ages 12 or older.	
T-Cell Testing Program	(619) 293-4732
A one-time, free confidential T-cell test for HIV positive individuals.	

Community Epidemiology
HIV/AIDS Epidemiology
P.O. Box 85222
San Diego, CA 92186-5222

