

# ***Examining the Impact of the HIV-related State Budget Cuts: Comparing Alameda, Fresno, and Los Angeles Counties***

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## Executive Summary

In April 2009, the UCSF AIDS Policy Center was funded by the California HIV/ AIDS Research Program to provide, among other policy research aims, a rapid response team that would investigate policy matters that arise both nationally and locally and assess their impact on the HIV epidemic within the State of California. Working with the collaboration of community partners, the San Francisco AIDS Foundation and Project Inform, as well as an advisory board (the Policy Research Advisory Council), the AIDS Policy Center was charged with examining the impact of the HIV-related budget cuts in the State of California. This study utilized rapid appraisal procedures in three counties to assess the impact of the state budget cuts on the provision, delivery and access of HIV-related services. Following the statewide fiscal reductions, reports in the local media and press releases indicated that several community-based organizations and AIDS service organizations had to close their doors or drastically reduce the level of HIV-related services, including activities like testing and counseling. A rapid appraisal of the impact of the state budget cuts was launched in three counties to capture the impact of the budget cuts to prevention services on both HIV-related service personnel and agency clientele in the State of California.

### Overall Findings

- **Transparency and Collaboration:** In counties where there were existing tensions between community-based organizations, health department personnel, providers and other local stakeholders, the budget reductions exacerbated the tension and increased competition for fiscal resources. Transparency, even when the news is bad news, seemed to alleviate fears and made local HIV professionals feel part of the process and better able to cope with the consequences of the state budget cuts. In some places, this meant collaborating with other agencies to maintain client services.
- **Size:** Providers with more resources were more likely to be “at the table,” such as being part of the local planning councils or better networked into larger policy discussions. This better positioned them to weather the impact of the budget cuts. These agencies were best prepared to hear of potential changes in funding streams and plan accordingly by not adding new hires or conserving organizational resources. Smaller entities that were not part of the policy discussions were sometimes further marginalized in the redistribution of limited resources.

#### What mattered in preserving HIV-related services?

- **Transparency and Collaboration**
- **Size**
- **Networking and Information Sharing**
- **Capacity**

- **Networking and Information Sharing:** Those who were in the know, shared the know, and were able to have advanced insight regarding the future budget cuts. This knowledge of those in the know allowed for them to devise strategies to survive past the impending funding reductions.
- **Capacity:** As workers had to be let go, and services consolidated or cut, many remaining agencies have gone into “survival mode,” characterized by low morale and workers often wearing multiple hats at existing agencies. As a result, already strained resources have been stretched and there remains little time to attend community planning meetings, or, in the case of providers, to attend trainings. Some agencies fear that they are no longer part of the decision making process and their client perspectives are no longer represented, others are concerned about staying abreast of new developments in the field of HIV prevention. For other organizations there are longer term fears that center on people “slipping through the cracks” and becoming infected or, for those already infected, not receiving the support they need to stay healthy.

## Policy Implications

- ***The cuts compromise California’s ability to achieve desired HIV prevention and treatment outcomes.*** All of the band aids are on. Informants said that the HIV-related service sector could not withstand another cut in funding. Many of those still working in the field mourned the loss of talented colleagues, as well as the closure of carefully crafted prevention programs and care services for PLWHA. They feared that California will suffer from increases in HIV incidence and morbidity in the coming years due to these cuts.
- ***The cuts will hinder California’s participation in national efforts to reinvigorate the US response to HIV/AIDS.*** Although many felt inspired by the reinvigoration of HIV prevention efforts at the federal level, there was also a realization that there were no local or state funding streams to implement the ideas laid out in the National HIV/AIDS Strategy.
- ***The cuts will likely reduce the success of new models of treatment and prevention in the state.*** The budget cuts gutted prevention funding throughout the State, and eliminated some services that were designed to support PLWHA. Providers worried that in an increasingly medical model, where there is an emphasis on test and treat, there may not be adequate support structures in place to help people stay adherent to medications, or to identify those that need to be brought in for testing. Indeed, the test and treat paradigm cannot work without prevention outreach, stigma reduction, and social marketing to encourage individuals to test.
- ***The cuts may result in a loss of talent from California agencies and clinics.*** There was a great deal of concern over brain drain, both in terms of HIV service providers, such as case managers and test counselors, and also in terms of medical professionals who specialize in HIV care. Even with funding available for training HIV medical staff, with multiple clinic closures across the state and the consolidation of existing services, there were concerns that HIV medical staff are overextended, with no time to attend trainings or to provide adequate quality care to their patients.

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## Introduction

In response to California's budget crisis in fiscal year 2009-10, Governor Arnold Schwarzenegger cut more than 59 million dollars in state funds from the California Office of AIDS (OA), removing support for HIV-related services and programs and bringing the total reduction in funding to the OA to approximately 82 million dollars. Affected programs included prevention and education, testing services, outreach work, case management services, housing allowances, home and community-based care, and therapeutic blood monitoring across the state [1]. Among the 10 states with the highest numbers of HIV/AIDS cases, California ranks second, yet with the budget cuts enacted in July 2009, its HIV prevention funding was limited to only \$18 million, all of which was drawn from federal funding sources. The magnitude of the cuts, and the extent to which they impacted prevention funding in particular, prompted tremendous concern among service providers, clinicians, public health personnel, researchers, advocates, and also those living with HIV/AIDS. With California having approximately 100,000 people currently infected with HIV/AIDS, there is fear that the reduction in funding will lead to dire public health consequences and a rise in HIV incidence rates.

In April 2009, the UCSF AIDS Policy Center was funded by the California HIV/AIDS Research Program to provide, among other policy research aims, a rapid response team that would investigate policy matters that arise both nationally and locally and assess their impact on the HIV epidemic within the State of California. Working with the collaboration of community partners, the San Francisco AIDS Foundation and Project Inform, as well as an advisory board (the Policy Research Advisory Council), the AIDS Policy Center was charged with examining the impact of the HIV-related budget cuts in the State of California. This study utilized rapid appraisal procedures in three counties to assess the impact of the state budget cuts on the provision, delivery and access of HIV-related services. Following the statewide fiscal reductions, reports in the local media and press releases indicated that several community-based organizations and AIDS service organizations had to close their doors or drastically reduce the level of HIV-related services, including activities like testing and counseling [2-4]. A rapid appraisal of the impact of the state budget cuts was launched in three counties to capture the impact of the budget cuts to prevention services on both HIV-related service personnel and agency clientele in the State of California.

We chose to focus our efforts in three counties: Alameda County, Fresno County, and Los Angeles County. These three were selected based on the size and epidemiological characteristics of their local epidemics, their location in the state (Los Angeles is an urban county in Southern California, Alameda is a semi-urban county in Northern California, and Fresno is a rural county in the Central Valley), and whether the counties received direct federal funding through the Centers for Disease Control and Prevention (CDC). The focus of this study was to gauge the impact of the budget cuts on the provision of services for PLWHA and those affected by HIV, as well as to understand the experiences of PLWHA in accessing curtailed support services or, in some cases, dealing with the consequences of eliminated services. We sought additional information on the process that each county went through in responding to the budget cuts, and how decisions were made by staff and stakeholders to preserve, reduce, or eliminate local programs.

## Reallocating Shrinking State Resources Across California

Approximately \$82 million were eliminated from the budget of the California Office of AIDS (OA) for FY 2009-2010, about half of the allocation of \$167 million in 2008-2009. Although the AIDS Drug Assistant Program (ADAP) was backfilled, funds for surveillance, early intervention programming, home and community-based care, therapeutic blood monitoring, and prevention were reduced or eliminated. Approximately 80% of the funding for prevention was cut, leaving that as the hardest hit programmatic area. The only funding that remained was federal dollars that were administered by the State, all General Fund allocations for HIV/AIDS were eliminated. In terms of the 18 million dollars remaining for prevention activities, 46% went to San Francisco and Los Angeles, which have the highest numbers of HIV and AIDS cases in the state, while 47% of the funding went to 15 other Local Health Jurisdictions (LHJs) around the state, Alameda and Fresno counties being among them. In order to redistribute the remaining funds, OA produced a new formula to determine new allocations (see Figure 1 below): The new formula is based on: number of new HIV infections identified through counseling and testing, number of newly reported HIV cases, number of living AIDS cases, number of male syphilis cases over 1 year period, number of male gonorrhea cases over a one year period, number of African Americans, number of Hispanics, and number of people living below the poverty line.

**Figure 1: California Office of AIDS allocation of formula-based funding, 2009-2010**

Formula: 
$$\text{County}\$ = \left( \frac{a}{A} * 0.20 + \frac{b}{B} * 0.20 + \frac{c}{C} * 0.20 + D * 0.075 + E * 0.075 + F * 0.15 + G * 0.05 + H * 0.05 \right) * \text{State}\$$$

a = number of new HIV infections identified through C & T in the county	D = % of state total syphilis in men
A = number of new HIV infections identified through C & T in California	E = % of state total GC in men
b = number of newly reported HIV cases in the county	F = % of state total African Americans
B = number of newly reported HIV cases in California	G = % of state total Hispanics
c = number of living AIDS cases in the county	H = % of state total people living below federal poverty line
C = number of living AIDS cases in California	

Note: Taken from the Office of AIDS FY 2009-10 Budget Reduction Implementation Plan (v.8/12/09)

There were additional guidelines for prevention funding based on the epidemiological characteristics of local epidemics. For example, the OA specifically proposed that those LHJs receiving funding needed to certify that “*a weighted proportion of OA funds had been directed to services for African Americans... LHJs would be certifying that they spend prevention allocation dollars on prevention interventions focused on African Americans in proportion greater than or equal to 2 times the proportion of living African American male HIV/AIDS cases in their jurisdiction.*” This guideline caused controversy in places, such as Alameda County, where this proportion was quite high and would therefore absorb a high percentage of the reduced funding for prevention activities. Furthermore, those counties receiving direct CDC funding (San Francisco and Los Angeles) had their state allocations halved under the new formula and the remaining funds were distributed to the remaining 15 LHJs.

In terms of funding for care and support services, the OA had to contend with a cut of approximately 61% of funding for care and support services, including housing, from fiscal year 2008-2009 to 2009-2010. HOPWA continued to be administered by the OA under the new budget, as did the AIDS Medi-Cal Waiver Program. Early intervention program (EIP), Therapeutic Monitoring Program (TMP), Case Management Program (CMP), Care Services Program and Residential Licensed Facilities Programs were all eliminated. The Care Program Model, based on HRSA-defined service categories, was used to prioritize support for services for PLWHA. Tier 1 services, which essentially covered outpatient/ambulatory care, were maintained. Tier 2 services, which support access to Tier 1 services, and are designed to help maintain treatment access and adherence for PLWHA, were those that were proposed for reductions or elimination at the local level, based on their prioritizing by local health departments and planning councils. The counties we assessed used the priority planning they had done to qualify for Ryan White funding to determine which care and support services they would continue at the local level. Still, this was a difficult, and, at times, a contentious process. Funding levels from FY 08-09 to FY 09-10 in each of the three counties are presented in Table 1 below, by service category.

**Table 1: Reductions in State support in Alameda, Fresno and Los Angeles Counties, 2008-2010**

	Alameda County*			Fresno County			Los Angeles County		
	2008-2009	2009-2010	Percent Reduction	2008-2009	2009-2010	Percent Reduction	2008-2009	2009-2010	Percent Reduction
Prevention	\$1,118,310	\$591,860	47%	\$625,647	\$205,038	67%	\$7,518,956	\$1,814,848	76%
Care	\$2,749,896	\$1,190,123	57%	\$1,034,178	\$526,996	49%	\$14,399,298	\$9,578,960	33%
Housing**							\$385,644	0	100%
Surveillance**							\$2,033,603	\$2,033,603	0%
<b>TOTAL</b>	<b>\$3,868,206</b>	<b>\$1,781,983</b>	<b>54%</b>	<b>\$1,659,825</b>	<b>\$732,034</b>	<b>56%</b>	<b>\$24,337,581</b>	<b>\$13,427,491</b>	<b>45%</b>

\*Alameda County is part of the Oakland TGA which also includes Contra Costa County. Furthermore, these calculations do not include any supplementary funding that the Alameda County Office of AIDS Administration received directly through Congressional allocations.

\*\*Data only available for Los Angeles County

## The National Context

While the crisis in California is notable, nationally HIV prevention funding has remained relatively flat in recent years, despite the Centers for Disease Control and Prevention's upward adjustment of annual HIV infection estimates from 40,000 to 56,000 [5, 6]. However, there are signals that more funding may become available to support HIV prevention activities, as the Obama administration becomes more focused on the domestic HIV epidemic. Interestingly, as Californians have spent the past year adjusting to a new era of limited resources for HIV prevention and care, the White House Office on National AIDS Policy (ONAP) has been focused on developing a National HIV/AIDS Strategy [7, 8]. In the recently announced strategy, ONAP details a promising roadmap for halting the domestic epidemic, the fruit of months of community meetings around the country, expert advice and thoughtful consideration. The strategy contains many innovative suggestions, such as increasing routine testing and promoting testing in nontraditional settings (such as jails) to increase coverage; increased social marketing activities; overhauling discriminatory policies against PLWHA; encouraging people to know their status; prioritizing HIV as a public health issue; creating more tailored approaches to prevention; focusing prevention and care services in those areas most impacted by the epidemic, increasing support services such as childcare, food, and transportation

services for PLWHA to assist with treatment adherence; providing job training; emphasizing drug treatment programs; training more doctors in HIV, particularly in rural areas; and improving insurance coverage for medications. A long list of comprehensive prevention and care activities are included as recommendations for a sound national strategy.

Yet, in California, many of these recommendations cannot be implemented or sustained without an infusion of fresh resources. Indeed, some of the recommended programmatic approaches that were incorporated into the National HIV/AIDS strategy, such as providing access to housing, food and transportation to PLWHA, doing regular viral load and CD4 testing for PLWHA or adopting community-level prevention approaches to reduce health disparities, were once implemented in California and have since been dismantled or severely cut due to funding shortfalls. Our research unfortunately uncovered instances where programming cuts have impacted the lives of people infected and affected by HIV, in some cases making it more difficult to remain adherent to treatment regimens, and in other cases creating unnecessary barriers to accessing even the most basic prevention services. With the implementation of a National HIV/AIDS Strategy on the horizon, there is a great deal of hope that there will be additional resources put in place to support comprehensive HIV prevention and care services and some of this will be rectified, in California and elsewhere.

## Methods

Due to the quickly moving nature of the policy arena, we decided that using rapid assessment procedures would be the best research method to document the impact of the HIV-related state budget cuts. Rapid assessment, also known as rapid appraisal procedures, has its roots in rural development work from the 1970s, and was devised by a team of University of Sussex anthropologists [9]. According to the method, a diverse team of researchers – culled from differing disciplinary perspectives and often including “local” players – go into the field for a minimum of 5-7 days. While in the field, they interview key informants, review relevant written materials, conduct participant observation, compile fieldnotes and have intensive debriefing sessions at the end of each day. A written report detailing findings is produced within 2-4 weeks of the fieldwork.

The data for this report were collected over 3 intensive waves of fieldwork, in each site, from January-April 2010. In preparation for our fieldwork in the chosen three counties, local media, notes from planning council meetings, epidemiological data, and lists of key stakeholders were compiled and reviewed. For certain sites, we consulted with members of our advisory council to elicit suggestions of key informants that should be approached for participation. Participants were approached prior to our arrival in each site and those who were interested scheduled an in-depth interview with a member of the research team. A total of 44 in-depth interviews were conducted with key stakeholders, including clinicians, local health department personnel, leaders and/or staff of community-based organizations and AIDS service organizations, planning and/or care council members, and consumers of HIV-related services. Each of these took place in private offices and lasted from 45-90 minutes. Participants who were consumers received a stipend of \$40.00 in return for their time, and those participants who spoke to us as HIV-related service professionals had donations of \$100.00 made to their respective agencies or clinics. Interview topics for professionals included: a timeline delineating when budget cuts were announced and what actions were taken in response; FY 08-09 agency budgets and impact of budget cuts on FY 09-10 fiscal well being; impact of cuts on programs and services; layoffs, staffing and morale; strategies enlisted to try to maintain services; recommendations for the State Office of AIDS; and priorities for funding in an era of limited resources.

Interview topics for consumers included: the different agencies and services accessed, the impact of the budget cuts on the provision of services over the past year, perceptions of existing staffing compared to prior to the budget cuts, and strategies for accessing services in the current fiscal climate. Researchers took extensive notes during the in-depth interviews and wrote summaries immediately following each meeting.

In addition to the in-depth interviews, researchers attended meetings of the planning councils and drafted fieldnotes afterward. At the end of each day in the field, the rapid assessment team members would gather for intensive debriefing meetings, at which all data collected that day was reviewed and analyzed and plans regarding theoretical sampling (to capture new perspectives or to add more detail on a underdeveloped topic) were established. All of the study procedures were reviewed and approved by the UCSF Committee on Human Research.

### **Interview topics for professionals:**

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- **Budget cut timeline**
- **Agency response to cuts**
- **Impact on programs, services, and consumers**
- **Staffing issues**
- **Strategies incorporated**
- **Recommendations for California Office of AIDS**

### **Interview topics for consumers:**

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- **Agencies and services accessed pre- and post-cuts**
- **Perceived impact on service provision in past year**
- **Perceptions of staff and programs after the cuts**
- **Strategies used to access care and support services**

## Findings

In this section we will present a background for each county (Alameda, Fresno and Los Angeles), and then we will discuss the major qualitative themes that emerged in each site regarding the impact of the budget cuts and how players in the county responded to shrinking state resources. Note that counties are presented in alphabetical order and that themes within each county are neither ranked nor prioritized. For each county, HIV/ AIDS epidemiologic profile data come from the respective local department of public health [10-12], unless referenced otherwise. Population data for all counties were obtained from the United States Census website [13].

### Alameda County

#### **Background:**



Alameda County is located in the San Francisco Bay Area, covering 737 square miles, bordered by the San Francisco Bay on the West and the Berkeley/Oakland Hills on the East. According to the 2000 Census, approximately 1.49 million people live in the County, which encompasses Oakland, the largest city in the County with approximately 400,000 inhabitants. A relatively diverse county, the population is 56% white, 13.5% African American, 24.9% Asian, and 1.5% Native American/Alaskan or Native Hawaiian. Despite its location in the relatively

wealthy San Francisco Bay Area and a median household income of \$70,217, about 10.8% of county inhabitants were living under the federal poverty line as of 2008.

Alameda County is part of the Oakland Transitional Grant Area (TGA), which includes Alameda and Contra Costa Counties, as well as the City of Berkeley which has its own health jurisdiction. The Collaborative Community Planning Council (CCPC) is the Ryan White mandated community planning body that makes recommendations regarding prevention and care across the three jurisdictions, and it has a series of subcommittees that handle specific duties. These include: Quality Data and Services Planning Committee, People Living with HIV/AIDS Committee, Executive Committee, Membership and Community Involvement Committee, Policy Education and Review Committee, and the Prevention Committee. There is also a separate Contra Costa County Consortium within the CCPC, which is more focused on HIV-related issues in that specific county. The CCPC includes the director of the Alameda County Office of AIDS Administration (OAA), as well as several staff members, and meetings often take place at the offices of the OAA in downtown Oakland. Although there are a variety of council members that represent the target populations most impacted by the epidemic, attendance at the CCPC meetings has been a concern in the past year, and there have been ongoing efforts to rectify this situation and increase CCPC member involvement.

According to data collected in the Oakland TGA, there were 6,997 PLWHA as of December 31, 2007, and AIDS prevalence was 4,259, HIV prevalence was 2,738, and AIDS incidence over a two-year period (January 2006 through December 2007) was 548 [14]. The epidemic in Alameda County most heavily impacts African Americans, which represent 43% of prevalent AIDS cases and 50% of HIV cases, with both men who have sex with men (MSM) and increasing numbers of heterosexual women

being affected. In fact in 1998, a group of community service providers, agencies, and advocates presented the Alameda County Board of supervisors with a declaration of a State of Emergency citing the disproportionate impact of the HIV epidemic in the African American community. The Board approved the declaration and the State of Emergency remains in effect. Other populations impacted by the epidemic emerged in the most recent epidemiological statistics from 2006-2007: approximately 30% of prevalent HIV cases were among Whites, 12.5% among Latinos, and 4% among Asian/Pacific Islanders. MSM were the most common behavioral risk group among HIV prevalent cases (56%), followed by heterosexuals (approximately 20%), and then injection drug users (IDUs) (about 10%). Incarceration, poverty, lack of housing, mental health and substance use are common drivers of HIV infection in Alameda County, and the 2009-2012 Comprehensive Service plan included strategies for addressing these as co-factors to HIV and AIDS.

### **Themes:**

**The budget crisis exacerbated existing tensions in the community over funding allocations and provision of services to diverse clientele.** According to health department staff and service providers, the budget cuts occurred as the OAA was preparing to finalize its contracts with agencies that had responded successfully to the 2009-2010 prevention RFPs, creating an immediate need for the OAA to reassess the direction of prevention activities in light of new economic realities. In the ensuing limbo, the county re-issued its RFP and did not honor the previously awarded RFPs that had gone to contract, but had not been finalized. Unfortunately, due to a breakdown in communication and transparency between the OAA, local advocates and leaders, and members of the CCPC, the funding allocation process became highly politicized, exacerbating tensions in the HIV prevention community. Certain planning council members felt that prevention funds needed to be reserved for those most impacted by the epidemic, in this case, African Americans. And, indeed, the State Office of AIDS had released “guidelines” stating that existing funds should be prioritized for African American communities. Yet other constituents had concerns for the need for prevention activities in other communities where incidence rates in recent years have been starting to climb, such as Latino and Transgender populations. Unfortunately, the RFP process that took place left some feeling baffled by the way that the final allocations for prevention were made. *“It was completely baffling,”* stated one executive director. *“How could we be getting a state mandate to focus on African Americans and the RFP didn’t even mention African Americans in it? It’s no wonder we are still in a State of Emergency.”* At the time of our assessment, this confusion and tension still lingered.

**There were no warnings that the State funding would be cut, and so the County was not able to have contingency plans in place.** Because the OAA did not foresee the funding cuts and plan for them, basic services like HIV testing and counseling actually ceased or were cut back in some CBO’s for several months over the summer and early fall. *“We told agencies that we would not be paying for any more tests, they had to stop testing,”* reported one OAA informant. Indeed, a review of CCPC minutes from August 2009 notes that the county had ceased to provide funds for tests and had requested that those providing tests continue to do so and “absorb the costs under their own operating budgets. Some agencies will be able to absorb the costs and those that are unable to will downsize/close.” At one county hospital, where the general consent process in the Emergency Room had been tailored as part of a pilot program to have opt-out HIV testing in ER settings, test kits had to be used based on more conservative criteria. *“We went from screening 1200-1300 people a month to only doing about 600 a month, with no warning and no back-up plan. So instead of screening everyone, we used the CDC guidelines, so only for those ages 13-64, with no testing in the past 6 months.”* Once services resumed, testing became less available due reduced outreach staff

and resources. For example, in the case of one CBO working in East Oakland, the agency no longer has the resources to repair their mobile clinic to provide community-based testing. Other clinics had to close their doors, leaving parts of the county underserved. For those able to still access remaining services, people have to travel further to get to them, and wait-times are often longer.

**County resources were stretched, and there was no ability to ‘backfill.’** Alameda County itself experienced the impact of the economic recession and had to curtail county-provided social services, at a time when many clients needed them even more. Unlike in other counties, it was not possible for the county to help backfill the reduction in HIV-related funding with money from the general fund. In fact, Alameda County has been hurt by the economic downturn and is facing another serious shortfall in public funding again this year. As a consequence, other services that PLWHA depend on, such as General Assistance (GA) were cut. Housing allowances, Medicare, emergency bill payments -- all were either cut back entirely or had long waits associated with getting benefits. One project director explained, *“I have clients who don’t realize what’s happening, but GA is being cut from 12 months to 3 months. So as of March, they are not going to be getting any more GA. People are struggling financially and it is hard for them to stay in care. There is strain on Ryan White services, on other medical and social services, what’s going to happen? People are going to go off their meds. They are going to do whatever they have to do to pay the bills. Yet no one wants to talk about sex work and how people will do things in tough economic times.”* Perhaps because of this feeling of shortage, there were also reports of stockpiling medications and finding ways to conserve resources: HIV test kits, therapeutic blood monitoring tests (such as viral load counts), outreach and manpower. *“We don’t run a panel [which would have been previously paid for under therapeutic monitoring] until we know that they are our client. So if we get a person newly diagnosed, we wait for them to come back after that initial diagnosis before we do a panel. In the past, we would have done one during the first visit so we could get them started on treatment sooner.”* There was a fear that the ultimate consequences of the budget cuts would mean higher incidence rates, and higher viral loads among those living with HIV.

**Among remaining staff, there was a sense of frustration, and powerlessness as agencies closed offices and carefully constructed services disappeared.** Executive directors expressed frustration over the loss of funding for culturally-competent, meticulously built programming that had been the source of great pride for agency staff. Mono-lingual immigrant and migrant communities are particularly hard-to-reach and we spoke with service providers that had invested years of time and resources identifying a need, building rapport with community members, and creating specialized services for specific at-risk populations. In these cases, there was a sense of sadness over seeing these programs either taken over by larger agencies that perhaps did not have the linguistic abilities and deep cultural understanding of the staff from the downsized agency, or watching a program be slowly dismantled due to there being less resources to fund programming activities.

**Yet there was also a great deal of resiliency and adaptation to challenging economic times.** In some cases, the budget cuts were taken with a silver lining, forcing agencies to do more fundraising themselves, to expand prevention activities to reach different populations, and to compete for new funding streams. In many places, we encountered a willingness and a drive to explore new funding mechanisms and sources for support. *“I haven’t ever written a Kaiser Foundation grant before, but I’m going to learn now,”* one provider explained. There was also a willingness to adapt in order to keep doors open and to stay fiscally viable. In some cases, this meant *“We’re going to water down the beans,”* and so agencies tried to *“do more with less.”* For example, this meant cutting the full work week to three days, or eliminating health benefits for staff. Sometimes, though, the adaptation

took other forms. Two organizations that had previously been more oriented to prevention work were in the process of retooling themselves to become more clinically oriented, training staff, getting the appropriate licensing in place, and renovating space. Certainly, in Alameda County we discerned a deep commitment on the part of service providers, public health personnel, clinicians, and advocates to continue to do whatever is possible to support those living with HIV/AIDS, and to continue providing prevention activities, however limited, to the broader population despite the fiscal constraints.

## Fresno County

### **Background:**



Located in the heart of California's Central Valley, and covering a large geographical area of 5962 square miles, Fresno County has been the #1 agricultural county in the state for the past 45 years. The population of Fresno County was 909,153 as of July 2008 and is approximately 48% Hispanic or Latino, 35% White (not of Hispanic or Latino origin), 6% African American, and 2% American Indian/Alaskan Native. The median household income as of 2008 was \$43,534, and approximately 22% of the population lives below the federal poverty line. Fresno also suffers from the current foreclosure crisis and from relatively high unemployment (18.7% in March 2010, compared to the state average of 13%). The City of Fresno's population is estimated at 505,479, making it the fifth largest city in California. The city is the hub for the county, and the county in turn is a hub for the surrounding, more rural parts of the Central Valley.

From February 1983 through July 31, 2009, Fresno County reported 1,691 AIDS cases and 876 deaths. As of July 2009, the most recent month with data reported, Fresno County reports 203 cumulative HIV cases reported by name since April 2006. In 2008, the last year with complete data reported, Fresno reported 67 HIV cases for the year. Based on cumulative HIV cases reported until July 2009, the majority of the cases are among MSM (approximately 61%), then IDU (18%), and then MSM/IDU (7%). There are few cases due to heterosexual contact (13%). Reflecting the larger demographics of the area, 50% of cases are among Hispanics, 23% among Whites, and 20% among African Americans.

The Fresno Community Planning Working Council (CPWC) is made up of a relatively small, tight knit group of members that have known one another and worked together for many years. Senior staff from the Fresno County Office of AIDS, the local Medical Center, and from a large community-based agency anchor the group. Skilled facilitation is provided by a local professor skilled in community action and advocacy work, and members from the local organization for PLWHA are also heavily involved. The council handles both care and prevention planning, and was started when Fresno's application for Ryan White funding was granted approximately 10 years ago. Although the County health department controls the procurement of funds to local agencies and providers, it also until recently, provided prevention and care services itself through a County clinic. Still, there is a great deal of transparency that occurs at council meetings with OA staff sharing detailed financial spreadsheets and openly sharing news of funding shifts as they see them developing.

## **Themes:**

**The impact of closed facilities and loss of talented, compassionate staff placed additional burdens on remaining service providers.** In an era of consolidation and closing down public clinics, more and more private doctors who were not trained in HIV were providing testing and services—sometimes in an insensitive or incompetent manner. Thus, already overburdened HIV service providers found themselves also assisting providers who were uncomfortable with dealing with HIV, or who were not aware of the most recent treatment guidelines. One county health worker we interviewed explained that she had had to drive 90 minutes the night before to a corner of the county to deliver a positive HIV test result. The provider had called and said, *“I just don’t know how to tell him he’s positive. I don’t know what to do.”* Indeed, there were concerns from consumers over the possible closure of one of the only agencies left that catered to positive clients. *“This is the only place I’m comfortable, it feels like home....I don’t know where I’ll go if they close down.”* The agency had gone from having 8 case managers and staff to having 2, and this consumer noted that *“now there’s no ‘one on one’ time to talk”* due to the burdens placed on remaining staff. Interestingly, this consumer spoke of moving to the Bay Area because he had heard that services were done in a more confidential manner and that there were just more services for PLWHA in general.

**There was a cohesive community of HIV prevention workers and care providers.** While Fresno has a sizable population, for HIV/AIDS providers it is a somewhat tight-knit community, where many of the key players are the same longstanding core group that has been consistently active since the 1980s. Many in this group know each other well and have worked together closely for many years. They benefit from easy communication, as they often see each other several times each week. In difficult times, some reported feeling like at least they were *“all in the lifeboat together.”* And, indeed, when the budget cuts were announced and the possibility of layoffs discussed, it was apparent that there is a general concern about the wellbeing of core group members. As one County employee stated, *“We’re talking about people’s jobs here, their ability to pay the mortgage, to send their kids to school.”* The core group of dedicated HIV-related workers knew one another, and had a definite cohesion. While this cohesion made it possible for the group to pull together during tough times, it is also possible for people outside this group to feel excluded.

**Office of AIDS staff members were transparent with CPWC members.** The county Department of Public Health is in regular, frequent communication with providers and agencies, and the impression is one of transparency regarding fiscal matters. For example, at the April Community Planning Working Council (CPWC) meeting the Division Manager for Community Health from the Department of Public Health came in person to present updates about the likely forthcoming closure of its Specialty Clinic, thus giving agencies advance warning about impending cuts that would ripple through the community. News of the possible clinic closure was announced at to the CPWC on April 15; the closure was approved in a 3-2 vote by the Fresno County Board of Supervisors on May 11 [15].

**The social service net was contracting due to difficult economic times.** The closure of the Specialty Clinic was the direct result of lower tax revenues at the state and local level, and there was a general feeling that resources were drying up across the county. Indeed economic distress came up in many our interviews. For example, consumers we interviewed cited the cost of gasoline and the loss of gas vouchers as a barrier to attending support groups and accessing food pantries. Consumers and providers alike noted the total absence of HIV prevention efforts as well. One client noted, *“I wish Fresno was more like Africa.”* When pressed to explain his sentiment, he explained

that he understood that the government educated people about HIV in Africa, and there were ads about it and radio announcements, unlike in Fresno, where he lived. Providers noted challenges including a need to do more frequent outreach to the growing “tent city” in one part of town due to increasing homelessness. County workers noted, ironically, that their ability to provide outreach to people living in the tent city had contracted as that community grew. A definite air of needing to conserve dwindling resources permeated the County.

**In response to recent budget cuts, many providers and clients were being “set free,” a term we heard in several contexts.** For agency staff, being “set free” simply referred to lay-offs as funding streams dried up. In some cases, the layoffs were directly related to the state budget cuts. For example, one of the County staff that had been responsible for partner notification and HIV testing had to be “set free” and was sorely missed. In other instances, though, being “set free” referred to the closure of clinics or case management programs and the actual transfer of the cases to another service provider. The closure of the county’s Specialty Clinic, which occurred on June 28, 2010, eliminated services to 100 HIV-positive clients and 300 patient visits per month. Patient alternatives included the Community Medical Centers Specialty Clinic, which was prepared to take as many as 65 new clients from the Specialty Clinic, but it was unclear how many of the remaining clients could be “set free” if they were not able to see one of the two private providers available. At the time of our assessment, there were grave concerns about the continuity of care for these patients and the need to help them maintain appropriate treatment.

**These events highlighted the need for more diverse funding streams, with many agencies highly dependent on one or two sources of funding.** HIV-related service providers, health department personnel, and consumers all saw the value in branching out to seek out new sources of funding and trying to diversify the sources of support they received. Because many places were previously reliant on a few sources of support, when contracts were not renewed, they often had no alternative but to cut off services. This is true from smaller agencies to the county Department of Public Health, which receives no direct funding from Fresno County itself for the services they provide. The members of the planning council openly discussed the need to apply to private foundations to find novel avenues for funding to flow into the care and prevention of HIV.

**For those remaining staff, it was increasingly necessary to wear multiple hats and take on additional duties, both officially and unofficially.** One agency’s cook was also a case manager, and a public health manager in HIV prevention was newly charged with vital records. Combining job duties as positions were eliminated allowed individuals to remain employed, but complicated and diluted their job responsibilities. Demoralization and burnout are risks as the remaining service providers see people are slipping through what seems like an unraveling safety net. One incident reported to the CPWC involved a recent diagnosis of an 18-month-old child with full-blown AIDS, previously undetected.

**On the other hand, there was an increased sense of the need for volunteerism to get the job done in times of tight budgets.** During our site visit in April 2010, the CPWC took up a proposal to initiate volunteer-based prevention and outreach in bars, tentatively slated to start during the summer, based on commitments from agencies and staff at the table. Thus, people already facing increased job responsibilities were taking on even more, because they concluded it was the only way that prevention and outreach were going to happen in the current environment. Consumers and clients (such as the We C.A.R.E. group at the Community Health Centers Specialty Clinic, which is a

growing body of local PLWHA) are increasingly organized and involved as well as a “do it yourself” mentality becomes more prevalent.

## Los Angeles County

### **Background:**



Home to nearly 10 million residents, Los Angeles County was the largest of the three counties visited in terms of size, number of HIV/ AIDS cases, number of AIDS Service Organizations, and in terms of HIV/ AIDS funding. Indeed, Los Angeles County is the most populous county in the nation and has a diverse demographic profile with Latinos accounting for 46% of the population, Whites comprising 32% of residents, Asian/ Pacific Islander 13%, Black 9%, and American Indian less than 1%. From the time period 1990-2000, Latinos represented the fastest growing community with a 28% increase, and are expected to be a majority within the 2010 Census.

There are over 42,000 persons are currently living with HIV/ AIDS in Los Angeles County, with 36% of living AIDS cases in California residing in Los Angeles County. Of those living with HIV/ AIDS, an estimated 39% are Latino, 35.6% White, 22% Black, 3.1% Asian/ Pacific Islander and less than 1% American Indian. HIV/ AIDS has a clear disproportionate impact on Blacks in Los Angeles County as they represent 9% of the total population, yet constitute 23% of those living with HIV/ AIDS. With respect to gender, 87% of the HIV/ AIDS cases are among men and 13% among women. Men who have sex with men constitute the greatest burden of disease with 72% of cases being among this population, while heterosexual transmission accounts for 11% of cases.

Encompassing over 4,000 square miles of land, eight Service Planning Areas (SPAs) were created in Los Angeles County in 1993 by the Children’s Planning Council. The SPAs were approved by the County Board of Supervisors and are used by County and City Departments as geographically designated areas that encompass at least two Board of Supervisor boundaries. Each SPA has its own unique demographic and HIV/ AIDS profile. An important characteristic of the SPAs is that they re-craft traditional zoning and political areas across the large landscape of the county.

According to data from the National Center for Charitable Statistics [16], in Los Angeles County there are over 60 registered AIDS Service Organizations. These organizations vary greatly in terms of size, revenue and assets. The largest organization in Los Angeles, AIDS Healthcare Foundation, generates over \$68 million in revenue and \$48 million in assets. AIDS Project Los Angeles, the next largest organization in Los Angeles, creates \$17 million in revenue and \$9.5 million in assets. However, most organizations create much less revenue and many are dependent on State and Federal dollars to maintain operations. A reduction in fiscal dollars has greatly dampened the sustainability of these smaller agencies.

As noted in the 2009-2013 LA HIV Prevention Plan [17], in 1990 local activists in Los Angeles County formed the County/ Community Planning Council to collaborate with the County AIDS Program office (now known as the Office of AIDS Programs and Policy) to develop an HIV Strategic Plan. This original council predates the CDC 1993 directive for local community planning. In 1995, an act of the

Los Angeles County Board of Supervisors established a fully functional Commission, known as the Los Angeles County Commission on HIV (commonly referred to as 'The Commission'), to prioritize and allocate Ryan White funds. The Commission replaced the former Planning Council and remains the primary HIV/ AIDS Care community planning group to date. The HIV Prevention Planning Committee (PPC) serves as the CDC-required community consultation and planning committee. The PPC has the responsibility to make recommendations regarding targeted HIV risk groups and appropriate prevention interventions in Los Angeles County. Membership of the PPC is comprised of community provider staff, local community leaders, and staff from the county health office. Together, the PPC and the Commission take roles in working with the OAPP to prioritize HIV programming in Los Angeles County.

Prior to the State fiscal reductions, the County Office of AIDS Programs and Policy received the majority of its funding from three major sources: Los Angeles County general funds (\$17 million), State Office of AIDS (\$24 million), and Ryan White funding (\$35 million). After the reductions, State funding dropped \$11 million to \$13 million. Facing an \$11 million dollar deficit, the OAPP worked with the PPC and the Commission to re-prioritize HIV/AIDS service categories and its remaining funding. Through this process, which consisted of cutting or reducing lower priority services, Los Angeles County was able to preserve or partially preserve many service categories. However, certain service categories, such as peer support, capacity building, and treatment adherence were cut altogether, and those cuts actually did impact the health of consumers we spoke to in Los Angeles.

### ***Themes:***

**Key stakeholders in Los Angeles County did a “*smart job*” in allocating general funding to programs that stakeholders prioritized.** Various participants gave praise to the OAPP in their proactive approach to preserving HIV service categories and for their transparency in relaying actual dollar amounts lost due to the State fiscal reductions. In a Provider Briefing on 18 September 2009, Mario Perez, Director of OAPP, delivered a power point presentation that addressed the OAPP response to the State budget cuts. The presentation included specific funding amounts for Los Angeles County pre- and post-budget cuts, as well as outlined the service category areas that would be preserved, partially preserved or eliminated. The Los Angeles County Commission on HIV also took a lead role in prioritizing funding allocations and influencing the preservation of HIV/ AIDS service categories. Proactive engagement and strong leadership of these key stakeholders in the County helped to lessen the impact of the fiscal reductions and maintained a sense of collaboration during a critical transition period. .

**“*Sunsetting*” of health education and risk reduction services and movement toward more “*clinical*” based services.** Participants noted that many agencies are currently trying to piece together programs that may not be as effective or as culturally sensitive as they had been previously. This was especially true for smaller agencies that focused on prevention programs. Agency staff acknowledged that there has been a reshuffling of services and that their organizations are moving in new programmatic directions. In particular, these agencies are looking at programs geared toward issues such as outpatient substance abuse as well as capacity building with organizations in order to stay afloat in the current fiscal climate. Some participants we spoke to noted that they fear that reductions to prevention services, such as prevention outreach, may end up creating resurgence in the epidemic in the years to come. Yet, as testing and counseling services were not impacted by the last round of budget cuts due to the re-prioritization, agencies are looking toward incorporating these types of clinical services into their programmatic activities. During the negotiation of the impact of the

budget cuts, LA County faced difficult choices trying to balance cuts to prevention and care and support services. We interviewed staff at prevention agencies that felt that badly needed, culturally tailored prevention programs were cut at the expense of support services, and we likewise spoke to care advocates who believed some badly needed support services were cut to save prevention modalities. Either way, among all of the participants interviewed, there was a consensus that the impact of the cuts were being felt in both prevention and care sectors and the consequences of the budget reductions will likely result in higher incidence rates in Los Angeles in the years to come.

***“Times are tough right now.”*** Clients were feeling the impact of the greater economic recession as well as reduced prevention and support services in Los Angeles County. This had led to the careful monitoring of those services still being provided to make sure they reach their intended beneficiaries. For example, at a larger AIDS service organization a provider explained that the staff at one of their satellite offices had had to start turning people away from their food bank who were not residents of Los Angeles County. He explained that the larger economic recession and cutbacks to public services had led to increased demand for their agency’s food support services and the pantry had been running out of food early. Agency staff discovered that people living with HIV from a neighboring county had been trying to access the pantry because there were no longer food support services in their home county, and they were unemployed. Along with carefully rationing existing but reduced services, there was also the impact of services that had been cut altogether. For instance, a client participant had switched medical providers recently (her previous provider stopped taking Medi-Cal) and after several months, she discovered that her new doctor had put her on the wrong treatment regimen. This situation might have been avoided with the help of a treatment advocate, one of the care-related support services that the County had to discontinue in the wake of the budget cuts. Although microcosmic examples, these client and provider narratives speak to the notion that although some services were able to be preserved or partially preserved, the longer wait times and scarcity of services through consolidation and elimination have affected the way PLWHA navigate the social service arena.

***“Serving populations is not the same as being culturally competent.”*** Participants stated that in Los Angeles County, over the years, many agencies began to specialize in certain populations (e.g., Latino MSM, Black women, etc.). These organizations became “one stop shops” for their chosen populations. That is, they provided a gamut of services ranging from prevention to mental health to substance use. After the budget cuts, these agencies had to reassess their programmatic activities and began to refer clients to other organizations to fill deficiencies left in their agency as programs were eliminated and/or reduced due to the budget cuts. However, concern exists among consumers and providers regarding the competency of those agencies to absorb client populations from other organizations, and that they have not traditionally specialized in. One participant compared the importance of providing culturally competent services to shopping at a specialized ethnic food market. He explained, *“When one goes to a regular (mainstream) market there’s always the ‘ethnic aisle.’ But, for example, when one goes to a Latino supermarket, everything about it is ethnic: the food, the smells, the music, the people.”* In effect, the State fiscal reductions have reduced the number of specialized HIV “markets,” and limited the availability of services for populations that used to have specialized programs to meet their needs. As 40% of the HIV epidemic is among Latinos and a significant number of undocumented Latino immigrants are living with HIV/ AIDS in Los Angeles County, there is particular concern to continue to meet the needs of this population.

**As the initial aftermath of the fiscal reductions was met with a time of transition, “the true impact of the cuts is just starting to be seen.”** The State fiscal reductions had direct impacts on

agency staff that received state funding. A participant from one organization noted that the past six months had been a reshuffling process for all HIV service agencies. It was stated that initially agencies had to reprioritize their programs and staff, then clients had to adjust to these changes and re-acclimate themselves in the new social service terrain. *“It was just chaos,”* noted one participant when describing the immediate aftermath of the cuts. More and more there have been limited spaces available among agencies to meet a growing demand of client services, and there is concern about what happens now that *“next year is here.”* With the increases in client enrollment, larger agencies questioned the appropriateness of maintaining enrollment when there was less capacity to deliver services. As one of our informants took note, the basic dilemma is: *“is it ethical to bring on clients when you know you can’t really help them out?”* Some organizations are beginning to look at waiting lists as a solution.

**The question of “who’s at the table?” prevails in Los Angeles County HIV programming politics.** Because individuals representing agencies sit on the Commission and PPC, those who were at the table were able to be “in the know” and to share their knowledge with their constituents. That is, those who saw the proverbial “writing on the wall” were able to relay this information to their organizations and collaborators. However, after the budget cuts, agencies that suffered greater staff losses began to lose their voice at the table. Those organizations that had staff taking on the roles of former colleagues who were lost due to the fiscal climate, no longer were able to have those staff take time to represent and sit at stakeholder meetings. This process occurred despite efforts on the part of planning council members to keep meetings open and welcoming. Still, limitations caused some agencies to stop attending meetings. This has a two-fold effect. On the one hand, the agencies that can no longer represent at the table are no longer “in the know.” On the other hand, there is concern by some participants that not being present at the meetings could be perceived as though these agencies no longer want to participate in the discussions. One reason for the importance of having diverse representation at the stakeholder meetings is that some of our participants perceived that the experiences of those at the table did not necessarily reflect the experiences of their particular clients.

**“All of the band-aids are on.”** Many stakeholders feared reductions to other services due to additional budget cuts in coming years. In particular, there is a great deal of concern for AIDS Drug Assistance Program (ADAP) funding. According to staff at OAPP, there are an estimated 61,000 people living with HIV/AIDS in Los Angeles County. Of those, 17,000 are part of the Ryan White Program-funded system of services. Of those 17,000, 14,500 rely on the County specifically for medical services, with about 1000 new people each year requiring services. As it is now, the County consumes about 40% of overall ADAP spending throughout the State of California. If ADAP were to be cut, *“the system would dismantle.”* Indeed, many participants highlighted the concern for the future of ADAP and the role the State would play in maintaining or eliminating those funds. One participant noted that with the current growth curve of ADAP, its sustainability for future years may not be fiscally sound. This participant suggested that a better solution would be to lobby and advocate for drug prices to be reduced and to initiate rebates for drug companies. ADAP remains a key piece of the HIV service puzzle. Many participants worried that with the safety net of services stretched to capacity, “there are no more band-aids” to help lessen the blow of further fiscal reductions, especially those that might somehow impact ADAP spending.

## Themes Across Counties

Although each county we visited had its own unique characteristics, demographics and HIV/AIDS profile, four themes emerged that were common among all the counties. The following findings reflect the significant influences associated with the way HIV-related services were preserved, reduced or eliminated. These findings also highlight the factors that enabled local stakeholders to collaborate in a time of fiscal transition.

1. **Transparency and Collaboration Matter:** In counties where there were tensions between community-based organizations, health departments, and providers, the budget exacerbated the tension and competition for resources. Transparency, even when the news was bad news, seemed to alleviate fears and made local HIV stakeholders feel part of the process and better able to cope with the consequences of the state budget cuts. In some places, this meant collaborating with other agencies to maintain client services.
2. **Size Matters:** Providers with more capacity tended to be at the table, whether part of the planning councils or networked into larger policy discussions, and were better able to weather the impact of the budget cuts. They were able to hear about potential changes in funding streams and plan ahead by not making new hires or by conserving organizational resources. Those smaller entities that were not included were sometimes further marginalized in the redistribution of limited resources.
3. **Networking and Sharing Information Matters:** Those who were in the know, shared the know, and were able to prepare for the budget cuts and therefore survive.
4. **Capacity Matters:** As workers had to be let go, and services consolidated or cut, many remaining agencies have gone into “survival mode,” which is characterized by low morale and workers often wearing multiple hats. As a result, already strained resources are now stretched and there is little time to attend community planning meetings, or, in the case of providers, to attend trainings. Some fear that they are no longer part of the decision making process and their client perspectives are no longer represented; others are concerned about staying abreast of new developments in the field of HIV prevention. For others, there were more long term fears that centered on people “slipping through the cracks” and becoming infected or, for those already infected, not receiving the support they need to stay healthy.



## Moving Forward

- ***The cuts compromise California's ability to achieve desired HIV prevention and treatment outcomes.*** All of the band aids are on. Informants said that the HIV-related service sector could not withstand another cut in funding. Many of those still working in the field mourned the loss of talented colleagues, as well as the closure of carefully crafted prevention programs and services for PLWHA. They feared that California will suffer from increases in HIV incidence and morbidity in the coming years due to these cuts.
- ***The cuts will hinder California's participation in national efforts to reinvigorate the US response to HIV/AIDS.*** Although many felt inspired by the reinvigoration of HIV prevention efforts at the federal level, there was also a realization that there were no local or state funding streams to implement the ideas laid out in the National HIV/AIDS Strategy.
- ***The cuts will likely reduce the success of new models of treatment and prevention in the state.*** The budget cuts gutted prevention funding, and even some services that were designed to support PLWHA. Providers worried that in an increasingly medical model, where there is an emphasis on test and treat, there may not be adequate support structures in place to help people stay adherent to medications, or to identify those that need to be brought in for testing. Indeed, the test and treat paradigm cannot work without prevention outreach, stigma reduction, and social marketing to bring people in for testing.
- ***The cuts may result in a loss of talent from California agencies and clinics.*** There was a great deal of concern over brain drain, both in terms of HIV service providers, such as case managers and test counselors, but also in terms of medical professionals who specialize in HIV. Even with funding available for training HIV doctors, with multiple clinic closures across the state and the consolidation of existing services, there were concerns that HIV doctors are overextended, with no time to attend trainings or to provide high quality care to their patients.

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