APLA
AIDS Project
Los Angeles

30 years

APLA'S FIRST SITE: 1983

2012 Annual Report

DEAR FRIENDS: This year, AIDS Project Los Angeles marks its 30th year of service.

It is astonishing to look back over that broad span of time and realize how much we've learned—yet how far we still must go.

No longer are children who are living with HIV routinely kicked out of school from baseless fears of contamination—yet sons and daughters are still barred from family gatherings for similar and senseless reasons.

No longer are people who are HIV-positive regularly refused medical care, and universal precautions are just that—universal. But our clients are still met with resistance and fear from dentists and other health care providers who don't understand even the basics about HIV.

And no longer are we seeing dramatic, across-the-board jumps in HIV infection rates—but the disease continues to spike among certain high-risk groups. In many parts of the U.S., one in two African American gay men, for example, is now HIV-positive.

At milestones like this, it's easy to turn toward the data—the numbers that help us to understand and make sense of the tragedy.

Yes, 1.2 million Americans are now HIV-positive. Twenty percent of them do not know it. We have lost 600,000 in the U.S. since the epidemic began. And on average, we lose another 50 people each day. But behind these numbers are people—their lives changed and uprooted by HIV and so many other challenges.

There's the Green family, Kelly and Jackie and their daughter, all three HIV-positive. They've battled poverty and hunger, but through APLA's Housing Support Services, they were able to find a home. And from our Vance North Necessities of Life Program food pantry site in Long Beach, they were able to put life-sustaining food on their table.

There's Lisa, an Air Force veteran with two college degrees, rendered jobless and homeless when HIV stole her health. She lost her son to the foster care system—but she, too, found housing from APLA, and mother and son are happily reunited.

There's John, a mid-20s college student who tested HIV-positive at our APLA Health & Wellness Center in Baldwin Hills. Initially frozen with fear and far from family, he connected with peers at our support group for those who are newly diagnosed, and he's become an outspoken young advocate of frequent HIV testing.

And there's Raul, whose weight plummeted to 90 pounds in the throes of AIDS. An even further indignity, his tightly knit family refused him access to their bathroom, forcing his weakened frame to walk blocks to a gas station restroom. But through the unyielding efforts of an APLA nurse and social worker, he regained his health, a stable home, and even flew to Washington, D.C. to testify before Congress on behalf of others living with HIV/AIDS like him.

At APLA, we don't "celebrate" our anniversary in the traditional sense, because we've worked over these decades to offer life-sustaining support to people facing incredible and seemingly insurmountable strife. The very fact that we exist speaks to ongoing pain and hardship in our own neighborhoods.

But here's what we do celebrate: the unbelievable accomplishments of our clients, so many of whom have made tremendous strides in the face of such adversity. We also cherish the generosity of our volunteers, incredible people who, this past year, gave more than 65,000 hours of their time to do everything from staff our special events to pack our food pantry grocery bags. And we treasure your amazing gifts of funds, because private dollars have been our single most important and dependable source of providing critical client services, education, and advocacy—from day one.

In this, our 30th year, we **THANK YOU** for your enduring support.

Rodney Gould

Rodney Gould
Chair, Board of Directors
AIDS Project Los Angeles

Craig E. Thompson

Craig E. Thompson
Executive Director
AIDS Project Los Angeles

AIDS PROJECT LOS ANGELES

What We Do

Since our founding in 1983, APLA has grown to become one of the largest and most effective AIDS service organizations in the nation. We are proud to be commemorating 30 years of service.

IN 2012:

1285 HIV TESTS Were Given

4,527 CALLS were answered on our Clientline

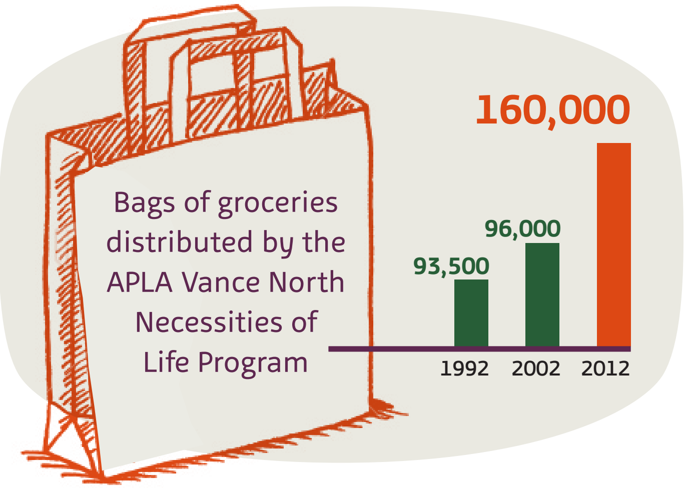
65,000 HOURS were worked by our volunteers

71,815 HOURS of in-home health care were provided for clients too sick to leave home

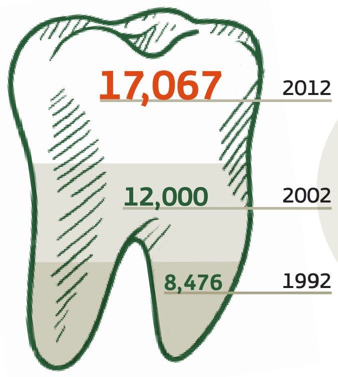
2,424 HOURS of counseling services were provided

95% of our clients live on less than $20,000 a year

OVER HALF OF OUR CLIENTS LIVE ON LESS THAN $10,000 A YEAR



Bags of groceries distributed by the APLA Vance North Necessities of Life Program



Dental procedures performed by APLA Dental Services

1980s | THE EPIDEMIC

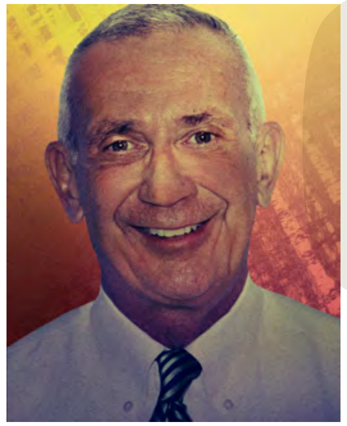
1983—From Patients to People: *The Denver Principles*

The history of HIV and AIDS begins long before today's reality of HIV drug cocktails, comprehensive funding packages, and networks of AIDS service providers. It stretches to the earliest days of the 1980s, before the words "HIV" or "AIDS" even existed.

Intertwined with its medical history are powerful social and political histories. Those living with AIDS, often labeled as helpless "patients" and "victims," would quickly launch a striking movement toward self-empowerment that would fundamentally change not only the AIDS epidemic but the entire relationship between health care providers and those in their care.

It began with a constitution of sorts, The Denver Principles, *that articulated exactly how people living with the disease wanted to be treated: No longer as passive victims but in fact as "people with AIDS," experts in their own stories, and key stakeholders in their own treatment.*

We spoke with **Lee Klosinski, Ph.D.,** *the Senior Associate Director of the UCLA Nathanson Family Resilience Center, about the significance of the Principles and the movement that followed—both for those living with HIV/AIDS and for all who interact with the healthcare system. Dr. Klosinski served as the director of programs at APLA from 1990 through 2005.*



> "We ask for a sense of support. We discourage blame and stigma in medical care."

Lee Klosinski, Ph.D.

APLA: *The Denver Principles* begins with the phrase, "We condemn attempts to label us as 'victims,' a term which implies defeat, and we are only occasionally 'patients,' a term which implies passivity, helplessness, and dependence upon the care of others. We are 'People With AIDS.'" But this was a different era. There was no Internet, no rapid spread of information from researchers to the public, and many people with HIV and AIDS lived under a cloud of stigma and fear. How did *The Denver Principles* change that?

Lee Klosinski, Ph.D. (LK): In 1983, the general public was terribly fearful and under-informed about the disease. People often held a one-sided view: An AIDS diagnosis was a grisly death sentence, and those who had it were viewed as sinful, criminal, even mentally ill. The public distanced itself and looked down on the disease and those diagnosed with it. As a result, a vast amount of stigma descended on those diagnosed. But rather than being silent, parts of the community erupted. We realized that we had to take care of ourselves because no one else was going to. So one of the first steps was to make a bold assertion: That someone with a life-threatening, highly stigmatized illness could claim that disease as part of their identity. That we were not primarily patients and victims but "people with AIDS."

What led to this realization? A sense of anger, frustration, or being misunderstood? Panic about the disease?

LK: Perhaps all of those things. The earliest helpful public discussions about AIDS were led by physicians, scientists, and public health officials. The authors of *The Denver Principles* recognized that none of the voices in the conversation came from those who actually lived with the daily reality of AIDS. So they began to speak up. This effort grew from the "our bodies, ourselves" philosophy of the women's health movement and the "out of the bars and into the streets" spirit of Stonewall and the gay liberation movement—come out, be out, speak your mind, and never be silenced again.

Do you think those early advocates anticipated that their views would become a call to action for so many others affected by chronic disease?

LK: I don't think they realized the momentous impact their work would have on the practice of medicine in the United States. It had far-reaching implications for the patient-physician relationship; it affected how information was shared from provider to patient; it raised the notion of patient privacy and provider sensitivity to an entirely new level; it even pushed the envelope of patient safety in a good way and raised awareness about the need for universal precautions that are just that—universal. Not based on stereotype but based on genuine concern for biohazards.

Do you believe that The Principles still hold as much significance today? And for whom?

LK: Absolutely. You can't really find anything in *The Principles* that doesn't apply today. They are the abiding beliefs and aspirations of the people with AIDS/HIV empowerment movement: We ask for a sense of support. We discourage blame and stigma in medical care. We form caucuses in medical decision-making that include the person with the illness. We haven't added or removed anything from this document. What we have done is moved this ethos out into other communities and new generations. ◢

1980s | APLA

1983—Powerful Compassion: AIDS Walk Los Angeles

In the 1980s, a new era was dawning in the United States.The Reagan presidency was changing America. So too was the AIDS epidemic. At the time, **Craig R. Miller** *was in his early 20s and working as a community organizer and political activist. He was also California's youngest professional campaign manager, with close ties to local elected officials including Congressman Henry Waxman. He had participated in a number of pledge-type fundraising events but had never organized one. Soon he would: AIDS Walk Los Angeles.*

In late 1984, at age 25, Miller, while working as a staffer for both a California state senator and a U.S. Congressman, approached APLA with a written proposal: Miller, with business partner Richard Zeichik, would produce a "walk-a-thon" fundraiser to provide APLA desperately needed funding to serve skyrocketing numbers of clients. Miller requested $13,000 in starting capital and set an ambitious goal to raise $100,000.

Now, 28 years later, the Walk has become a nationwide movement, raising an astonishing sum of more than $350 million nationwide to fight AIDS. We sat down with Craig Miller to find out how it happened.

> "To me, the future of the movement means not forgetting the lessons we've learned along the way."

Craig R. Miller

APLA: When did you first realize that you were going to do something to change the course of the epidemic?

Craig Miller (CM): After attending a candlelight vigil sponsored by APLA in 1983, I realized that we had a full-scale emergency on our hands. And I saw two very scary things co-occuring: The beginning of a massive epidemic—at a time when the federal government was focused on shrinking "discretionary" spending—of the type that would be needed to respond to a colossal public health emergency. I was enough of a student of politics to know that our federal government's response would be anemic at best. So the idea behind the Walk was to fill the funding gap left by an unresponsive government. I knew enough about campaign budgeting and messaging from my political work; and Richard [Zeichik] had a background in grassroots fundraising; and thus it began.

What was that first meeting with APLA organizers like?

CM: I remember it so well. Bill Misenhimer, APLA's executive director at the time, was working from rented apartments that comprised APLA. I outlined the game plan and emphasized that it was a relatively low-risk proposition. As we spoke, desperately sick young men would be ushered into Bill's office, with fear and hunger in their eyes, and he would hand them food vouchers that he kept in a drawer in his desk. It was devastating to watch—so when Misenhimer agreed to the proposal, we knew that we had to work quickly.

What were your expectations around that first AIDS Walk Los Angeles?

CM: At first, we set an ambitious goal to raise $100,000 with 1,000 attendees. But as the event date neared and we surpassed our goal, Richard and I realized that we might hit a quarter of a million dollars. And then, on event day, as the numbers came in, it hit us: We were going to raise well over $600,000 with 4,500 participants. I'll be honest: I cried. Bill cried. And I thought back on that march on the federal building, and I felt that we had built a forum for the community to express a sense of powerful compassion. We felt embraced, filled with hope, and we thought, "You know, we just might be on the right track."

How did you go about building this into a whole movement?

CM: We didn't go into this as a career move or with a long-term business plan or organizing agenda. We were simply responding to a crisis as best we knew how. Then we realized there was a real need—stretching from Los Angeles to New York and elsewhere—and I felt that we could help fill that need… to spread this powerful compassion that the first event gave rise to.

You have, indeed, given rise to a movement—one that has raised hundreds of millions for the fight against the epidemic. What do you see as the movement's future?

CM: I feel grateful to continue making a difference. To me, the future of the movement means not forgetting the lessons we've learned along the way. That is, that government cannot always be counted on to effectively confront every public health emergency. That's why I'm so deeply honored to continue our partnership with APLA and to act on the lessons we've learned in this 30-plus year struggle. ◢

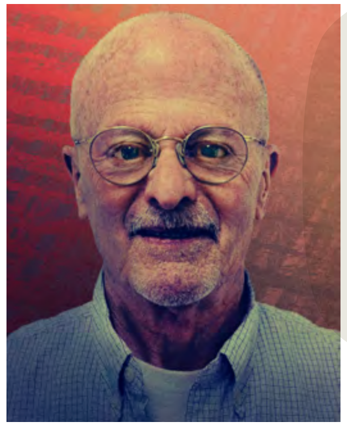
1990s | THE EPIDEMIC

1993—Ryan White: The Feds Step In

By various accounts, the federal government's response during the early years of the AIDS epidemic was "anemic," "uncertain," "belated," or in the words of some, "a deadly failure."

But the 1990s ushered in a new era of federal support—chiefly through what is loosely known as "The Ryan White Program," the single biggest federal program to help people living with HIV/AIDS. According to the Kaiser Family Foundation, "The program provides care and support services to individuals and families affected by the disease, functioning as the 'payer of last resort' by filling the gaps for those who have no other source of coverage or face coverage limits." It took its name from Ryan White, a young Indiana boy who contracted HIV via blood transfusion and died in 1990.

We spoke with ***Phil Curtis,*** *APLA's current director of government affairs, about the program's enduring impact. Curtis was a case manager at APLA at the time that the program began.*



Phil Curtis

> "What the Act really offered was a stable source of funding for HIV medical treatment."

APLA: How did Ryan White funding come about—and what took so long?

Phil Curtis (PC): In many ways, the Ryan White CARE Act was the eventual result of what was initially a catastrophic failure of political will. Something very dangerous was happening, but because it was associated from the start with gay men, a highly stigmatized group, political leaders just didn't know what to do about it. [Editor's Note: "CARE Act" served as an acronym for "Comprehensive AIDS Resources Emergency Act."] It wasn't until 1990 that things started to turn around. Policy leaders, like Henry Waxman and Orrin Hatch, finally started to take action, and their progress was pushed along through increased public attention, spurred largely by a Congressional visit from Elizabeth Taylor. After the first dollars were allotted, she demanded that they be quickly spent for the benefit of those suffering. What was perfectly clear to many people was that there was a rolling emergency going on, what was needed was action, and it was slow in coming.

So in those early years, how did people get help—especially if they couldn't afford the first AIDS drugs?

PC: You had a small amount of federal funding—but that's really where private organizations like APLA stepped in to help. They were sustained by private donors—individuals and corporations that understood the scope of what was happening—and volunteer power. Some state and local funding came in, but private dollars sustained the response for a very long time. The CARE Act was the first major, federal infusion of dollars that we saw.

How did the CARE Act affect the response, then?

PC: The CARE Act really built itself around the response that was already taking place—given that we were nine years into the epidemic. You had individual government entities and organizations like APLA responding, so the CARE Act filled in the blanks to a certain extent. It was much like a response to a disaster—you had the local relief efforts, and then you had the federal government stepping in, as well.

What did that response look like?

PC: Initially, it really provided funding for care and treatment, where previously there were no funds. So for those who were too ill to work, they would lose their jobs—and their health insurance—so the only solution was to turn to public clinics and hospitals. What the Act really offered was a stable source of funding for HIV medical treatment for both people living with HIV/AIDS and the organizations that served them. And, sadly, it did come at a time when death rates were catastrophic, when many people couldn't turn to their families because of stigma, when mothers were still infecting their babies. Before the Act, you could argue that the U.S. was really still at a place that, unfortunately, some developing nations are still at with HIV.

How has it grown and adapted over the decades?

PC: It's certainly grown financially—from $220 million at the start to nearly $2.4 billion now. More than 500,000 people benefit from this vital funding, and there are a number of different facets now: It funds everything from treatment to HIV testing to dental care to specialized services for specific populations, like youth, women, gay men, and people of color who are living with HIV and AIDS.

So what's the future of the Act, especially in light of the Affordable Care Act (the ACA)—or so-called "Obamacare"?

PC: That's not entirely known. It's certainly evolved from an emergency relief measure into a vital part of the planned, national response. And there's no question that the Act has been critical to getting people linked and maintained into medical care. But the ACA will do a lot of the heavy lifting now, so Ryan White will certainly evolve. But two things are clear: It was a long time coming, and it's still a critical source of support for life-saving care and treatment—now and into the future. ◢

1990s | APLA

1993—The Landscape Shifts: HIV Drug Therapies

In the early 1990s, the outlook for people living with HIV/AIDS was particularly bleak. Only one anti-HIV drug existed, and by 1994, the rate of death from AIDS-related causes was at an all-time high. More than 241,000 had died nationwide, and AIDS had become the number one cause of death for all Americans ages 25 to 44. But the landscape of HIV treatment was about to undergo a tectonic shift.

The year 1995 ushered in HAART, or Highly Active Antiretroviral Therapy. Ultimately, HAART would end the era of an HIV diagnosis as a death sentence and fundamentally change the role of AIDS service organizations like APLA.

We spoke with ***Dr. Michael Gottlieb,*** *a Los Angeles-based physician and immunologist, on the impact of HAART. Dr. Gottlieb is widely known as the author of the first official report, released June of 1981, that described five patients who presented with a cluster of highly unusual symptoms that would ultimately become known as AIDS. All five would die within a year.*

Dr. Michael Gottlieb

> "I remember literally getting goosebumps when I heard of HAART."

APLA: Thank you, Dr. Gottlieb, for taking the time to share your experience. Will you begin by explaining how you became so intimately involved in the epidemic?

Michael Gottlieb, M.D. (MG): It was really by chance. Over the course of a few weeks, five young, gay male patients came to me with Pneumocystis carinii pneumonia (PCP) and clearly compromised immune systems. I could see that they were afraid—but they also viewed doctors as capable of diagnosing and treating their disease. They didn't know—and we didn't know—that this was the beginning of a downhill course. When all five died, it was a tremendous loss for me, and it drew me in with a desire to find out what was happening and how I could help.

As you and other providers realized that an epidemic was spreading rapidly, what did you tell your patients who presented with the disease?

MG: Honestly, we didn't have to tell them much. Many already realized that they would likely die within months and just wanted to ease the pain of the process. At times, I would still hold out hope that there might be something we could do to save their lives. But it was wishful thinking.

So after nearly 15 years of losing so many patients to AIDS, let's talk about HAART.

MG: I remember literally getting goosebumps when I heard of HAART. It was a fundamental change in the way we could treat HIV, using combinations of medications that attack the virus from multiple angles.

These powerful drugs work in concert to interfere with how HIV enters your cells, spreads through your body, and transmits from one person to another. In this way, HAART protects the body's immune system from rapid damage. Without it, HIV can quickly spread and destroy the immune system, allowing otherwise-treatable infections (like flu, pneumonia, or even a cold) to become deadly. HAART created tremendous change for people with HIV and AIDS.

How has HAART impacted the need for services from providers like AIDS Project Los Angeles (APLA).

MG: At the outset, many people living with HIV were focused mainly on one thing—dying. But with HAART, many realized that they would live. It was miraculous, but it also brought on an entirely new set of challenges. Those living with the disease were (and often still are) ostracized from family and friends, facing an entirely different set of hardships, including poverty, hunger, homelessness, addiction, lack of access to care, and much more. That's where APLA and other organizations have really played a crucial role. APLA links its clients directly into care to ensure that all can benefit from the advances of HAART—but it really doesn't just stop there. APLA offers an entire network of services for the whole person: dental clinics, in-home care for those in fragile health; mental health counseling for those facing anxiety and depression; housing help; and more. If those issues go unaddressed, the chances are far less that clients will access and benefit from HAART. I've literally had clients tell me that APLA has served as the key connection between getting care and not getting care—a bridge between life and death.

With the treatment and social services that are now available, what do you tell new clients who have just been diagnosed. What does the future of life with HIV look like?

MG: Just today, I saw a 22-year-old who is HIV-positive. He's getting connected into care and is receiving comprehensive social support. He's coming to grips with the fact that he has a chronic disease that will require ongoing treatment. But I told him to plan for retirement. Life with HIV isn't easy, but the outlook is much more hopeful now. Will we see a cure for him tomorrow? Sadly, no. But in his lifetime? We just might. ◢

2003—The U.S. Global Response: PEPFAR

Researchers debate where and when HIV first infected humans. But the AIDS epidemic "officially" began in Los Angeles, when doctors, including Dr. Michael Gottlieb (interviewed on the preceding page), began seeing a small cluster of gay men in 1981 who reported unusual symptoms of a quickly fatal disease.

By 1982, the first AIDS case was reported in Africa—a continent which would ultimately become the nexus for the international epidemic. By 2003, about one million Americans were living with HIV or AIDS—but globally, more than 31 million were infected.

That year, President George W. Bush proposed PEPFAR, the President's Emergency Plan for AIDS Relief. PEPFAR began as a five-year, $15 billion initiative and remains the single largest commitment of any nation to fight a disease.

We spoke with ***Noah Metheny,*** *the Director of Policy at the Global Forum on MSM & HIV (MSMGF), on PEPFAR's decade-long impact. The MSMGF, for which APLA serves as Secretariat and provides fiscal and administrative support, is an expanding network that works worldwide against HIV and for the health and human rights of men who have sex with men (MSM).*

> "Through PEPFAR, the U.S. became a global leader on HIV/AIDS."

Noah Metheny

APLA: The U.S. began its involvement in the global AIDS fight in the mid-1980s. But in 2003, how did PEPFAR represent such an increased level of commitment in fighting the epidemic worldwide?

Noah Metheny (NM): Through PEPFAR, the U.S. became a global leader on HIV/AIDS. The initiative led to the creation of the Office of HIV/AIDS within USAID and the Office of Global AIDS Coordinator (OGAC) within the State Department, making the head of OGAC an ambassador-level position. The formation of these and other new offices led to the creation of a cross-department collaboration that allowed the U.S. to work in more coordinated, holistic, and aggressive ways to address this epidemic. PEPFAR's work was further enhanced and complemented as the Global Fund and other bi/multi-lateral donors started committing more money to fight HIV/AIDS.

PEPFAR began with a focus on 15 of the hardest-hit countries. What was the on-the-ground impact of the program in those regions?

NM: Originally, PEPFAR's goal in these 15 countries was to achieve "2-7-10": to get two million people onto treatment, seven million people into care, and avert 10 million new HIV cases. Within a few years, these goals were exceeded. During this time, men who have sex with men (MSM) were included as a "most-at-risk population" (or a "MARP"), but there was no policy guidance or programmatic focus on MARP issues in these countries.

Five years ago, PEPFAR was reauthorized with a commitment of up to $48 billion by the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. How did this unprecedented increase in funding impact the global AIDS fight?

NM: The MSMGF, with our allies in DC, lobbied hard for the Reauthorization Act, which dramatically scaled up the original target numbers. We aimed to get six million people onto treatment, 12 million into care, and to prevent 15 million new HIV infections. Furthermore, the PEPFAR programs were more mature, allowing for greater coordination and evaluation, increasing not only the effectiveness of these programs but also their cost.

Overall, what have been some of PEPFAR's greatest successes?

NM: Again, PEPFAR's greatest success has been the number of new people receiving HIV treatment—now over five million. PEPFAR has helped politically mainstream HIV care in developing countries, getting people to view HIV as a chronic disease. For MSM, the MSMGF and allies worked with PEPFAR to issue a technical guidance addressing prevention programs for MSM. The MSMGF remains committed to working with PEPFAR to continue building on these successes, particularly those for MSM.

This year, the reauthorization of PEPFAR expires, and it has largely shifted from an "emergency" response to a sustained commitment. How do you envision the future of the United States' commitment to fighting AIDS worldwide?

NM: The U.S. will remain committed to fighting AIDS worldwide, including through the ongoing funding of PEPFAR and the Global Fund. But increased funding is unlikely, given the lasting impacts of the recession. So the U.S. will likely offer more technical assistance to allow countries to take ownership of their HIV programs with, sadly, less direct funding. ◢

2003—Expanding the Network: APLA Countywide

As APLA rapidly expanded through the late 1980s and 1990s, the model remained a one-stop shop for comprehensive HIV/AIDS-related services: dental care, housing, free groceries and more. We were in Hollywood, close to the epicenter of the Southern California epidemic.

But by the late 1990s, it was clear that the epidemic had spread, and significant numbers of people living with HIV/AIDS resided all across the county—in Long Beach, in South Los Angeles and in the San Fernando Valley. APLA responded, moving its main service site further south to Wilshire Center. And we developed a countywide network of satellites and services to better serve a broad region.

We spoke to APLA Executive Director ***Craig E. Thompson*** *about APLA's strategic expansion. Thompson has led the agency since 1998.*

> "We respond quickly and deliberately to leverage our 30 years of expertise…"

Craig E. Thompson

APLA: What advantages did centralization of services provide early in the epidemic?

Craig E. Thompson (CET): At the outset, the epidemic was seen as localized among gay men living in Hollywood, West Hollywood, and Silverlake. Services were comprehensive, convenient for our clients and volunteers, and the neighborhood was supportive. Funding was almost nonexistent; our first "offices" were in a converted motel on Cole Street in Hollywood. (Editor's note: An illustrator's rendering of that first site appears on the cover of this annual report).

As the epidemic expanded, how did APLA respond?

CET: First, we provided more and more services from our Hollywood site to meet the needs of the growing numbers who desperately needed care. However, the epidemic was far more widespread. LA County is unique: It is the largest county in the nation, and its population exceeds that of most U.S. states. Meanwhile, partners were providing critical services to specific populations or areas of the county. A core concept of APLA's mission has always been to collaborate—to not duplicate scarce services and waste precious resources. So not only did we have to expand, but we had to be strategic and focus on areas of the county with the greatest unmet need.

"…be more strategic…" What did that look like?

CET: We began to build the infrastructure that exists today. We moved our largest services site, The David Geffen Center, to Wilshire Blvd., convenient to public transportation because the epidemic demanded it. We moved our dental clinic to a medical office tower near downtown—the most convenient location to serve clients countywide. We moved our food pantry program to a new warehouse in North Hollywood, which now serves as the distribution center for a network of eight countywide sites. In 2004, we launched a mobile dental van, which offers state-of-the-art dental care to the county's most underserved areas. In 2006, we opened a second, permanent dental clinic, co-located with a food pantry, on the campus of the former Martin Luther King-Drew Hospital in South L.A. In 2010, we added a West Hollywood satellite for support groups and counseling services. And in 2011, we opened a new APLA Health & Wellness Center in Baldwin Hills, home to cutting-edge HIV education and testing programs that target today's highest-risk groups, including gay men of color, youth, those who are transgender, and many others.

How does this trend continue for APLA as we mark 30 years of providing care, education, and advocacy?

I'm proud to say that we now operate the nation's largest networks of both food pantries and dental clinics for people living with HIV/AIDS.

Moving forward, we will continue to respond quickly and deliberately to leverage our 30 years of expertise to bring services to people in the hardest-hit communities—places like South LA. We recently began STD screening, treatment, and vaccination services at the APLA Health & Wellness Center, because we know both that the services are urgently needed and that untreated STDs are a direct link to HIV transmission.

We've even gone beyond our borders to form a unique partnership with The Global Forum on MSM and HIV (or MSMGF), offering administrative and fiscal support to a fast-growing network of activists who are successfully fighting AIDS globally and enhancing the health and well-being of men who have sex with men (or MSM) in some of the most decimated places on the planet. We've done so much, yet so much remains to be done. ◢

2010—A Master Plan: The National AIDS Strategy

On July 13, 2010, the White House unveiled the National AIDS Strategy—the nation's first-ever comprehensive plan to fight HIV/AIDS. While the federal government had, since the 1980s, committed significant resources to battle the epidemic, the Strategy represented the first-ever, coordinated and comprehensive approach with tangible goals and deadlines.

At the core of the National AIDS Strategy was this vision statement: The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

*The strategy's first deadlines are a mere two years away. To examine the strategy as a milestone in the history of the epidemic, and to check in on its progress three years post-launch, we spoke to **Jeffrey Crowley,** who was the Director of the Office of National AIDS Policy at the time the National AIDS Strategy was released.*

> "The Strategy's goals are clearly articulated and smart."
>
> Jeffrey Crowley

APLA: Certainly, before the National AIDS Strategy (NAS), the United States had made significant strides to fight AIDS—both domestically and especially abroad. But it was clear that a cohesive domestic plan would be required. Take us inside the White House at the time the strategy was conceived.

Jeffrey Crowley (JC): The impetus for this plan really came from President Obama. He was particularly struck by the fact that public awareness of the epidemic had dropped so sharply. In the first pages of the strategy, it cites a stunning Kaiser Family Foundation statistic: According to their survey, in 1995, 44 percent of Americans considered HIV/AIDS to be the most urgent health problem facing the nation. By 2009, that number had dropped to a mere six percent. President Obama was tremendously grateful to his predecessor for launching PEPFAR—The President's Emergency Plan for AIDS Relief, which focused on specific nations abroad. But we were also concerned that we'd communicated that things were under control with AIDS in America.

What was different about the NAS that set it apart from previous domestic AIDS efforts?

JC: It was a community-based plan from the start. We made a commitment to gain as much public input from the start. We went everywhere from rural America to the heart of Los Angeles. We held 14 meetings in total—and we had an online process, too. We had sign language interpreters, disability accommodations—everything we could so that we could gain input from every aspect of a very diverse community.

And what was the result?

JC: We synthesized what we heard across America—often similar things but sometimes different—into a Strategy with vision and goals. I'm grateful to President Obama and proud of this Administration's leadership in allowing us to do something bold. The president is extremely outcome oriented. He didn't just want something that looked good; he wanted it to have the greatest possible impact. The Strategy's goals are clearly articulated and smart: to reduce the number of people who become infected with HIV; to increase access to care and to optimize health outcomes for people living with HIV; and to reduce HIV-related health disparities.

Three years into the strategy, how do things look in terms of achieving these goals?

JC: It's important to understand that the Strategy wasn't released by itself. It was co-released with an implementation plan and a Presidential Memo. This was not "business as usual." We've shifted critical funding to evidence-based, high-impact prevention strategies: We're increasing the numbers of people who know their HIV status. We're focusing on access to condoms, free HIV testing, syringe exchange programs—all key drivers toward achieving the goals that we articulated in 2010.

What's the role of community-based organizations, or CBOs, like APLA in the strategy?

JC: This is not simply "the government's plan" for reducing HIV infection. It's the entire nation's plan. I particularly feel good when I hear community members, and community-based organizations, refer to the NAS as "our" strategy, not "the government's strategy." In those early and horrifying days of the epidemic, community-based organizations like APLA stepped up even before the government did. And when the government did step up, it formed key partnerships with CBOs that are vital today. CBOs today—those groups that are working in the field—are crucial partners in identifying people who are living with HIV and AIDS and linking them into care.

What's next for the domestic fight against HIV/AIDS? What's next for the Strategy?

JC: I think the ACA (the Affordable Care Act) is an incredible platform to move the Strategy forward. It will allow us to be as strategic as possible in the way that we are able to find those who are living with HIV and AIDS but don't know it and link them to (and retain them in) care. There will certainly be challenges, but I believe that, in partnership with CBOs like APLA, we will continue to make substantial progress. ◢

> The Strategy's goals are clearly articulated and smart: to reduce the number of people who become infected with HIV; to increase access to care and to optimize health outcomes for people living with HIV; and to reduce HIV-related health disparities.

2011—New Strategies, New Services

Since its very first major educational campaign (1985's "L.A. Cares," which featured billboards, brochures, and a safer sex guide for gay men), APLA has been a leader in HIV prevention and education efforts.

As the epidemic has evolved, a number of factors has become clear: There is still great stigma surrounding HIV, AIDS, and the identities of gay men in many communities, and that stigma fuels new infection rates; among those living with HIV or AIDS, one in five does not know that he or she is infected; the epidemic disproportionately impacts communities of color, particularly in South Los Angeles; and, lastly, other sexually transmitted diseases often co-occur among (or before) people are living with HIV.

So how are all these factors related? We spoke with ***Vallerie Wagner*** *and* ***Terry Smith,*** *APLA's director and associate director of education, respectively, to find out—and to offer a snapshot of APLA's future.*

Vallerie Wagner

> "These programs represent our best efforts to stop the tide of new infections…"

Terry Smith

> "HIV prevention is at the core of what we do."

APLA: In response to the trends of the epidemic, the agency has significantly expanded its offerings for communities of color—in particular, African Americans, Latinos, Native Americans/Alaska Natives, along with men who have sex with men and the transgender community. And in 2011, we cut the ribbon to open our newest site, the APLA Health & Wellness Center, located in the South Los Angeles neighborhood of Baldwin Hills. There's a lot of activity at the site. What's happening there?

Vallerie Wagner (VW): The APLA Health & Wellness Center is where we now house APLA's HIV prevention and education programs, under the brand APLA Health & Wellness. These programs represent our best efforts to stop the tide of new infections among the communities that are hardest hit—those you just listed.

Our goal is really to address the holistic needs of the community we're serving. We want to build community so that people can meet others like themselves, who are dealing with some of the same challenges. It's a supportive, safe, and social space. Our groups encourage social activities and interaction—but it's always with an eye toward education, and each program has underlying HIV education messages built in, implicitly or explicitly. After all, one of our main goals is to increase individual awareness of HIV and STD status, whether positive or negative.

Terry Smith (TS): That's right. As Vallerie says, HIV prevention is really at the core of what we do—but we make sure that it's done in an affirmative, culturally competent way. And in addition to HIV testing and now STD screening and treatment, we use the Center as a place for community meetings, focus groups, and open discussions about relevant issues.

Let's talk specifics. What education programs are under the APLA Health & Wellness moniker?

VW: It's really an incredible variety.

We've got MPowerment, our youth HIV prevention program; our African American Gay Men's Health Initiative and "Many Men, Many Voices," or 3MV, which focuses on African American gay men; our crystal methamphetamine program; Positive Connections, which seeks to bring men and women who are HIV-positive into medical care; our Red Circle Project, with HIV education especially for Native American/Alaska Native gay, bisexual, and transgender people; and Project TND, or "Toward No Drug Abuse," which focuses on the correlation between drug use, addiction, and HIV.

Let's go point-by-point. What does each of these programs do?

TS: Mpowerment is a core group of 10 to 12 young men who meet weekly to plan activities for their peers, a larger group of between 25 to 50 young men. The core group plans everything from poetry slams, drag shows, outreach at gay pride events, yoga classes, and even a meeting with a life coach. Underlying all of this is a strong effort to boost self-esteem among these often-stigmatized youth, to help them realize that they matter to our community, and to encourage them to stay safe and healthy sexually.

Our Crystal Meth Group, "Partywise," is a unique intervention in English and Spanish for men who use crystal but who want to reduce or stop their drug use. We have a harm-reduction, meet-them-where-they-are philosophy. Ideally, sure, they wouldn't use; but the reality is that some will, and so we want to arm them with all the info we can to keep them as safe and healthy as possible. There's no question that uncontrolled crystal meth use is a huge risk factor in HIV infection.

Our African American Gay Men's Health Initiative is cutting edge—and makes a real difference in fighting stigma. A group of men (like a cohort) meets over the course of a number of weeks, and they talk about issues that matter: homophobia, racism, stigma, identity, and HIV risk. By validating their experiences, we're trying to send a message that they are vital members of our community—that we need them to be here, to stay healthy and safe. For men who are already living with HIV, we have an entirely different set of conversations: how to negotiate dating, sexuality, telling a partner about their HIV, taking their meds properly—it runs the gamut.

And in Positive Connections, we have peer health educators who help our HIV-positive clients access care. It's an active, hands-on approach. We even accompany them to their first few medical appointments for emotional support. The key is that we're not doing for the client, but we're empowering them to do it for themselves. That underlies our HIV education philosophy at APLA: offer culturally appropriate strategies, but then empower the client to put them into practice him or herself.

VW: Terry is exactly right. It's about meeting the client where he or she is, offering empowering strategies, and then stepping back and allowing the individual to put those into practice.

That's also what we do in Red Circle and Project TND. I'm proud to say that our Red Circle Project is the largest HIV prevention program of its kind in Los Angeles County especially for Native American/Alaska Native men who have sex with men. We focus particularly on what the community calls "two-spirit" men (those who are gay) and transgender women (Native people who transition from male to female). Specifically, we look at the role of historical trauma that they have suffered and how this may impact their substance use and sexual behavior.

In Project TND, we work primarily with those who are just beginning to dabble in drug use—exploring. We help them understand the path to addiction; the stressors that can accelerate that process; and we provide them with healthier, stress-relieving alternatives that can reduce or eliminate substance use.

That's a great summary of the work that's happening at APLA Health & Wellness. Anything you'd like to add?

TS: I want to emphasize that many of our programs include an element for those who are transgender. It's a group of people who are very disenfranchised and often incredibly isolated. They also face very high rates of HIV infection. So we work program-wide to bring a sense of community, allow them to share their stories, and help them identify resources that are trans-friendly.

VW: That's exactly right. We want to provide a space where they feel comfortable talking.

I also want to add that APLA offers both capacity building assistance (through our SharedAction and SharedActionHD programs) and community-based research—two more key elements to the response to the epidemic.

Our capacity building team does just that: They travel the country to help other organizations and health departments to build the capacities of their own HIV/AIDS programs—to serve more people and to serve them more effectively. We leverage APLA's 30 years of experience to inform that work.

And our Community-Based Research program uses sophisticated data analysis techniques to help shape the programs that we and other organizations are offering—to provide more services of a higher quality.

There's certainly no shortage of work to be done here. Even though it's relatively new, there's already a lot happening under the APLA Health & Wellness brand. What's next for these programs and the brand as a whole?

VW: We're incredibly fortunate to benefit from private sources of funding—and not just because it helps us do more work. The more we're funded by the government, the closer we have to play by their rules—meaning that some programs can be more restrictive in how they're delivered. But private funding allows us to really respond to what the community thinks would be most effective, and we can deliver programs that are cutting-edge while still grounded in research about what we know works. We're also expanding our testing services beyond HIV. In 2013, we'll begin offering STD screening and STD treatment, provided by licensed practitioners at the APLA Health & Wellness Center.

TS: The APLA Health & Wellness Center really represents the future of HIV prevention: It's a matrix of programs under one roof, closely tied to testing, helping those who are positive to get into care and those who are negative to stay negative. The notion of services in silos—where one hand may not know what the other is doing—is over. We're working together, now and in the future, so that people who could benefit from our services can walk through our doors and get the support they need.

AIDS PROJECT LOS ANGELES and APLA HEALTH & WELLNESS

Condensed Consolidated Statement of Financial Position (as of June 30, 2012 and 2011)

Fiscal Year (Ending June 30)

ASSETS	2012 TOTAL	2011 TOTAL
Cash and Investments	$ 3,655,208	$ 3,287,819
Government Grants Receivable	1,383,241	1,605,877
Contributions Receivable	1,086,805	1,097,968
Medi-Cal Receivable	291,912	249,194
Other Receivables	189,855	145,707
Prepaid Expenses and Other Assets	465,069	625,792
Deposits	200,000	300,000
Inventory	168,157	188,200
Property and Equipment (Net)	1,633,536	1,228,660
TOTAL ASSETS	**$ 9,073,784**	**$ 8,729,217**
LIABILITIES AND NET ASSETS		
Accounts Payable and Accrued Expenses	1,054,470	892,575
Deferred Revenue	200,780	11,950
Notes Payable	479,490	489,490
Net Assets	7,339,043	7,335,202
TOTAL LIABILITIES AND NET ASSETS	9,073,783	8,729,217
SUPPORT AND REVENUE		
Contributions	4,440,725	3,754,300
Fundraising Events	3,862,605	3,585,262
Government Grants	8,071,585	7,564,478
Medi-Cal Waiver	1,166,916	1,215,964
Contributed Goods and Services	1,163,059	1,435,750
Other Revenue	136,293	185,122
TOTAL REVENUE	18,841,183	17,740,876
EXPENSES		
Program Services	14,232,711	13,222,528
Management and General	1,723,423	1,883,860
Fundraising	2,881,208	2,596,718
TOTAL EXPENSES	18,837,342	17,703,106
CHANGE IN NET ASSETS	$ 3,841	$ 37,770
NET ASSETS AT BEGINNING OF YEAR	$ 7,335,202	$ 7,297,432
NET ASSETS AT END OF YEAR	$ 7,339,043	$ 7,335,202

AIDS Walk Los Angeles

Participants who raised $1000 or more

Akinyemi Abiodun
Dennis Alabaso
Everett Alexander
★Patrick Alexandre
Jennifer Alvarado
Bill Alvidrez
Craig Ames
Margot Anderson
Gary Andrews
★Teddy Antolin
Bonny Anvari
James Arnone
★Vikas Arora
Robert Atwood
Seth Augustine
Shaun Avnet
Lucia Ayson
Helen Back
Mark Badagliacca
Rick Bailey
Robert Bain
Melanie Baird
Louise Baker
Raymundo Baltazar
Charles Banfield
Layla Baradaran
Jeremy Barenholtz
★Todd Barnes
★Michael Barrett
Mark Basick
★Teddy Bass
Guillermo Bass
★Joel Bellman
Sean Benedict
★Michael Berckart
Lesley Beyer
★Leslie Bibb
Ivy Bierman
★John Blackman
Richard Blanche
★Keith Blau
Mauro Bordovsky
★Shona Borevitz
★Walter Bost
Chris Bradshaw
Steven Brady
★Ivy Bragin
★Robin Bram
Rod Bran
Nikki Bridges
★Keith Brown
★Gary Brown
Steven Brown
David Buchan
Michael Buchanan
★Garett Burnham
★Ronn Burns
★Paul Bushnell
Ann Bybee
Gabriel Byrne
Porfirio Caamal Jr
Carlo Caccavale
Carrie Carbonneau
★Eric Carr
Louis Carr
Carolyn Carrera
★Kendra Castleberry
Racheal Caswell
★Mike Catlett
Cookie Ceco
Andrew Ceco
Tony Ceco
Fenella Chacon-Ravago
Patrick Chavez
Veronica Chavira
Valerie Chiovetti
Paul Chitlik
★Richard Chung
Priscilla Chung
Louise Clauson
Hilda Climb
Daniel Clivner
★Michael Collins
Linda Cooper
James Corp
★Clay Cosse
Larry Craft
★Chrissy Crawford
★Gavin Creel
Aaron Crowley
Charles Cryor
★Tracey Cunningham
Joe Custer
John Dagostino
John Dahlstorm
Emma Daily
Armineh Davoodian
★Chaz Dean
Derek Dear
Tim DeBellis
Nichole Delansky
Esther Delgado
Rick Dergan
Lynn DeRose
Avi DeTurenne
Mario Diaz
Matthew Dill
★Oren Dori
Robin Dorn
★Teryne Dorret
Tenesha Dorsey
Carrie Dowd
★Jessica Drake
Margaret Lorrie Drenk
★David Drury
★Cait Drury
Bill Duckett
Eric Durrschmidt
Loretta Eason
★Barry Edelman
Caroline Edwards
James Engelhardt
Adam Eramian
★Larry Ewaska
★Mike Faiola
Louis Falzarano
Fred Farris
Thomas Fay
Maria Ferguson
★Michael Ferrara
Robert Fielder
★Zina Figilis
Fine Stuart
Marvin Fishman
Nancy Fletcher
★Wayne Flick
James Flood
★Donald Foley
Allie Foote
Carla Ford
Aubrey Forman
Scott Foy
Blake Frahm
Diana Franklin

AIDS WALK LOS ANGELES GOLD TEAMS

Team Toyota
WEN in Spirit
DreamWorks Animation
Gang of 100
APLA
TEAM POPULAR
County of Los Angeles
NBC Universal
Latham & Watkins
PwC
Anthem Blue Cross
AIDS Walk Staff, Family & Friends
Hollywood United Methodist Church
Team Price is Right
Kids Who Care
TEAM WICKED
LA Commercial Community
M•A•C Cosmetics
colors for a cause
CMG LA
Paramount Pictures
Team Time Warner Cable
Fox Entertainment Group
City of Los Angeles
The Abbey/SBE/SLS and Friends
C.W.F.A (Chubb Walk For AIDS)
Deloitte
The Sweat Spot
Keller Williams Realty
Bank of America

Jessica Franks
★Audrey Friedman
Cathryn Friedman
Daisy Fuentes
Lacey Gallagher
★Sandy Garcia
Cheryl Garcia
Armando Garcia
Sophia Garcia
John Gardner
Megan Gaver
Gregory Gentile
Heather George
Gail Goldberg
★Robyn Goldman
Steven Golightly
Michael Gonzales
★Ellen Goodman
★Chris Gorham
Gage Gorman
MaryEllen Gorski
★Rodney Gould
Andrew Gouldh
Suzanne Goulet
★Terry Grand
Teri Gray
Laurie Green
Robert Green
Rachel Griffin
Paul Groves
Doug Guenther
★Anthony Guthmiller
Abdullah Hall
Nowlin Haltom
Jackie Hampton
DongHee Han
Heidi Harmon
Hayward Harris
Sean Hauge
Ryan Heffington
John Heilman
★Jefferson Hendrick
Laura Henson
Jim Hoffman

Andrew Holinsky
Christopher Hoodye
Lisa Howery
Elizabeth Hudson
Kristine Hughes
★Joseph Husman
David Ibarra
Thomas Inatomi
Felipe Infante
★Gaynell Jackson
David Janollari
Clyde Jenkins
Omaira Jesus
Nicholas Jimenez
Roy Jimenez
Che Johnson
★Ben Jones
Petra Jones
Jesus Jornacion
★Jackie Juico
Scott Kaminsky
George Kan
★Kortney Kane
Ryan Kang
★Barbara Kappos
★Gabriella Kasley
Christy Keefe
David Keesey
Dana Kent
Bethany Kenyon

David Kessler
Shawn Khorrami
Mykal Kilgore
Kim Saeromi
Kevin Kiniry
Dennis Kirkpatrick
Shari Kirkpatrick
Kimberly Kisler
Luke Klipp
Sara Konecky
★Kalli Kouf
Lauren Krapf
Andrea Krauss
Mary Kretzmar
Daniel Kruger
Sophie Kupetz
Kurth Kevin
Aaron Ky-Riesenbach
★Tony Laanan
Kevin Lafond
★Harriette Landau
Gabriela Larios
Rowena Lauayan
Elen Lauper
Jorge Lazaro
Brianna Lear
Darryl Leavitt
Jason Lee
Michele Lee
Nichole Lee

Chad Leffler
Heather Leider
Christine Lewison
Janelle L'Heureux
Louise Lieberman
Alex Liebeskind
Claes Lilja
Patrick Link
Karl Linz
Bentley Lopez-Curtis
Aldwin Lorica
Gina Lozano
Patrick Luyet
Mari Luyet
Joel Lyle
Carol Lynch
Kathy Lynch
Robert Macias
Pamela Magette
Happy Mahaney
Charles Maizland
Gyron Julius Makasiar
Vincent Manarite
John Manelski
★Lefky Mansi
Kimberly Marable
John Mark
Madria Marshall
Cynthia Martin
★Alma Martinez

Marisela Martinez
★Yolanda Mationg
Brian McCabe
Jeremy McEathron
David McFarlane
Amber McGindley
Brooke McIntyre-Tuley
★Victor McKamie
Michael McKeon
Ken McLean
Marc McMillin
★Kara McNamara
Scott McPherson
Marty Meekins
Chet Mehta
Tamara Mello
Tammy Lynn Michaels
★Thomas Michel
★Drew Michelman
Mark Miller
Craig R. Miller
Erin Mills
Parker Mills
Joan Miner
Nando Mireles
Bryan Miyamoto
Juliet Moffett
Ric Mondragon
Jeannie Moreno
Jessica Morfin
★Rich Morrisey
Tiff Mulligan
★Michael Murphy
Patrick Murray
Stevie Nelson
Katy Nelson
Tyler Nguyen
Andrew Nicastro
Robin Nicholas
Novy Brian
★Jeffery Nunes
★Nancy Nyberg
Sark Ohanian
Lauren Osmer

Richard Ostlund
Haley Paddock
★George Padilla
★Cynthia Park
Lyndsey Parker
Suzy Parker
★Aubrey Parnell
Manny Patel
Evan Payne
Brayden Payne
Coleman Payne
Emmi Payne
Stephanie Peel
Lois Perilman
Paul Perilman
★Pauley Perrette
Marco Perry
★Penny Peyser
Marthoa Phan
Charlie Phillips
Jamie Phillips
Mollie Pier
Deborah Pinkstaff
★Nancy Polacheck
Carly Pope
★Julien Price
★Dale Pringle
Edgar Quinones
Jovin Raethz
Lois Ramer
★Alicia Ramos
Danielle Ramos
Amy Reichbach
Taylor Reiss
Dave Reynolds
Chris Rhine
Derek Richmond
Daniel Rinck
Mark Rivera
Simone Robinson
Donald Rodriguez
Miguel Rodriguez
Jai Rodriguez
Emily Roe

Lee Rosenthal
Jonathan Ross
★Sara Rue
Tamar Salibian
Waseem Samaan
Nelson Sanchez
Paul Santello
Erin Saporta
John Schmall
Shari Schneider
★Barry Schoenfeld
Allan Schwegmann
Scorpio
★Lenny Scroggins
Michael Serra
Elizabeth Shaffer
Kyle Shepard

Lawrence Silverman
Michelle Simbajon
★Susan Simons
★Scott Singer
Charles Solomon
John Spence
Caroline Spiegel
★John Squatritto
Sasha Sterling
Harvey Sternheim
Lejon Stewart
★Scott Stone
Ethan Stone
Harrison Stone
Laura Stover
★Nadia Sutton
Trevor Takahashi

Angel Tang
Mark Tarbox
Trisa Taro
Glenn Taro
Alan Tarsky
Ken Taylor
Craig Taylor
Andrew Thompson
Craig E. Thompson
★Kristie Tien
Kevin Tierney
Ed Tillman
Jerry Toadvine
Julian Torres
★Karrueche Tran
Manuel Trujillo
Belinda Trujillo

Louie Trujillo
Joy Turek
★Brigitte Tweddell
Natalie Ungvari
Angel Vain
Kamran Valipour
★Allison Velkes
Nancy Vinicor
Mary Vogt
Dianne Waldman
★Chuck Wallau
Roy Wallenstein
William Wallis
Dan Walters
Douglas Warde
Dakota Warde-Levie
Sandra Warde-White

★Hillel Wasserman
Chris Weber
Anne Webster
David Weigand
Kevin Weiler
John Welch
Antonio Whiteley
★Tom Whitman
★Thea Williams
Donovan Williams
Carol Williams
Ben Williams
Bryan Wilson
Keith Wishon
Jane Wishon
Eric Wlasak
Aaron Wyner

★April Yamamoto
Todd Young
★Wayne Zahner
★Rhonda Zamore
★Ronald Zate
John Zenone
Arthur Zweig
Richard Zylmans

★ GOLD STAR WALKERS who have raised $2,500 or more

TEAM TO END AIDS

Participants in the 2012 Honda LA Marathon, the Nautica Malibu Triathlon, the XTERRA Trail Running World Championship, and the 2012 Honolulu Marathon

Steven Addison
Yael Adef
Darby Aldaco
Michael Almacen
Christi Anderson
Ween Angulo
Scott Appel
Nadia Arandia
Paul Arevalo
Kristal Armijo
Mark Arteaga
Armando Barba
Scott Barnes
Jon Barrett
Russell Bartoli
Lynn Barut
Jennifer Baughman
Scott Bennett
Molly Beucher
John Bidstrup
Scott Boliver
Sarah Bradshaw
Jonathan Breen
Dennis Bruessel
Joel Bryant
John Bryan
Diana Buran
Griselda Callejas
Jose Callejas
Vanessa Callejas
Edwin Camacho
Tatiana Camacho-Daniel
Biff Campos
Steven Cannell
Elizabeth Carley
Caroline Clavin
Jeffrey Cohen
Emily Cohen-Meth
Lucky Conner
Kevin Costley
Keith Crasnick
John Crow
Jeffrey Cruz
Susan Cummings
Veronica Dang
Myra Daniel
Francisco Del Mar
Oscar Delgado
Andrew Deloza
Shannon Devaney
Scott Devine
William Dietlin
Oliver Drakeford
Margaret Lorrie Drenk
Jennifer Duarte
Jose Duarte
Laila Eisner
Susan Epperly
Trisha Epperly
Emilie Erskine
Mitra Eskandari-Azari
Laramie Fassbender
Annette Fasteau
Chris Feist
Jodi Feldman
Colbert Fennelly
Juan Carlos Fernandez
Kathleen Ferson
Chris Fisher
Calvin Fleming
Martin Flores
Lisa Frias
Tommy Garceau
Clare Garceron
Karen Garcia
Michelle Garcia
Patrick Garcia
Vicki Geis
Stephen Germain
Debby Germino
Alfred Gigliello
Corrado Giovannoni
Rachel Gleicher
Brad Goldberg
Cameron Gray
Andrew Guiyangco
Nadja Habinek
James Hahn
Rusty Hamrick
Eric Harbert
Yvette Hawley
Elizabeth Lashley-Haynes
John Heilman
Kristen Hellwig
Adam Hendershott
Samantha Hermann
Yuri Hernandez
Stephenie Higgins
David Hildebrand
Allison Hill
Annie Hollenbeck
Valerie Hooe
Mel House
Kevin Howald
Dianne Howes
Brandi Huber
Rob Hudson
Leslie Hunter
Stacy Huntington
Sue Huntington
Oscar Ibarra
Janice Ide
Hillary Iffrig
Shawn Imitates Dog
Dana Irwin
Brett Janecek
Melissa Judson
Andre Kavanagh
Adam Kear
Tom Keene
Stacey Kelly
Ben Kenber
Esther Kim
Christene Kings
Sarah Kovacs
Cindy Kramer
Kathleen Kreyns
Jay Krymis
Justin Lam
Jason Lass
Chad Lazzari
Laura Jean Leal
Michael Lee
Yanira Leon
Giovanni Leone
Christina Lewis
Paulina Lexington
Sandy Lin
Mindy Liron
Carina Ljungqvist
Judy Lohr
Joyce Lopez
Eric Lyons
Jennifer Machen
Sascha Macias
Patrick Mahon
Scott Mann
Taylor Marr
Jerome Marshall
America Martin
Brittany McDonald
Kevin McDonald
JoAnne McGrath
Amy Mcguire-Denis
Susan Mejia
Ryan Mendoza
Emmi Meyer
Randy Meyer
Rosemary Meyers
Craig R. Miller
Bret Mohlenhoff
Jennie Morales
Sean Moran
Jason Morgan
Nick Mouyiaris
Marissa Mullen
Bradly Munyon
Karina Nascimento
Jaymi Nau
Karol Nechushtan
Rick Nelson
Anne Nemer
Conchita Newman
Wing-Hon Ng
Richard Nguyen
Dwana Nicholson
Amber Nicolai
Blaine Noblett
Tony Nuccio
Karyn Ohlson
Melissa Okey
Brooks Oldridge
Thomas Omalley
Jessica O'Malley
Fredy Orellana
Joaquin Ortiz
Ashley Owen
David Page
Jamie Parker
Jeffrey Passino
Jody Perlmutter
Levi Petree
Joe Petrillo
Marta Portillo
Dene Preston
Audrey Prezgay
Christian Prezgay
Stephanie Purmort
David Pyle
Kerry Quakenbush
Ann Ramirez
Christopher Ramirez
Carolyn Ratcliffe
Anjali Raval
Kevin Ray
Khelsy Raymond
Steve Reed
Paul Reid
Michael Reis
Sherry Reuter
Tony Rios
Kevin Robinson
Steven Robinson
Loren Rodriguez
Becky Roscher
Lori Rostedt
John Saavedra
Eddie Salazar
Maddy Sanabria
Rene Sanchez
Paul Santello
Renee Santos
Michelle Sayre
Eric Schubert
Daniel Searle
John Shafai
Dan Shaner
Matt Sharbaugh
Ashley Sherman
Edward Shioyazono
Kirsten Shura
Leslie Simmons
Gene Simons
William Sipes
Adam Sires
John Sloan
Melissa Sly
Mark Smalley
Marlo Smith
Rand Smith
Daniel Solis
Gary Stevens
Naomi Sweredoski
Rafal Swiader
Susie Tae
Anri Tanabe
Bart Tangredi
Susanna Tevosyan
Cyndi Texeira
Gary Texeira
Dale Thompson
Kerry Thorne
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