Epidemiology of HIV in Los Angeles County

Division of HIV and STD Programs (DHSP)

Ending the HIV Epidemic in LAC

Tracking achievements in national targets for the EHE initiative, 2023-2024

	EHE 2025 targets	EHE 2030 targets	LAC results
Estimated number of new HIV infections (including diagnosed and undiagnosed infections)[1]	380	150	1,400 [880-1,800] (2023)
Estimated number of persons living with undiagnosed HIV in LAC[1]	n/a	n/a	4,900 [3,200-6,700] (2023)
Number of new HIV diagnoses[2]	450	180	1,635 (2023)
Estimated percentage of PLWH with knowledge of their HIV-positive status[1]	95%	95%	91% [89% - 94%] (2023)
Percentage of newly diagnosed persons linked to HIV care within one month of diagnosis[2]	95%	95%	79% (2023)
Percentage of persons living with diagnosed HIV (PLWDH) with viral suppression[2]	95%	95%	66% (2024)
Estimated percentage of HIV-negative persons with indications for PrEP who have been prescribed PrEP[3]	35%	50%	N/A

1. Using the CD4-based depletion model developed by the CDC, modified for use by LAC. See technical notes. Knowledge of status is the estimated percent of people with HIV who have received an HIV diagnosis. EHE targets are calculated from the baseline of 1,500 estimated HIV infections in the year 2017 among persons aged ≥13 years, as reported to CDC's National HIV Surveillance System through December 2019. 2022 estimates are provisional using 2021 results from the CD4-based model.
2. Using LAC HIV surveillance data in the CDC Enhanced HIV/AIDS Reporting system (eHARS). New HIV diagnoses: 2023 HIV infections confirmed by laboratory or clinical evidence and entered into eHARS; Percentage linked to HIV care: percent of persons newly diagnosed in 2023 with ≥1 reported CD4, VL, or Genotype test performed within 1 month of HIV diagnosis; Viral suppression: Numerator is PLWDH, diagnosed through 2023 and living in LAC at year-end 2024 (based on most recent residence) whose most recent reported VL in 2024 was suppressed (HIV-1 RNA < 200 copies/mL). Denominator is PLWDH, diagnosed through 2023 and living in LAC at year-end 2024 (based on most recent residence). Note, PLWDH with no reported VL in 2024 are assumed to be virally unsuppressed. PLWDH with no reported VL in 2024 represent 29% of the denominator; EHE targets are calculated from a baseline of 1,799 HIV infections in the year 2017 among persons aged ≥13 years, as reported to CDC's National HIV Surveillance System through December 2019.
3. In 2024, CDC paused PrEP coverage reporting to update overall PrEP coverage estimates using newly available data sets and determine the best way to present PrEP coverage. However, CDC remained unable to resume PrEP coverage reporting at the release time of this report, due to a reduction in force affecting the Division of HIV Prevention (DHP). As part of this staffing reduction, the DHP branches that produced HIV incidence estimates and provided the statistical expertise needed to assess PrEP coverage were eliminated. CDC is currently evaluating plans and capacity to resume this work.

County of Los Angeles Public Health

HIV Epidemic Monitoring

Difference in the Impact of HIV by Sex and Race/Ethnicity

- An estimated 9.8 million people resided in LAC in 2023.

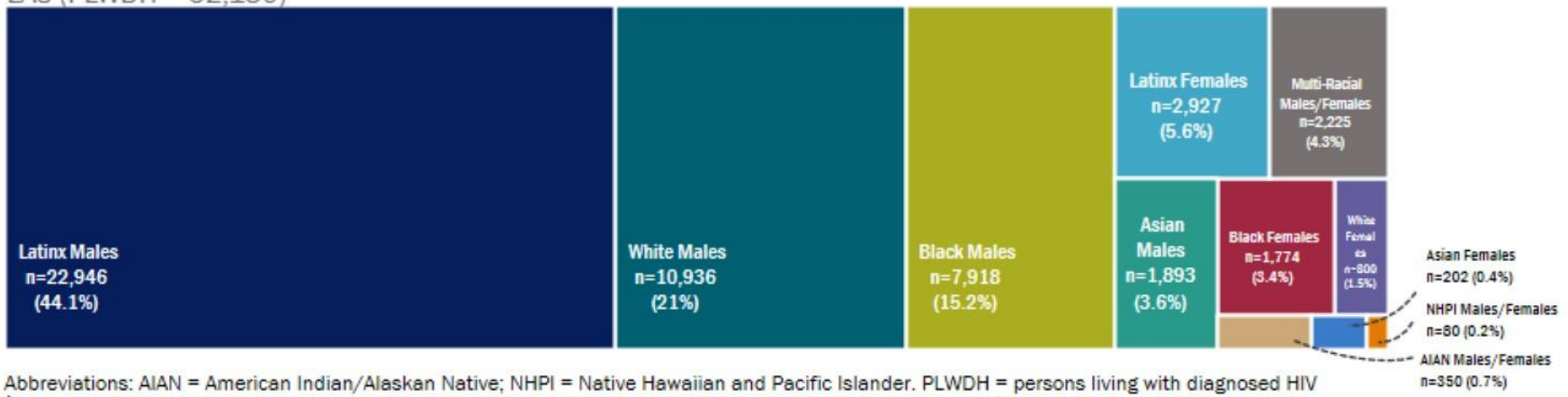
- Latinx males and females represented 25% and 24% of the LAC population, respectively, followed by White males (12%), White females (12%), Asian females (8%), Asian males (7%), Black females (4%), Black males (4%), and multi-racial persons (3%). American Indians and Alaska Natives (AIAN) and Native Hawaiians and Pacific Islanders (NHPI) represented less than 1% of the total LAC population.

- In contrast, Black, Latinx and White males disproportionally represented 15%, 44%, and 21% of PLWDH in LAC. Altogether, AIAN, NHPI, and multi-racial men and women represented about 5% of PLWDH in LAC. PLWDH with unknown race/ethnicity are not presented in the graph (n=79).

Black males are disproportionately affected by HIV, comprising only 3.6% of the LAC population but 15.2% of PLWDH, four times their population share. Latinx males (24% vs. 44%) and white males (12% vs. 21%) follow. Altogether, AIAN, NHPI, and multi-racial persons represented about 5% of PLWDH in LAC.

Distribution of sex listed at birth[1] and race/ethnicity[2] among LAC residents in 2023
(LAC est. population size = 9,825,708)

Distribution of sex listed at birth[1] and race/ethnicity[2] among persons living with diagnosed HIV at year-end 2024
LAC (PLWDH = 52,130)



Abbreviations: AIAN = American Indian/Alaskan Native; NHPI = Native Hawaiian and Pacific Islander. PLWDH = persons living with diagnosed HIV
[1] Population estimates are not currently available for transgender persons therefore male and female categories are based on sex listed at birth.
[2] PLWDH with unknown race/ethnicity are not shown (n=79)

Source: HIV Surveillance data as of December 2024

History of HIV disease surveillance in Los Angeles County (LAC)

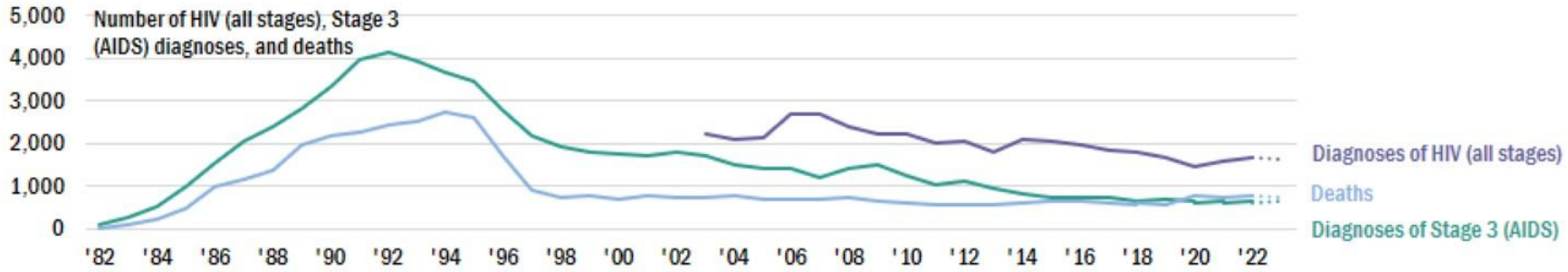
1982	Stage 3 HIV Disease (AIDS) case surveillance began in LAC
2002	Non-AIDS HIV case surveillance began in California using a non-name, code-based system
2006	California law revised to require reporting of HIV cases and laboratory test results indicative of HIV infection by name
2008	CD4+ T-cell test result reporting mandated by California law
2011	California law changed to allow use of HIV surveillance data for public health purposes – such as linking newly infected persons to care
2013	Use of new HIV testing algorithm for California laboratories was approved by a State Emergency Public Health Regulation to allow for better identification of acute HIV
2016	California law required reporting of acute HIV infection within one day of diagnosis

History of the HIV epidemic

- In LAC, AIDS reporting began in 1982 and the annual number of cases peaked in 1992 with more than 4,000 cases reported that year.
- In 1994, deaths reached an all-time high followed by a significant decline that coincided with the introduction of highly active antiretroviral treatment (HAART) for HIV in 1996.
- In 2006, name-based HIV reporting began in California, allowing for better tracking of trends in diagnosed HIV irrespective of disease stage.

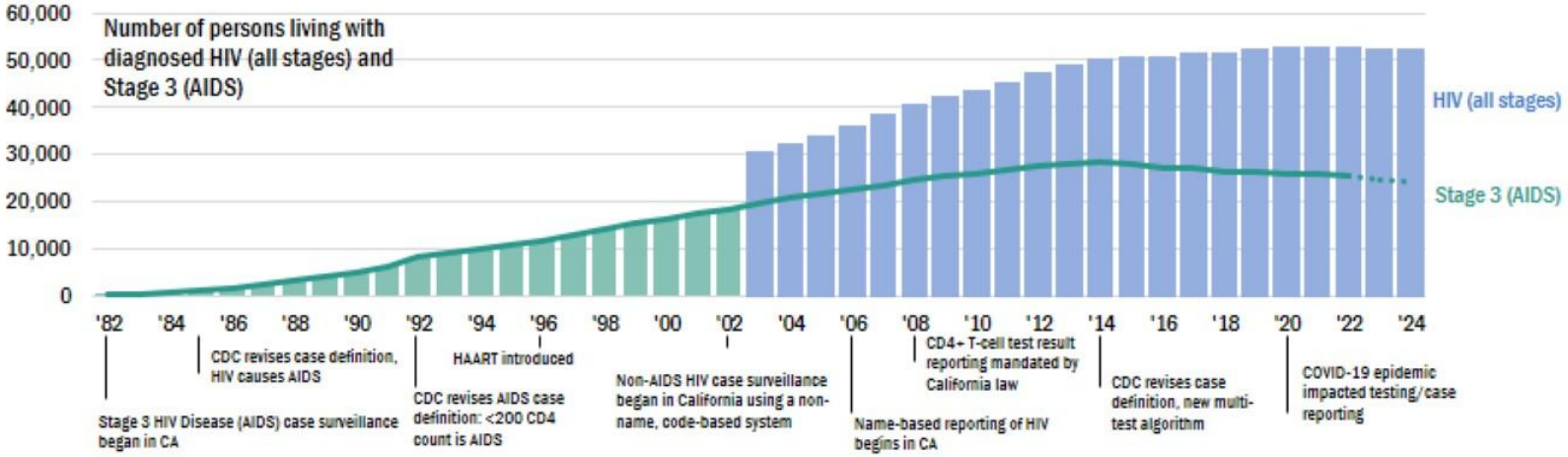
In the past decade, the number of persons diagnosed with HIV (all stages), Stage 3 (AIDS), and deaths have gradually declined.

HIV diagnoses, AIDS diagnoses, and deaths among persons reported with HIV, LAC 1982-2023[1,2,3]



With prescribed antiretroviral therapy (ART), people with HIV (all stages) can live long and healthy lives, leading to a steady rise in the prevalence of HIV over time, which has plateaued in recent years.

Persons living with diagnosed HIV and AIDS, LAC 1982-2024[2,3]

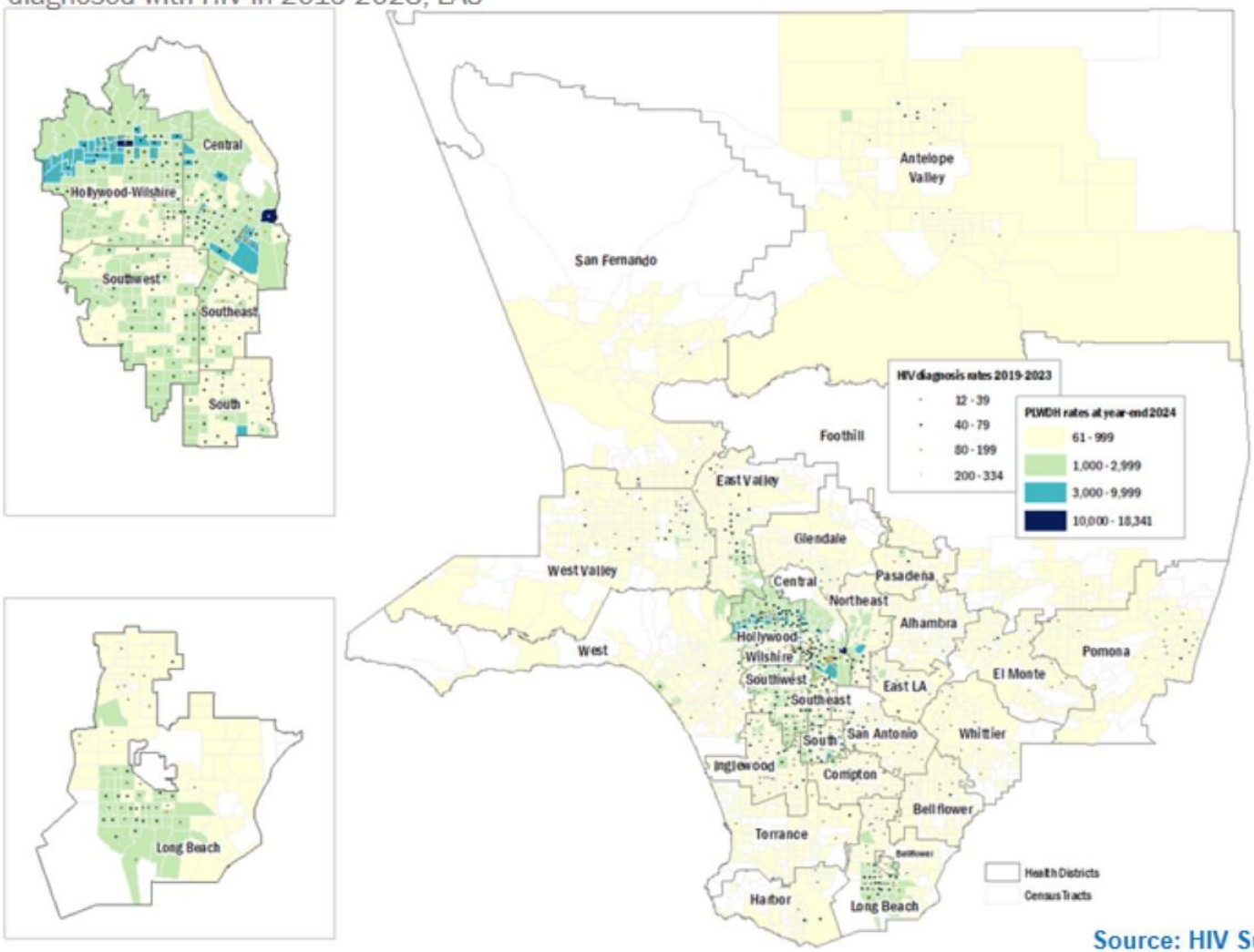


[1] Includes new diagnoses of HIV infection regardless of the disease stage at time of diagnosis.
[2] Includes persons whose residence at death was in LAC or whose most recent known address before death was in LAC, when residence at death is missing.
[3] 2023 data for diagnoses of HIV/AIDS and deaths and 2023/2024 data for persons living with non-AIDS HIV and AIDS are provisional as indicated by the dashed line and patterned bar. 2024 diagnoses of HIV/AIDS and deaths are underreported/unreliable due to significant reporting delay and therefore are not shown.

Source: HIV Surveillance data as of December 2024

The highest density of new HIV diagnoses occurred in the central and southern regions of LAC. Among all 26 Health Districts, the Central and Hollywood-Wilshire Health Districts were identified as the epicenters for HIV, reporting the highest rates of new HIV diagnoses in 2019-2023 and persons living with diagnosed HIV at year-end 2024.

Geographic distribution[1] of rates per 100K population for PLWDH aged ≥13 years at year-end 2024 and persons newly diagnosed with HIV in 2019-2023, LAC



Source: HIV Surveillance data as of December 2024

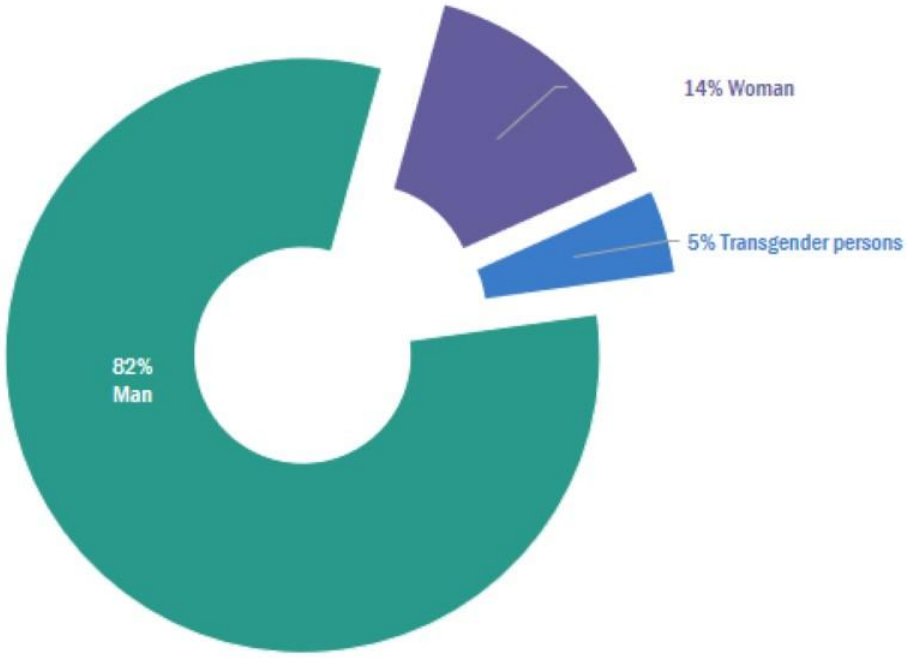
Trends in HIV diagnoses

Trends in HIV diagnosis

- This section presents information on persons newly diagnosed with HIV in LAC.
- Trends are presented from 2014 through 2023.
- Due to reporting delays, the 2023 HIV diagnosis data are provisional as indicated by dashed lines or patterned bars.
- All 2020-2022 data should be interpreted with caution due to the impact of the COVID-19 pandemic on HIV testing.

Consistent with prior years, men made up most of the new HIV diagnoses in 2023 (N=1,333, 82%). Women represented fourteen percent (N=229) and transgender persons, 5% (N=73) of new HIV diagnoses in 2023.

HIV diagnoses by gender among persons aged ≥ 13 years, LAC 2023[1]

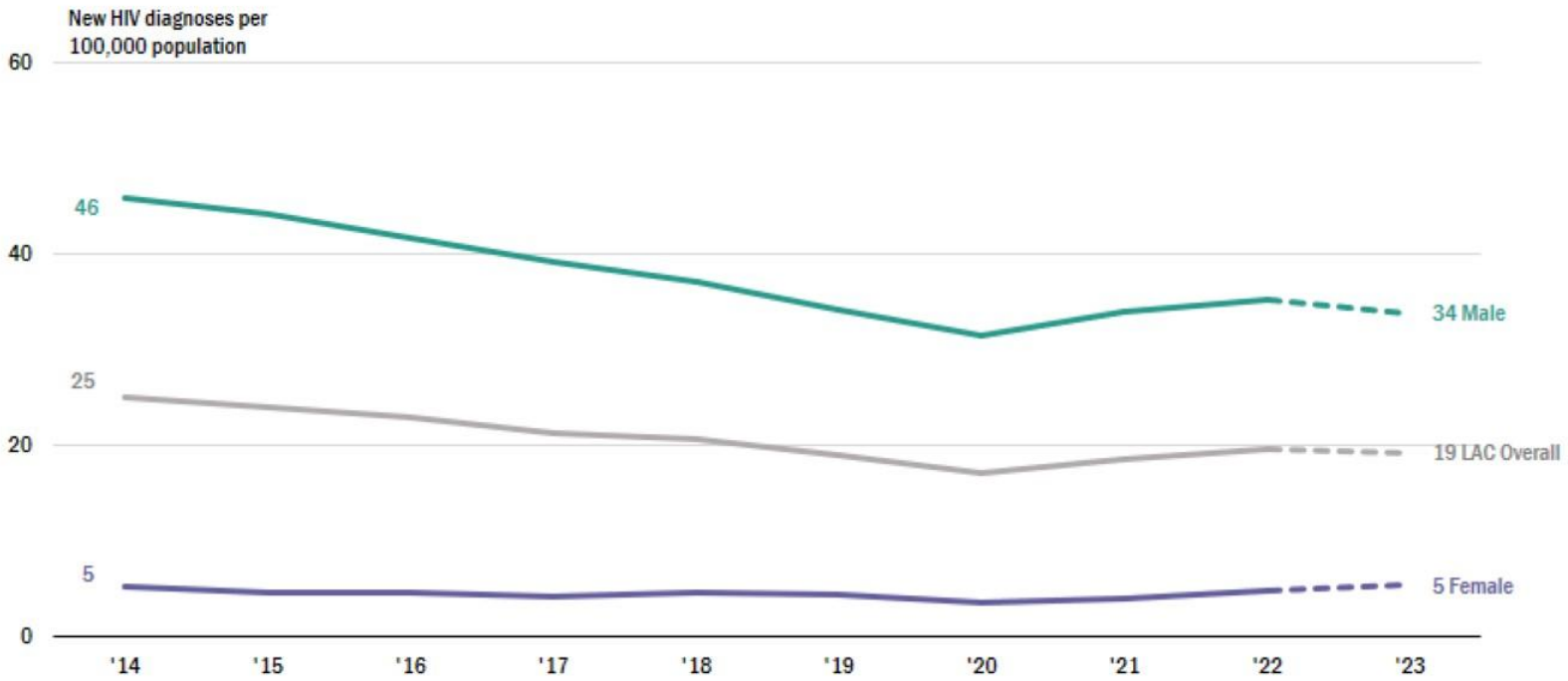


[1] Among the 73 transgender persons newly diagnosed with HIV in 2023, most identified as transgender women. Since transgender reporting relies on accurate gender classification from laboratories and health care providers, it is likely to be underreported.

Source: HIV Surveillance data as of December 2024

HIV diagnosis rates remain substantially higher among males compared with females. Over the past decade, HIV diagnosis rates among males have declined, while rates among females have remained stable.

HIV diagnoses rates by sex listed at birth[1] among persons aged ≥ 13 years, LAC 2014-2023[2,3]

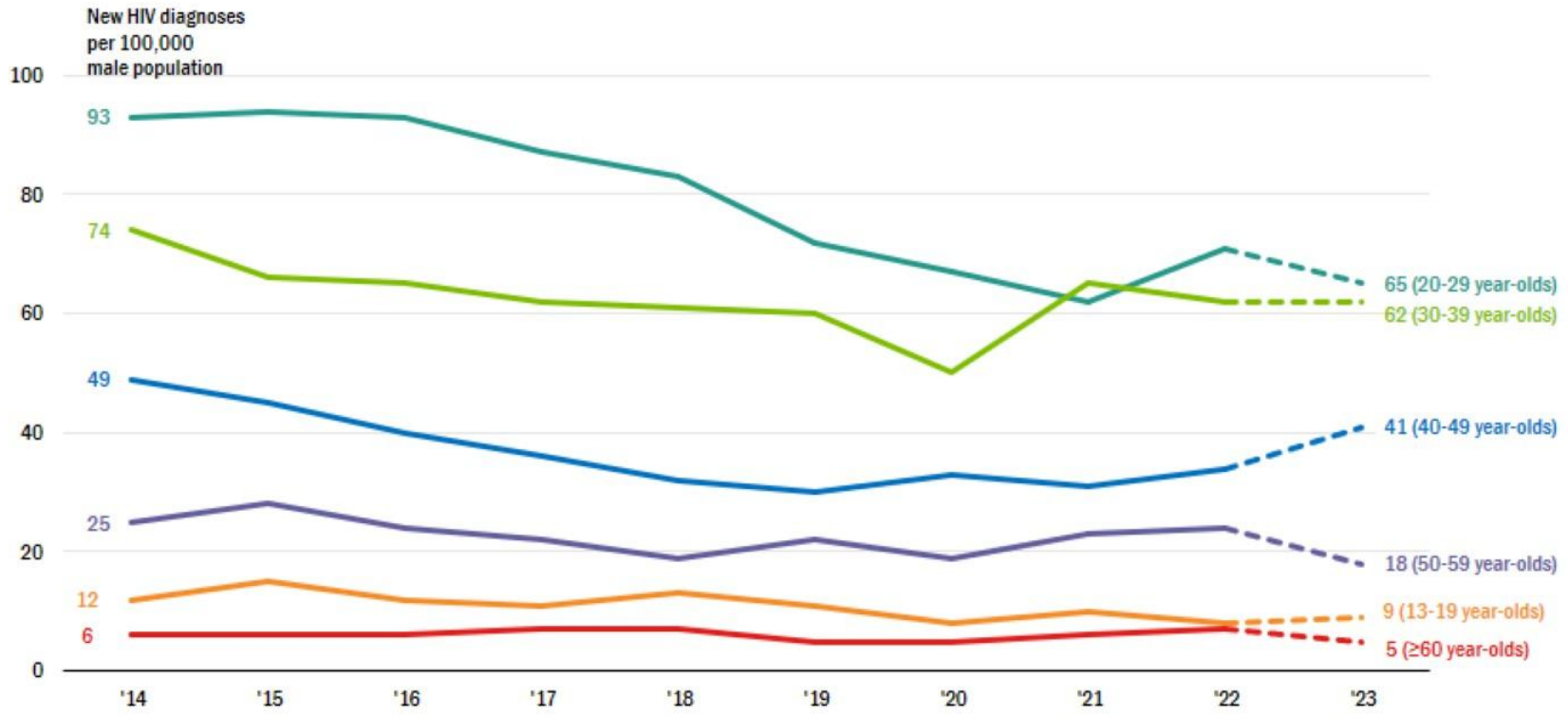


[1] Rates are presented by sex listed at birth due to the unavailability of population size estimates in LAC by gender categories.
[2] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.
[3] The decline in HIV diagnoses rates observed in 2020, a year in which the COVID-19 pandemic may have depressed HIV testing and reporting, seems to have been followed by a rebound in diagnoses in 2021 and 2022.

Source: HIV Surveillance data as of December 2024

Over the past decade, HIV diagnoses rates have declined among LAC males[1] across all age groups. However, males aged 20–29 years and 30–39 years continue to have significantly higher rates than other age groups.

HIV diagnoses rates among males (sex listed at birth)[1] aged ≥ 13 years, by age group, LAC 2014-2023[2,3]

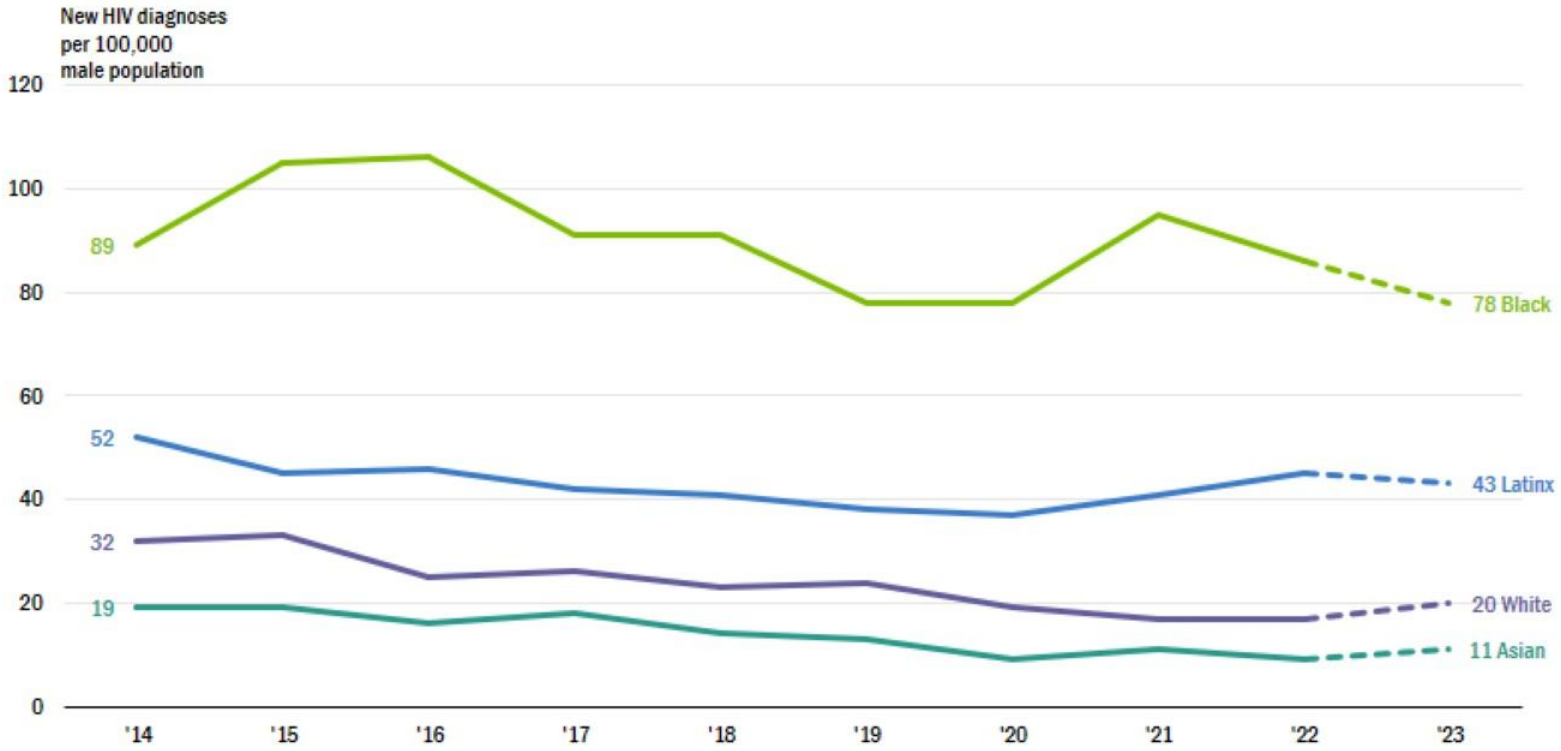


[1] Rates are presented by sex listed at birth due to the unavailability of population size estimates in LAC by gender categories.
[2] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.
[3] The decline in HIV diagnoses rates observed in 2020, a year in which the COVID-19 pandemic may have depressed HIV testing and reporting, seems to have been followed by a rebound in diagnoses in 2021 and 2022.

Source: HIV Surveillance data as of December 2024

Over the past decade, HIV diagnoses rates have declined among LAC males across all race/ethnicity groups. However, stark disparities persist, with Black males experiencing significantly higher rates than other race/ethnicity groups.

HIV diagnoses rates among males (sex listed at birth)[1] aged ≥ 13 years by race/ethnicity,[3] LAC 2014-2023[2]

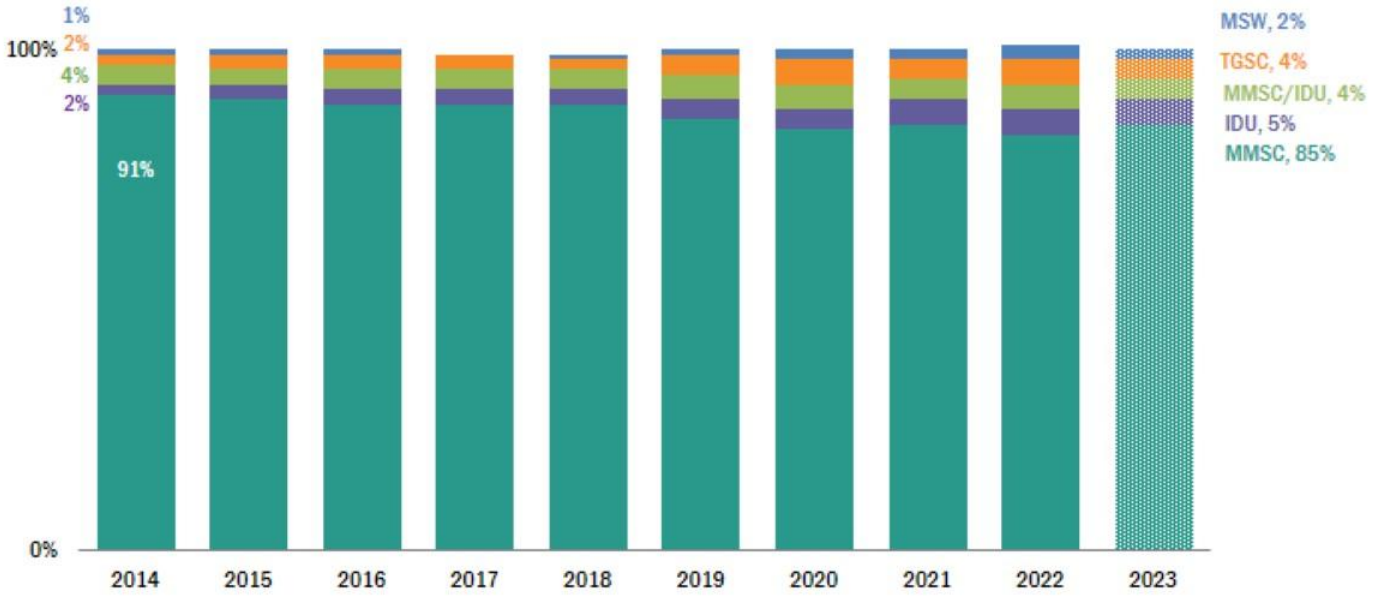


[1] Based on sex listed at birth.
[2] The decline in HIV diagnoses rates observed in 2020, a year in which the COVID-19 pandemic may have depressed HIV testing and reporting, seems to have been followed by a rebound in diagnoses in 2021 and 2022.
[3] American Indians and Alaska Natives (AIAN) and Native Hawaiian and Pacific Islanders (NHPI) were not included in the analysis due to small numbers. In 2023, NHPI, AIAN, and multi-racial persons represented 0.3%, 0.4%, and 1.3% of males newly diagnosed with HIV, respectively.

Source: HIV Surveillance data as of December 2024

The primary HIV transmission route among males diagnosed with HIV in LAC is having sex with other men, though it declined from 91% to 85%. By contrast, injection drug use rose from 2% to 5%, marking a steady upward trend.

Transmission category[2] among males (sex listed at birth)[1] newly diagnosed with HIV, LAC 2014-2023[3]



Abbreviations: IDU = injection drug use; MMSC = male-to-male sexual contact; TGSC = transgender persons with sexual contact

[1] Based on sex listed at birth.

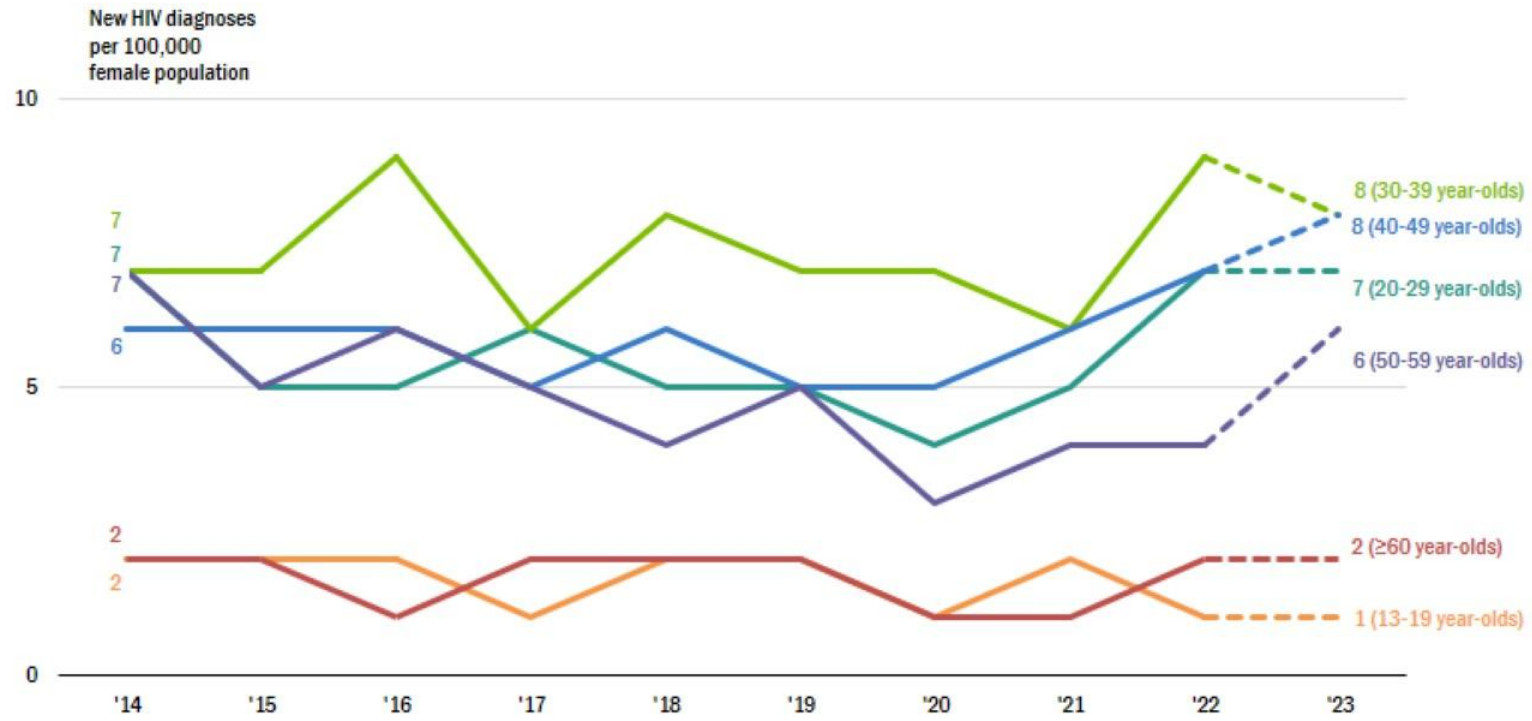
[2] A diagnosis of HIV is counted only once in the hierarchy of transmission categories. Persons with more than one reported risk factor for HIV are classified in the transmission category listed first in the hierarchy. The exception is men who had sexual contact with other men and injected drugs; this group makes up a separate transmission category. Not presented in the chart are less than 1% other risks, which include perinatal exposure, hemophilia, coagulation disorder, blood transfusion, and risk factor not reported/identified, due to small numbers. Persons without an identified risk factor were assigned a risk factor using CDC-recommended multiple imputation methods.

[3] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the patterned bar.

Source: HIV Surveillance data as of December 2024

HIV diagnosis rates among females[1] aged 20-49 years are higher and appear to be rising. By contrast, rates for females aged 13-19 years and those 60 years and older remain low and relatively stable.

HIV diagnoses rates among females (sex listed at birth)[1] aged ≥ 13 years by age group, LAC 2014-2023[2]

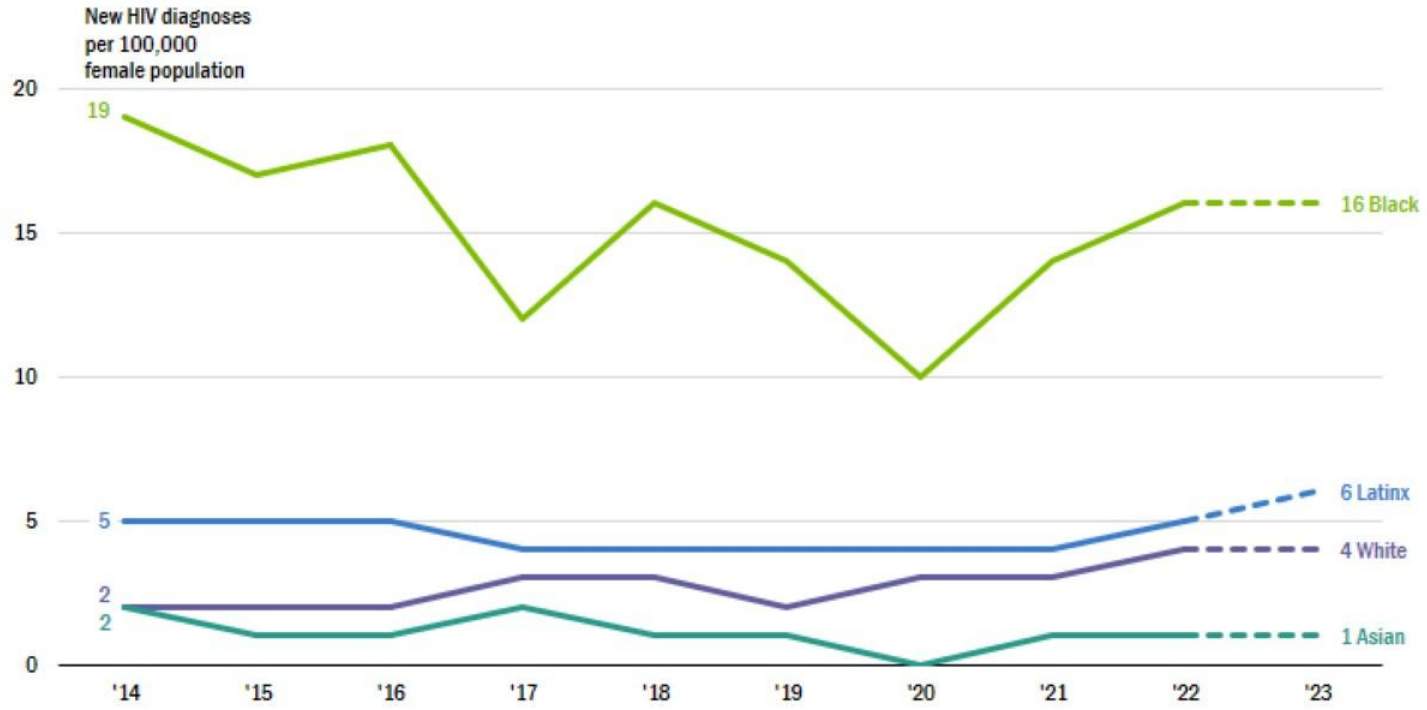


[1] Based on sex listed at birth.
[2] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.

Source: HIV Surveillance data as of December 2024

Over the past decade, HIV diagnosis rates have remained relatively low and stable among Latinx, White, and Asian females[1] in LAC. By contrast, rates for Black females have consistently remained higher than other racial/ethnic groups and have increased in recent years, reaching 16 per 100,000 in 2023.

HIV diagnoses rates among females (sex listed at birth)[1] aged ≥ 13 years by race/ethnicity,[2] LAC 2014-2023[4]

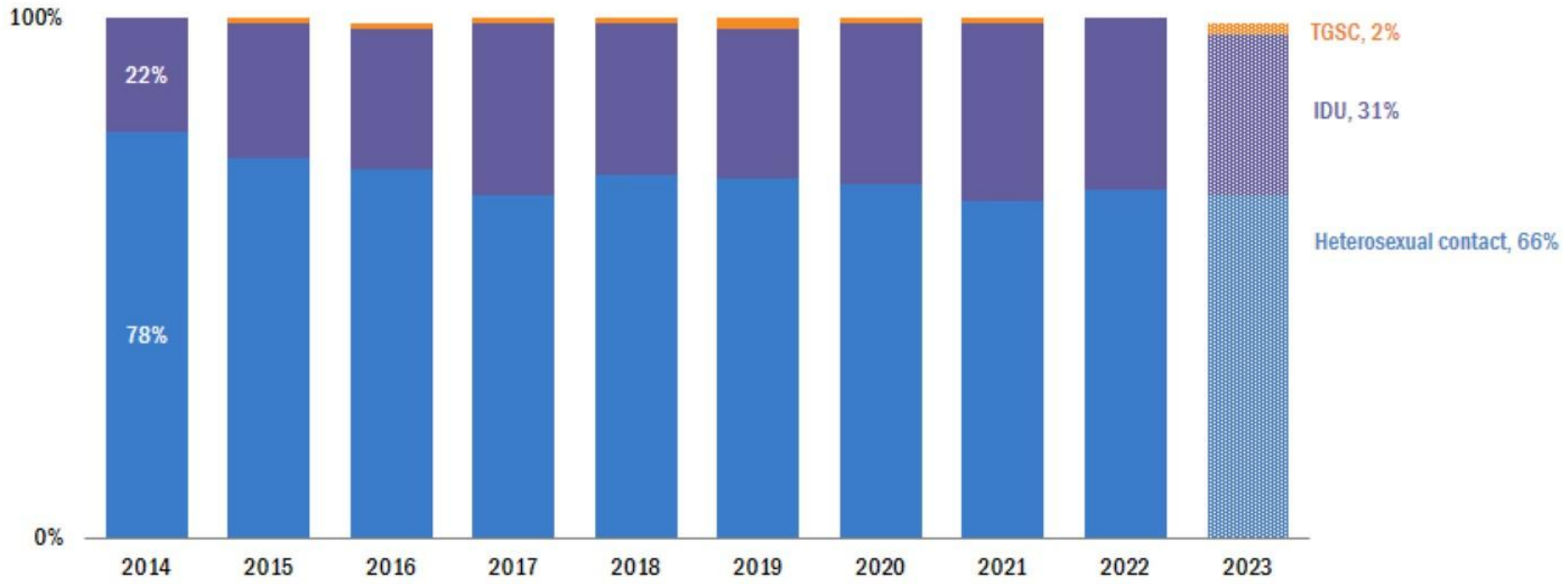


[1] Based on sex listed at birth.
[2] American Indians and Alaska Natives (AIAN) and Native Hawaiian and Pacific Islanders (NHPI) and were not included in the analysis due to small numbers. In 2023, NHPI, AIAN, and multi-racial persons represented 0.4%, 1.7%, and 1.3% of females newly diagnosed with HIV, respectively.
[3] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.
[4] The decline in HIV diagnoses rates observed in 2020, a year in which the COVID-19 pandemic may have depressed HIV testing and reporting, seems to have been followed by a rebound in diagnoses in 2021 and 2022.

Source: HIV Surveillance data as of December 2024

From 2014 to 2023, the primary HIV transmission route among females[1] diagnosed with HIV was heterosexual contact, though it declined from 78% to 66%. By contrast, injection drug use (IDU) rose from 22% to 31%, marking a steady upward trend.

Transmission category among females (sex listed at birth)[1] newly diagnosed with HIV, LAC 2014-2023[3]



Abbreviation: IDU = injection drug use; TGSC = transgender persons with sexual contact

[1] Based on sex listed at birth.

[2] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the patterned bar.

[3] Not presented in the chart are <1% other risks, which include perinatal, hemophilia, coagulation disorder, blood transfusion, and risk factor not reported/identified, due to small numbers. Persons without an identified risk factor were assigned a risk factor using CDC-recommended multiple imputation methods.

Source: HIV Surveillance data as of December 2024

HIV incidence and undiagnosed HIV

- Several indicators important for planning, monitoring, and evaluating the local HIV response are not directly measured through HIV surveillance, including:
  - the number of persons who acquired HIV each year (i.e., new HIV infections), regardless of whether they received an HIV diagnosis and
  - the number of people living with HIV (PLWH) who do not yet know they have HIV (i.e., undiagnosed HIV).

- An estimate of these indicators can be computed using a mathematical model developed by the US Centers for Disease Control and Prevention.
  - the model produces estimates (not true values).

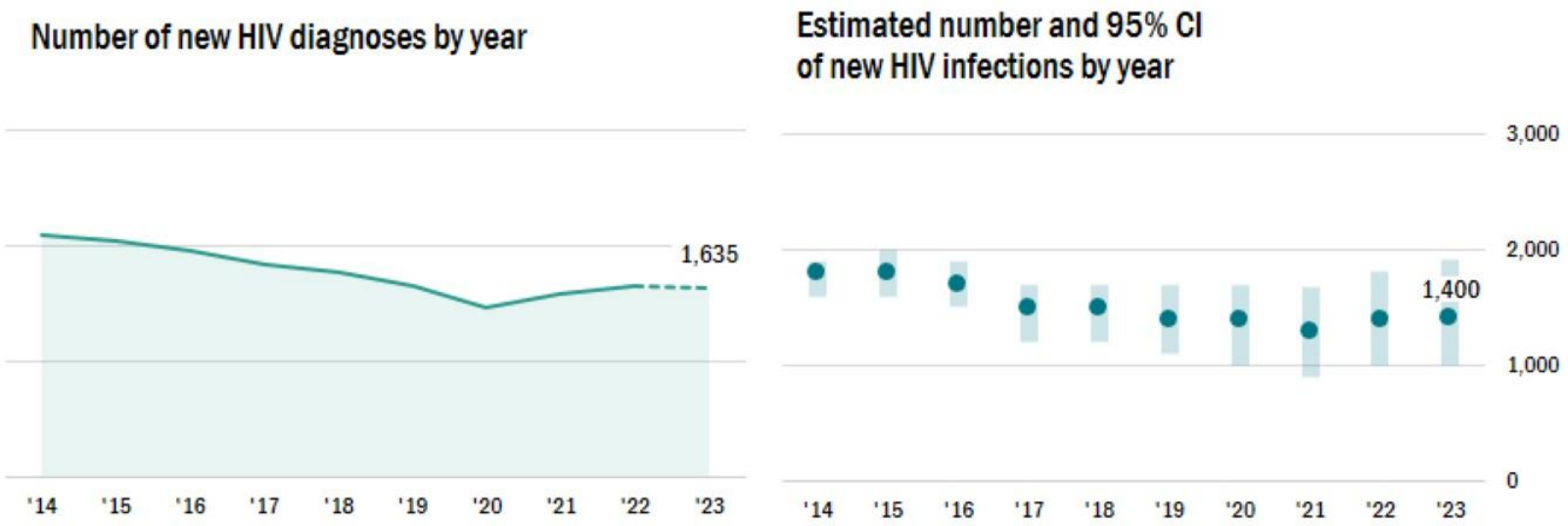
HIV incidence and undiagnosed HIV – cont.

- The estimates are presented with their 95% confidence intervals that show the range of values likely to contain the true value.
- Estimates are subject to periodic revisions due to updates to the surveillance data and methodological refinements in CDC's model.
- The 2020-2022 estimates may be particularly unreliable due to disruptions in HIV testing and reporting during the COVID-19 pandemic.

- Here, we present estimates of newly acquired HIV (new HIV infection) and undiagnosed HIV among PLWH in LAC based on CDC's model.

The number of persons newly diagnosed with HIV and the estimated number of persons who newly acquired HIV have been on a declining trend.

Number of persons newly diagnosed with HIV compared with the estimated number of persons who newly acquired HIV among PLWH aged ≥ 13 years, LAC 2014-2023[1]



Abbreviation: PLWH = persons living with HIV, including persons who are unaware that they have HIV.

[1] Estimates based on the CD4-based model v6.0 developed by CDC, which were derived by using HIV surveillance and CD4 data for persons aged ≥ 13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of ≤ 1,000 to reflect model uncertainty.

Source: HIV Surveillance data as of December 2024

The percent of PLWH who are aware of their HIV-positive status has increased over the last 10 years from 87% to 91% but has yet to meet the EHE goal of 95% by 2025. In 2023, an estimated 4,900 PLWH remained unaware of their HIV-positive status.

Awareness of HIV-positive status among PLWH aged ≥ 13 years, LAC 2014-2023[1]

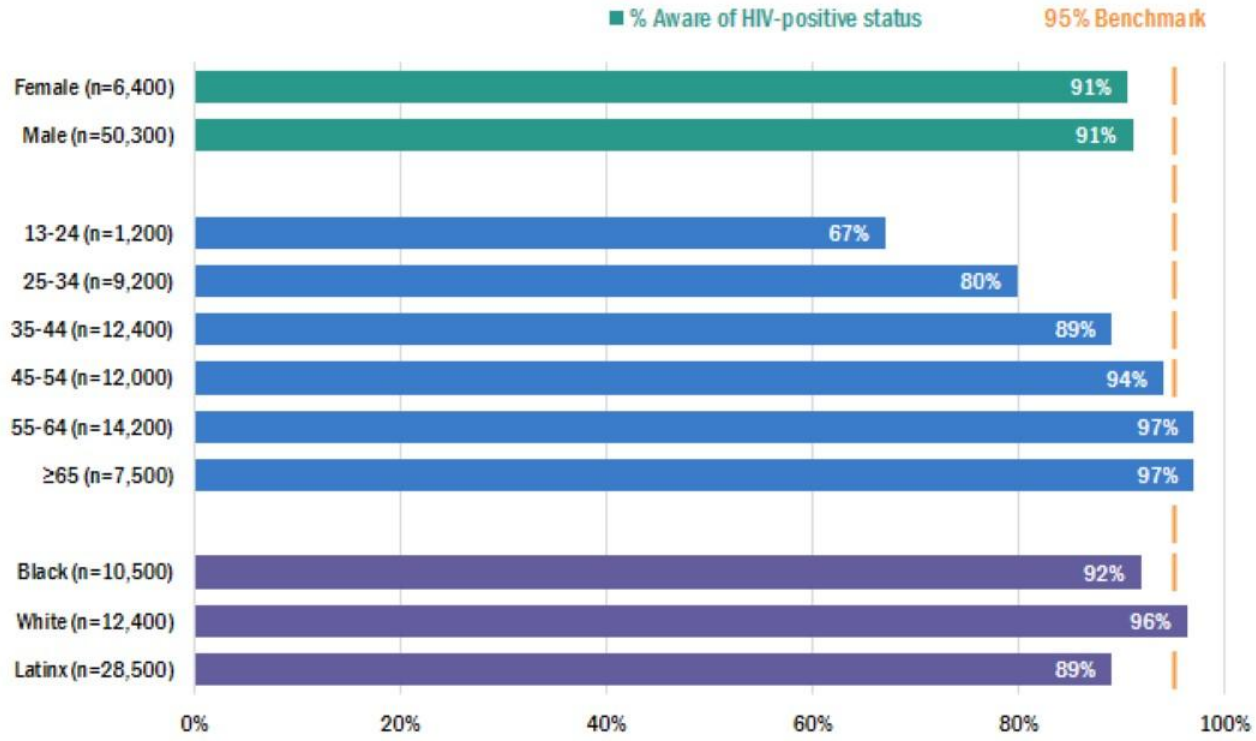
Abbreviation: PLWH = persons living with HIV, including persons who are unaware that they have HIV.

[1] Estimates based on the CD4-Based Model v6.0 developed by CDC, which were derived by using HIV surveillance and CD4 data for persons aged ≥ 13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of ≤ 1,000 to reflect model uncertainty.

Source: HIV Surveillance data as of December 2024

Latinx PLWH (11% unaware) and young PLWH 13-24 years (33% unaware) are disproportionately unaware of their HIV-positive status.

Awareness of HIV-positive status among PLWH aged ≥ 13 years by sex listed at birth, age group, and race/ethnicity, LAC 2023[1,2]



Abbreviation: PLWH = persons living with HIV, including persons who are unaware that they have HIV.

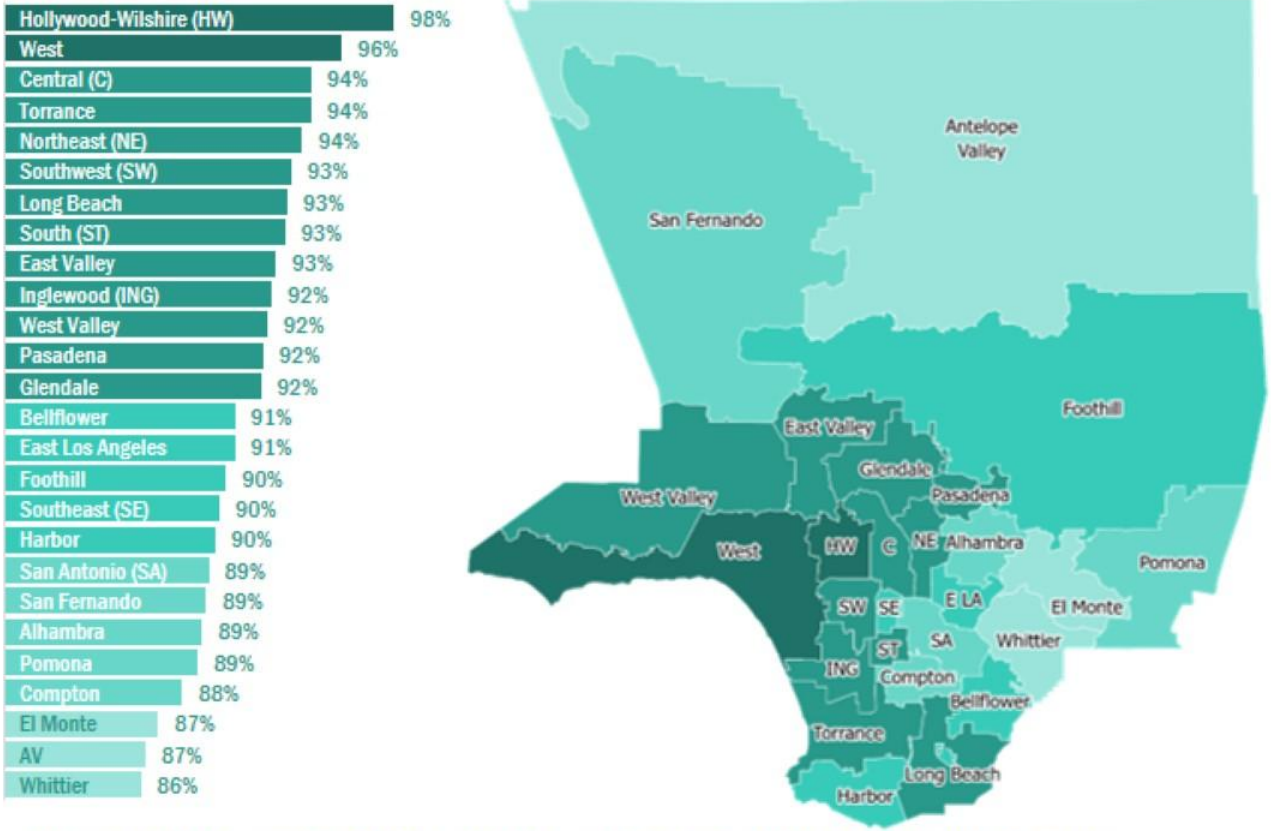
[1] Estimates based on the CD4-Based Model v6.0 developed by CDC, which were derived by using HIV surveillance and CD4 data for persons aged ≥ 13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of ≤ 1,000 to reflect model uncertainty.

[2] Asians, Native Hawaiian and Pacific Islanders, American Indians and Alaska Natives, and persons of multiple races/ethnicities were not included in the analysis due to small numbers.

Source: HIV Surveillance data as of December 2024

The percentage of persons living with HIV who are aware of their HIV-positive status varies by location. Two LAC Health Districts have met the EHE target (95%) for awareness of HIV-positive status among PLWH: Hollywood- Wilshire (98%) and West (96%).

Percentage of PLWH aged ≥ 13 years who are aware of their HIV-positive status by Health District, LAC 2023[1,2,3]



Abbreviation: PLWH = persons living with HIV, including persons who are unaware that they have HIV; AV=Antelope Valley

[1] Based on HIV surveillance data as of December 31, 2024, for persons aged ≥ 13 years at year-end 2023.

[2] Estimates based on the CD4-Based Model v6.0 developed by CDC, which derived by using HIV surveillance and CD4 data for persons aged ≥ 13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of ≤ 1,000 to reflect model uncertainty.

[3] AV = Antelope Valley

Source: HIV Surveillance data as of December 2024

Stage of HIV disease at diagnosis

- Information on stage of HIV disease at the time of diagnosis provides direct insight into the timeliness of an HIV diagnosis.
- The HIV surveillance case definition of HIV has four stages: Stage 0, 1, 2, and 3. Stage 0 HIV disease indicates early infection which includes acute HIV (infection occurred within 60 days of HIV diagnosis) and early but not acute HIV (infection occurred within 61-180 days of HIV diagnosis).
- Stage 3 disease indicates a late or delayed diagnosis of HIV.

Stage of HIV disease at diagnosis – cont.

HIV disease staging for surveillance purposes

HIV disease stage	Acute HIV Status	Staging criteria
Stage 0	Acute HIV	Based on the difference in days between the first HIV-positive test result and last documented HIV-negative test result. If the difference falls within 60 days, HIV is classified as stage 0 disease with acute HIV.
	Not Acute HIV or Unknown	Based on the difference in days between the first HIV-positive test result and last documented HIV-negative test result.[1] If the difference falls between 61 and 180 days, HIV is classified stage 0 disease with "not acute HIV" or "unknown if acute HIV".
Stage 1	N/A	Based on first CD4 test result within 90 days of HIV diagnosis. If CD4 ≥ 500 cells/µL, HIV is classified as Stage 1 disease.
Stage 2	N/A	Based on first CD4 test result within 90 days of HIV diagnosis. If CD4 is between 200-499 cells/µL, HIV is classified as Stage 2 disease.
Stage 3	N/A	Based on either first CD4 test result or a diagnosis of an opportunistic illness within 90 days of HIV diagnosis. If CD4<200 cells/µL, HIV is classified as Stage 3 disease.
Unknown	N/A	Based on first CD4 test result within 90 days of HIV diagnosis. If there is no CD4 test result within this timeframe, HIV is classified as unknown stage.

[1]The date of the last HIV-negative test is based on a laboratory result, or client's self-report of last HIV-negative test date when laboratory information is not available.

Source: HIV Surveillance data as of December 2024

Stage of HIV disease at diagnosis – cont.

- Diagnosis of HIV in the acute phase allows for early treatment, which helps reduce forward transmission of HIV.
- In 2023, 14% of new HIV diagnoses were diagnosed at Stage 0 (an indicator of recent infection) and over half of those had acute HIV at diagnosis.
- Among those diagnosed in the acute phase, women, persons aged >30 years, PWID and persons with heterosexual transmission risk are underrepresented.

HIV disease stage among persons ≥13 years newly diagnosed with HIV, LAC 2023

	New HIV Diagnoses	Stage 0 [1]				Stage 1 [2]		Stage 2 [3]		Stage 3 [4]		Unknown [5]	
		Acute Infection		Not Acute									
	N	N	%	N	%	N	%	N	%	N	%	N	%
Total	1,635	142	9%	79	5%	399	24%	479	29%	301	18%	235	14%
Gender													
Man	1,333	125	9%	72	5%	300	23%	394	30%	250	19%	192	14%
Woman	229	11	5%	3	1%	71	31%	66	29%	44	19%	34	15%
Transgender	73	6	8%	4	5%	28	38%	19	26%	7	10%	9	12%
Race/Ethnicity													
White	256	16	6%	8	3%	87	34%	58	23%	37	14%	50	20%
Black	295	27	9%	16	5%	75	25%	77	26%	37	13%	63	21%
Latinx	967	93	10%	52	5%	215	22%	304	31%	199	21%	104	11%
Asian	76	<5	-	<5	-	16	21%	25	33%	19	25%	10	13%
Multiracial	21	<5	-	<5	-	<5	-	7	33%	6	29%	<5	-
Unknown	7	<5	-	<5	-	0	-	0	-	<5	-	<5	-
Age at Diagnosis													
13-19	47	8	17%	<5	-	13	28%	9	19%	<5	-	11	23%
20-29	507	49	10%	34	7%	120	24%	170	34%	60	12%	74	15%
30-39	540	50	9%	30	6%	140	26%	146	27%	102	19%	72	13%
40-49	317	16	5%	7	2%	74	23%	90	28%	82	26%	48	15%
50-59	150	10	7%	5	3%	38	25%	44	29%	33	22%	20	13%
60+	74	9	12%	<5	-	14	19%	20	27%	20	27%	10	14%
Transmission Category													
MMSC	1,193	117	10%	71	6%	271	23%	353	30%	211	18%	171	14%
IDU	137	<5	-	<5	-	38	28%	31	23%	36	26%	26	19%
MMSC/IDU	55	5	9%	<5	-	10	18%	18	33%	14	25%	7	13%
Heterosexual	181	10	6%	<5	-	54	30%	58	32%	34	19%	23	13%
TGSC	65	6	9%	<5	-	24	37%	18	28%	6	9%	7	11%

[1]Stage 0 includes those with acute infection at diagnoses (Acute HIV) and those with no evidence of acute infection at diagnosis (Not Acute HIV). If the difference between first HIV-positive test result and last HIV-negative test result falls within 60 days, HIV is classified as acute HIV. If it falls between 61 and 180 days, HIV is classified as stage 0 disease, not acute. The number of newly diagnosed persons during stage 0 are likely underestimated due to under-reporting of HIV-negative test results.

[2] The criterion for Stage 1 disease is CD4 ≥ 500 cells/μL within 90 days of diagnosis.

[3] The criterion for Stage 2 is CD4 between 200-499 cells/μL within 90 days of diagnosis.

[4] Stage 3 criteria include either CD4 < 200 cells/μL within 90 days of HIV diagnosis or a diagnosis of an opportunistic illness within 90 days of HIV diagnosis.

[5] Unknown stage includes persons without a CD4 test within 90 days of HIV diagnosis.

Source: HIV Surveillance data as of December 2024

Monitoring trends in CD4 counts at diagnosis

- One way we evaluate the timeliness of a patient's HIV diagnosis is by assessing their CD4+ T-cell counts at the time of, or shortly after their HIV diagnosis.
- Patients with relatively low baseline CD4+ T-cell counts (CD4 < 200 cells/μL) within 1 month of diagnosis are defined as having late-stage disease while those with relatively high baseline CD4+ T-cell counts (CD4 > 500 cells/μL) within 1 month of HIV diagnosis are defined as having early-stage disease.
- We want to minimize late-stage diagnoses as late-stage diagnoses are associated with poorer outcomes and increased morbidity and mortality.

CD4 count-based implementation metrics are used to evaluate the public health response to HIV epidemics. Over the past 3 years, approximately one in four new HIV cases in LAC was diagnosed at late-stage (CD4 <200 cells/µL or stage 3). The percent of late-stage diagnoses has not decreased appreciably over the past decade.

CD4+ T-cell count within 1 month of HIV diagnosis, LAC 2015-2024[1]

[1]Based on first CD4 test within 1 month of HIV diagnosis. Among persons who were 13 years of age or older and were newly diagnosed with HIV between 2015-2024, 50% had a CD4 test within this period. Data for 2024 are provisional and should be interpreted with caution.

Source: HIV Surveillance data as of December 2024

HIV transmission clusters, molecular HIV surveillance, and transmitted drug resistance

- Federal guidelines for the care and treatment of PLWDH recommend HIV viral genotype testing at initiation of HIV care to determine whether an individual's HIV strain is resistant to certain anti-retroviral drugs.
- Genotype testing, which results in a genetic sequence report reflecting an individual's HIV strain, is reported to Public Health along with other HIV laboratory and clinical test results.
- Through a comparison of the viral genotype reports of PLWDH in the local area, it can be determined if there are multiple people with a highly similar HIV strain.

HIV transmission clusters, molecular HIV surveillance, and transmitted drug resistance – cont.

- Because HIV's genetic sequence constantly evolves, people whose viral strains are highly similar are likely to be in the same social HIV transmission network (i.e., transmission cluster); it is important to note that this information cannot be used to determine either direct transmission or the direction of transmission between any two individuals.
- Transmission clusters with numerous individuals newly diagnosed with HIV may indicate that recent and rapid HIV transmission is occurring among a group of individuals.
- When a cluster is identified, it informs the delivery of services and interventions to minimize transmission in the social or sexual network and helps prioritize efforts to those who need them the most.
- However, only 51% of new HIV diagnoses receive a timely genotype test, indicating a need to improve completeness of genotype testing at initiation of HIV care.

Timely (within 90 days of diagnosis) genotype test results were reported for only 51% of new HIV diagnoses. However, of those 2023 new diagnoses with a reported genotype, 88% received a timely genotype test. This suggests that in the instances where genotypes are performed, they are timely.

Proportion of new HIV diagnoses[1] with a genotype resistance test within 90 days of an HIV diagnosis,[2] LAC 2023

Note: **Genotypic resistance testing is recommended at entry into HIV care to guide treatment.**

[1]Persons aged ≥ 13 years newly diagnosed with HIV in 2023. Data are provisional due to reporting delay.
[2]Race/ethnicity categories with fewer than 10 diagnoses (American Indian/Alaska Native and Native Hawaiian and Other Pacific Islander), Multi-race, and unknown persons were included in Other.

Source: HIV Surveillance data as of December 2024

In 2023, 20% of new HIV diagnoses in LAC had a transmitted drug resistant mutation (TDRM). The prevalence of TDRM among new HIV diagnoses has remained relatively stable (range: 20-25%) over the last 10 years. Transmitted drug resistance to NNRTI is consistently higher than transmitted drug resistance to NRTI or PI.

Proportion of transmitted drug resistance (TDR) by drug class[1] among persons aged ≥13 years newly diagnosed with HIV with an eligible sequence,[2] LAC 2014-2023

PI = Protease Inhibitors
NRTI = Nucleoside Reverse Transcriptase Inhibitors
NNRTI = Non-Nucleoside Reverse Transcriptase Inhibitors

Notes: In 2023, 58% of people newly diagnosed with HIV had a sequence eligible for drug resistance analysis.

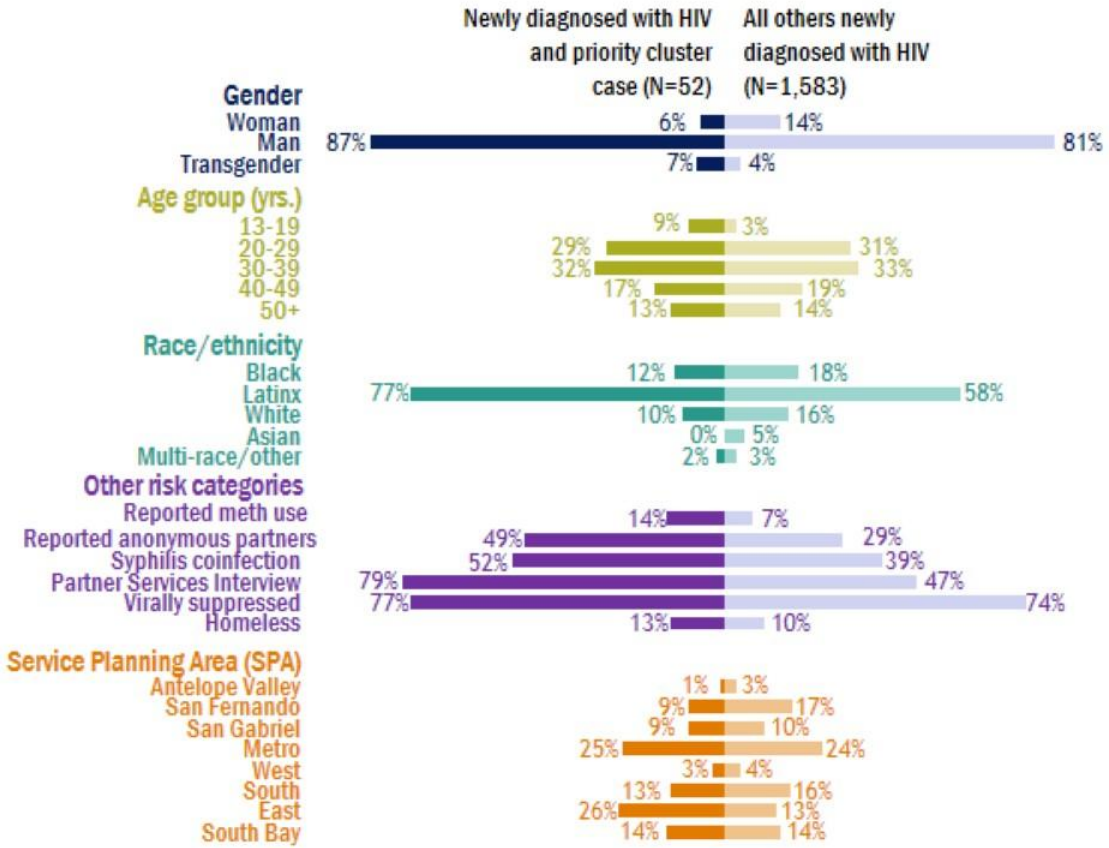
The proportion of specimens with resistance to integrase inhibitors did not exceed more than 0.1% (data not shown).

[1]NNRTI= Non-nucleoside reverse transcriptase inhibitors; NRTI= Nucleoside reverse transcriptase inhibitor; PI= Protease inhibitor; TDRM= Transmitted drug resistance mutation; Resistance can include multi-drug classes and individuals may have been represented in more than one category.
[2]An eligible sequence is a genotypic resistance test which has met the following criteria: obtained within 3 months of HIV diagnosis and has a sequence length that is ≥ 100 bases. Cases who have a prior history of anti-retroviral use are excluded as eligible.

Source: HIV Surveillance data as of December 2024

In 2023, 3% of people newly diagnosed with HIV were associated with a high priority transmission cluster. These persons were more likely to be men, aged 20-39 years, and Latinx compared with those not associated with high priority clusters. People who report methamphetamine use, anonymous partners, have syphilis co-infection, or live in the Metro and East SPAs were also more likely be part of a high priority cluster.

Priority[1] cluster diagnoses compared to non-cluster diagnoses among those newly diagnosed with HIV by selected characteristics, LAC 2023[2]



[1]Priority transmission clusters are identified by HIV-TRACE and have at least five people diagnosed within the prior 12 months at a 0.5% genetic distance threshold.
[2]Age groups, race/ethnicity groups, and transmission risk categories with fewer than 5 persons are suppressed.

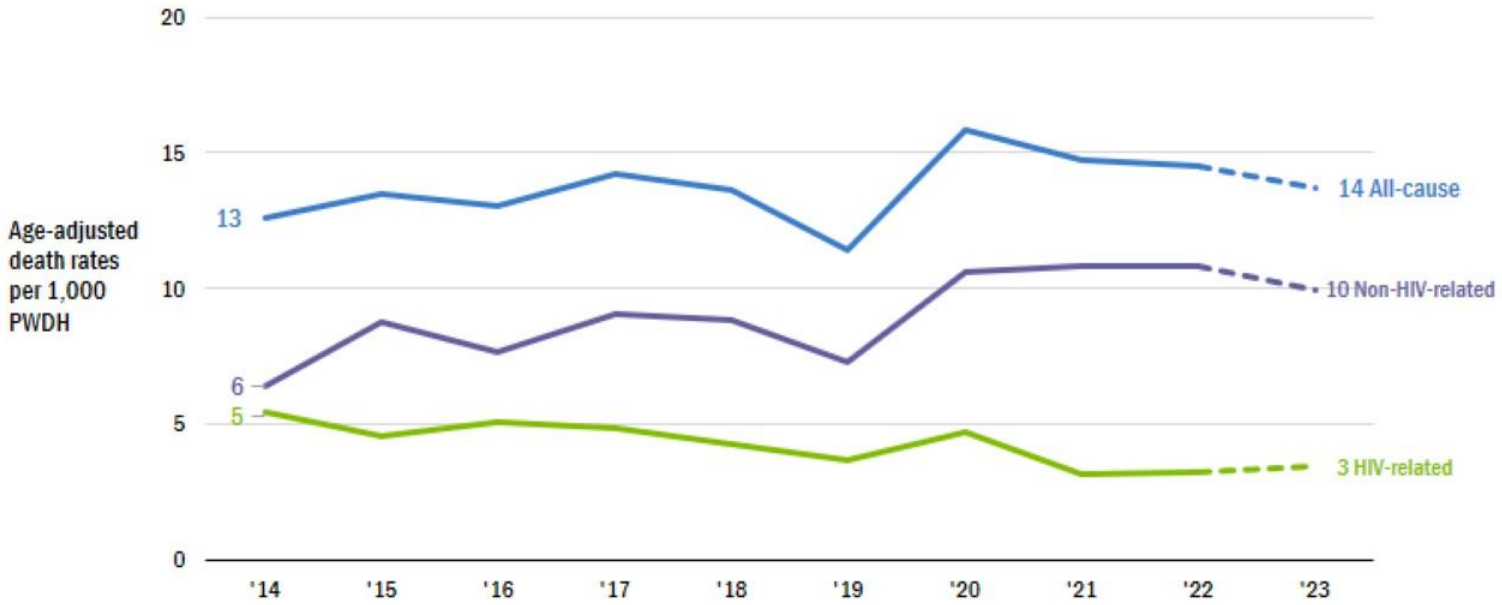
Source: HIV Surveillance data as of December 2024

HIV Mortality

- Ultimately the most important goal in the public health response to HIV is for persons living with HIV to live long and healthy lives.
- Rapid access to and consistent use of high-quality services across the HIV care continuum is fundamental to achieving this goal.
- This section presents trends in cause of death and death rates among PLWDH.

Between 2014 and 2019, age-standardized death rates among persons with diagnosed HV due to HIV-related, non-HIV-related, and all-causes have been relatively stable. With the onset of the COVID-19 pandemic in 2020, non-HIV related deaths rates increased from 7 per 1,000 in 2019 to 10 per 1,000 in 2023 and HIV-related death rates decreased from 4 per 1,000 in 2019 to 3 per 1,000 in 2023.

Age-adjusted death rates among persons aged ≥ 13 years with diagnosed HIV (PWDH), by HIV-related and non-HIV related cause of death, LAC 2014-2023[1,2,3,4]

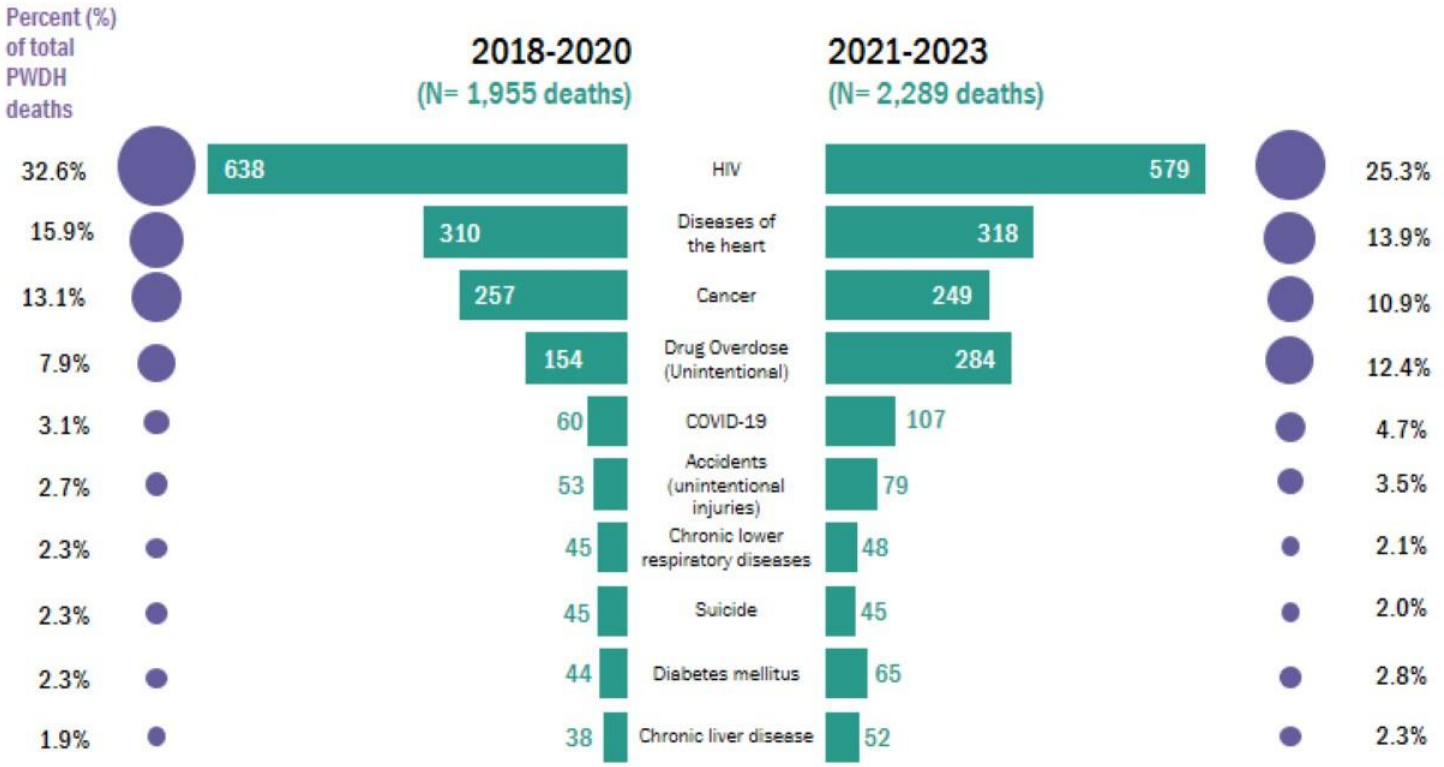


[1] Age-adjusted to the U.S. 2000 standard population.
[2] 2023 death rate data among PWDH are provisional due to reporting delay as indicated by the dashed line.
[3] For each calendar year in which the deaths occurred, PWDH includes persons living with HIV infection at the beginning of the calendar year plus persons newly diagnosed in the calendar year.
[4] All-cause death rates include persons with unknown causes of death, which accounted for 2.6% of all deaths among PWDH during this period (2014-2023).

Source: HIV Surveillance data as of December 2024

HIV as the main cause of death among PWDH declined from 32.6% in 2018-2020 to 25.3% in 2021-2023. Conversely, deaths resulting from unintentional drug overdose saw a significant uptick from 7.9% to 12.4% during those comparative time frames.

Underlying causes of death[1] among persons aged ≥ 13 years with diagnosed HIV (PWDH), LAC 2018-2020,2021-2023[2]



Note: Over the past decade, the number of deaths among PWDH has remained stable at approximately 600 deaths per year but increased sharply in 2020 during the onset of the COVID-19 pandemic to nearly 800 deaths per year (data not shown).

[1] The percentage of deaths among persons diagnosed with HIV was based on total deaths, which includes 71 (4%) individuals with unknown causes and 159 (8%) with other causes of death from 2018 to 2020. From 2021 to 2023, this figure comprises 182 (8%) individuals with unknown causes and 184 (8%) with other causes of death.

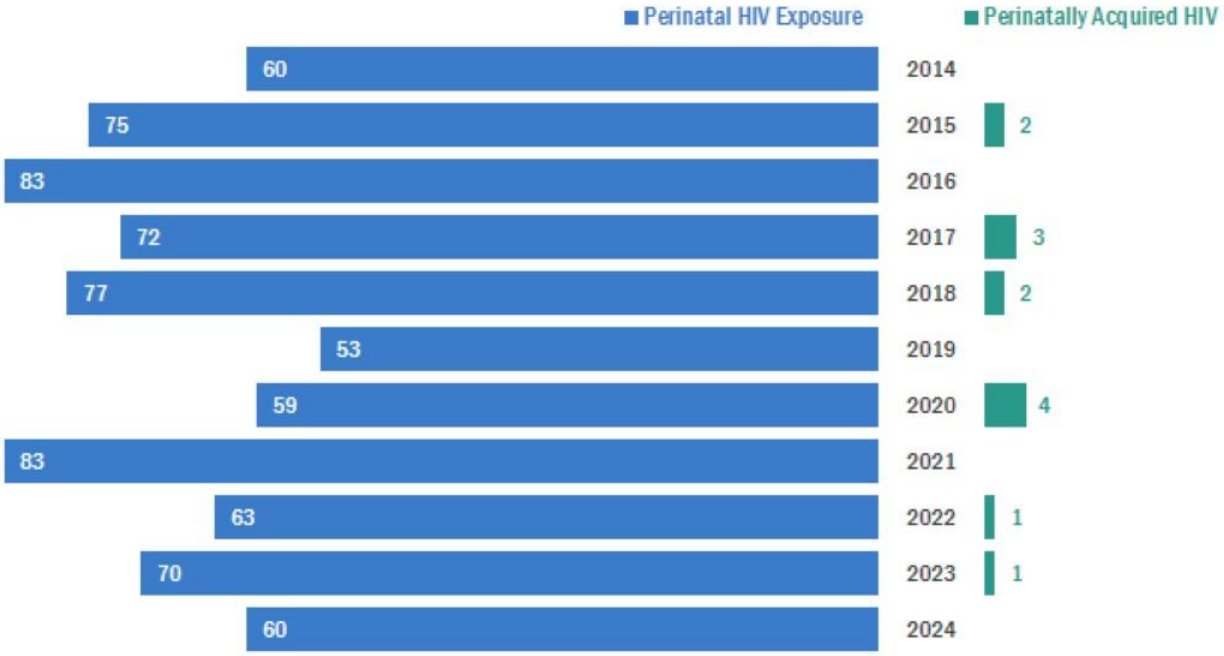
[2] Annual percentages may not add to 100% due to rounding error.

Source: HIV Surveillance data as of December 2024

Vulnerable Populations

From 2020 to 2024, <2% of all perinatal exposed infants resulted in perinatally acquired HIV.

Number of infants with perinatal HIV exposure vs. Number of infants with perinatally acquired HIV, LAC 2014-2024[1,2]



[1] Due to reporting delay, 2023 and 2024 HIV data are provisional.
[2] The number of infants with perinatally acquired HIV includes perinatal transmissions among babies born and/or diagnosed in LAC for a given birth year. The number of infants with perinatal HIV exposure was derived from 7 pediatric HIV-specialty sites which serve over 90% of the HIV-exposed children and infected children seeking HIV evaluation and care in Los Angeles County as well as from the annual birth registry match. Since the denominator is likely underestimated, while the numerator presumed accurate, the calculated perinatal transmission rates may be an overestimate of the actual rate.

Source: HIV Surveillance data as of December 2024

In 2024, LAC met the perinatal incidence and perinatal HIV transmission national targets for elimination of mother-to-child transmission.

HIV incidence and perinatal transmission among infants aged < 18 months, LAC 2014-2024[1]

Birth Year	Number of infants newly diagnosed with HIV	Live Births	Number of HIV-exposed infants	Perinatal HIV incidence rate per 100,000 live births	Perinatal HIV transmission rate per 100 HIV-exposed infants
2014	0	130,150	60	0	0
2015	2	124,438	75	1.6	2.7
2016	0	123,092	83	0	0
2017	3	116,850	72	2.6	4.2
2018	2	116,063	77	1.7	2.6
2019	0	113,027	53	0	0
2020	4	102,610	57	3.9	7.0
2021	0	100,641	83	0	0
2022	1	100,057	63	1.0	1.6
2023	1	94,967	69	1.1	1.4
2024	0	94,779	60	0	0

National targets for elimination of mother-to-child transmission of HIV

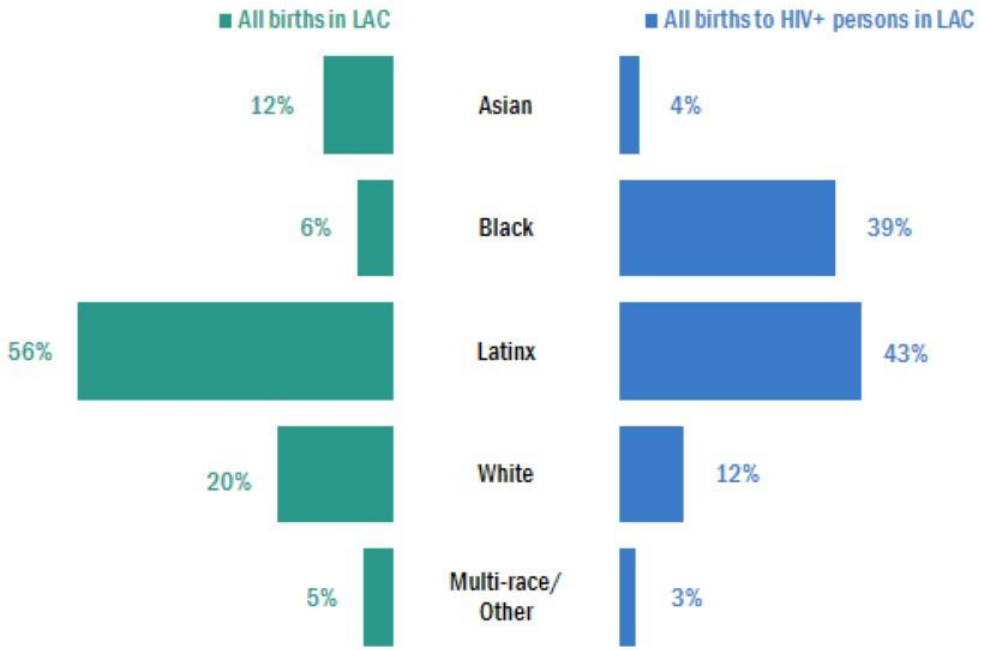
1. **Perinatal HIV incidence <1 per 100,000 live births**
2. **Perinatal transmission rate <1 per 100 HIV-exposed infants**

[1] Over 90% of the HIV exposed and infected infants identified in birth years 2023 and 2024 were born at and/or received care at one of the 7 pediatric HIV-specialty sites. Additionally, since 2018 the CA SOA has conducted a birth registry match with HIV+ women in eHARS and LAC birth certificates. This is an underestimate of the total number of infants with a perinatal HIV exposure in Los Angeles County since perinatal HIV exposure reporting is not mandated in California. For this reason, perinatal HIV transmission rates are not generalizable to Los Angeles County. Data for 2023 and 2024 are provisional due to reporting delay. Live birth data for 2013-2017 were derived from the Los Angeles Almanac and live birth data after 2017 were derived from the California Department of Public Health-California Vital Data (Cal-ViDa) Query Tool since this tool was not available for birth years prior to 2018.

Source: HIV Surveillance data as of December 2024

Black persons are disproportionately impacted by perinatal HIV risk. Black infants accounted for 6% of all births in the general LAC population but made up 39% of all HIV-exposed births in 2023–2024.

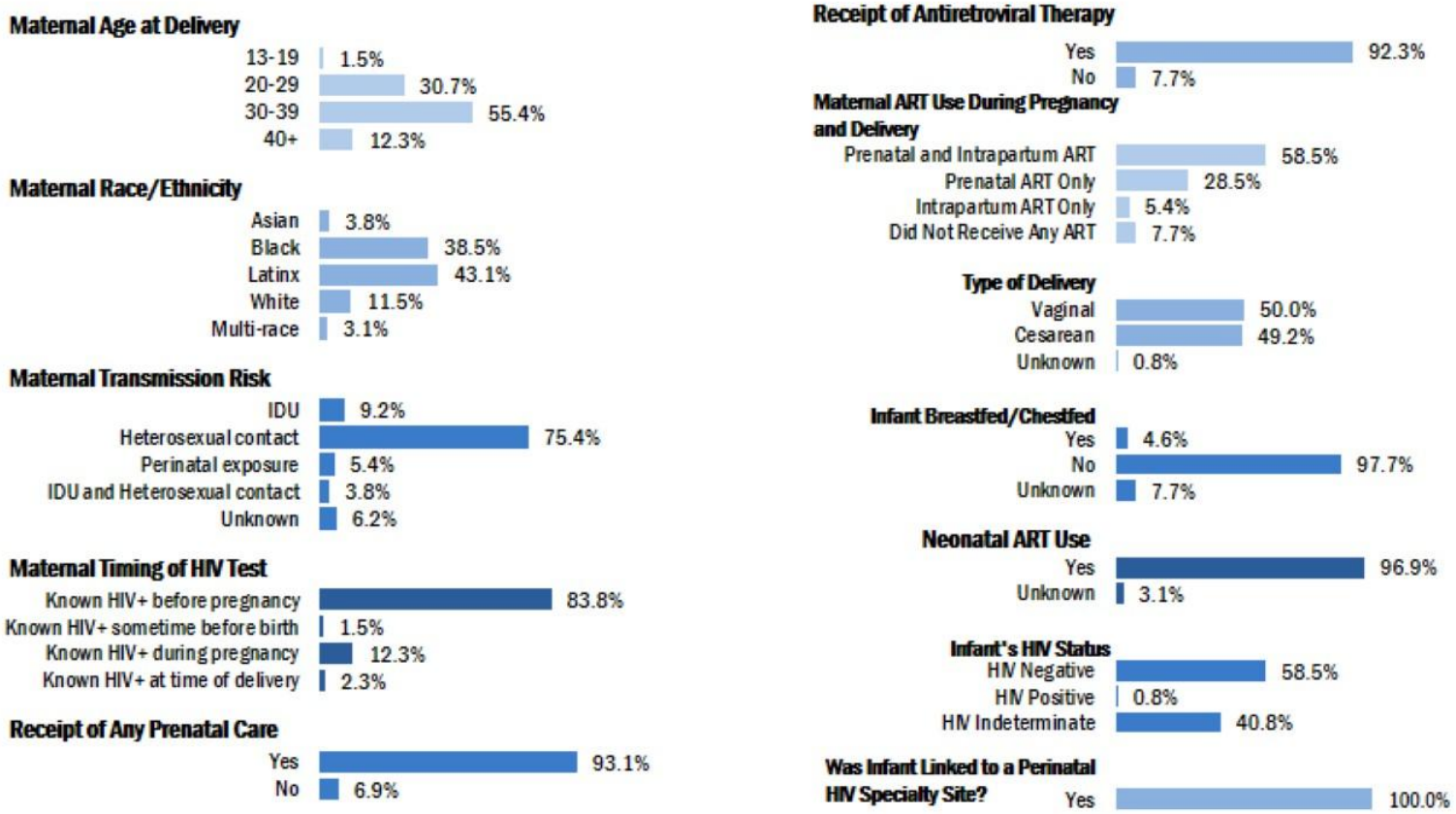
Rate of all LAC births vs. perinatal HIV-exposed births in LAC by race/ethnicity, LAC 2023-2024



Source: HIV Surveillance data as of December 2024

Prenatal care and ART use during pregnancy and labor and delivery are an essential component of prevention of perinatal HIV transmission.

Demographic and clinical characteristics of pregnant persons with diagnosed HIV and exposed infants, LAC 2023-2024[1,2]

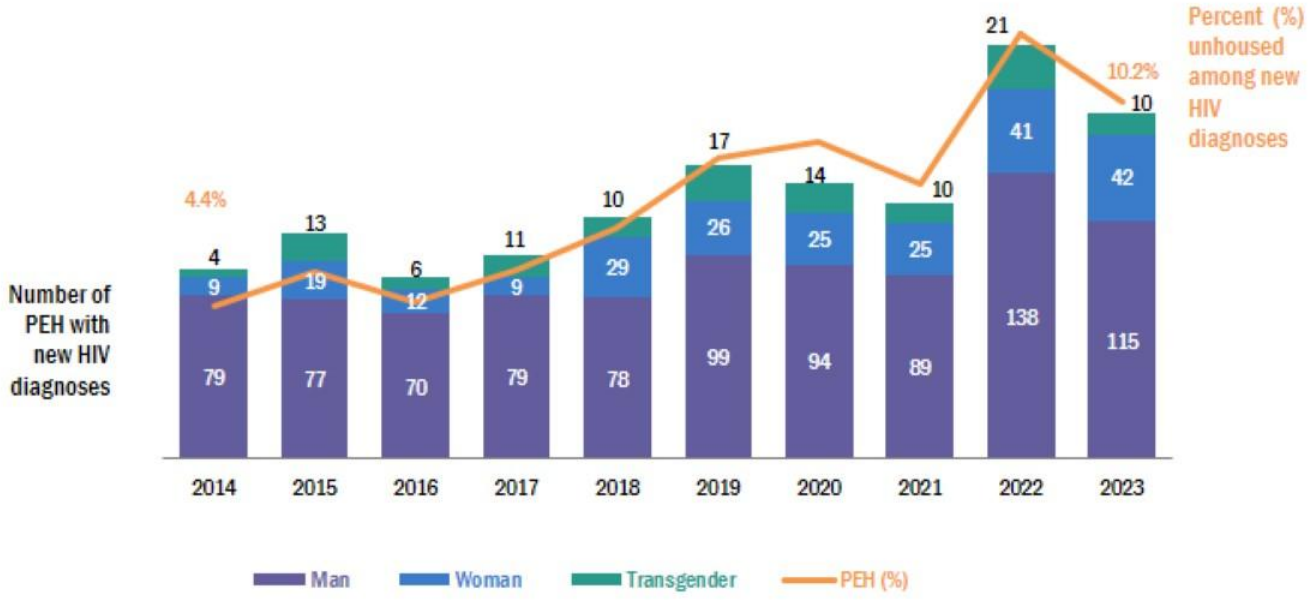


[1] Data are provisional due to reporting delay
[2] Due to rounding, totals may not equal 100%

Source: HIV Surveillance data as of December 2024

Between 2014 and 2023 the percentage of persons newly diagnosed with HIV who were experiencing homelessness at the time of their diagnosis, increased from 4.4% to 10.2%. Among 167 PEH with a new HIV diagnosis in 2023, 69% were men, 25% were women, and 6% were transgender persons.

Number and percent of persons aged ≥ 13 years newly diagnosed with HIV who experienced homelessness (PEH) within 6 months of diagnosis[1] by gender, LAC 2014-2023

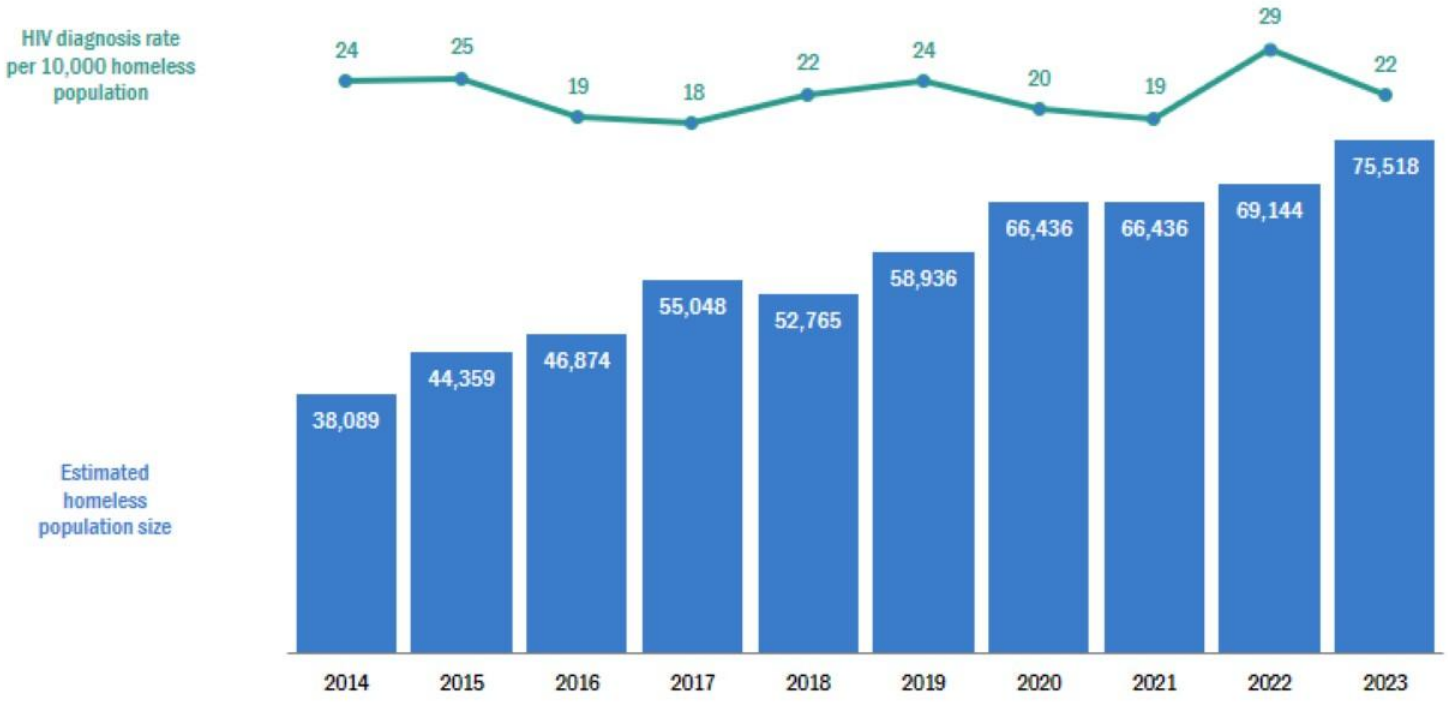


[1] Persons newly diagnosed with HIV were classified as PEH if they were experiencing homelessness within 6 months of their HIV diagnosis date. For the PEH definition, please refer to the Los Angeles Housing Services Authority definition under "Category 1" at https://www.lahsa.org/documents?id=1349-homeless-definition-part-1-.pdf

Source: HIV Surveillance data as of December 2024

Except for an uncharacteristic rate spike in 2022 (29/10,000), the relatively stable HIV diagnosis rates among PEH suggests that underlying increases in the unhoused population in Los Angeles County largely explain the increasing trend in HIV diagnoses among PEH over the past decade.

HIV diagnoses rates among persons aged ≥ 13 years experiencing homelessness, LAC 2014-2023[1]



[1] Data from the Greater Los Angeles County Homeless Count, 2023 results. Note that the count was not performed in 2021, so the 2020 results were applied to 2021. The estimated population size of PEH includes persons of all ages.

Source: HIV Surveillance data as of December 2024

Most transgender people, whether newly diagnosed or living with diagnosed HIV, identified as trans women and Latinx. Sexual contact was the primary route of transmission. Newly diagnosed trans people were more likely to be young (<40 years).

Transgender people aged ≥ 13 years diagnosed in 2021-2023 and living with diagnosed HIV infection at year-end 2024 by gender and age group, race/ethnicity, transmission category, diagnosed while incarcerated, PEH, and viral suppression, LAC 2024

	HIV diagnoses 2021-2023						PLWDH 2024					
	Trans women		Trans men		Total		Trans women		Trans men		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Age group (yrs.)												
13-19	6	(3)	<5	(-)	7	(3)	<5	(-)	<5	(-)	<5	(-)
20-29	79	(37)	<5	(-)	83	(37)	146	(11)	6	(12)	152	(11)
30-39	77	(36)	5	(50)	82	(37)	461	(33)	15	(29)	476	(33)
40-49	37	(17)	<5	(-)	37	(17)	335	(24)	17	(33)	352	(25)
≥50	15	(7)	<5	(-)	15	(7)	440	(32)	13	(25)	453	(32)
Race/ethnicity												
Asian	6	(3)	<5	(-)	8	(4)	57	(4)	<5	(-)	60	(4)
Black	46	(21)	<5	(-)	47	(21)	345	(25)	13	(25)	358	(25)
Latinx	137	(64)	6	(60)	143	(64)	798	(58)	23	(44)	821	(57)
White	14	(7)	<5	(-)	15	(7)	94	(7)	11	(21)	105	(7)
Other	11	(5)	<5	(-)	11	(5)	89	(6)	<5	(-)	91	(6)
Transmission category												
TGSC	190	(89)	8	(75)	197	(88)	1,213	(88)	38	(73)	1,251	(87)
IDU	<5	(-)	<5	(-)	5	(2)	8	(1)	13	(25)	21	(1)
TGSC/IDU	22	(10)	<5	(-)	22	(10)	162	(12)	<5	(-)	162	(11)
Other	<5	(-)	<5	(-)	<5	(-)	<5	(-)	<5	(-)	<5	(-)
Diagnosed while incarcerated												
Yes	10	(5)	<5	(-)	10	(4)						
No	204	(95)	10	(100)	214	(96)						
Experienced homelessness												
Yes	41	(19)	<5	(-)	41	(18)	412	(30)	10	(19)	422	(29)
No	173	(81)	10	(100)	183	(82)	971	(70)	42	(81)	1,013	(71)
Virally suppressed (VL<200 mL)												
Yes	138	(64)	9	(90)	147	(66)	902	(65)	29	(56)	931	(65)
No	76	(36)	<5	(-)	77	(34)	447	(32)	19	(37)	466	(32)
Total	214	(96)	10	(4)	224	(100)	1,383	(96)	52	(4)	1,435	(100)

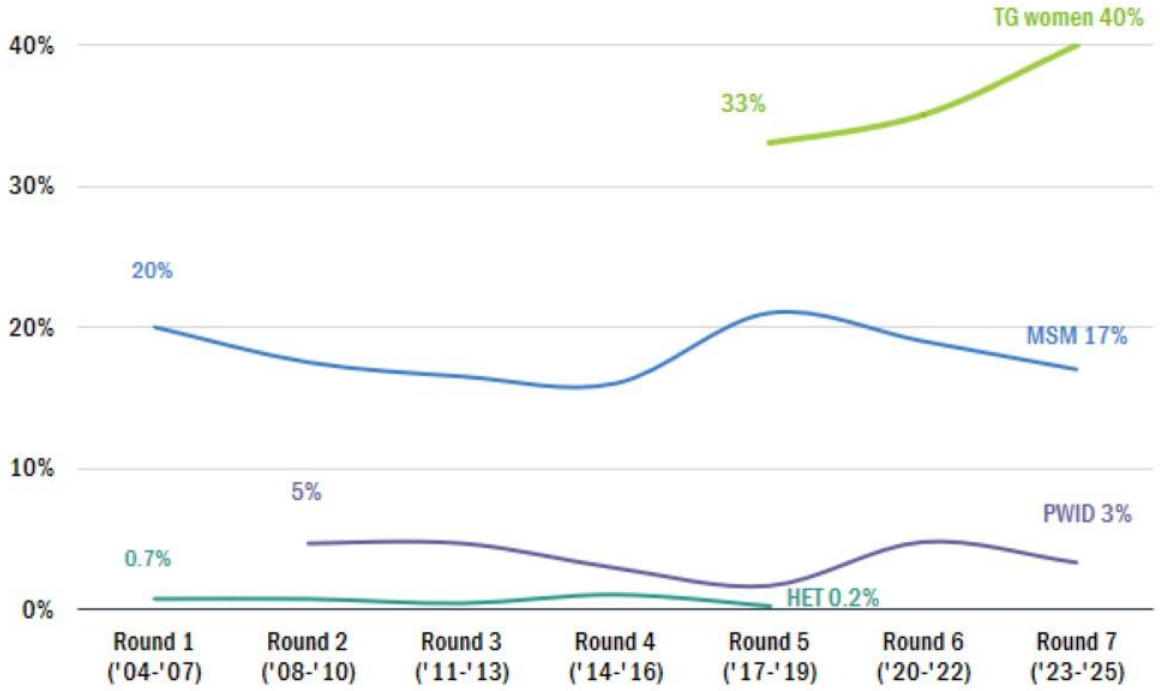
Source: HIV Surveillance data as of December 2024

HIV biobehavioral surveillance

- HIV biobehavioral surveys are surveillance tools that use probability-based sampling methods for estimating HIV prevalence and relevant behavioral and clinical indicators in a given population. Information from biobehavioral surveys helps us understand factors that may be associated with behavioral and clinical outcomes in vulnerable populations at increased risk for HIV or living with HIV.
- National HIV Behavioral Surveillance (NHBS) is a CDC-funded HIV surveillance activity that allows state and local health departments to monitor HIV prevalence and risk behaviors among select populations at elevated risk for HIV. These populations include men who have sex with men (MSM), persons who inject drugs (PWID), heterosexual persons at increased risk for HIV (HET), and transgender (TG) women. Probability-based sampling methods are used to recruit survey participants, including venue-based, time space sampling for the MSM survey and respondent driven sampling for PWID, HET, and TG surveys.
- The Medical Monitoring Project (MMP) is a CDC-funded HIV surveillance activity that provides national and local data on behavioral and clinical outcomes in a representative sample of PLWDH. MMP uses a 2-stage sampling strategy to select a sample of persons from which nationally and locally representative data are derived.
- In this section, we highlight key findings from NHBS and MMP efforts in LAC. While the data in this section provide the best estimates available for the populations presented, they are estimates (not true values) and thus any generalizations to broader population groups represented should be made with caution.

Among the populations studied in NHBS, Transgender (TG) women have the highest HIV prevalence, followed by MSM and PWID. HET consistently have the lowest estimated HIV prevalence.

Trends in HIV prevalence[1] by NHBS population, LAC 2004-2024[2,3]



Note: **Testing frequency among MSM and TG women was high compared with PWID and HET. MSM (85%) and TG women (86%) reported high levels of HIV testing in the past year. By contrast, only 45% of PWID and 31% of HET reported testing for HIV in the past year (not shown).**

Abbreviation: NHBS = National HIV Behavioral Surveillance; TG = transgender; MSM = men who have sex with men; PWID = persons who inject drugs; HET = heterosexuals at increased risk for HIV infection

[1] "HIV Prevalence" refers to the percentage of participants with a confirmed positive HIV test result among the total number of participants tested in NHBS.

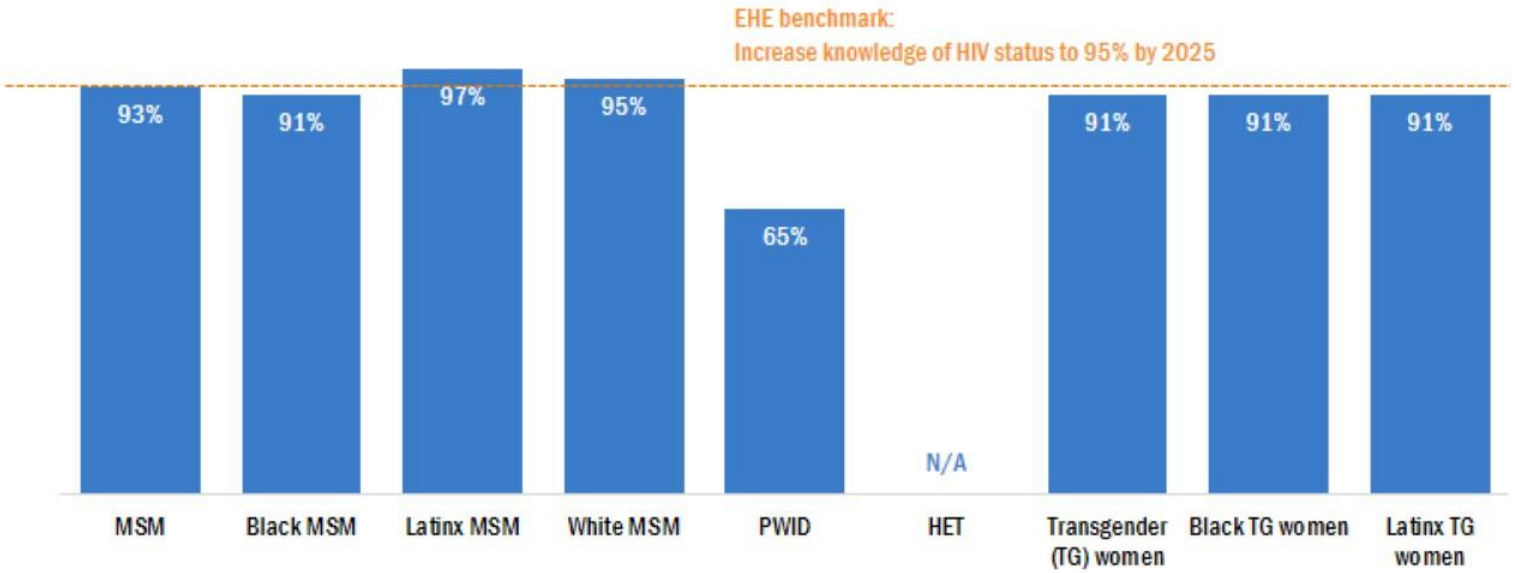
[2] Participants were recruited into NHBS using a probability-based sampling method. MSM were recruited using time location sampling; PWID, HET, and Transgender Women were recruited using respondent driven sampling. MSM were surveyed in all NHBS rounds and HET; PWID were surveyed starting in NHBS Round 2; Transgender women were surveyed starting in NHBS Round 5 and Round 7(ongoing recruitment).

[3] In the most recent PWID cycle in 2022, we observed a slightly higher HIV prevalence than the last PWID cycle in 2018. One factor that likely contributed to the higher HIV prevalence rate is the identification of MSM-PWID participants. Among PWID in 2022, it was found that 6% of PWID were sexually active MSM, and the HIV prevalence rate among this group was 39%, which is notably higher than the prevalence among non-MSM PWID (approximately 2.5%).

Source: HIV Surveillance data as of December 2024

In the most recent NHBS cycle, 93% of MSM (2023), 91% of TG women (2023), and 65% of PWID (2024) living with HIV were aware of their HIV-positive status

Awareness of HIV-positive status among participants aged ≥ 18 years living with HIV by NHBS population and race/ethnicity, LAC 2017-2024

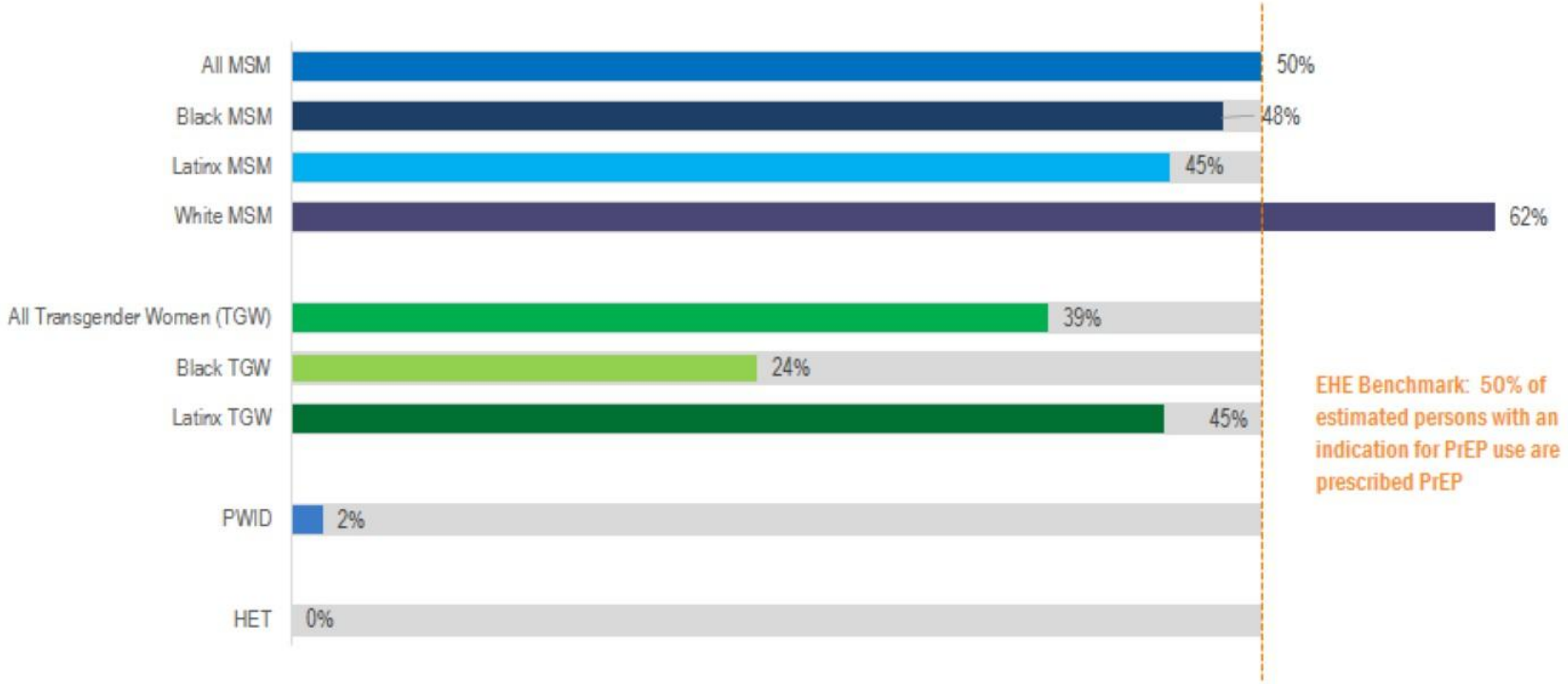


1 National HIV Behavioral Surveillance (NHBS) is a national behavioral surveillance system designed to generate nationally representative estimates of HIV prevalence and behaviors among groups at highest risk for HIV infection. Data presented in this figure are not weighted. The purpose of this figure is to provide a detailed summary of surveillance data collected as part of NHBS. Unweighted data provide an efficient and transparent way to do so.
2 MSM: Gay, bisexual and other men who have sex with men in the past 12 months. The NHBS-MSM cycle collects information on persons who report sex with a male partner in the 12 months before interview. A total of 729 MSM participated in NHBS-MSM in 2023, including 309 Black MSM, 243 Latinx MSM, and 133 White MSM.
PWID: Persons who inject drugs; A total of 518 PWID participated in NHBS-PWID in 2022;
HET: Heterosexually active persons at increased risk for HIV infection; A total of 509 HET participated in NHBS-HET in 2019;
Transgender women (TG): Adults who (1) reported a gender identity of woman or transgender woman, and (2) were assigned male or intersex listed at birth. A total of 501 transgender women enrolled in NHBS-Trans in 2019.
3 Awareness of HIV infection among PWID and HET is unstable due to small numbers.

Source: HIV Surveillance data as of December 2024

PrEP use varied across NHBS populations (MSM, TG women, PWID), with the highest uptake observed among MSM reaching 50% in 2023. White MSM were the only subgroup to surpass the EHE PrEP use benchmark. PWID had the lowest PrEP uptake.

PrEP Use during the past 12 months among NHBS Populations with a negative HIV test result, LAC 2019-2024[1]

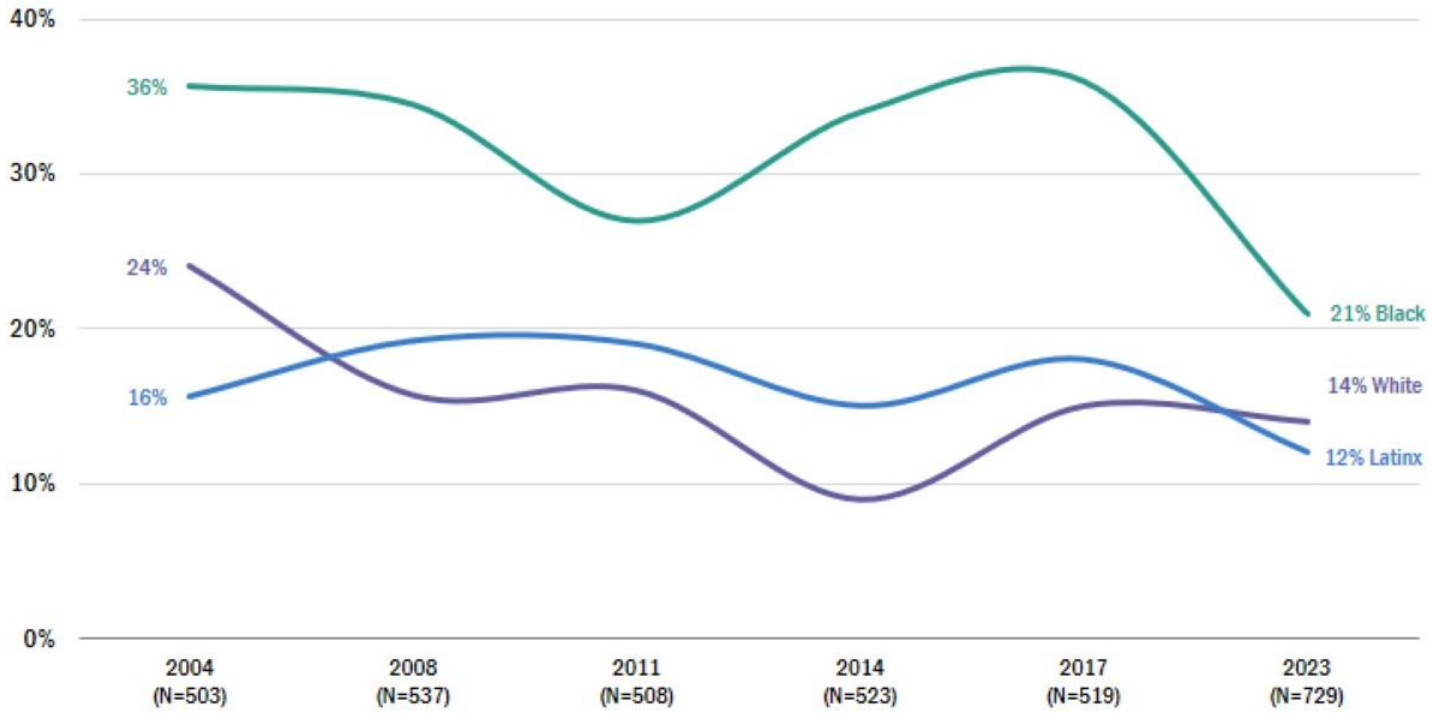


[1] MSM2023: A total of 577 HIV-negative MSM were included in the PrEP analysis, consisting of 234 Black MSM, 203 Latinx MSM, and 108 White MSM. Trans2023: a total of 350 HIV negative transgender women were included in the PrEP analysis, consisting of 98 black TGW and 222 Latinx TGW. PWID2024: A total of 496 HIV negative PWID included in this analysis in the PrEP analysis in 2024; HET2019: A total of 509 HET participated in NHBS-HET in 2019.

Source: HIV Surveillance data as of December 2024

Since 2004, HIV prevalence has been on a declining trend for MSM in LAC across all race/ethnicity groups. However, Black MSM have had a consistently higher HIV prevalence than all other race/ethnicity groups.

Trends in HIV prevalence among NHBS-MSM participants by race/ethnicity, LAC 2004-2023

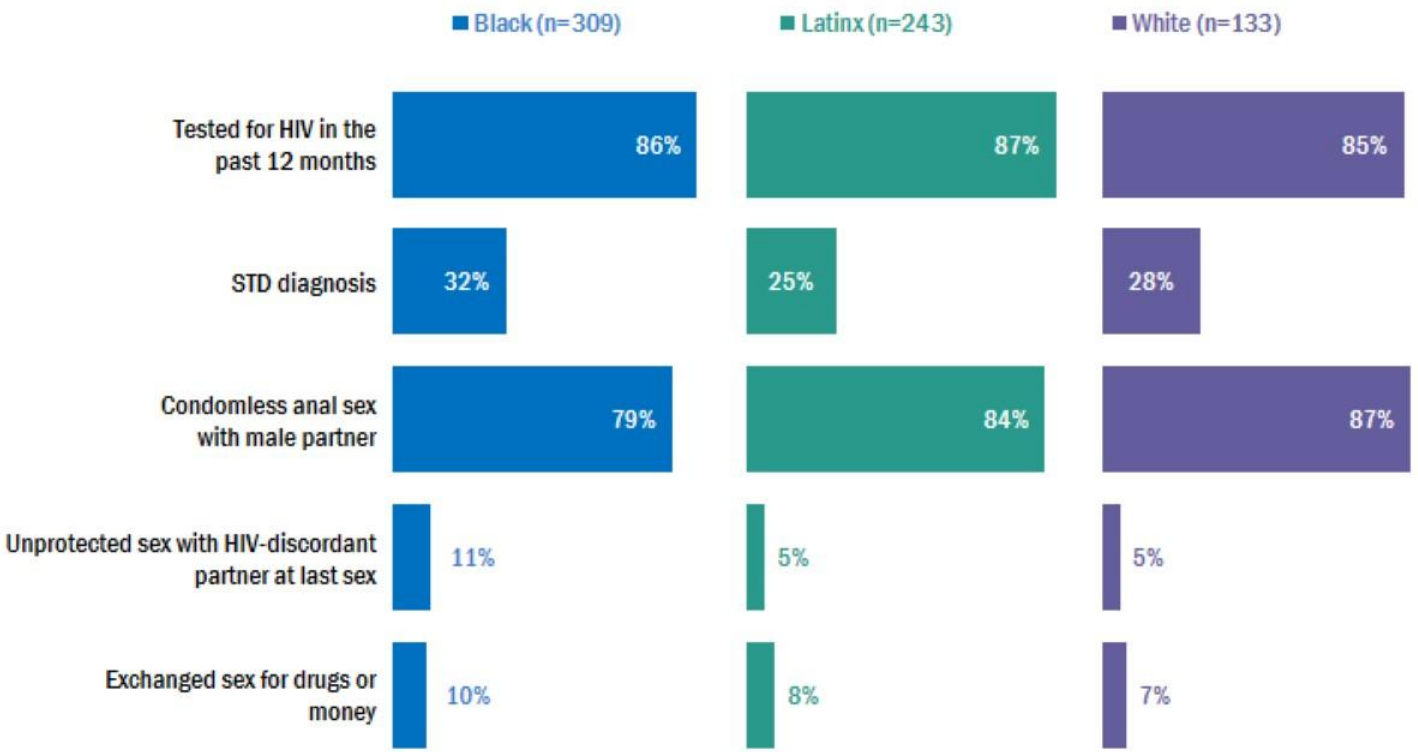


Abbreviation: MSM = men who have sex with men; NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

In the 2023 NHBS MSM cycle, self-reported condomless anal sex with male partners ranged from 79% among Black MSM to 87% among White MSM

HIV testing behavior, STD diagnosis, and sexual behavior among NHBS-MSM participants by race/ethnicity, LAC 2023[1]

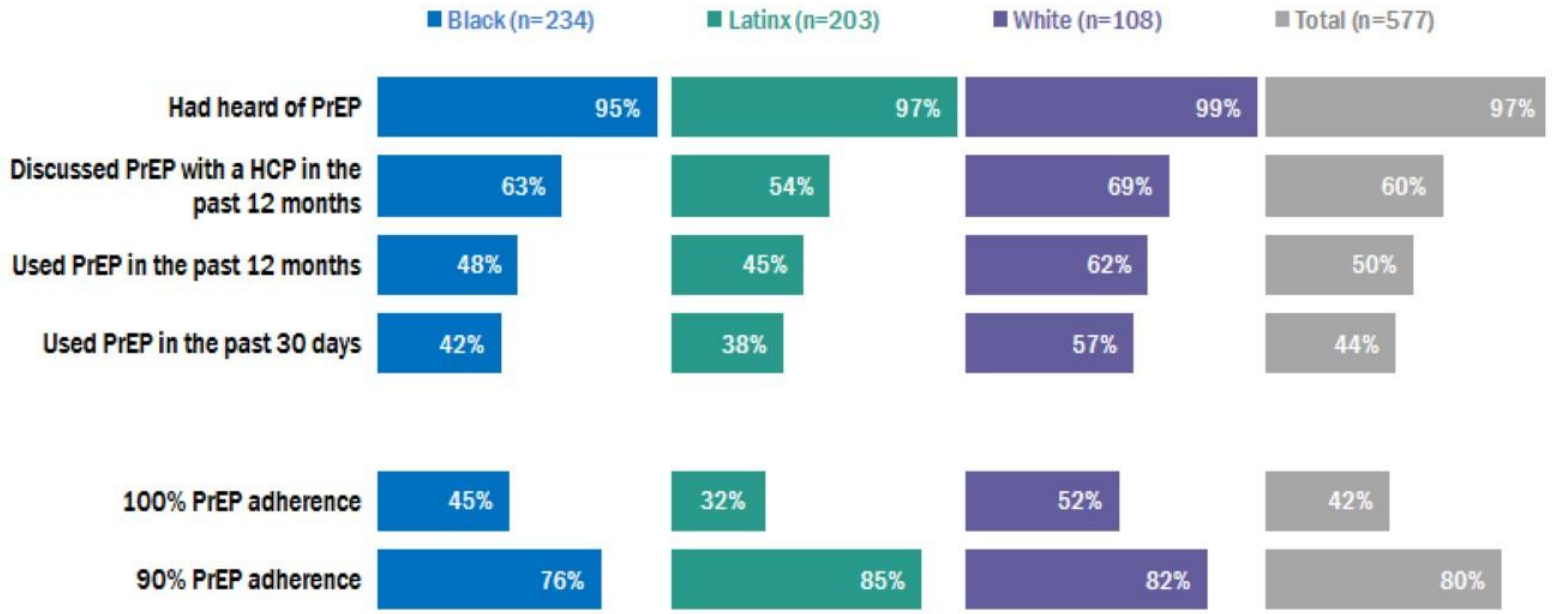


[1]There were 309 Black MSM, 243 Latinx MSM, and 133 White MSM NHBS participants in the 2023 surveillance round. All sexual behavior indicators reflect behavior in the 12 months prior to the interview. HIV testing in the past 12 months excluded participants who were diagnosed with HIV more than 12 months prior to the interview. STD diagnosis was based on respondent's self-report of at least 1 STD diagnosis by a health care provider's diagnosis in the 12 months prior to the interview. Condomless anal sex refers to either or both condomless receptive and/or condomless insertive anal sex. Unprotected sex refers to sex without the participant's use of either condoms or HIV medications (i.e., HIV PrEP or antiretrovirals). HIV-discordant partner refers to a sex partner of different HIV status.

Source: HIV Surveillance data as of December 2024

Among NHBS MSM participants who reported PrEP use in the past 30 days, 42% were 100% adherent (took their medication as prescribed) and an additional 38% reported 90% adherent (missed 1-3 days of their medication).

PrEP use among NHBS-MSM participants who reported as HIV-negative status, by race/ethnicity, LAC 2023[1]



PrEP awareness was high (≥ 95%) among MSM across all racial and ethnic groups, and 44% reported using PrEP in the past 30 days prior to the interview encounter. PrEP is highly effective at preventing new HIV infections when taken consistently. White MSM had higher rates of both PrEP use and adherence compared with Black MSM. Notably, none of the participants who used PrEP in the past 12 months tested positive for HIV during the interview encounter.

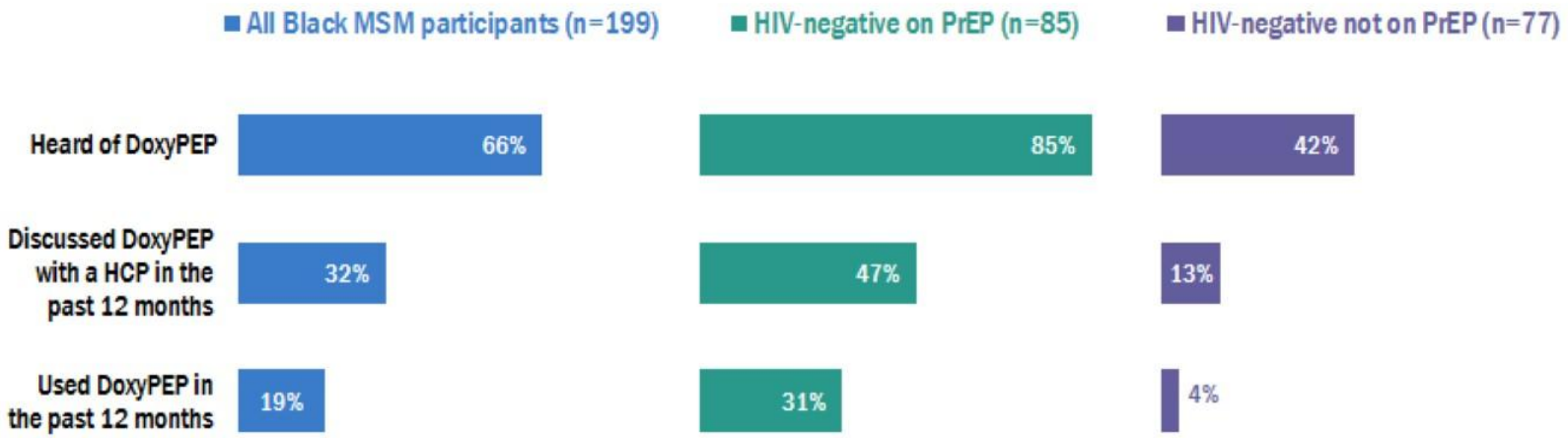
Abbreviation: PrEP =pre-exposure prophylaxis; PEP = post-exposure prophylaxis; MSM = men who have sex with men; NHBS = National HIV Behavioral Surveillance

[1] A total of 577 HIV-negative MSM were included in the PrEP analysis, consisting of 234 Black MSM, 203 Latinx MSM, and 108 White MSM.

Source: HIV Surveillance data as of December 2024

Among a sample of 199 Black MSM, DoxyPEP use was highest among those on PrEP compared with those not on PrEP.

Doxycycline Post-Exposure Prophylaxis (DoxyPEP) knowledge and uptake among a sample of black MSM, NHBS-MSM, LAC, Jan-March 2024[1]



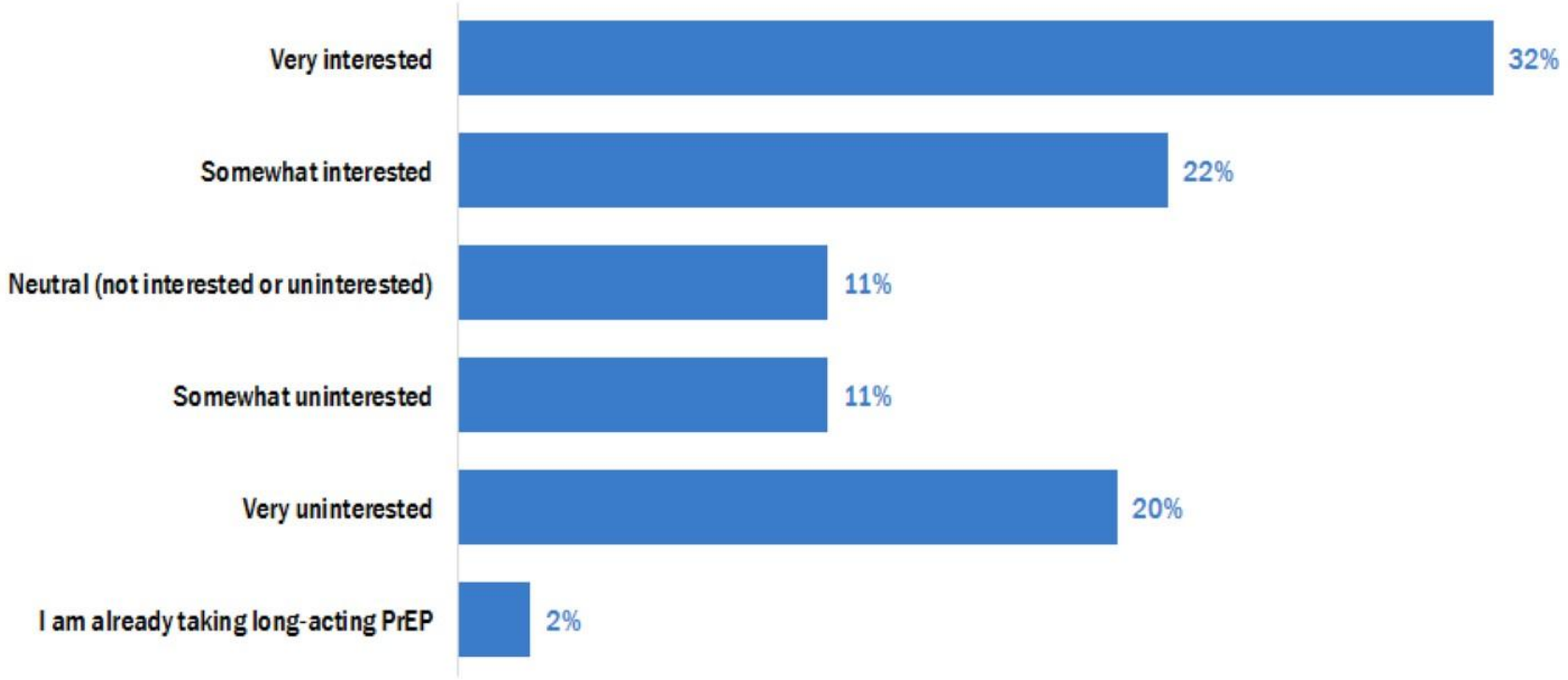
DoxyPEP, as a targeted intervention for bacterial STIs, has the potential to reduce STI acquisition and transmission. In a recent local study, we examined DoxyPEP awareness and uptake among a sexually active Black MSM community. Overall, 66% reported having heard of DoxyPEP, and a third had discussed it with a healthcare provider (HCP), and 19% had used DoxyPEP in the 12 months prior to the interview. When analyzing specific subgroups, participants on HIV PrEP reported the highest DoxyPEP use, with 31% using it in the past 12 months.

Abbreviation: PrEP =pre-exposure prophylaxis; PEP = post-exposure prophylaxis; MSM = men who have sex with men; NHBS = National HIV Behavioral Surveillance
[1]There were 199 Black MSM included in the DoxyPEP analysis and the sample was collected from January through March 2024 as a local expansion of NHBS-MSM 2023. The DoxyPEP use was only assessed during the local study. The reported median number of male sex partners in the past 12 months was 6.

Source: HIV Surveillance data as of December 2024

Among HIV negative NHBS-MSM participants (n=444), over half (54%) were interested in taking Long-Acting PrEP and 2% reported they were already taking long-acting PrEP

"How interested are you in taking long-acting PrEP?" Among HIV negative NHBS-MSM participants (n=444), LAC 2023

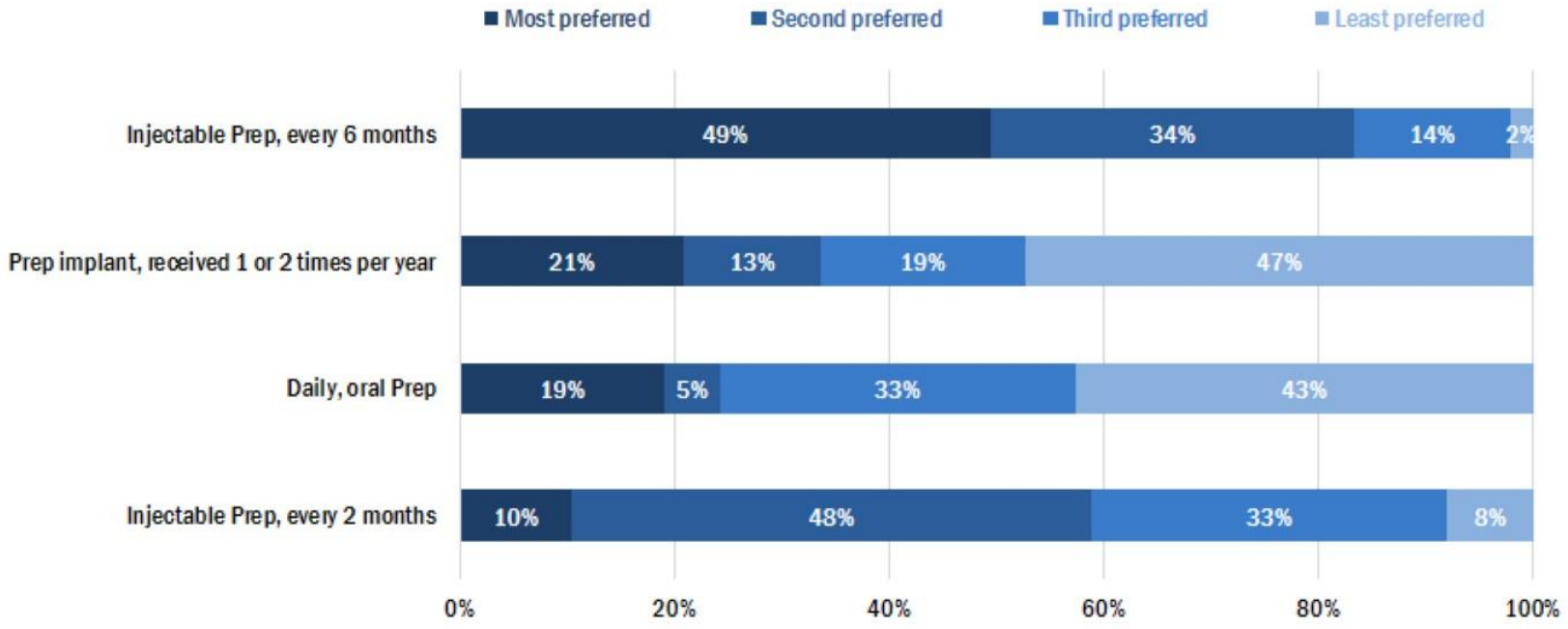


Abbreviation: PrEP =pre-exposure prophylaxis; PEP = post-exposure prophylaxis; MSM = men who have sex with men; NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

The biannual injections were the most preferred (49%), followed by a PrEP implant received 1 or 2 times per year (21%), daily, oral PrEP (19%) and bimonthly injectable PrEP (10%).

Preferences for different Long-Acting PrEP modalities among HIV negative NHBS-MSM participants reporting being Very or Somewhat Interested in Long-Acting PrEP (n=277), LAC 2023

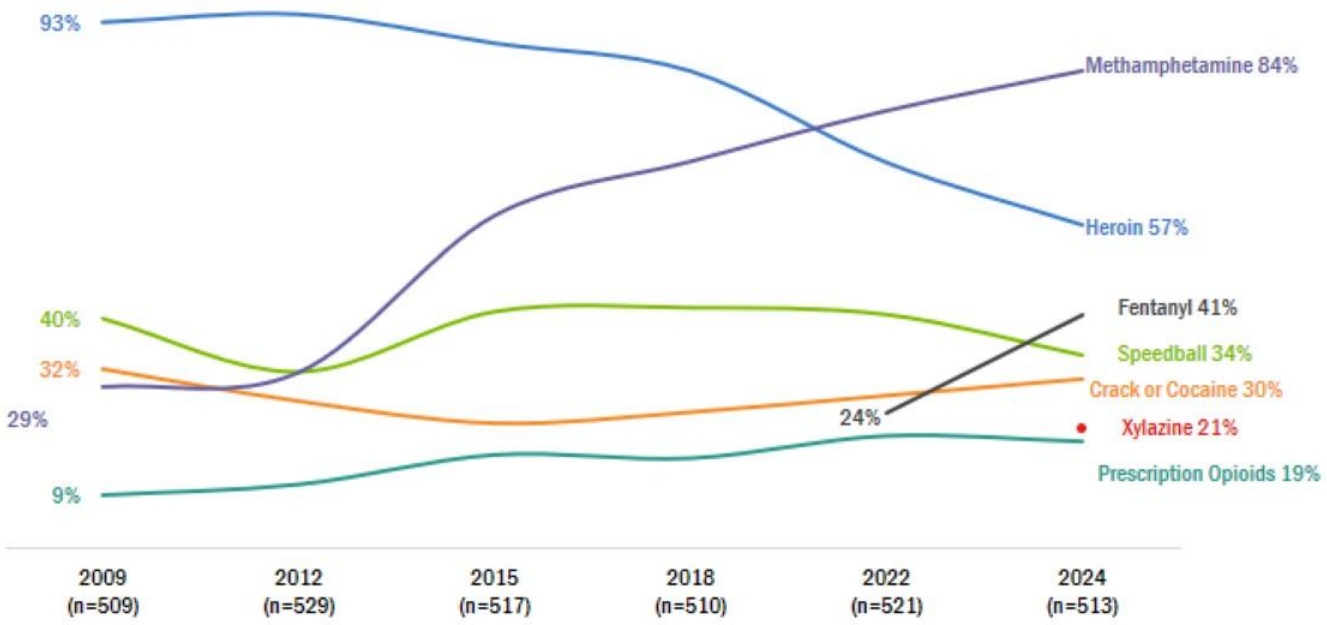


Abbreviation: PrEP = pre-exposure prophylaxis; PEP = post-exposure prophylaxis; MSM = men who have sex with men; NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

Over the past decade, the injection drug scene among PWID in LAC has shifted, with methamphetamine overtaking heroin as the primary drug.

Drugs injected in the past 12 months among NHBS-PWID participants, LAC 2009-2024[1]



The prevalence of past-year methamphetamine use by injection among PWID increased steadily from 29% in 2009 to 84% in 2024, overtaking heroin in 2022 and widening the gap. Among those reporting past-year methamphetamine injection, 56% reported injecting it daily (data not shown).

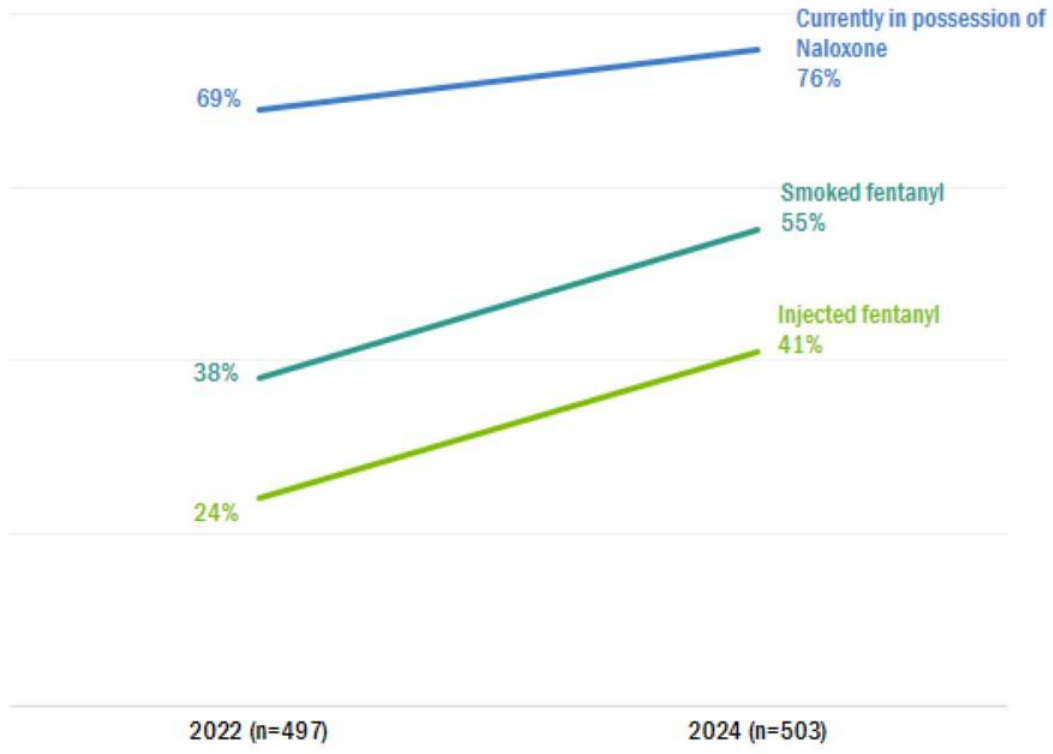
Abbreviation: PWID = persons who inject drugs; NHBS = National HIV Behavioral Surveillance

[1] Speedball is a polydrug mixture of heroin and cocaine.

Source: HIV Surveillance data as of December 2024

Fentanyl use continues to rise among PWID, and smoking fentanyl has become more common than injecting Fentanyl.

Fentanyl Use in past 12 months among NHBS-PWID participants, LAC 2022, and 2024



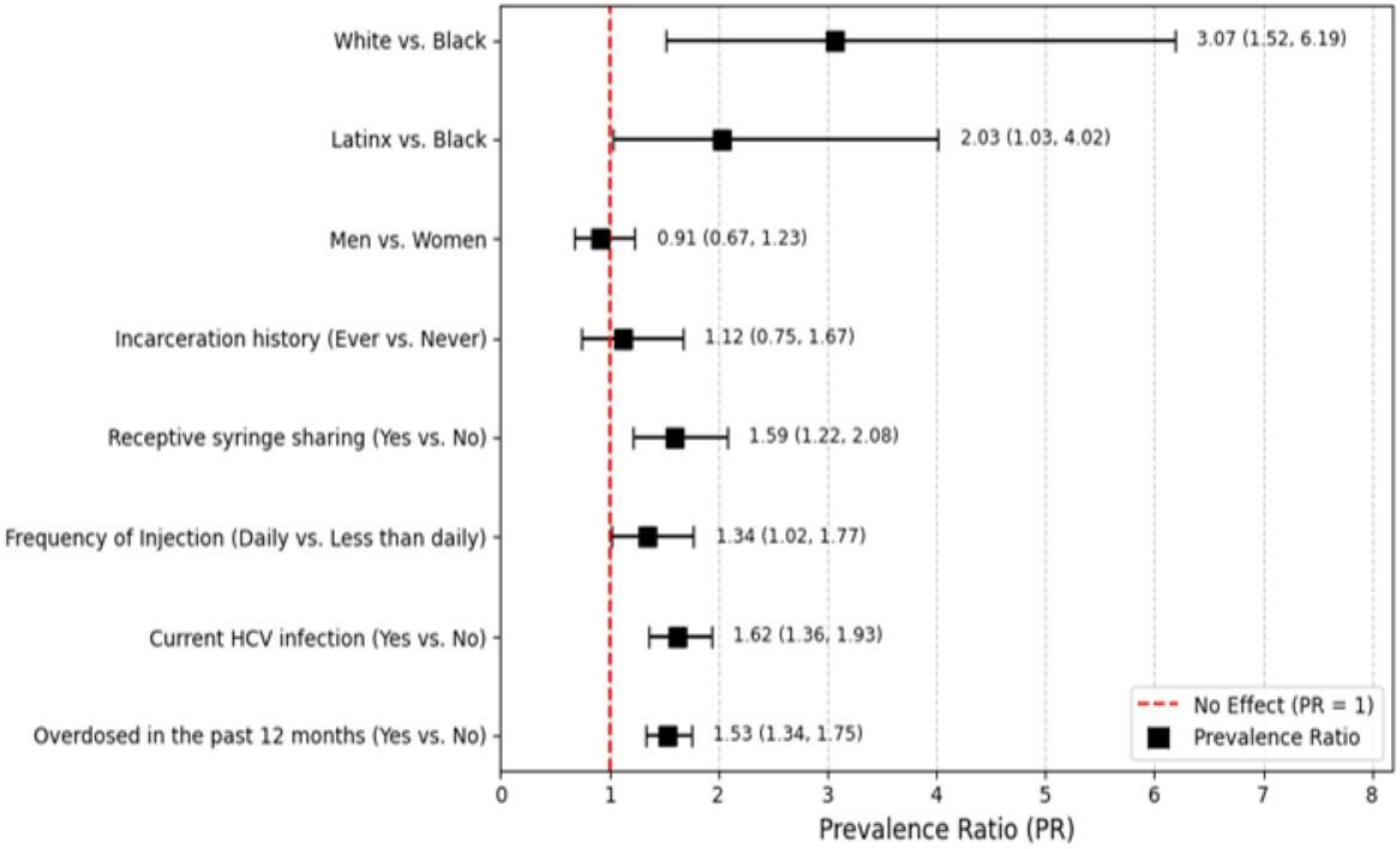
Fentanyl is a potent synthetic opioid that is often being mixed with other illicit drugs to increase its potency. Among NHBS-PWID participants, there was **a substantial increase in both injecting fentanyl and smoking fentanyl**, with injection rising from 24% to 41% and smoking from 38% to 55% between 2022 and 2024. This simultaneous rise in both injecting and smoking imply that **smoking is becoming more common** among PWID. T**he use of fentanyl test strips remained relatively unchanged** (26% vs. 27%).

Abbreviation: PWID = persons who inject drugs; NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

NHBS-PWID 2024 data indicate that fentanyl injection is more common among White or Latinx PWID compared with Black PWID, is strongly linked to syringe sharing, current hepatitis C infection, and experiencing an overdose in the past year.

Factors associated with fentanyl injection in past 12 months among NHBS-PWID participants, LAC 2024



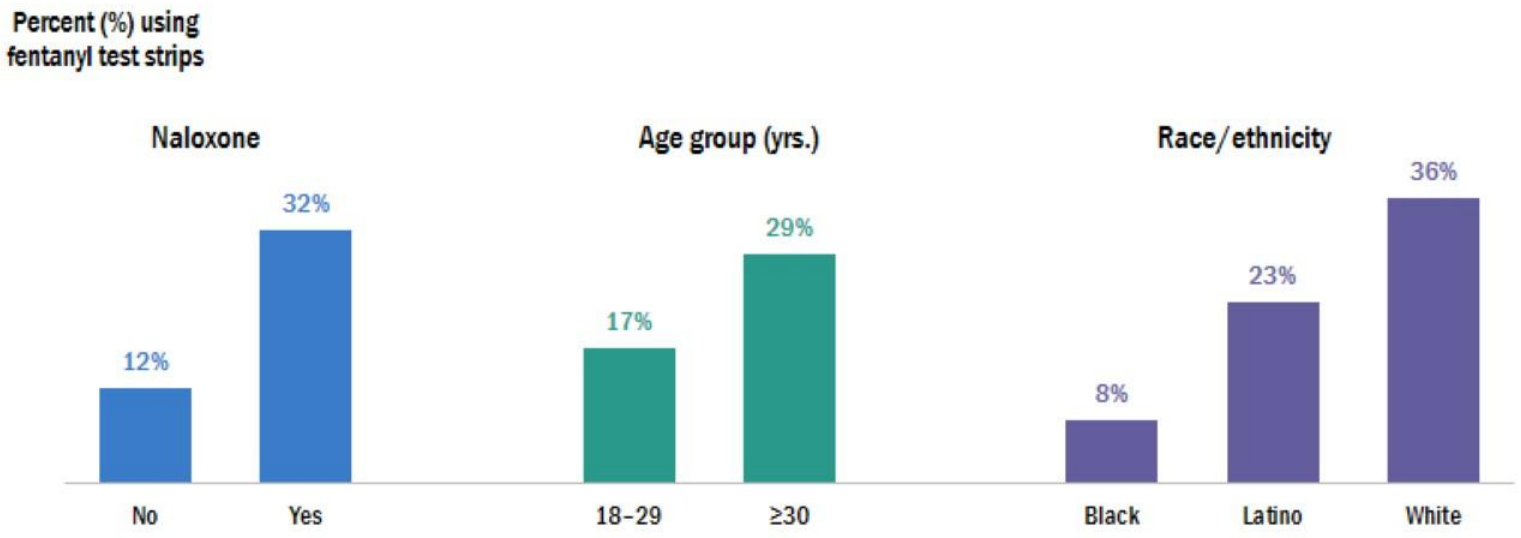
These associations suggest fentanyl use may lead to more frequent injection and syringe sharing, likely due to its short duration of effect, thereby increasing the risk of HCV and overdose among PWID.

Abbreviation: PWID = persons who inject drugs; NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

Fentanyl test strips are a tool to prevent overdose before it happens. In NHBS-PWID 2024, fentanyl test strips were used more often among PWID who routinely carry naloxone, but fentanyl test strips were used less often among younger PWID (aged 18–29 years) and among Black PWID.

Fentanyl Test Strip Use by Naloxone Access, Age or Race/Ethnicity, among NHBS-PWID participants, LAC 2024

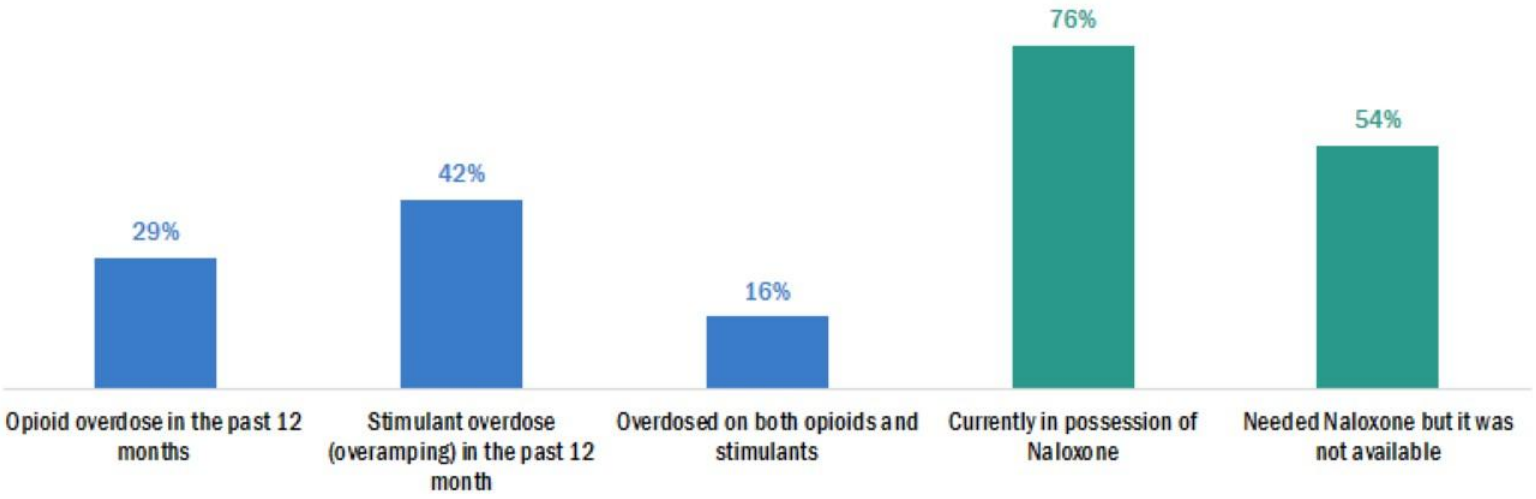


Abbreviation: PWID = persons who inject drugs; NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

The NHBS-PWID 2024 survey highlights the dual burden of opioid and stimulant overdoses among local PWID and indicates an unmet need in overdose prevention.

Non-fatal opioid heroin overdose, stimulant overdose, possession of naloxone and unmet naloxone need among LAC NHBS-PWID participants, LAC 2024, n=503



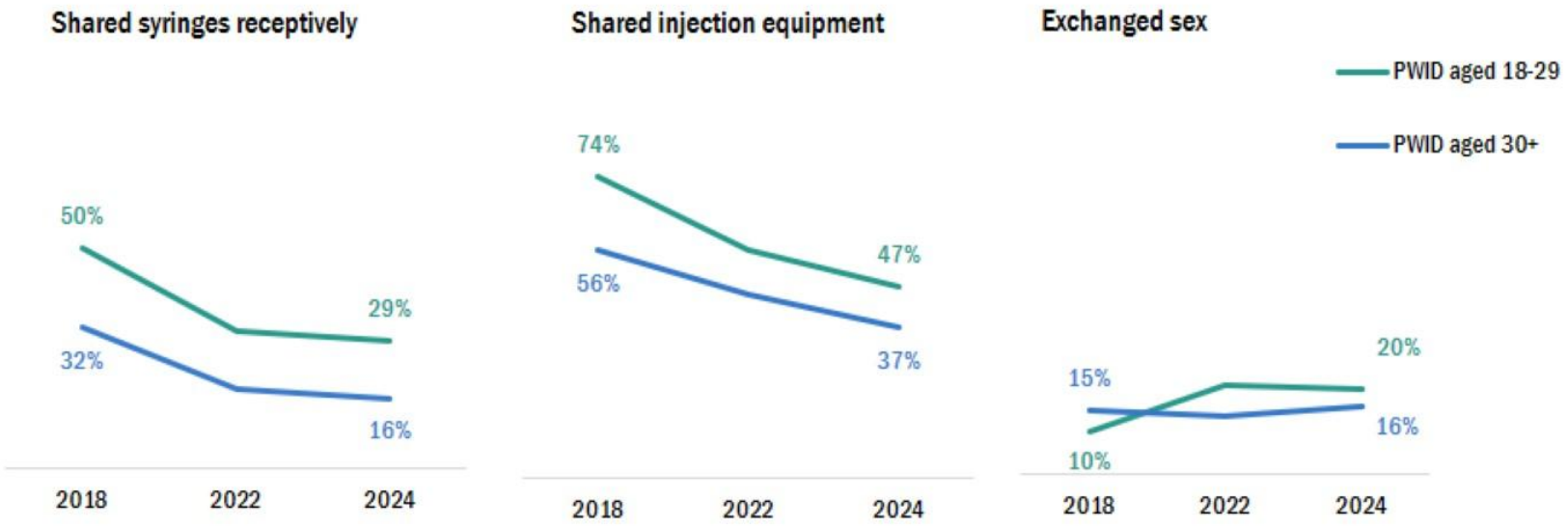
Opioid overdoses typically involve potentially fatal respiratory depression but overdosing on stimulants such as methamphetamine – known as 'overamping' – are characterized by symptoms such as overheating, extreme anxiety, and overstimulation. Findings from the 2024 NHBS-PWID survey showed substantial overdose risks among PWID: 29% reported experiencing an opioid overdose, 42% experienced a stimulant overdose (overamp), and 16% reported overdosing on both opioids and stimulants in the past 12 months. Naloxone can effectively reverse opioid overdoses, including those involving synthetic opioids like fentanyl, and can prevent overdose-related deaths. Among survey participants, 76% reported possessing naloxone at the time of the interview; however, 54% had experienced situations when naloxone was needed but unavailable, indicating a significant unmet need for naloxone access.

Abbreviation: PWID = persons who inject drugs; NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

From 2018 to 2024, injection-related risk behaviors declined among local PWID, suggesting progress in harm reduction efforts. However, younger PWID (aged 18–29 years) consistently reported higher levels of syringe and equipment sharing compared with PWID aged >30 years. Exchanging sex for money or drugs increased among younger PWID during this period

Injection drug use behavior and sex exchange among NHBS-PWID participants by age group, LAC 2018, 2022, and 2024[1]



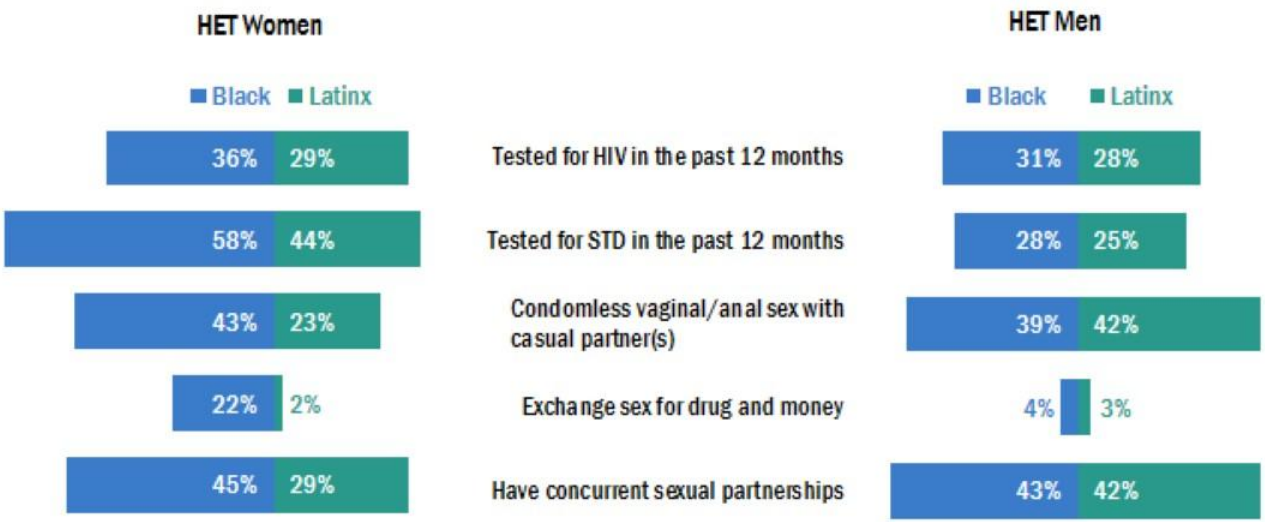
Abbreviation: PWID = persons who inject drugs; NHBS = National HIV Behavioral Surveillance

[1] Receptive sharing of syringes or injection equipment refers to using a syringe or injective equipment that has already been used by someone else. All injection and sexual behavior indicators reflect behavior in the 12 months prior to the survey interview.

Source: HIV Surveillance data as of December 2024

NHBS-Heterosexuals (HET) women were more likely to have tested for HIV and STIs than HET men.

Testing and sexual behavior among NHBS heterosexuals at increased risk of HIV (HET) by sex and race/ethnicity, LAC 2019[1]



Among HET women, more Blacks reported condomless sex with a casual partner, receiving money or drugs in exchange for sex, and having concurrent sexual partners than Latinx HET.

Abbreviation: NHBS = National HIV Behavioral Surveillance

[1] 136 Black males, 118 Latinx males, 142 Black females, and 98 Latinx females participated in the 2019 NHBS-HET cycle. All sexual behavior indicators reflect sexual behavior with the opposite sex in the 12 months prior to the survey interview. Tested for HIV in the past 12 months excludes participants who reported being diagnosed with HIV more than 12 months prior to the interview. Tested for STDs in the past 12 months included respondent's self-report of being tested for any STD other than HIV and hepatitis by a health care provider within 12 months prior to the interview. A casual partner is a sex partner that the respondent does not feel committed to or does not know very well. Having concurrent partners with last partner is measured by asking participants "when you were having a sexual relationship with last partner, did you have sex with other people?".

Source: HIV Surveillance data as of December 2024

Among the 593 TG women surveyed in the 2023 NHBS-Trans cycle, many reported experiences that make it difficult to access & use HIV prevention and care services.

Social determinants of health, NHBS-Trans, LAC 2023 (n=593)[1]

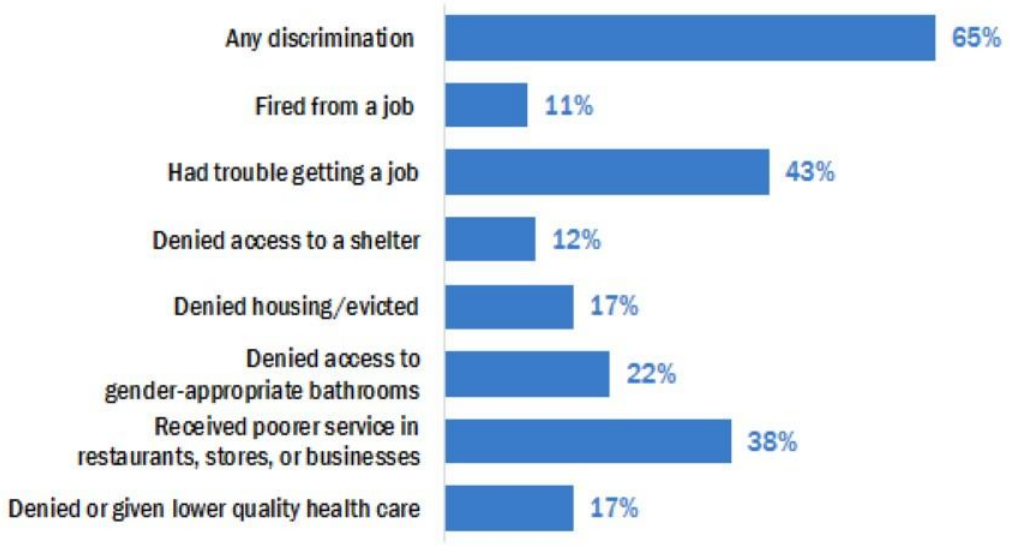
NHBS = National HIV Behavioral Surveillance

[1] Had a disability: DHHS standard uses 6 Yes/No questions to assess difficulty in basic domains of functioning (hearing, vision, cognition, walking, self-care, and independent living)

Source: HIV Surveillance data as of December 2024

Discrimination remains pervasive across many areas of life for the TG women community, particularly in employment, public services, housing, and healthcare, where they continue to face significant barriers and unequal treatment.

Transgender-specific discrimination among NHBS-Transgender women, LAC 2023[1]



Overall, **65%** reported experiencing at least one type of transgender-specific discrimination (employment, housing, bathroom, businesses, health care): **45%** were either fired from employment or had trouble getting a job, and **17% had** been evicted or denied housing during the past 12 months because of their gender identity.

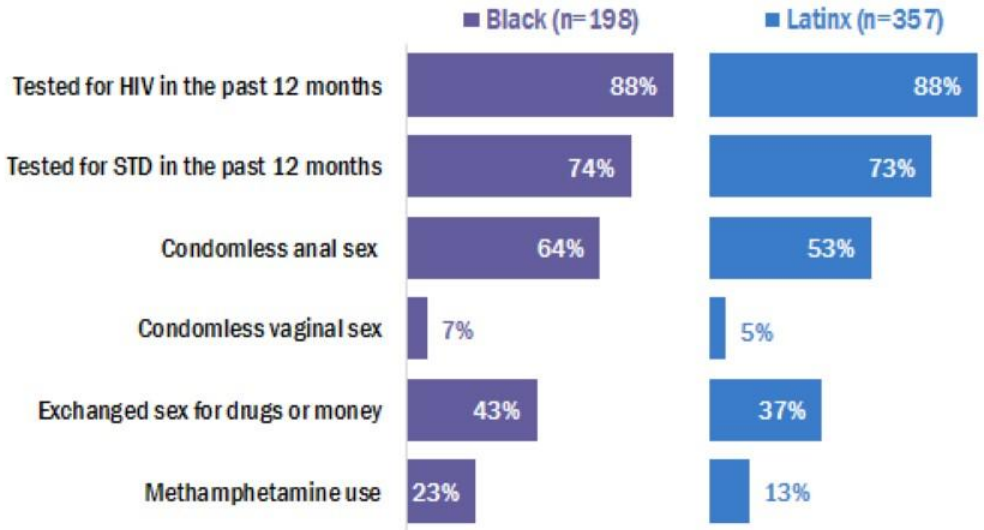
NHBS = National HIV Behavioral Surveillance

[1] Denied access to bathrooms that were appropriate to your gender identity or self-expression.

Source: HIV Surveillance data as of December 2024

Economic hardship and employment discrimination can increase the need for alternate means of survival. More Black TG women reported engaging in condomless anal sex, exchanging sex for drugs or money, and using methamphetamine compared to their Latinx counterparts.

Sexual behavior and drug use among NHBS-Transgender women by race/ethnicity, LAC 2023[1,2]



NHBS = National HIV Behavioral Surveillance

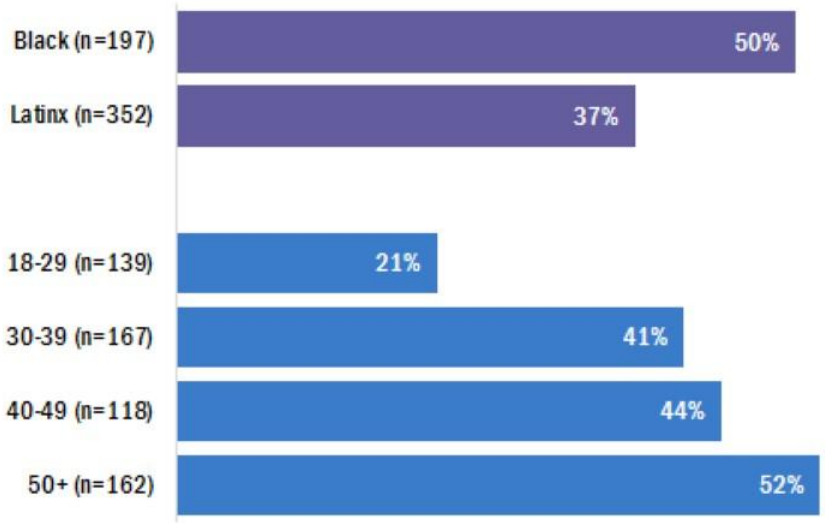
[1] All sexual behavior indicators reflect behavior in the 12 months prior to the interview. Condomless anal sex refers to self-reports of either or both receptive and/or insertive anal sex without a condom. Condomless vaginal sex refers to self-reports of either or both receptive and/or insertive vaginal sex without a condom (vaginal sex refers to penis in the vagina or neovagina). Methamphetamine use includes self-reports of meth, crystal, speed, or crank use in the 12 months prior to the interview.

[2] Estimates for white transgender women were not reported due to their small numbers.

Source: HIV Surveillance data as of December 2024

TG women, particularly those from marginalized racial and ethnic groups, continue to experience disproportionately high rates of HIV. Four in ten (40%, 234/586) NHBS –Trans 2023 participants tested positive for HIV; Specifically, 50% of Black and 37% of Latinx TG women surveyed had HIV.

HIV prevalence among NHBS-Transgender women by race/ethnicity, age, LAC 2023

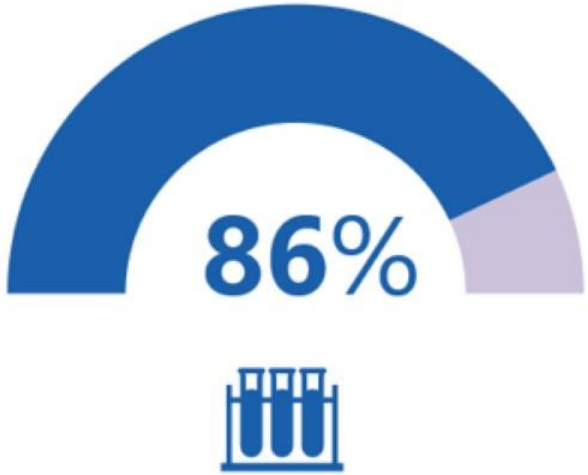


NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

All trans women should get tested for HIV annually.

HIV testing among NHBS-Transgender women, LAC 2023[1]



Ever tested for HIV among TG women: 97%

Tested for HIV in 12 months: 86%

Location of their most recent HIV test among TG women participants who reported being tested for HIV in the 12 months:

- **Clinical setting (62%)**: Public health clinic or community health center (35%), Family planning (14%), Private doctors' office (6%), or Correctional facility(3%);
- **Non-clinical setting (38%)**: HIV counseling and testing sites (28%); HIV street outreach program or mobile unit (10%), or home (1%).

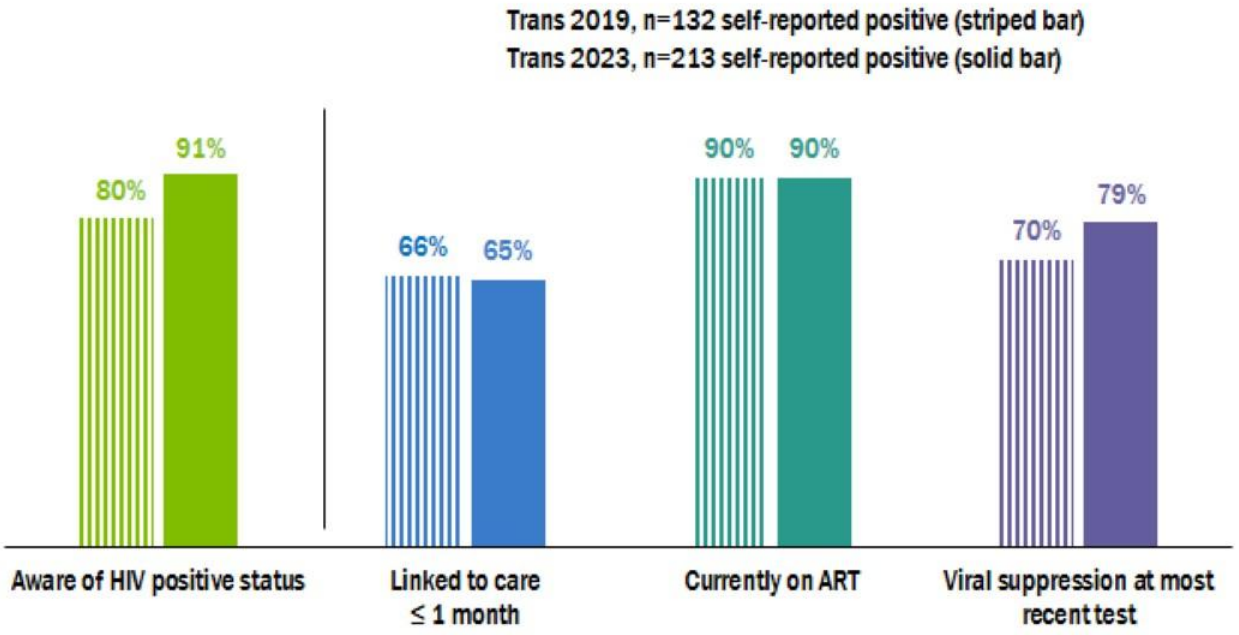
NHBS = National HIV Behavioral Surveillance

[1] Tested for HIV in the past 12 months excluded participants who reported being diagnosed with HIV more than 12 months prior to the interview.

Source: HIV Surveillance data as of December 2024

From 2019 to 2023, notable progress was made in HIV care for trans women, with increased awareness of HIV status (80% to 91%) and improved viral suppression rates (70% to 79%).

HIV care and treatment among NHBS-Transgender women 2019 vs. 2023, LAC[1]



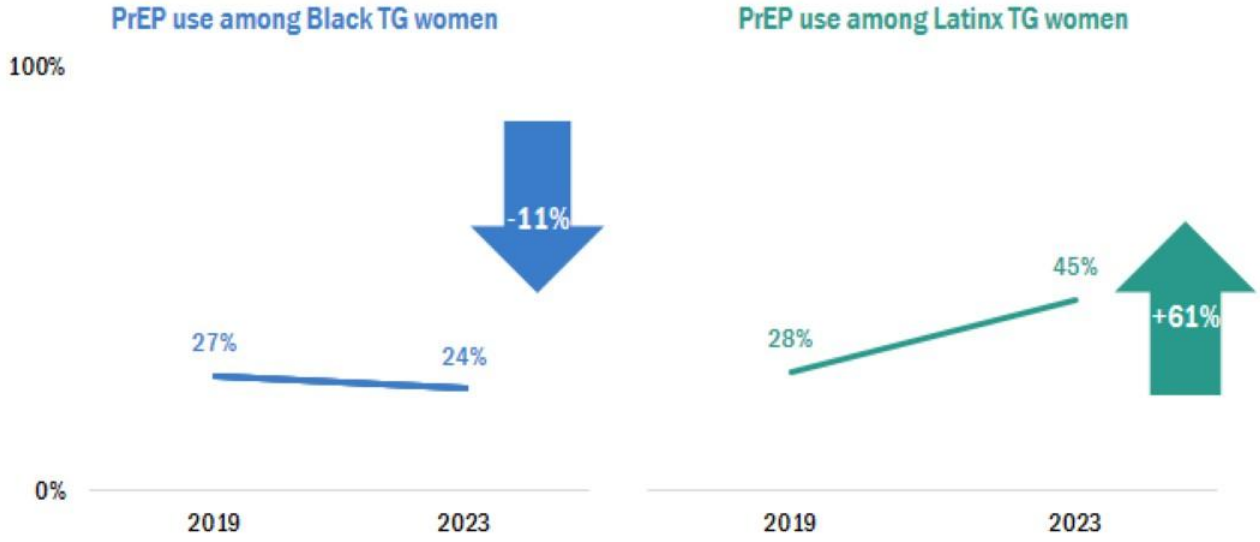
Nine in 10 HIV-positive trans women in the 2023 survey reported currently taking antiretroviral treatment (ART) and 8 in 10 were virally suppressed, which allows them to stay healthy and prevent transmitting HIV to others.

NHBS = National HIV Behavioral Surveillance
[1] Viral suppression: undetectable viral load based on most recent test in the past 12 months.

Source: HIV Surveillance data as of December 2024

PrEP use increased significantly among Latinx TG women (+61%) but declined among Black TG women (-11%) in Los Angeles County from 2019 to 2023, indicating a growing racial disparity. The lack of progress among Black TG women points to the urgent need for more racially and culturally tailored interventions addressing the unique social determinants of health within this community.

Change in PrEP use among Latinx and Black NHBS-Transgender women, LAC 2019 vs. 2023[1]



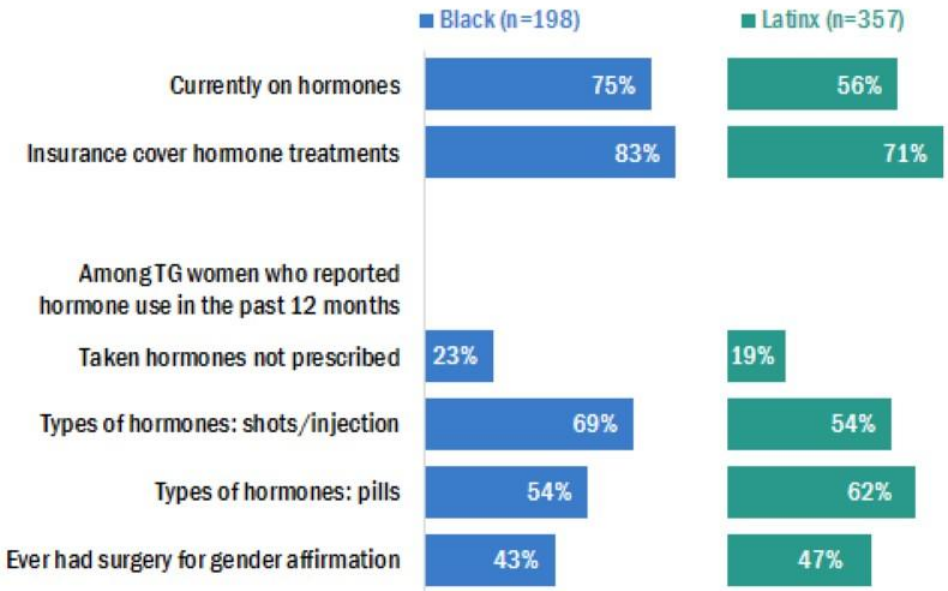
NHBS = National HIV Behavioral Surveillance

[1] The analysis was limited to HIV-negative Latinx and Black participants residing in Los Angeles County who participated in the study in 2019 and 2023.

Source: HIV Surveillance data as of December 2024

More Black TG women reported hormone use (75%) and insurance coverage for hormone treatments (83%), compared to Latinx counterparts (56% and 71%, respectively).

Hormone Therapy and Gender Affirmation among NHBS-Transgender women by race/ethnicity, LAC 2023

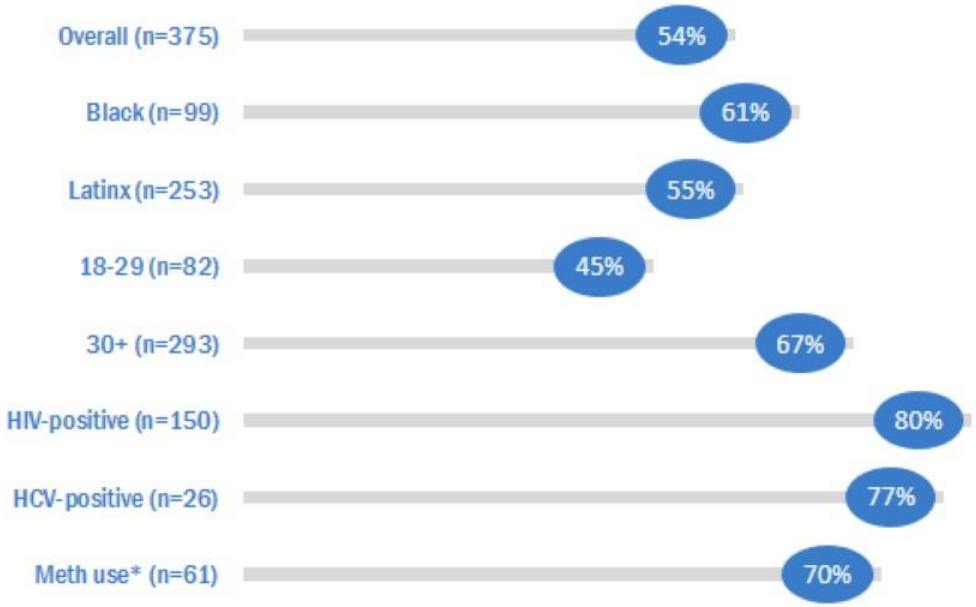


NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

About half of NHBS-Trans participants (54%) had been exposed to syphilis at some point in their lives. The prevalence was higher among Black TG women, people living with HIV, those with HCV antibodies, or those who reported methamphetamine use in the past 12 months.

Lifetime prevalence of Syphilis among NHBS-Transgender women by race/ethnicity, LAC 2023[1]



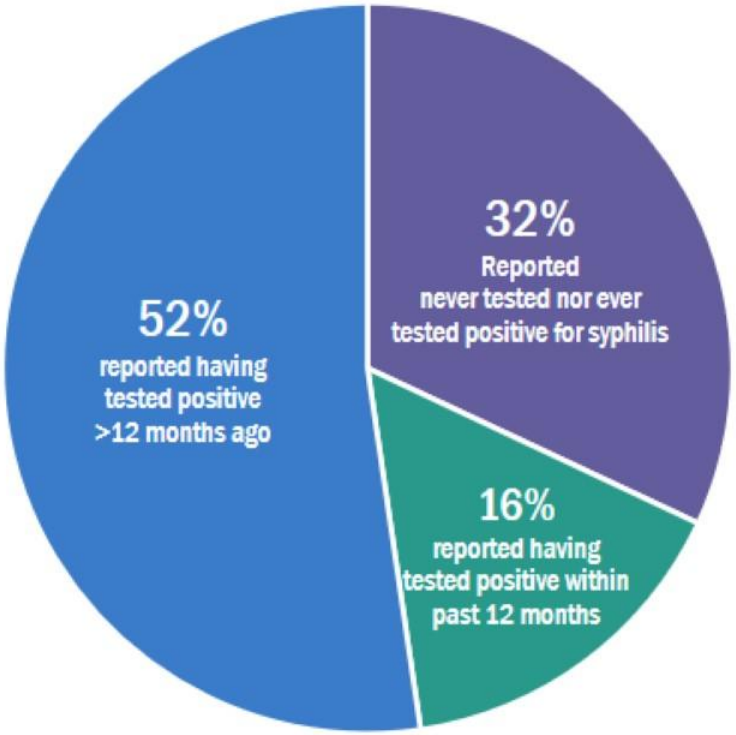
NHBS = National HIV Behavioral Surveillance

[1] Denominator: Persons with a valid Lab based syphilis treponemal test result. *Methamphetamine use in the past 12 months

Source: HIV Surveillance data as of December 2024

Among TG women participants who tested positive for syphilis, one in three (32%) were unaware that they had been exposed to syphilis.

Awareness of Syphilis status among NHBS-Transgender women by race/ethnicity, LAC 2023

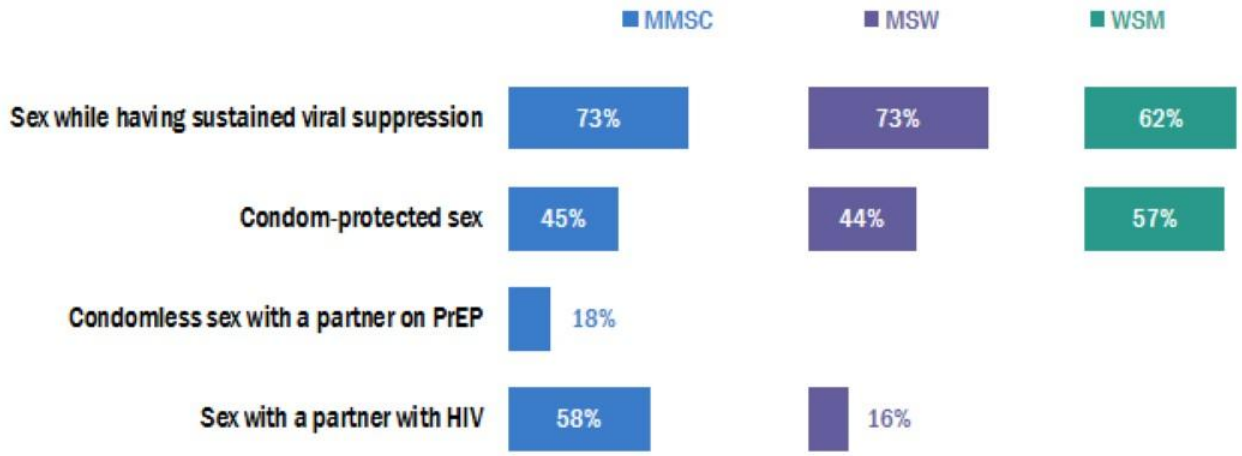


NHBS = National HIV Behavioral Surveillance

Source: HIV Surveillance data as of December 2024

Having sex while having sustained viral suppression was the most common HIV prevention strategy utilized by sexually active PLWDH.

Sexual behavior among sexually active PLWDH—Medical Monitoring Project, LAC 2018-2022[1,2,3,4]



Abbreviations: MMSC = Male-to-Male sexual contact

[1] Sexual behavior pertains to the past 12 months prior to the interview.

[2] Sustained viral suppression in MMP is defined as having all HIV viral loads being undetectable or <200 copies/mL, as documented in eHARS as well as the participant's medical record within the past 12 months before interview.

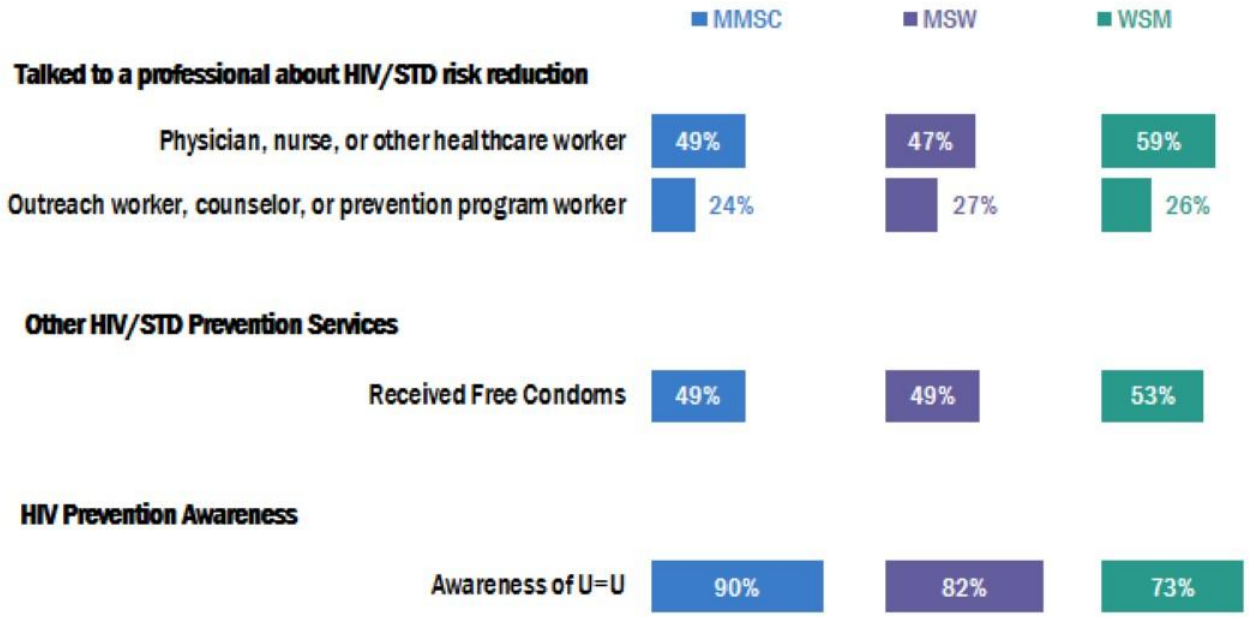
[3] Condom-protected sex is when condoms were consistently used with at least 1 vaginal or anal sex partner.

[4] PREP use was only measured among the 5 most recent partners and was reported by the participant.

Source: HIV Surveillance data as of December 2024

About 6 in 10 sexually active WSM reported talking to a physician, nurse, or other healthcare worker about how to prevent HIV or other STDs within the past 12 months. However, awareness of HIV treatment as prevention was highest among MMSC with 9 in 10 sexually active MMSC reportedly being aware of U=U.

Utilization of HIV/STD Prevention Services and Awareness of Undetectable = Untransmittable (U=U) Among Sexually Active PLWDH—Medical Monitoring Project, LAC 2018-2022[1,2]



Abbreviations: MMSC = Male-to-Male sexual contact

[1] Utilization and/or receipt of prevention services pertain to the past 12 months prior to the interview.

[2] Awareness of undetectable = untransmittable (U=U) is defined as having heard that if they have an undetectable viral load they will not pass on HIV to sexual partners.

Source: HIV Surveillance data as of December 2024

Met and unmet needs for HIV ancillary services among PLWDH

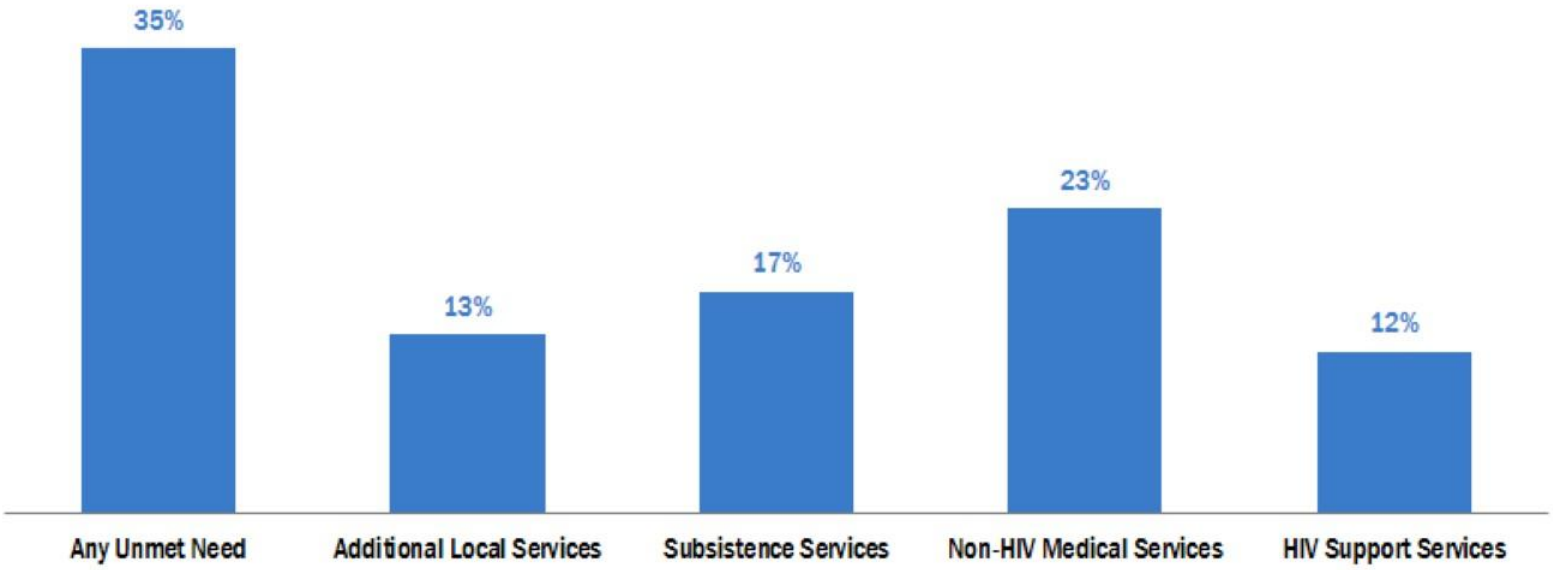
Ancillary HIV care services refer to a wide array of services that support the receipt and retention of HIV care to achieve viral suppression. Across all project areas, MMP ubiquitously collects data regarding the receipt and unmet needs of a host of ancillary services within the past 12 months. The CDC broadly classifies these into 3 categories: HIV support services, non-HIV medical services, and subsistence services.

Category	Services Included
HIV support services	Medicine through ADAP, HIV case management services, adherence support services, HIV peer group support, and patient navigation services
Non-HIV medical services	Dental care, mental health services, drug or alcohol counseling/treatment, and domestic violence services
Subsistence services	SNAP or WIC, transportation assistance, shelter or housing services, and meal or food services
Additional local services	Vision care, nutrition support, medical referrals, skilled nursing facility care, and physical rehabilitation services

On the local level, Los Angeles County also collects data for several other ancillary services. However, rather than including these additional local services into the previously aforementioned national categories, these services will be separately classified to allow for standardized comparisons across other MMP project areas. As a result, these unmet needs for these locally collected services will also not be counted towards the 'any unmet need' category below as well.

About 1 in 3 PLWDH in LAC reported needing an ancillary service but did not receive it within the past 12 months. Non-HIV medical services was the most common category of unmet needs, with nearly 1 in 4 PLWDH reportedly needing at least one non-HIV medical service but did not receive it within the past 12 months.

Percentage of PLWDH reporting at least one unmet need within the past 12 Months by category—Medical Monitoring Project, LAC 2018-2022[1,2]

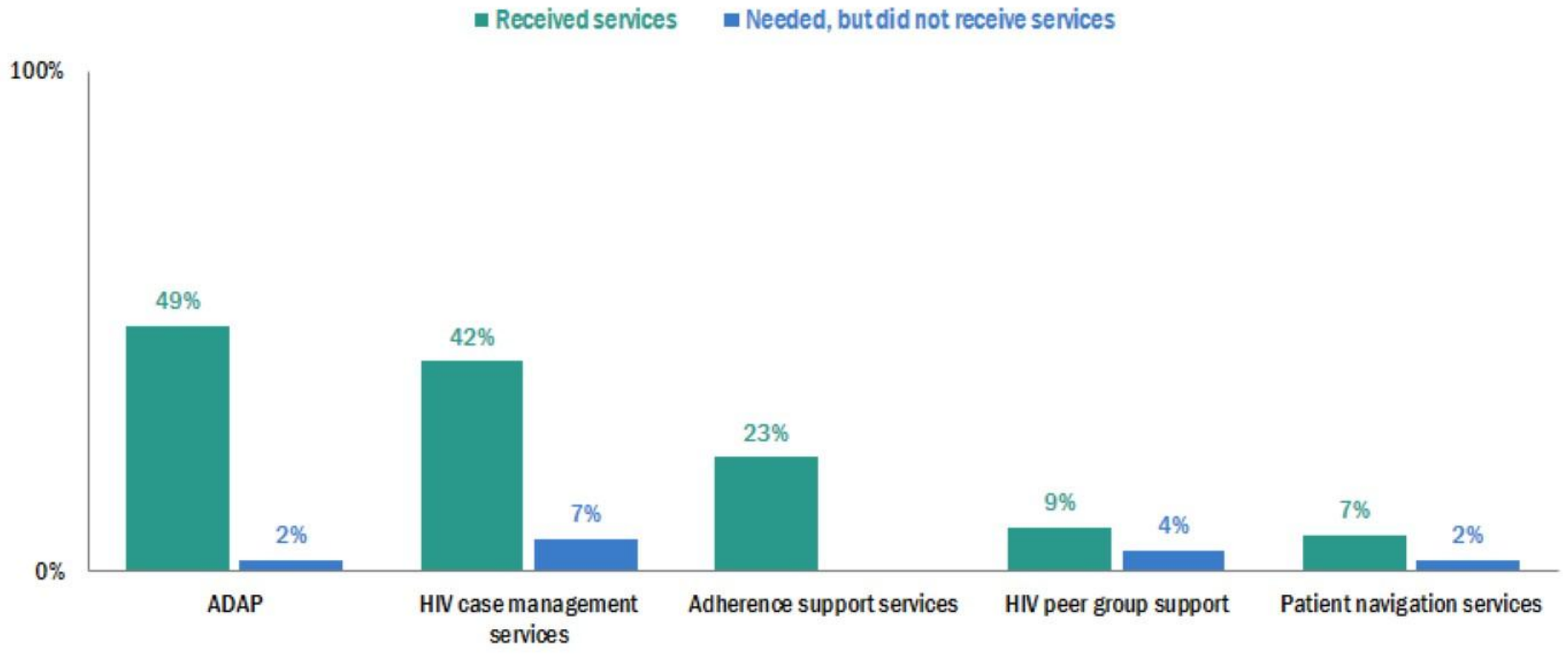


[1] Unmet need is defined as needing but not receiving a service within the past all 12 months among all PLWDH.
[2] The category of 'Any unmet need' does not include PLWDH who only reported an unmet need for services within the additional local services category to allow for comparisons nationally as well as across other project areas.

Source: HIV Surveillance data as of December 2024

AIDS Drug Assistance Program (49%) and HIV case management services (42%) were the most frequently received HIV support services. Meanwhile, HIV case management services (7%) and HIV peer group support (4%) were the most reported unmet HIV support services.

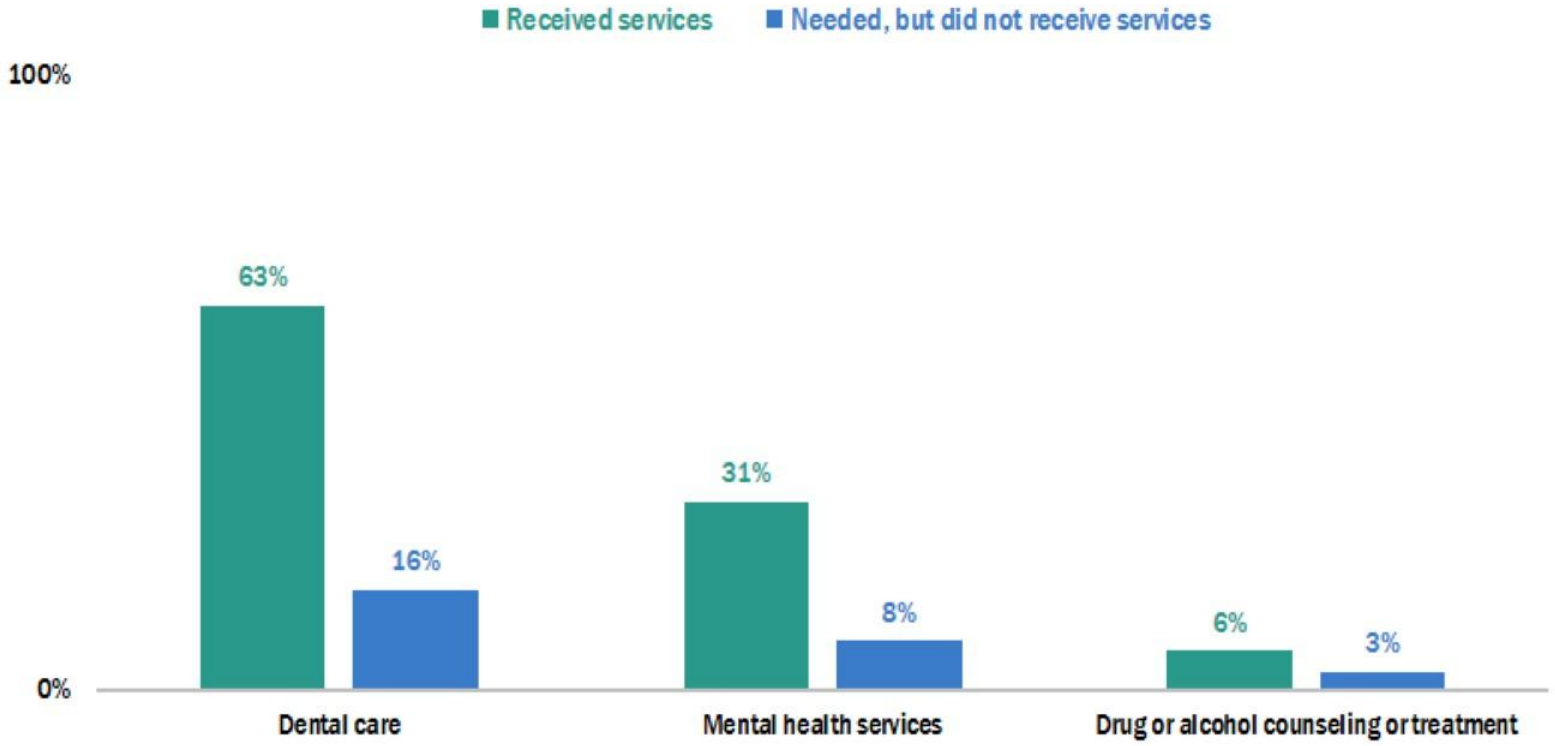
Percentage of PLWDH who received or had unmet needs for HIV support services within the past 12 months—Medical Monitoring Project, LAC 2018-2022



Source: HIV Surveillance data as of December 2024

Dental care (63%) and mental health services (31%) were the most commonly received non-HIV medical services, as well as the services that PLWDH reported having the most unmet need.

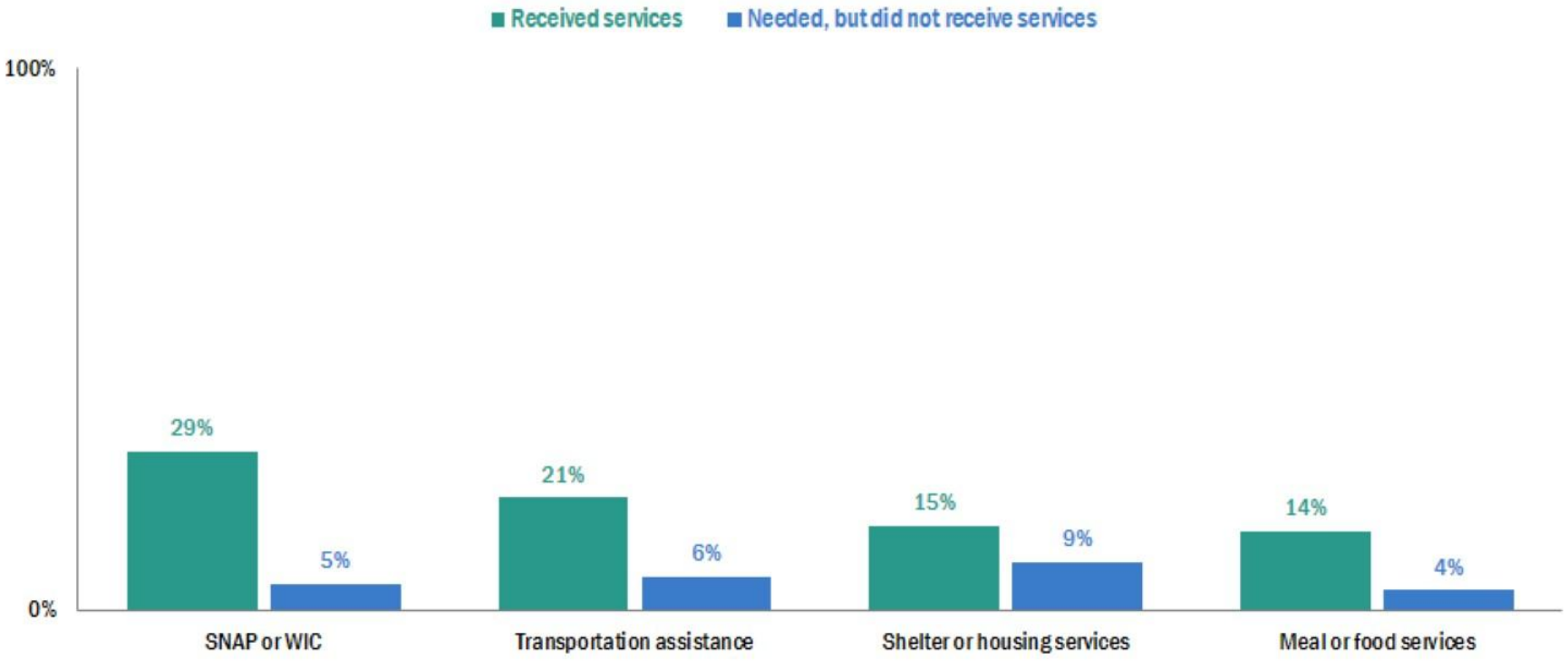
Percentage of PLWDH who received or had unmet needs for non-HIV medical services within the past 12 months—Medical Monitoring Project, LAC 2018-2022



Source: HIV Surveillance data as of December 2024

SNAP (also known as CalFresh) or WIC (29%) and transportation assistance (21%) were the most received subsistence services. About 1 in 11 PLWDH reported needing but not receiving shelter or housing services.

Percentage of PLWDH who received or had unmet needs for subsistence services within the past 12 months—Medical Monitoring Project, LAC 2018-2022[1]

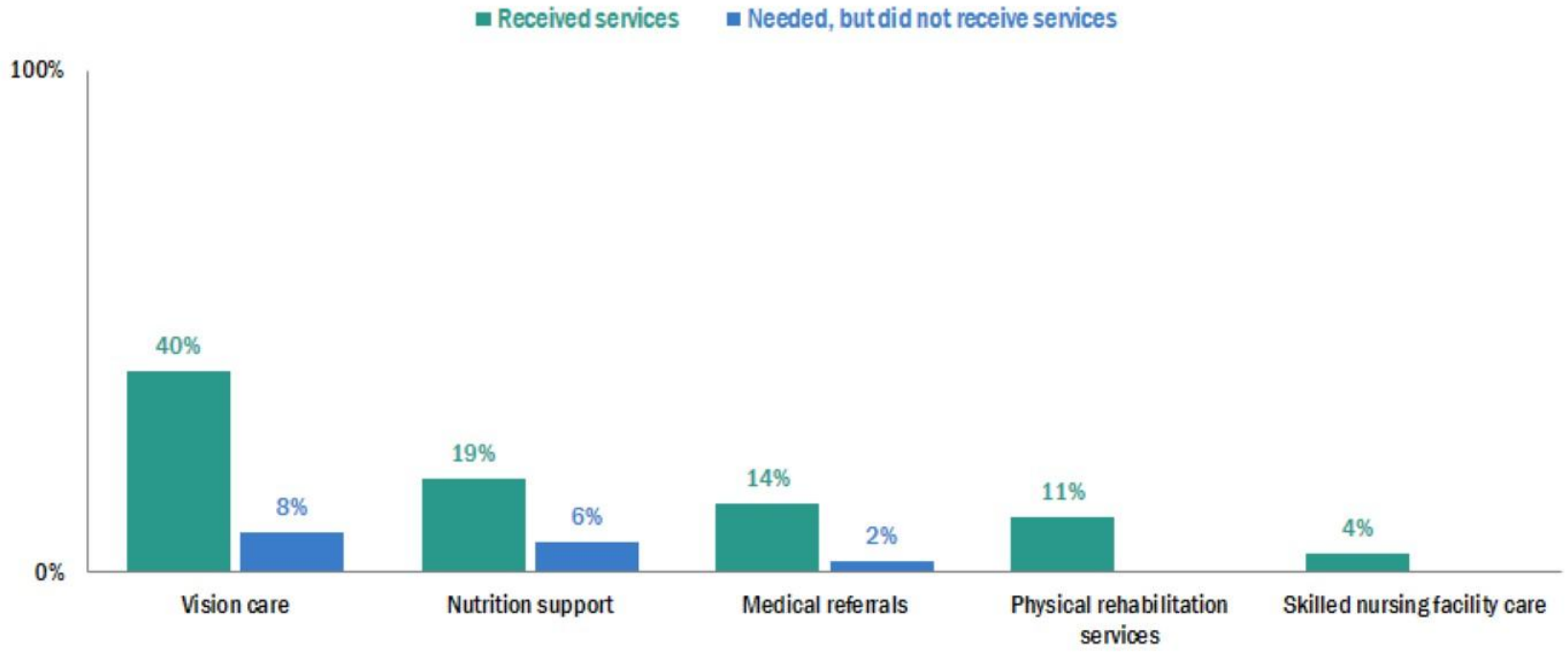


Abbreviations: SNAP = Supplemental Nutrition Assistance Program; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children..
[1] Meal or food services includes services such as soup kitchens, food pantries, food banks, church dinners, or food delivery services.

Source: HIV Surveillance data as of December 2024

Among the additional services collected by LAC, vision care and nutrition support were both the most received services, as well as the services with the highest unmet needs. Approximately 2 in 5 PLWDH received vision care while 1 in 5 received support from a nutritionist within the past 12 months.

Percentage of PLWDH who received or had unmet needs for additional local services within the past 12 months—Medical Monitoring Project, LAC 2018-2022[1]

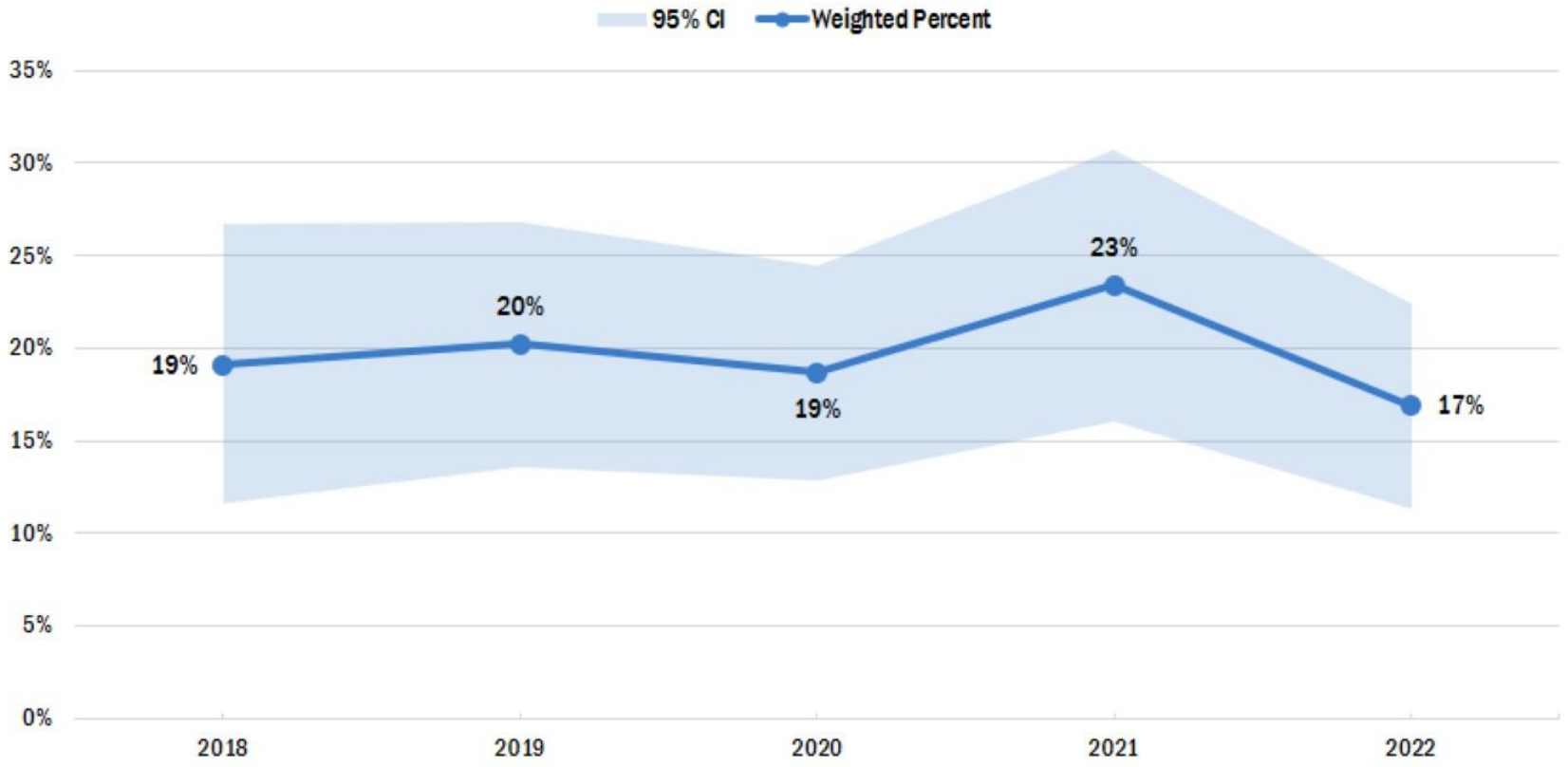


[1] Nutrition support refers to support provided b a nutritionist who evaluates diets, provides nutritional counseling, and/or recommends supplements to improve health.

Source: HIV Surveillance data as of December 2024

From 2021 to 2022, the prevalence of PLWDH reportedly experiencing homelessness or unstable housing within the past 12 months dropped from 23% to 17%, the lowest since 2018.

Prevalence of unstably housed PLWDH by year—Medical Monitoring Project, LAC 2018-2022[1]

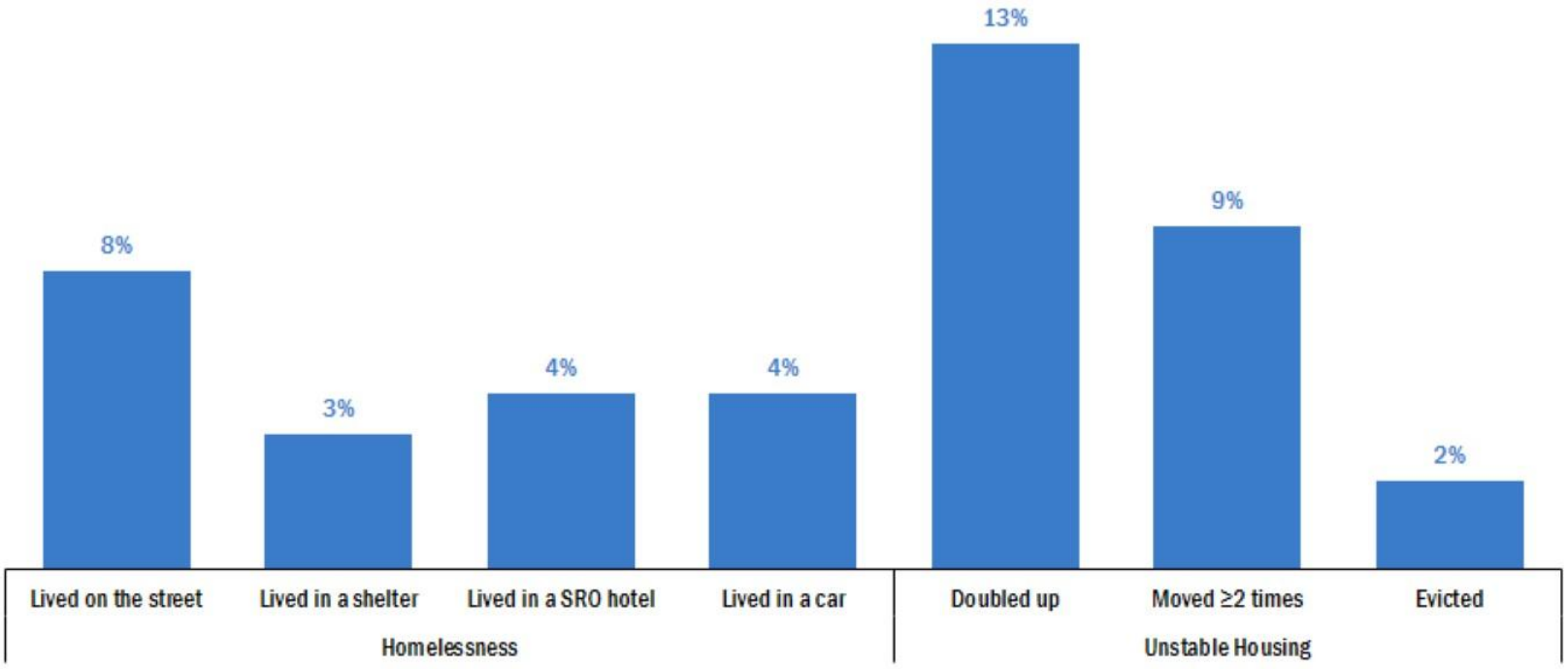


[1] Unstable housing includes experiencing unstable housing (i.e., moving in with others due to financial issues, moving 2 or more times, or being evicted at any time) or homelessness (living on the street, in a shelter, in a single-room-occupancy (SRO) hotel, or in a car at any time) during the past 12 months. Categories were not mutually exclusive, and participants could have experienced multiple options within the past 12 months.

Source: HIV Surveillance data as of December 2024

The most commonly reported forms of unstable housing were (1) having moved in with others due to financial concerns (13%), (2) having moved two or more times (9%), and (3) having lived on the street (8%).

Forms of unstably housing within the past 12 months, reported by PLWDH—Medical Monitoring Project, LAC 2018-2022[1,2]

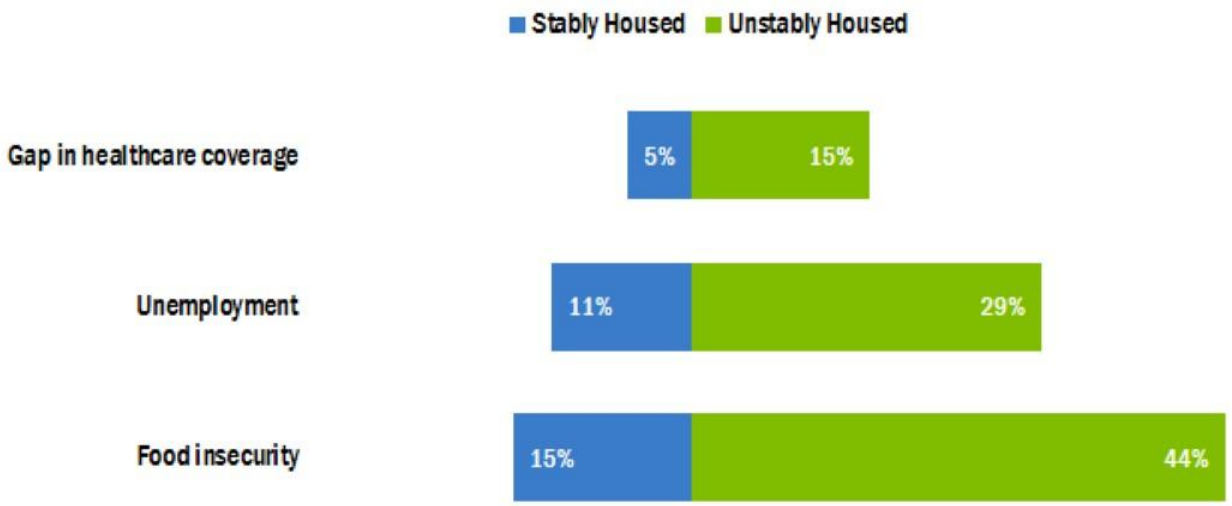


1 Unstably housed includes experiencing unstable housing (i.e., moving in with others due to financial issues, moving 2 or more times, or being evicted at any time) or homelessness (living on the street, in a shelter, in a single-room-occupancy (SRO) hotel, or in a car at any time) during the past 12 months. Categories were not mutually exclusive, and participants could have experienced multiple options within the past 12 months.
2 Doubled up is defined as having moved in with others due to financial issues.

Source: HIV Surveillance data as of December 2024

Higher proportions of unstably housed PLWDH reported adverse social indicators such as gaps in healthcare coverage, unemployment, and food insecurity within the past 12 months compared to their stably housed counterparts.

Select social indicators by housing status—Medical Monitoring Project, LAC 2018-2022[1,2,3]

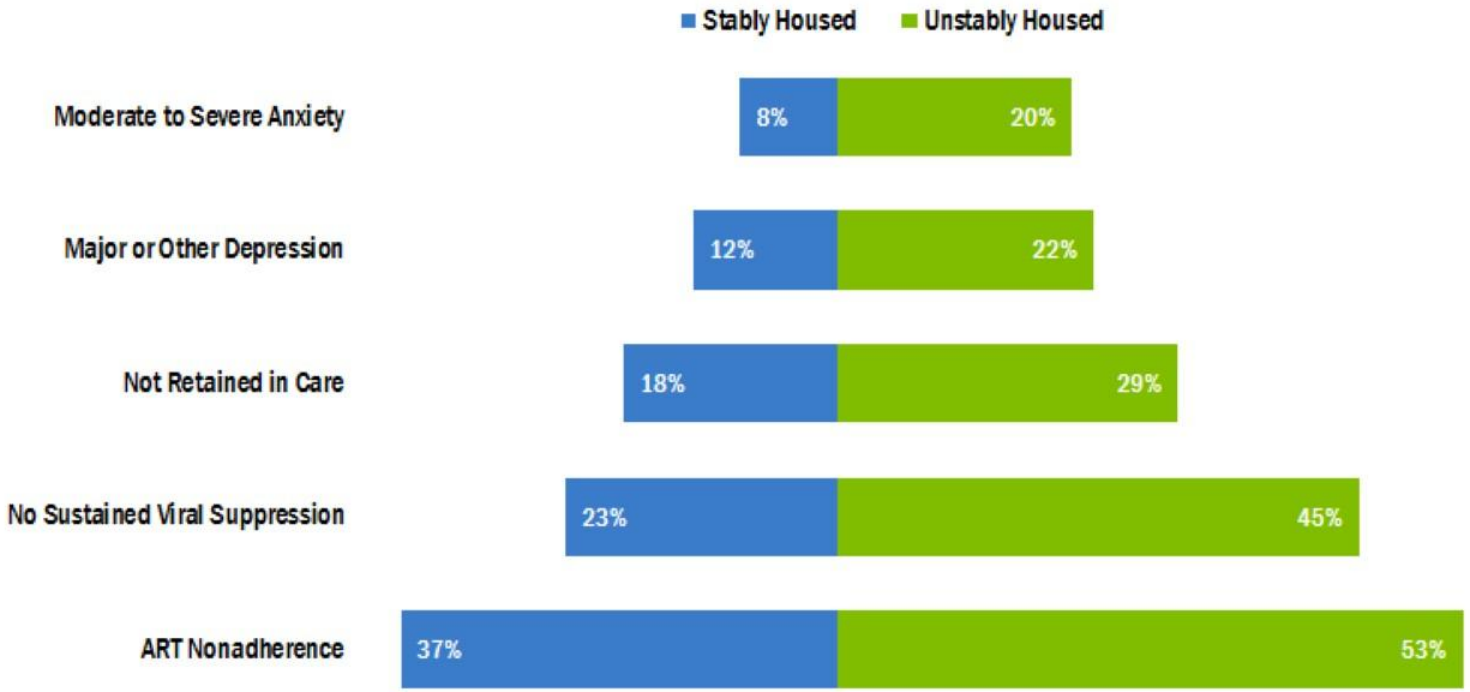


[1] Gap in healthcare coverage is defined as any time that the participant did not have any insurance or healthcare coverage during the past 12 months.
[2] Unemployment refers to participants who report being unemployed at the time of interview, excluding persons who were unable to work.
[3] Food insecurity is defined as going without food due to lack of money during the past 12 months.

Source: HIV Surveillance data as of December 2024

Compared to stably housed PLWDH, unstably housed PLWDH reported poorer mental health and HIV outcomes.

Select clinical and health indicators by housing status—Medical Monitoring Project, LAC 2018-2022[1,2,3,4]



[1] Responses to items on GAD-7 and PHQ-8 were used to define categories of anxiety and depression respectively according to criteria from the DSM-IV.
[2] Retained in care is defined as having two elements of outpatient care HIV care at least 90 days apart within the past 12 months.
[3] Sustained viral suppression in MMP is defined as having all HIV viral loads being undetectable or <200 copies/mL, as documented in eHARS as well as the participant's medical record within the past 12 months before interview.
[4] ART nonadherence is defined as missing one or more doses of HIV medicines within the past 30 days.

Source: HIV Surveillance data as of December 2024

HIV co-infected populations

- HIV and other STDs are syndemic in LAC.
- Persons with syphilis, gonorrhea, and/or chlamydia are at an increased risk of acquiring HIV due to biological and behavioral factors.
- STDs among PLWH can also increase HIV viral load and the risk of forward HIV transmission.
- We examined the co-occurrence of HIV and STD diagnoses in the same year among persons with newly diagnosed HIV. This method estimates the percentage of HIV-STD co-infections around the time of HIV diagnosis. Note that a person may be living with HIV for months or years before they are diagnosed, and other STDs may remain untreated.
- The cities of Long Beach and Pasadena are not included in this analysis due to reporting delays (these cities have their own health departments and report STD cases directly to the State of California, who then shares the data with LAC).

Over the past decade, among persons newly diagnosed with HIV in LAC, the percent who are also diagnosed with an STD in the same calendar year has increased from 28% to 42%.

Percentage of persons newly diagnosed with HIV aged ≥ 13 years who had syphilis, gonorrhea, and/or chlamydia in the same calendar year as HIV diagnosis, LAC (excluding Long Beach and Pasadena) 2014-2023[1,2,3,4]

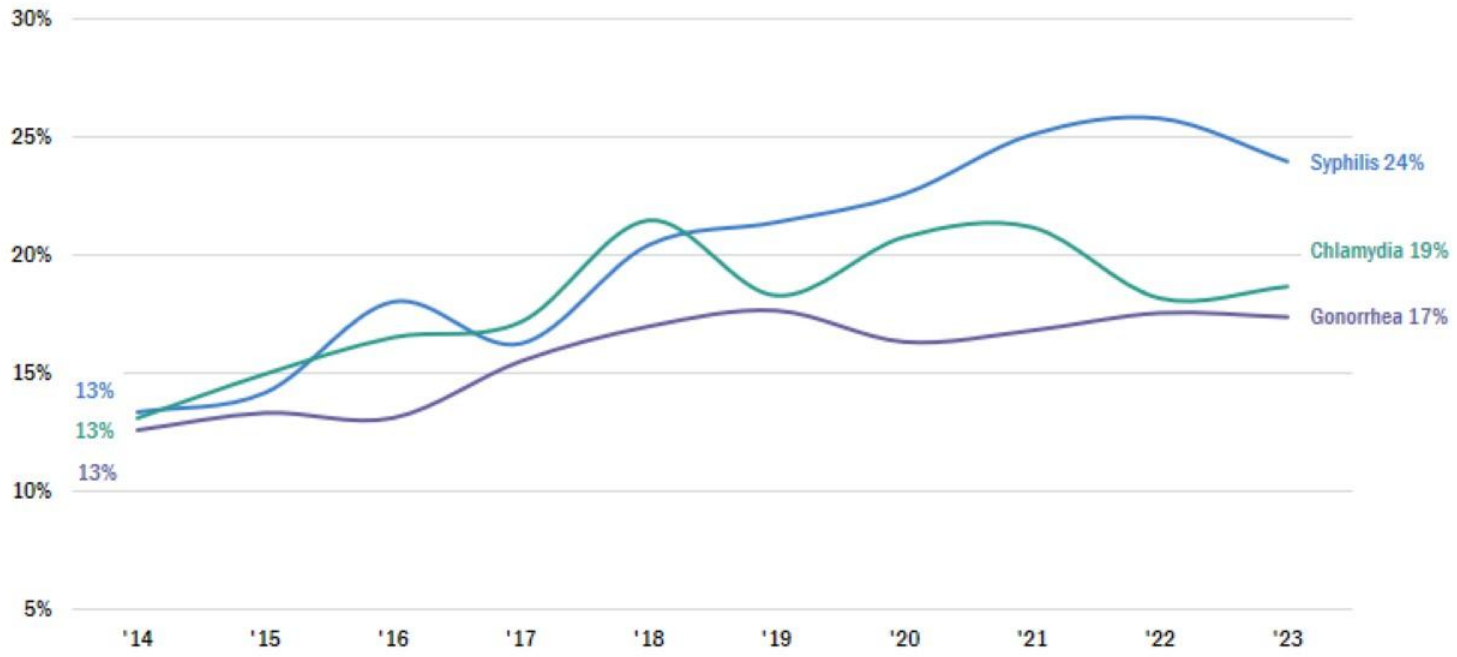
Note: The observed increase in persons co-infected with HIV and STDs in LAC reflects the rise in total STD cases over the same time period.

[1] PLWDH with more than one STD case per year are counted only once.
[2] DHSP prioritizes HIV, syphilis, and congenital syphilis cases for investigation.
[3] STD cases in the cities of Long Beach and Pasadena are reported to their respective health departments.
[4] Due to reporting delay and time needed for case investigations, data are shown through 2023 instead of 2024.

Source: HIV Surveillance data as of December 2024

HIV coinfections with syphilis, chlamydia, and gonorrhea have increased over the last 10 years. In 2023, syphilis co-infection was highest, followed by chlamydia and gonorrhea.

Percentage of persons newly diagnosed with HIV aged ≥ 13 years who had syphilis, gonorrhea, or chlamydia in the same calendar year as HIV diagnosis by STD, LAC (excluding Long Beach and Pasadena) 2014-2023[1,2,3]

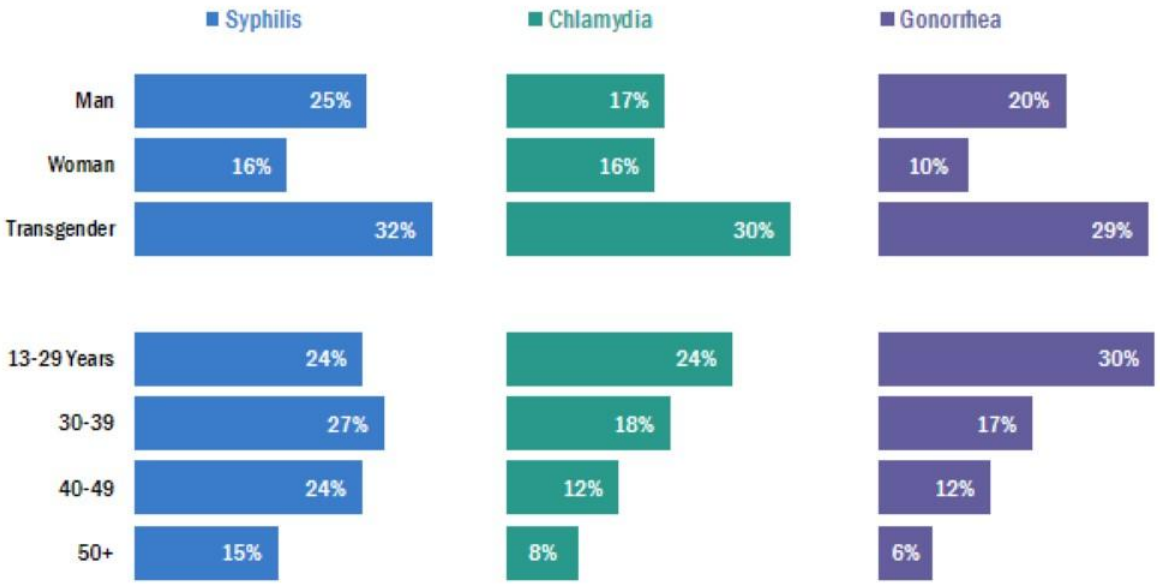


[1] HIV and STD co-infection is defined when a person newly diagnosed with HIV also receives a diagnosis of an STD (syphilis, chlamydia, and/or gonorrhea) in the same calendar year
[2] DHSP prioritizes HIV, syphilis, and congenital syphilis cases for investigation.
[3] STD cases in the cities of Long Beach and Pasadena are reported to their respective health departments.
[4] Due to reporting delay and time needed for case investigations, data are shown through 2023 instead of 2024.

Source: HIV Surveillance data as of December 2024

Syphilis co-infection[1] at the time of HIV diagnosis was higher than other STDs.
Syphilis co-infection[1] was highest among transgender people newly diagnosed with HIV.
Syphilis co-infection[1] was higher among people aged 49 years and younger compared with those aged 50 years and older.

Percentage of persons newly diagnosed with HIV aged ≥ 13 years who had syphilis, gonorrhea, or chlamydia in the same calendar year as HIV diagnosis by STD, gender, and age group, LAC (excluding Long Beach and Pasadena) 2023[2,3,4]

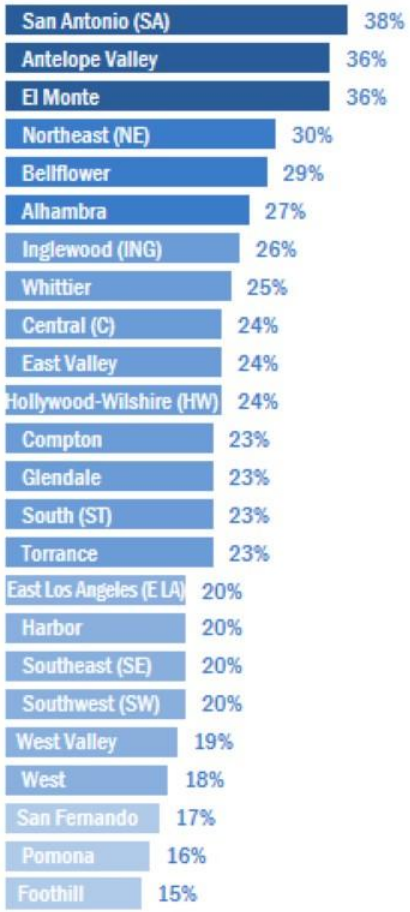


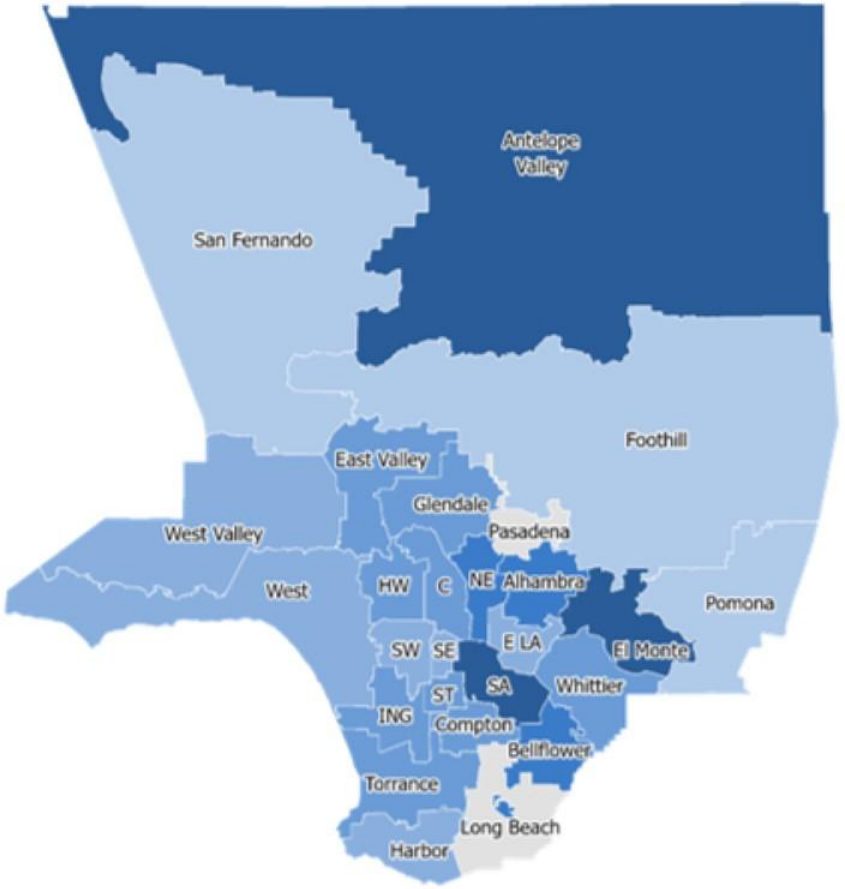
[1] HIV and STD co-infection is defined when a person newly diagnosed with HIV also receives a diagnosis of an STD (syphilis, chlamydia, and/or gonorrhea) in the same calendar year.
[2] DHSP prioritizes HIV, syphilis, and congenital syphilis cases for investigation.
[3] STD cases in the cities of Long Beach and Pasadena are reported to their respective health departments.
[4] Due to reporting delay and time needed for case investigations, data are shown through 2023 instead of 2024

Source: HIV Surveillance data as of December 2024

Persons newly diagnosed with HIV and living in San Antonio, Antelope Valley and El Monte health districts had the highest percentage of syphilis co-infection[1] in 2023.

Percentage of persons newly diagnosed with HIV aged ≥ 13 years who had syphilis in the same calendar year as HIV diagnosis by Health District, LAC (excluding Long Beach and Pasadena) 2023[2,3,4]





[1] HIV and STD co-infection is defined when a person newly diagnosed with HIV also receives a diagnosis of an STD (syphilis, chlamydia, and/or gonorrhea) in the same calendar year.
[2] DHSP prioritizes HIV, syphilis, and congenital syphilis cases for investigation.
[3] STD cases in the cities of Long Beach and Pasadena are reported to their respective health departments.
[4] Due to reporting delay and time needed for case investigations, 2023 is shown as the latest year.

Source: HIV Surveillance data as of December 2024

Mpox and HIV co-infection

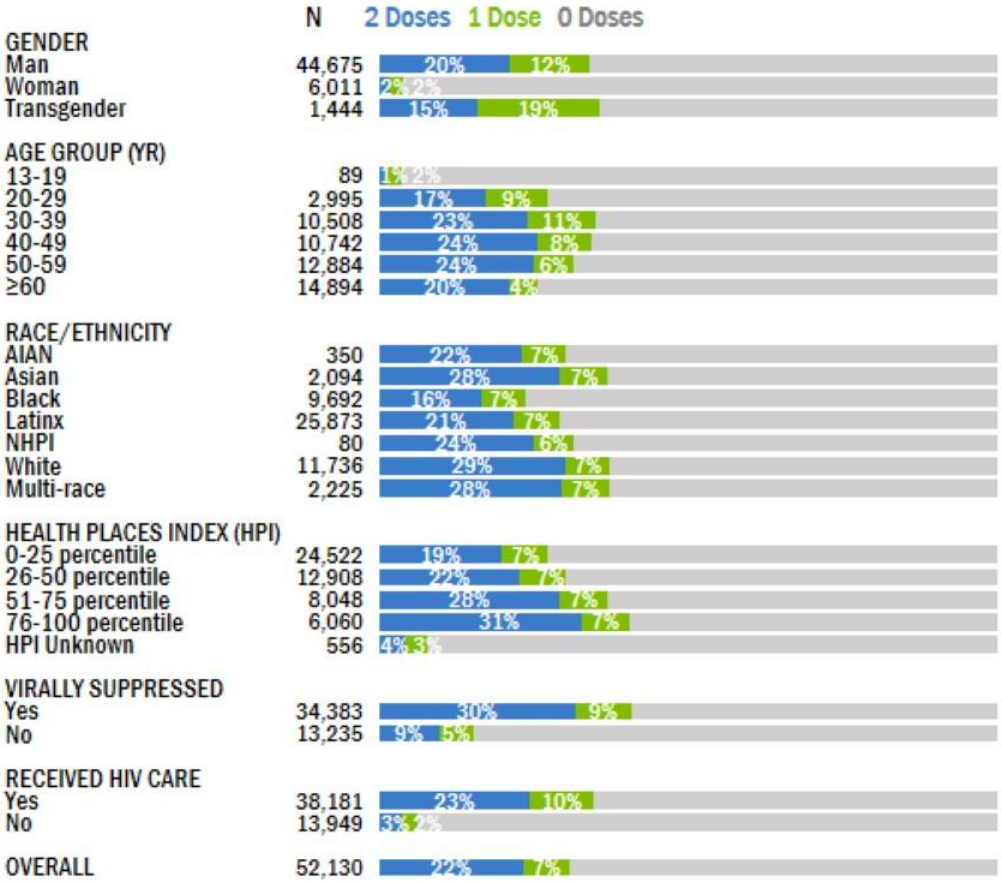
- In 2022, there was a widespread outbreak of mpox disease in the United States which primarily affected gay, bisexual, and other men who have sex with men. CDC reported high prevalence of concurrent HIV infection (38%) among persons with mpox across eight U.S. jurisdictions. Concurrent HIV infection was associated with poorer mpox clinical outcomes compared with persons with mpox who did not have HIV infection.[1]
- Using surveillance data on persons living with diagnosed HIV through December 2024 and newly diagnosed cases of mpox infection from the onset of the outbreak (May 2022) through end of year 2024, we calculated the HIV co-infection rate among mpox cases. CDC recommends that anyone with HIV be vaccinated with the 2-dose JYNNEOS vaccine. Therefore, we matched HIV surveillance data to JYNNEOS vaccination data and compared mpox HIV vaccination among PLWDH by selected characteristics. All data presented in this section are unadjusted and should be interpreted cautiously.
- Of the 2,280 persons in LAC diagnosed with mpox in 2022, 45% were coinfected with HIV. By contrast 35% of the 116 persons in LAC diagnosed with mpox in 2023 and 30% of the 220 persons in LAC diagnosed with mpox in 2024 were coinfected with HIV. Note that mpox and HIV co-infection data are for Los Angeles County and do not include Long Beach or Pasadena, as each of these cities have their own surveillance systems and do not directly report mpox data to LAC.

[1] https://www.cdc.gov/mmwr/volumes/71/wr/mm7136a1.htm

Overall, 22% of PLWDH are fully vaccinated for mpox (2 doses) and an additional 7% of PLWDH are partially vaccinated (1 dose). Among PLWDH, mpox vaccination is lowest in women, younger age groups, Black and Latinx persons, persons who reside in areas with a low HPI score, persons that are not virally suppressed and those who have not received HIV care in the last 12 months.

JYNNEOS vaccination dose among PLWDH aged ≥ 13 years by gender, age, race/ethnicity, Healthy Places Index (HPI),[1] and HIV care status, LAC 2024[2]

Note: Additional efforts are needed to improve mpox vaccine confidence and access among PLWH, especially among those who are <20 years old, persons of color, persons residing in areas with a low HPI score, and/or out of HIV care.



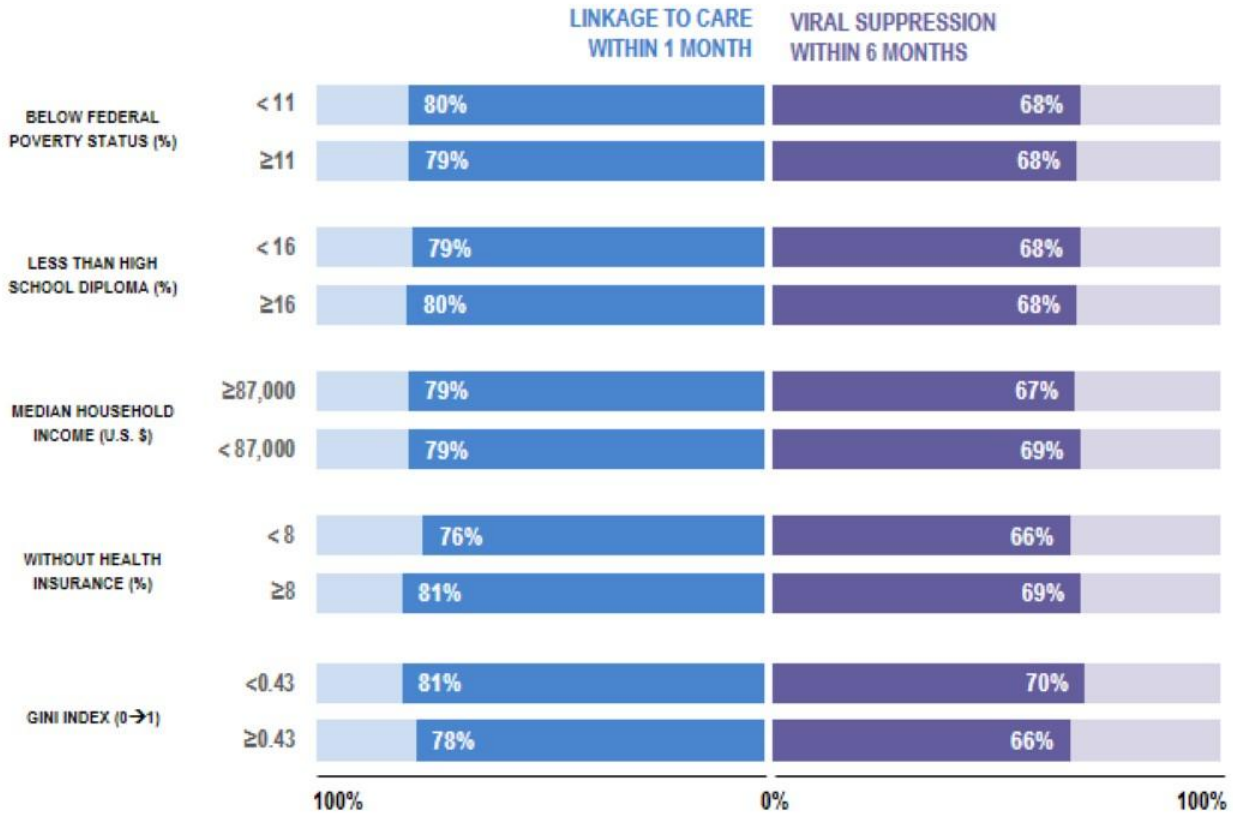
[1] Healthy Places Index (HPI): developed by the Public Health Alliance of Southern California, combines 25 community characteristics, like access to healthcare, housing, and education into a single score reflecting the overall health of the community. HPI scores were divided into quartiles, with the lowest quartile representing the least healthy communities

[2] Persons living with HIV are based on most recent known address at the end of 2024 in Los Angeles County.

Source: HIV Surveillance data as of December 2024

There appears to be little variation in timely linkage to care or viral suppression by federal poverty status, education, or median household income at the census tract level. However, slightly better outcomes were observed in census tracts with lower health insurance coverage (≥8%) and less income inequality (Gini index < 0.43) than their counterparts.

Linkage to care within one month and viral suppression within six months of HIV diagnosis among adults aged ≥ 18 years by select social determinates of health – census tract level, LAC 2023



Source: HIV Surveillance data as of December 2024

County of Los Angeles Public Health

HIV Surveillance to Partner Services Continuum

HIV Surveillance to Partner Services Continuum

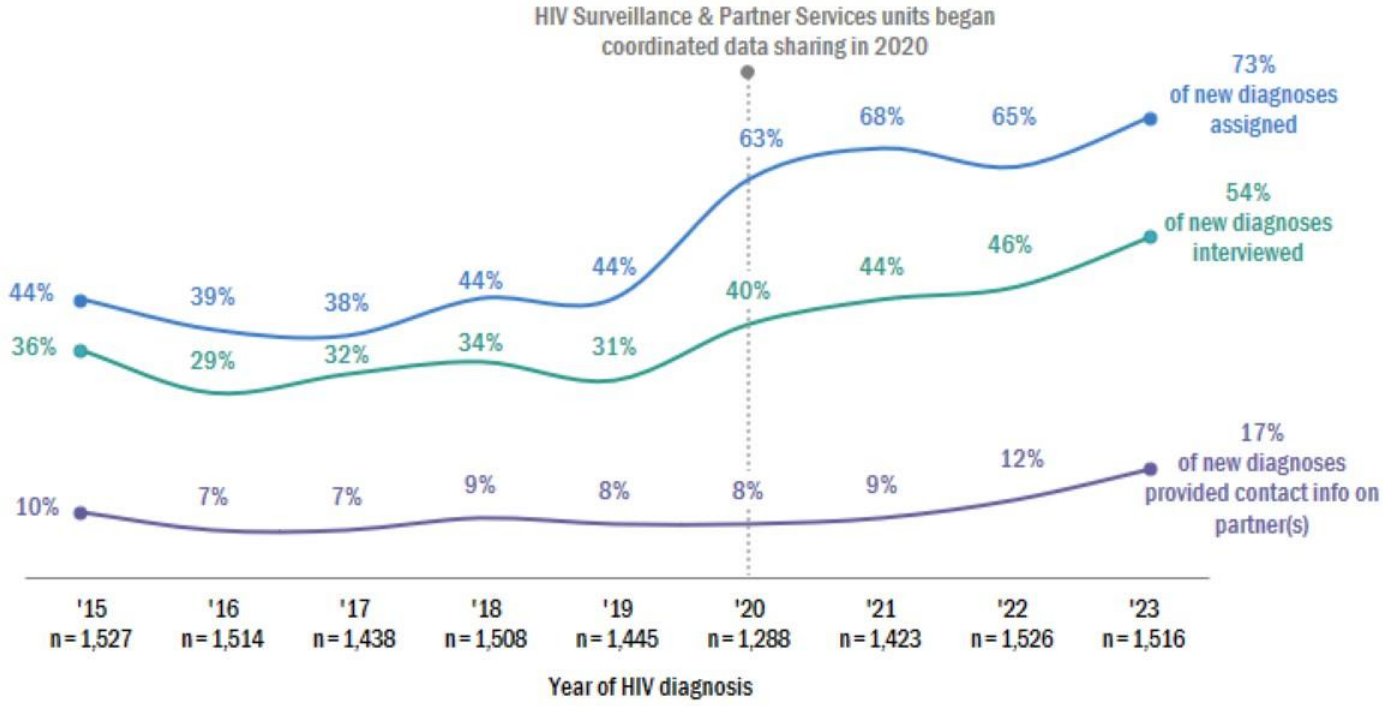
- Partner Services (PS) are a broad array of public health field services offered to persons with HIV or other sexually transmitted diseases (STDs) and their sexual or substance-using partners (e.g., needles and syringe sharing partners) to improve the health outcomes of infected persons and offer strategies and resources to protect partners from HIV and STDs
- An important component of Partner Services is partner notification, a process through which persons newly diagnosed with STDs and/or HIV are interviewed to elicit information about their partners, who can then be confidentially notified of their possible exposure and referred to testing and other interventions to help reduce their risk of acquiring HIV.

HIV Surveillance to Partner Services Continuum – cont.

- All people newly diagnosed with HIV should receive Partner Services. Historically, not all newly reported HIV cases were prioritized for Partner Services, creating missed opportunities for linking persons to HIV care and, for partners of PLWDH, to receive status neutral services. Currently, new HIV case reports are routed from Surveillance to the Partner Services unit where they are assigned to public health investigators (PHI). PHIs make multiple attempts to contact the patient for interview/linkage-to-care and partner elicitation. Through close coordination between the HIV Surveillance and Partner Services Programs, routine program analysis and dashboards have been implemented to track achievements and gaps along the HIV Surveillance to Partner Services continuum.
- The steps in the continuum start from a new diagnosis of HIV and are tracked through the following evaluation metrics: referral to HIV Partner Services, PS interview, linkage to care, contact tracing, locating contacts, determining the HIV status of contacts, and administering interventions to contacts. Improvements in each of the steps in the continuum increase the likelihood of infected persons and their partners to be linked to effective interventions for prevention, care, and treatment of HIV and STIs, and ultimately, reductions in community transmission of HIV and STIs.
- EHE Partner Services Targets
  - Increase percentage of persons newly diagnosed with HIV assigned for Partner Services to 95%.
  - Increase percentage of assigned cases interviewed for Partner Services to 75%.
  - Of those interviewed, 85% should be interviewed within 7 days of diagnosis

The percent of persons diagnosed with HIV who provide their sexual and/or needle sharing partner's contact information has been on an increasing trend since 2020. This is largely attributable to the implementation of coordinated data sharing between DHSP's HIV Surveillance and Partner Services teams. These coordinated efforts have resulted in marked improvements in the percent of newly diagnosed HIV-positive persons who are assigned for partner services and interviewed to elicit partner contact information.

HIV Partner Services continuum among new HIV diagnoses by year, LAC (excluding Long Beach and Pasadena) 2015-2023[1,2,3,4]



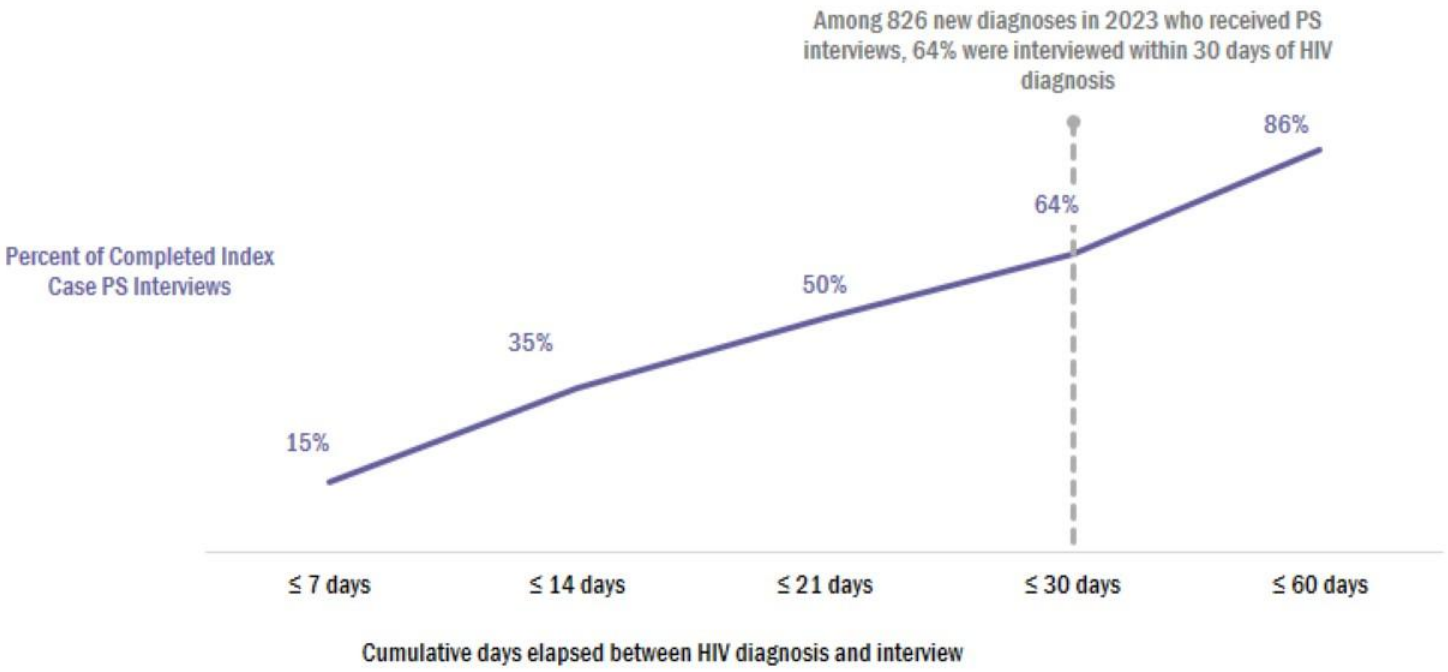
In 2023, 73% of newly diagnosed HIV-positive persons in LAC were assigned for a Partner Services interview and 74% of those persons assigned for Partner Services were interviewed. Of all new HIV diagnoses, 54% were interviewed and 17% provided contact information of sexual and/or needle sharing partners. Refusal by the client or inability to locate the client were the primary reasons why assigned cases were not interviewed.

[1] Denominator is persons in LAC newly diagnosed with HIV in 2023 and reported to Surveillance within 12 months of HIV diagnosis.
[2] Assigned: New HIV diagnoses assigned for partner services within 12 months of report among LAC HIV diagnoses (excluding Long Beach and Pasadena).
[3] Interviewed: New HIV diagnoses interviewed by public health investigators among new LAC HIV diagnoses (excluding Long Beach and Pasadena).
[4] Named contact(s): New HIV diagnoses who identified ≥1 sexual and/or cluster contact during interview among new LAC HIV diagnoses (excluding Long Beach and Pasadena).

Source: HIV Surveillance data as of December 2024

Among 826 Index Case Partner Services (PS) interviews, 15% were completed within 7 days, 64% within 30 days, and 86% within 60 days after the HIV diagnosis date.

Time from HIV diagnosis to HIV Partner Services interview among new HIV diagnoses (excluding Long Beach and Pasadena) who were successfully interviewed by Partner Services, LAC 2023[1]



[1] Denominator is persons newly diagnosed with HIV in 2023 (excluding Long Beach and Pasadena) who received a partner services interview (n = 826).

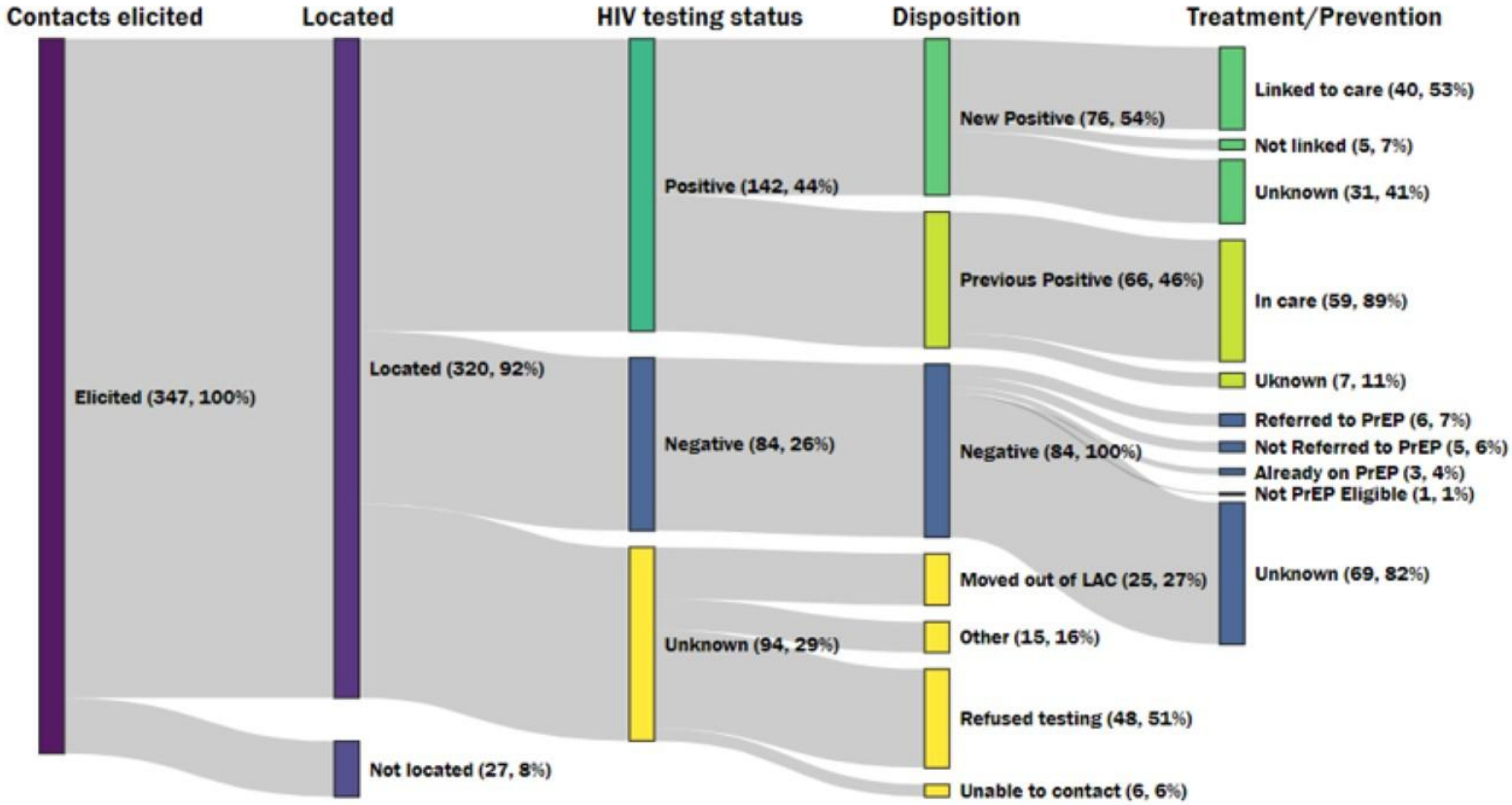
Source: HIV Surveillance data as of December 2024

Elicited Contacts

- An important component of Partner Services is partner notification, a process through which persons diagnosed with HIV are interviewed to elicit information about their partners, who can then be confidentially notified of their possible exposure or potential risk.
- Notifying contacts of their risk of HIV is a cornerstone public health intervention designed to reduce the forward transmission of HIV. As part of an HIV partner notification model, every named contact is investigated by a Partner Services staff member and once located, contacts are assessed and provided with opportunities for follow-up services according to their HIV status.
- A contact who is newly identified as having HIV will trigger a response to immediately link the contact to care. If the contact had a prior HIV positive diagnosis, their HIV care status should be assessed, and, if out of care, the contact should be linked or re-linked back to care.
- Contacts who test negative should be provided with high quality services to reduce their risk of acquiring HIV, including referral to HIV pre-exposure prophylaxis (PrEP).

Most contacts of persons newly diagnosed with HIV were located. Of those located, 44% tested HIV positive underscoring the efficiency of partner services as a case finding strategy.

HIV Partner Services continuum[1] among named contacts, LAC (excluding Long Beach and Pasadena) 2023[2,3,4]



[1] The HIV partner services continuum includes the following steps: 1) identifying people who were named as sexual or social contacts by index cases, 2) locating elicited contacts, 3) confirming contacts' HIV serostatus, and 4) connecting contacts who tested positive to HIV treatment and contacts who tested negative to preventative HIV treatment.
[2] 347 contacts named by 253 index cases newly diagnosed with HIV in 2023.
[3] In care: PLWDH diagnosed through 2022 who have at least one care visit within year 2023. Care status is available for contacts regardless of HIV testing disposition. Linked to care: PLWDH who were linked to care within 1 month of HIV diagnosis.
[4] PrEP information is unknown for clients without comorbid STD.

Source: HIV Surveillance data as of December 2024

HIV Care Continuum

HIV Care Continuum

- The HIV Care Continuum is a series of steps starting from when a person living with HIV receives a HIV-positive diagnosis through the achievement of viral suppression.
- By monitoring these steps at a population level, we can quantify progress at the local and national level.
- A deeper analysis of the steps along the HIV continuum of care can identify gaps in HIV care delivery.
- Knowing where and among whom the shortfalls persist along the HIV care cascade can inform where improvements are needed to support individuals in achieving and maintaining viral suppression, improving their health, and effectively eliminating further transmission to others.

HIV Care Continuum – cont.

- HIV care continuum indicators includes following:

1. among persons receiving a diagnosis of HIV in a given calendar year, the percentage of persons who were linked to HIV care within one month of diagnosis (defined as ≥ 1 CD4/VL/Genotype test reported within one month of HIV diagnosis); and

2. among all persons living with diagnosed HIV, the percentage of persons who
   a. received HIV care (defined as ≥ 1 CD4/VL/Genotype test per year),
   b. were retained in HIV care (defined as ≥ 2 CD4/VL/Genotype tests at least three months apart per year), and
   c. were virally suppressed (defined using most recent viral load per year).

HIV Care Continuum – cont.

- The base population for measuring linkage to HIV care is persons who received an HIV-positive diagnosis in a given calendar year.

- The base population for the downstream steps in the continuum of care is all persons who were diagnosed with HIV through the prior calendar year and living in LAC with diagnosed HIV at the close of the current year. The latter ensures that there is at least one year of follow-up to measure receipt of care, retention in care, and viral suppression.

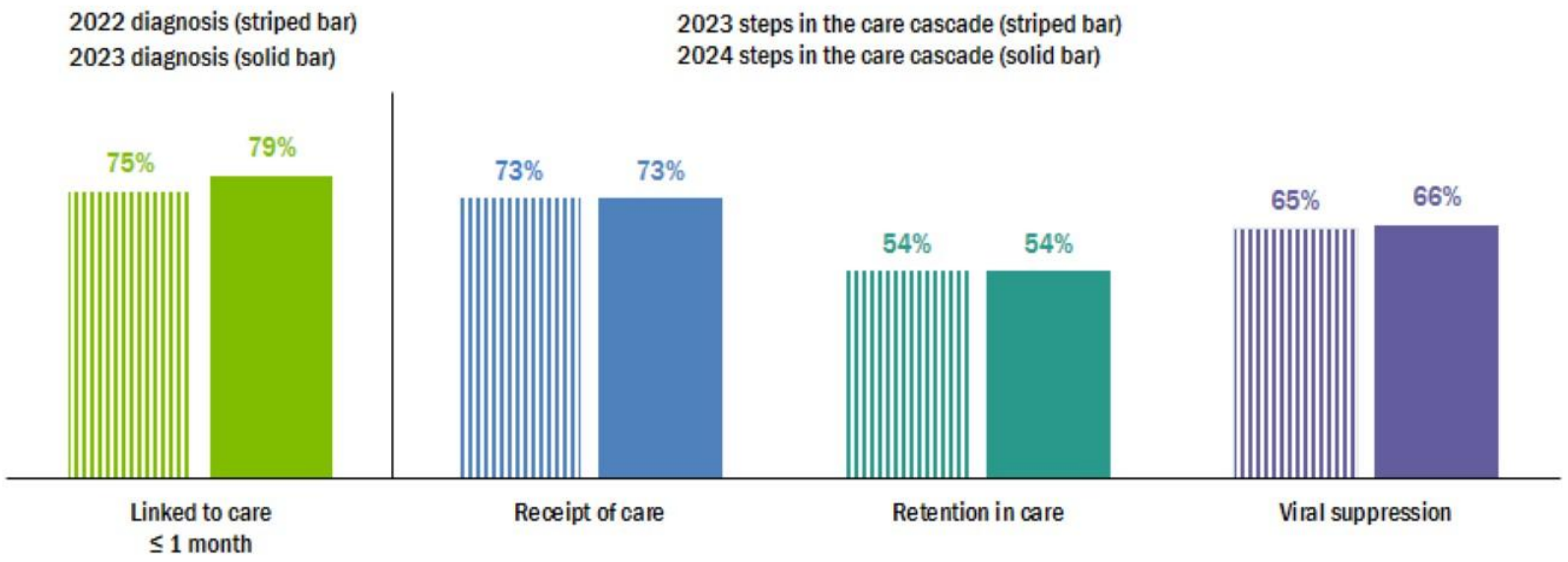
HIV Care Continuum – cont.

EHE HIV Care Continuum Targets

- Increase the percentage of newly diagnosed persons linked to care within one month to at least 95% by 2025
- Increase the percentage of persons living with diagnosed HIV who are virally suppressed to at least 95% by 2025

In 2023, 79% of persons diagnosed with HIV were linked to care within 1 month of diagnosis. All key steps along the HIV care continuum remained largely unchanged in 2024 compared with 2023.

HIV care continuum[1] among persons aged ≥ 13 years, LAC 2022-2023[2] and 2023-2024[3]

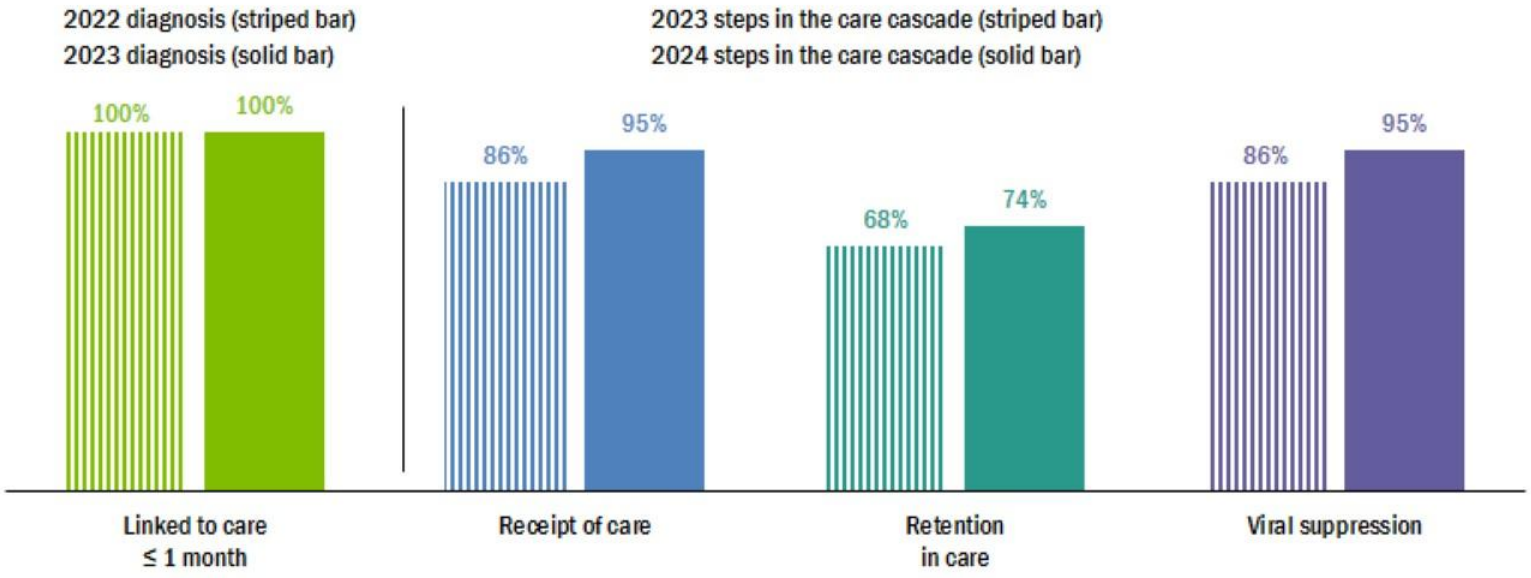


[1]The HIV care continuum includes the following steps in the care cascade: 1) the percentage of persons receiving a diagnosis of HIV in a given calendar year who were linked to HIV care within 1 month of diagnosis (defined as ≥ 1 CD4/VL/Genotype test reported within 1 month of HIV diagnosis); and 2) the percentage of all persons living with diagnosed HIV who (1) received HIV care (defined as ≥ 1 CD4/VL/Genotype test per year), (2) were retained in HIV care (defined as ≥ 2 CD4/VL/Genotype tests at least three months apart, per year), and (3) were virally suppressed (defined using most recent viral load, per year). PLWDH without a VL test in the measurement year were categorized as having unsuppressed viral load.
[2]The 2022-2023 HIV care continuum denominator includes persons diagnosed in 2022 to calculate linkage to care ≤ 1 month of diagnosis, and all PLWDH diagnosed through 2022 and living in LAC at year-end 2023 to calculate receipt of care, retention in care, and viral suppression.
[3]The 2023-2024 HIV care continuum denominator includes persons diagnosed in 2023 to calculate linkage to care ≤ 1 month of diagnosis, and all PLWDH diagnosed through 2023 and living in LAC at year-end 2024 to calculate receipt of care, retention in care, and viral suppression.

Source: HIV Surveillance data as of December 2024

In 2023, 100% of children aged <13 years diagnosed with HIV were linked to care within 1 month of diagnosis. All key steps along the HIV care continuum improved in 2024 compared to 2023.

HIV care continuum[1] among children aged < 13 years, LAC 2022-2023[2] and 2023-2024[3]

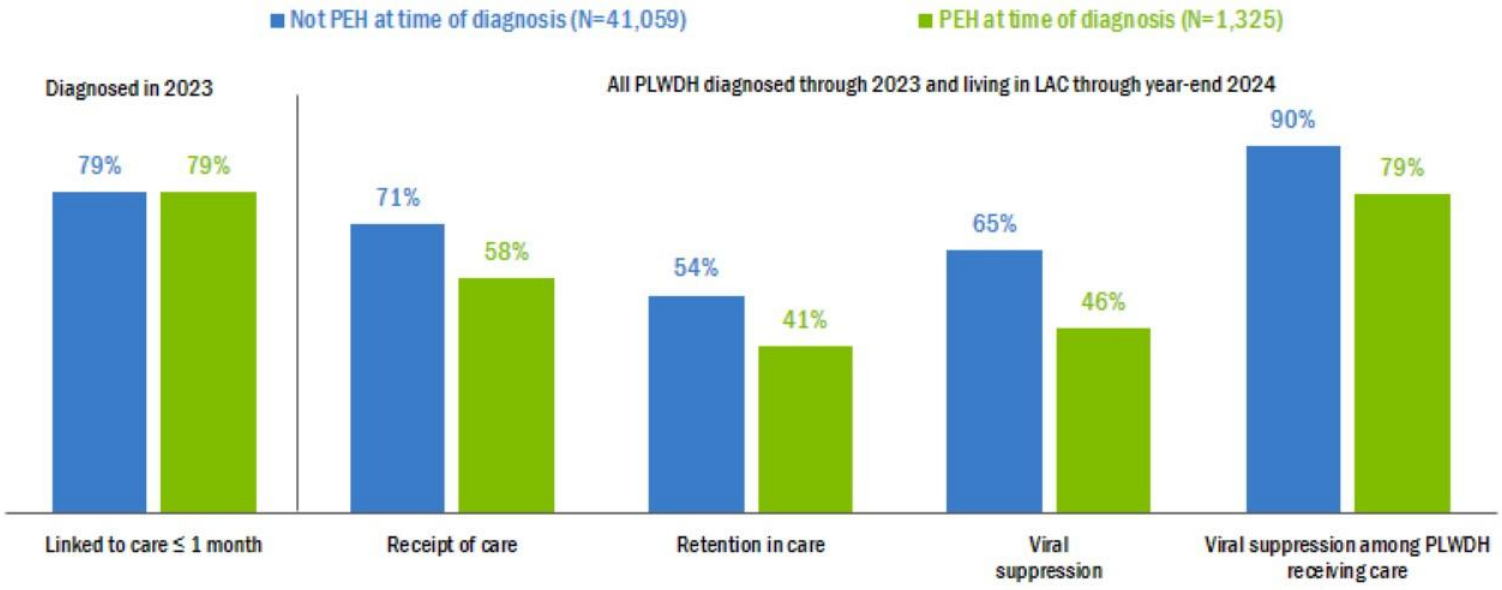


[1]The HIV care continuum includes the following steps in the care cascade: 1) the percentage of persons receiving a diagnosis of HIV in a given calendar year who were linked to HIV care within 1 month of diagnosis (defined as ≥ 1 CD4/VL/Genotype test reported within 1 month of HIV diagnosis); and 2) the percentage of all persons living with diagnosed HIV who (1) received HIV care (defined as ≥ 1 CD4/VL/Genotype test per year), (2) were retained in HIV care (defined as ≥ 2 CD4/VL/Genotype tests at least three months apart, per year), and (3) were virally suppressed (defined using most recent viral load, per year). PLWDH without a VL test in the measurement year were categorized as having unsuppressed viral load.
[2]The 2022-2023 HIV care continuum denominator includes persons diagnosed in 2022 to calculate linkage to care ≤ 1 month of diagnosis, and all PLWDH diagnosed through 2022 and living in LAC at year-end 2023 to calculate receipt of care, retention in care, and viral suppression.
[3]The 2023-2024 HIV care continuum denominator includes persons diagnosed in 2023 to calculate linkage to care ≤ 1 month of diagnosis, and all PLWDH diagnosed through 2023 and living in LAC at year-end 2024 to calculate receipt of care, retention in care, and viral suppression.

Source: HIV Surveillance data as of December 2024

PEH had much poorer outcomes in the HIV care continuum compared with persons not experiencing homelessness, with the greatest disparity observed in viral suppression.

HIV care continuum among persons aged ≥ 13 years by PEH status at the time of HIV diagnosis, LAC 2023-2024[1]



[1]Linkage to care: numerator includes persons newly diagnosed with HIV in 2023 with ≥1 CD4/VL/Genotype test reported within 1 month of HIV diagnosis; denominator includes persons who were diagnosed with HIV in 2023.
Receipt of care: numerator includes PLWDH with ≥1 CD4/VL/Genotype test in 2024; denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence and were originally diagnosed in LAC (excludes those diagnosed outside LAC).
Retention in care: numerator includes PLWDH with ≥2 CD4/VL/Genotype tests at least 3 months apart in 2024; denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence and were originally diagnosed in LAC (excludes those diagnosed outside LAC).
Viral suppression: numerator includes PLWDH whose last VL test in 2024 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence and were originally diagnosed in LAC (excludes those diagnosed outside LAC). PLWDH without a VL test in 2024 were categorized as having unsuppressed viral load.

Source: HIV Surveillance data as of December 2024

Linkage to HIV Care

- Linkage to HIV care is the first step in the HIV care continuum. It is the necessary precursor for receiving antiretroviral therapy to treat HIV.

- Linkage to HIV care is typically tracked as being linked to HIV care within one month of HIV diagnosis.

- Initiating HIV care services should occur faster, ideally within days, to ensure that treatment of HIV can be started immediately.

Though timeliness of linkage to care for persons newly diagnosed with HIV has improved over the past decade, only 79% were linked to HIV care within 1 month of their diagnosis in 2023 and only 55% were linked to HIV care within 1 week of their diagnosis.

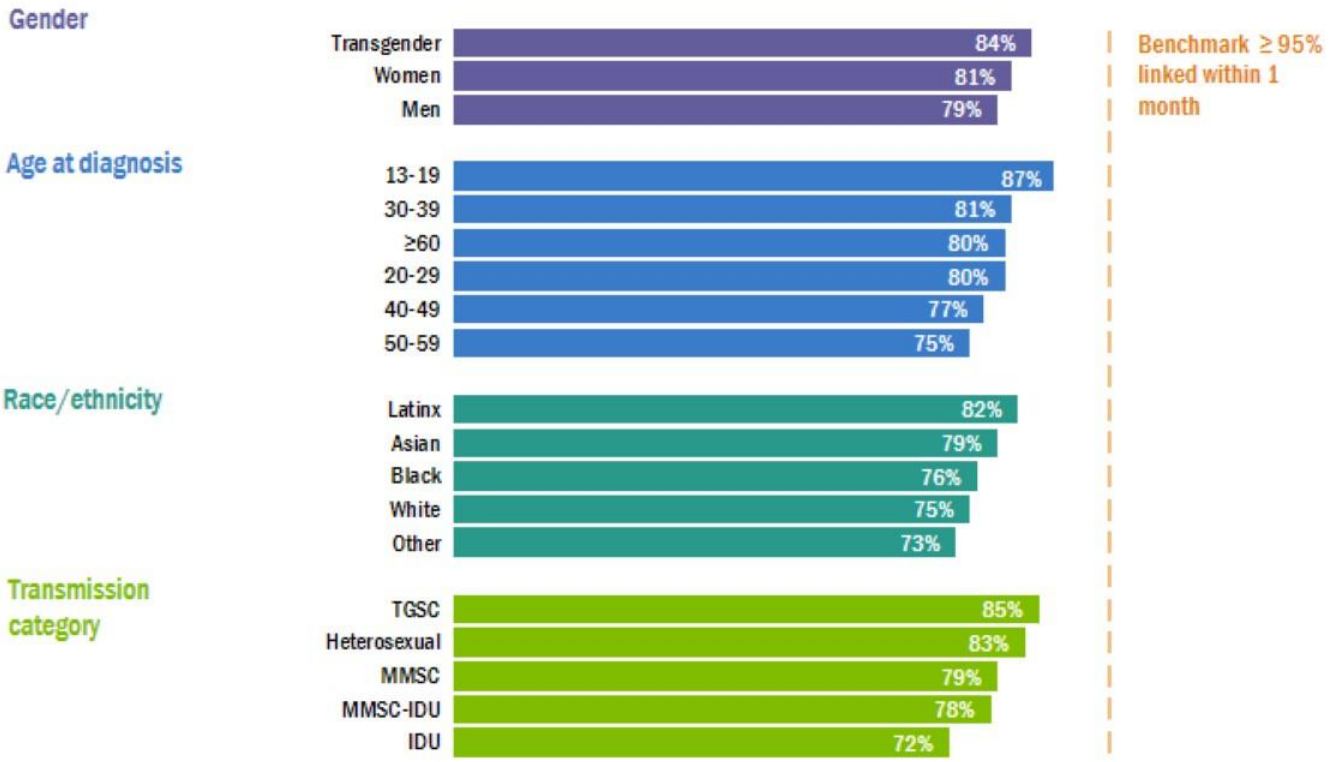
Time from HIV diagnosis to linkage to care among persons aged ≥ 13 years newly diagnosed with HIV by year of HIV diagnosis, LAC 2014-2023[1,2]

[1]Includes persons diagnosed with HIV in each calendar year with ≥1 CD4/VL/Genotype test reported within 1 week, as well as 1, 6, and 12 months of diagnosis.
[2]Due to reporting delay, 2023 HIV linkage to care data are provisional as indicated by the dashed line.

Source: HIV Surveillance data as of December 2024

None of the groups identified met the benchmark of 95% linked to HIV care within 1 month of diagnosis. Persons of other race/ethnicities, middle-aged adults (aged 50-59 years), and those whose transmission category was injection drug use were farthest from the benchmark.

Persons aged ≥ 13 years newly diagnosed with HIV and linked to care within 1 month of diagnosis[1] by select demographic[2] and risk[3] characteristics, LAC 2023



Abbreviations: TGSC = transgender persons with sexual contact; MMSC = male-to-male sexual contact; IDU = injection drug use

[1] Linked to care: numerator includes persons newly diagnosed with HIV in 2023 with ≥1 CD4/VL/Genotype test reported within 1 month of HIV diagnosis; denominator includes persons who were diagnosed with HIV in 2023.

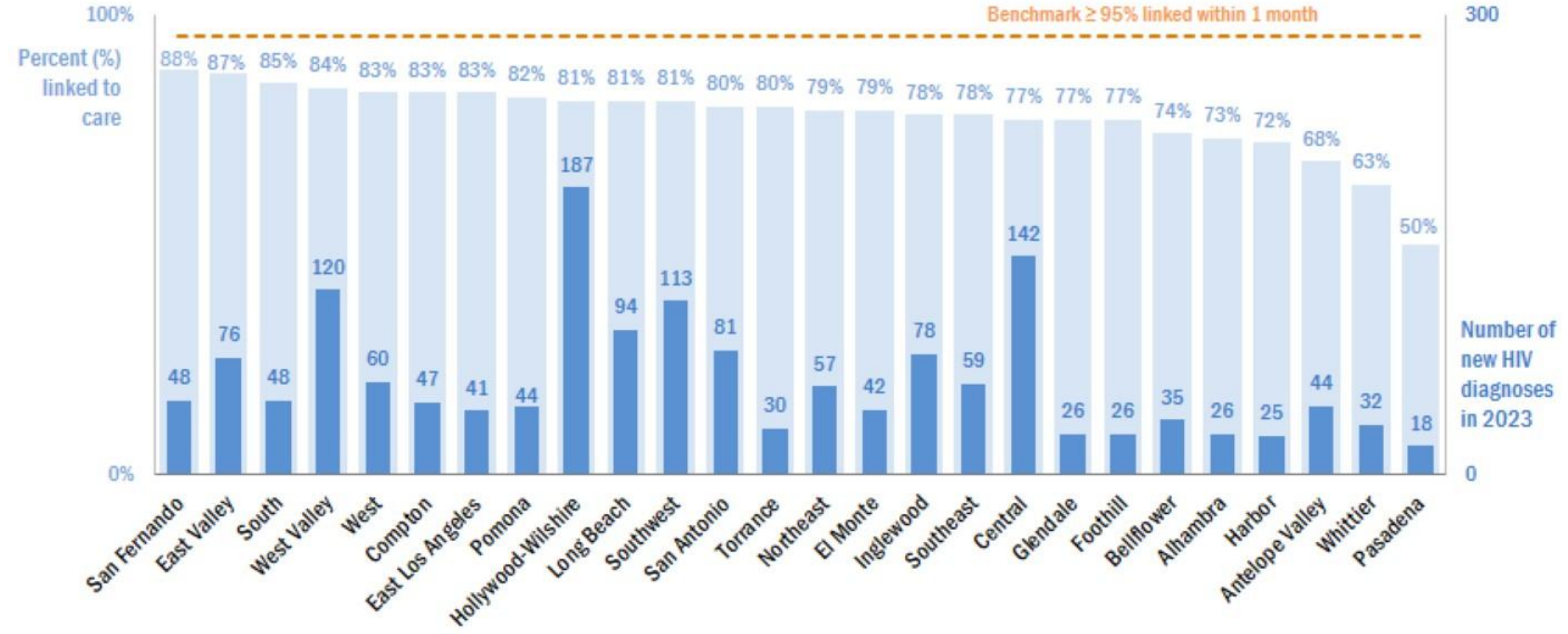
[2] Other race/ethnicity includes American Indian and Alaska Natives, Native Hawaiian and Pacific Islanders, persons of multiple race/ethnicities, and persons with unknown race/ethnicity.

[3] Other risk includes risk factor not reported/identified and is not shown due to small numbers.

Source: HIV Surveillance data as of December 2024

None of the Health Districts in LAC met the EHE target for timely linkage to HIV care within 1 month (at least 95% linked to care within 1 month), highlighting the need to identify solutions for improving linkage to care across LAC. Linkage to care was lowest for persons living in the Pasadena Health District, with only 50% of HIV cases linked to care within 1 month of diagnosis.

Persons aged ≥ 13 years newly diagnosed with HIV and linked to care within 1 month of diagnosis by Health District, LAC 2023[1,2]



[1] Linked to care: numerator includes persons newly diagnosed with HIV in 2023 with ≥1 CD4/VL/Genotype test reported within 1 month of HIV diagnosis; denominator includes persons who were diagnosed with HIV in 2023.

[2] Health Districts are based on 2023 boundaries. Persons are assigned a Health District using their geocoded residence at diagnosis joined to census tract 2020, followed by their ZIP Code if no valid residence at diagnosis was available. The correspondence tables were provided by LAC DPH Information Management and Analytics Office, Office of Health Assessment and Epidemiology, GIS Unit team.

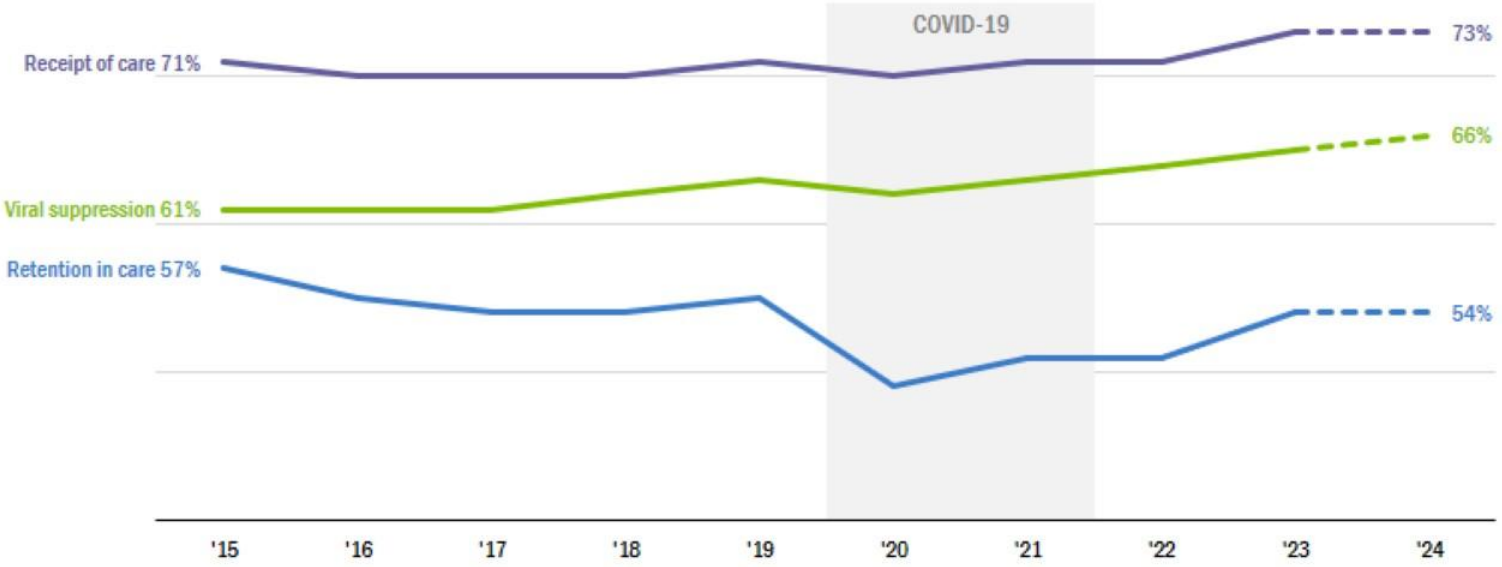
Source: HIV Surveillance data as of December 2024

Receipt of care, retention in care, and viral suppression

- Entering and staying in HIV care is necessary to ensure that adherence to HIV treatment occurs and viral suppression is achieved.
- Identifying disparities allows us to determine whether interventions are needed to help people stay in care, get back in care, and ensure they are taking their medication as prescribed.
- This section presents how LAC performed with respect to receipt of care, retention in care, and viral suppression in 2024 across different populations of PLWDH.

Since 2015, there have been modest improvements in the percent of PLWDH achieving viral suppression (+5 percentage points). The percent of PLWDH retained in care has not rebounded since dropping in 2020, when the COVID-19 pandemic impacted the accessibility of health care services.

Trends in receipt of HIV care, retention in care, and viral suppression for PLWDH aged ≥ 13 years living in LAC at calendar year-end and diagnosed with HIV through the previous calendar year, LAC 2015-2024[1,2]



Abbreviation: PLWDH = persons living with diagnosed HIV

[1] Receipt of care: numerator includes PLWDH with ≥1 CD4/VL/Genotype test in 2024; denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence.

Retention in care: numerator includes PLWDH with ≥2 CD4/VL/Genotype tests at least three months apart in 2024; denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence.

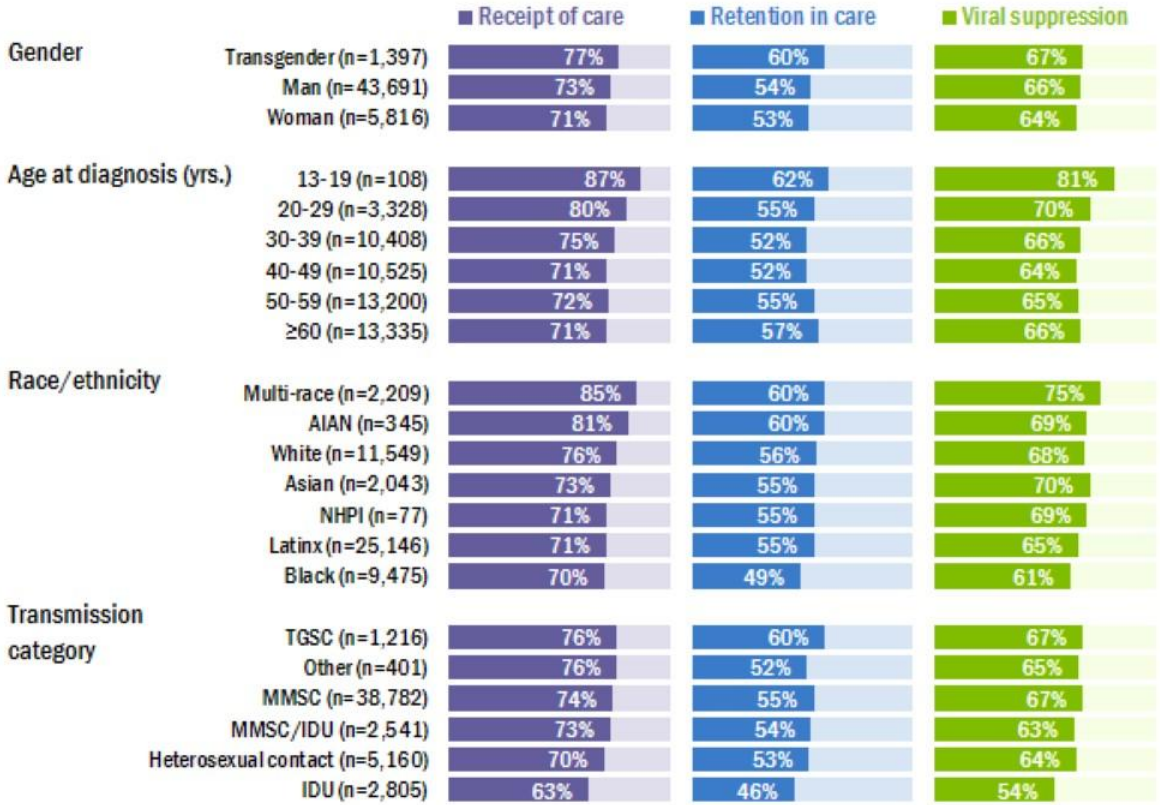
Viral suppression: numerator includes PLWDH whose last VL test in 2024 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence. PLWDH without a VL test in 2024 were categorized as having unsuppressed viral load.

[2] Due to reporting delay, 2024 HIV data are provisional as indicated by the dashed line.

Source: HIV Surveillance data as of December 2024

In 2024, the poorest HIV care outcomes were observed among women, 40–49-year-olds, Black persons, and persons who inject drugs.

Receipt of HIV care, retention in HIV care, and viral suppression by gender, age group, race/ethnicity, and transmission category [1] among PLWDH aged ≥ 13 years diagnosed through 2023 and living in LAC at year-end 2024,[2] LAC 2024



Abbreviation: PLWDH = persons living with diagnosed HIV; AIAN = American Indian and Alaska Natives; NHPI = Native Hawaiian and Pacific Islanders; MMSC = men who have sex with men; IDU = injection drug use; TGSC = transgender persons with sexual contact

[1] Other transmission risk includes perinatal, hemophilia, coagulation disorder, blood transfusion, and risk factor not reported/identified. Persons without an identified risk factor were assigned a risk factor using CDC-recommended multiple imputation methods.

[2] Receipt of care: numerator includes PLWDH with ≥1 CD4/VL/Genotype test in 2024; denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence; retention in care: numerator includes PLWDH with ≥2 CD4/VL/Genotype tests at least three months apart in 2024; denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence.; viral suppression: numerator includes PLWDH whose last VL test in 2024 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence. PLWDH without a VL test in 2024 were categorized as having unsuppressed viral load.

Source: HIV Surveillance data as of December 2024

HIV care continuum indicators showed increased percent of PLWDH who received care, were retained in care, and who were virally suppressed in 2024 after removing 6,602 persons who were not in care for the past 10 years from the assessed population. The difference is most pronounced among women, persons aged ≥50 years, and Latinx persons.

HIV care continuum among persons aged ≥ 13 years among all PLWDH compared to PLWDH who have been out of care for over 10 years, LAC 2024

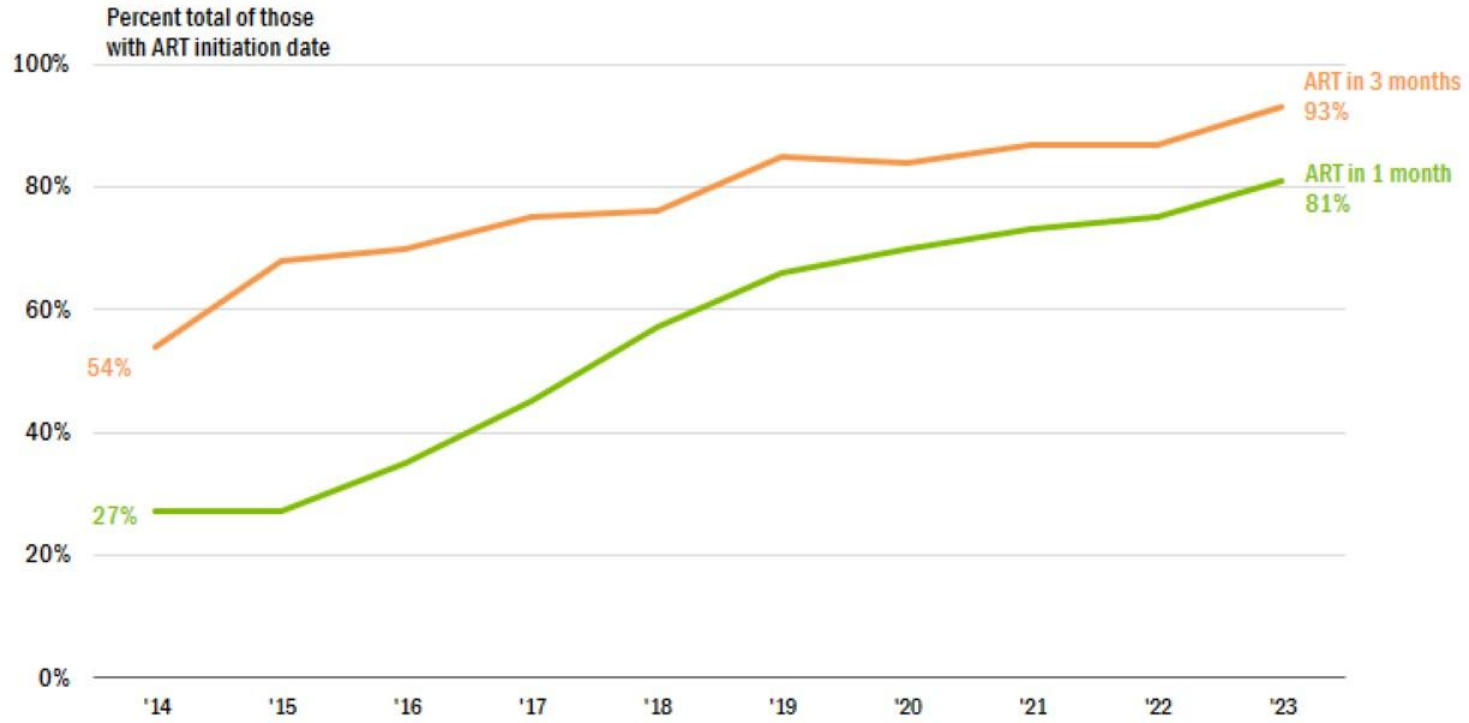
Source: HIV Surveillance data as of December 2024

HIV treatment

- Antiretroviral therapy (ART) coverage is not routinely monitored as a step in the HIV care continuum as treatment is presumed to occur once a patient is linked to care.
- HIV case reporting includes information on ART for PLWDH but relies on HIV providers to complete this information on HIV case reports, which is not commonly done
- To fill this information gap, Public Health collects supplemental information on a subset of persons newly diagnosed with HIV through the National Medical Monitoring Project (MMP) to understand progress and gaps in HIV treatment and other HIV care services for PLWDH.
- In this section, we provide information from HIV case reporting and MMP on the status of treatment among PLWDH in Los Angeles County.

The time from diagnosis to starting HIV treatment is improving. The percent who started ART within 1 month of diagnosis increased from 27% in 2014 to 81% in 2023 and the percent who started ART within 3 months of diagnosis increased from 54% in 2014 to 93% in 2023.

Time from HIV diagnosis to treatment initiation among persons aged ≥ 13 years newly diagnosed with HIV by year of diagnosis, LAC 2014-2023[1]

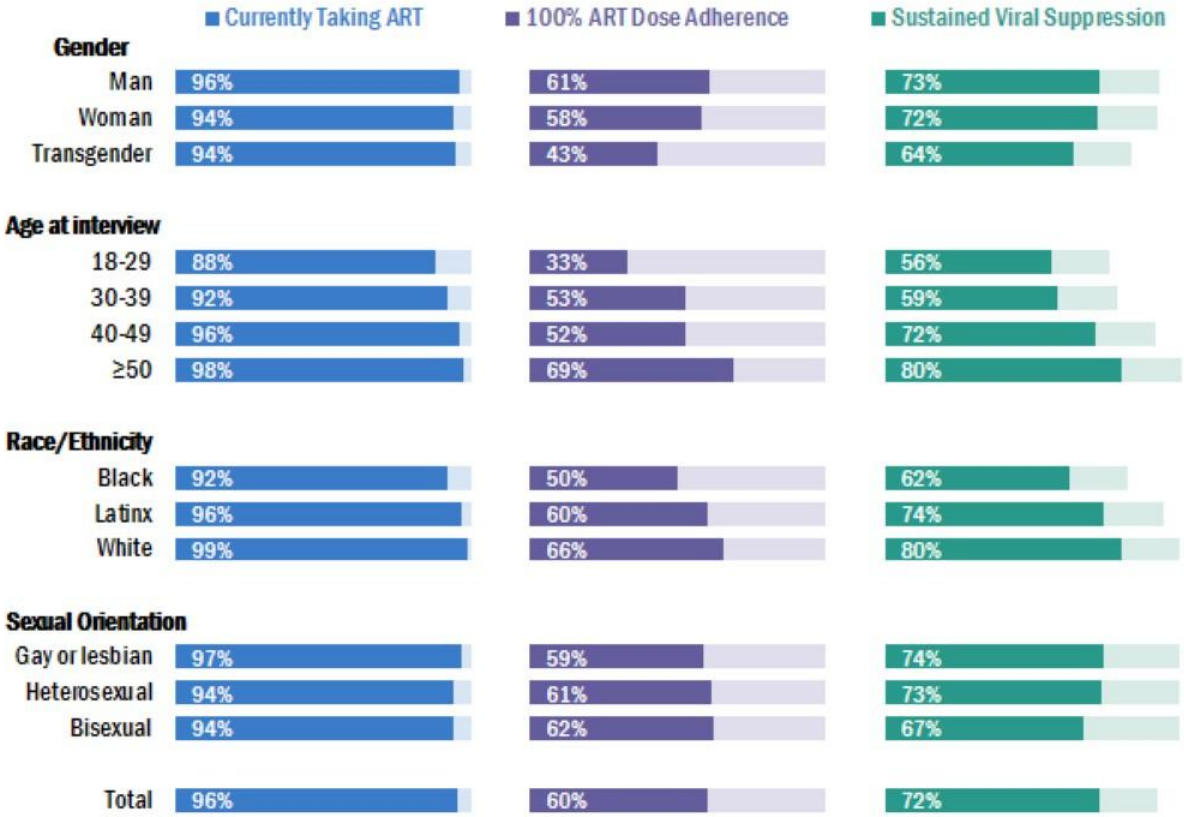


[1] Data represent a subset of persons newly diagnosed with HIV and reported in LAC. It includes 6,966 persons newly diagnosed with HIV between 2014 and 2023 for whom ART initiation date is complete and excludes 10,733 persons newly diagnosed with HIV between 2014 and 2023 for whom ART initiation date is incomplete.

Source: HIV Surveillance data as of December 2024

Younger PLWDH reported lower rates of current ART use, ART adherence, and sustained viral suppression compared with older PLWDH. Similarly, Black and Latinx PLWDH reported lower rates of current ART use, ART adherence, and sustained viral suppression compared with White PLWDH.

Antiretroviral therapy (ART) utilization, ART dose adherence, and sustained viral suppression among PLWDH by selected characteristics—Medical Monitoring Project, LAC 2018-2022[1,2]



[1] 100% ART dose adherence is defined as not missing any doses of HIV medicines within the past 30 days among persons reportedly currently taking ART.
[2] Sustained viral suppression in MMP is defined as having all HIV viral loads being undetectable or <200 copies/mL, as documented in eHARS as well as the medical record within the past 12 months before interview.

Source: HIV Surveillance data as of December 2024

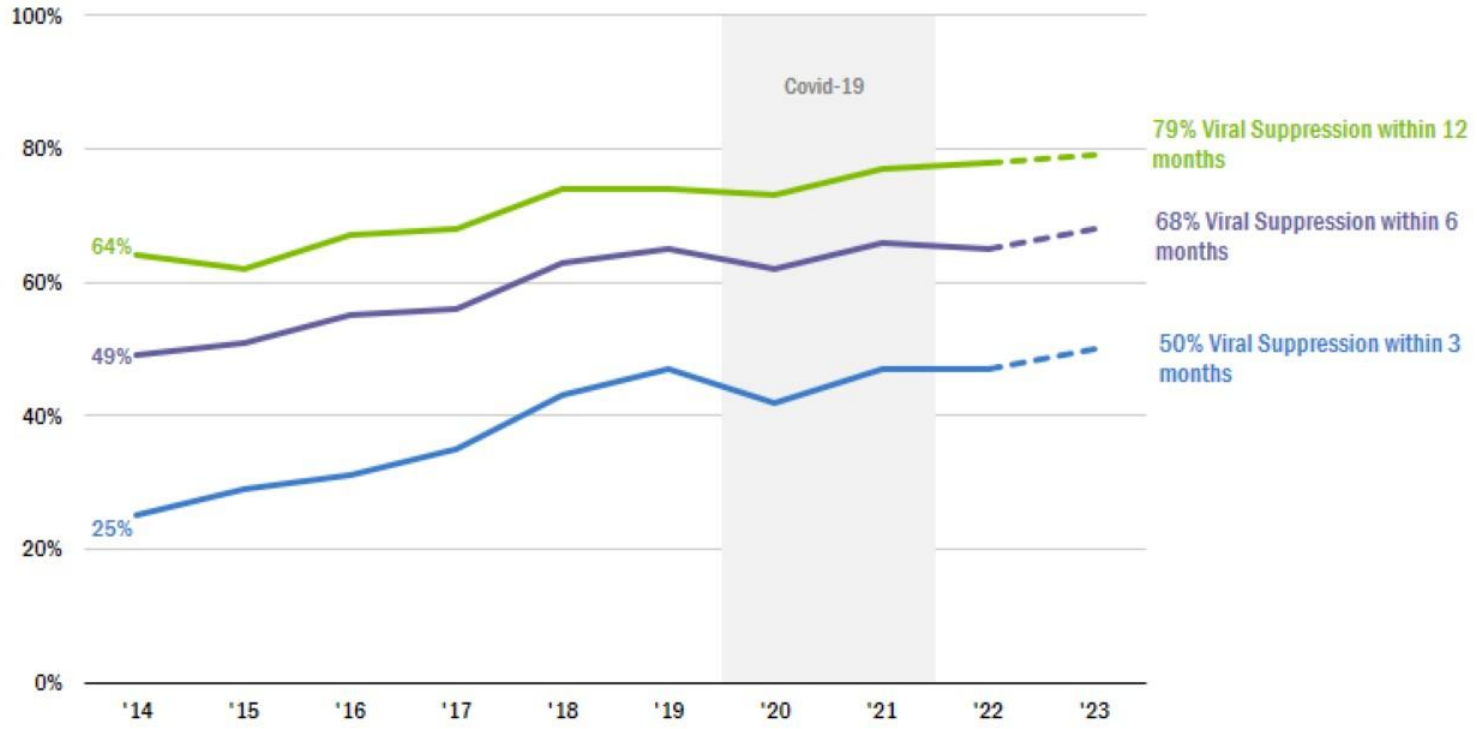
Viral load monitoring

- To end the HIV epidemic, viral suppression should be reached soon after HIV diagnosis for all PLWDH but as described earlier, this is dependent on how rapidly HIV-positive persons are linked into HIV care and receive HIV treatment.

- This section highlights where we are locally in our viral suppression achievements and highlights opportunities for where to target interventions to improve viral suppression in the population.

The time from HIV diagnosis to viral suppression has significantly improved over the past 10 years, from 25% of persons newly diagnosed with HIV in 2014 achieving viral suppression within 3 months to 50% for the same measure in 2023.

Time from diagnosis to viral suppression among persons diagnosed with HIV by year of HIV diagnosis, LAC 2014-2023[1,2]



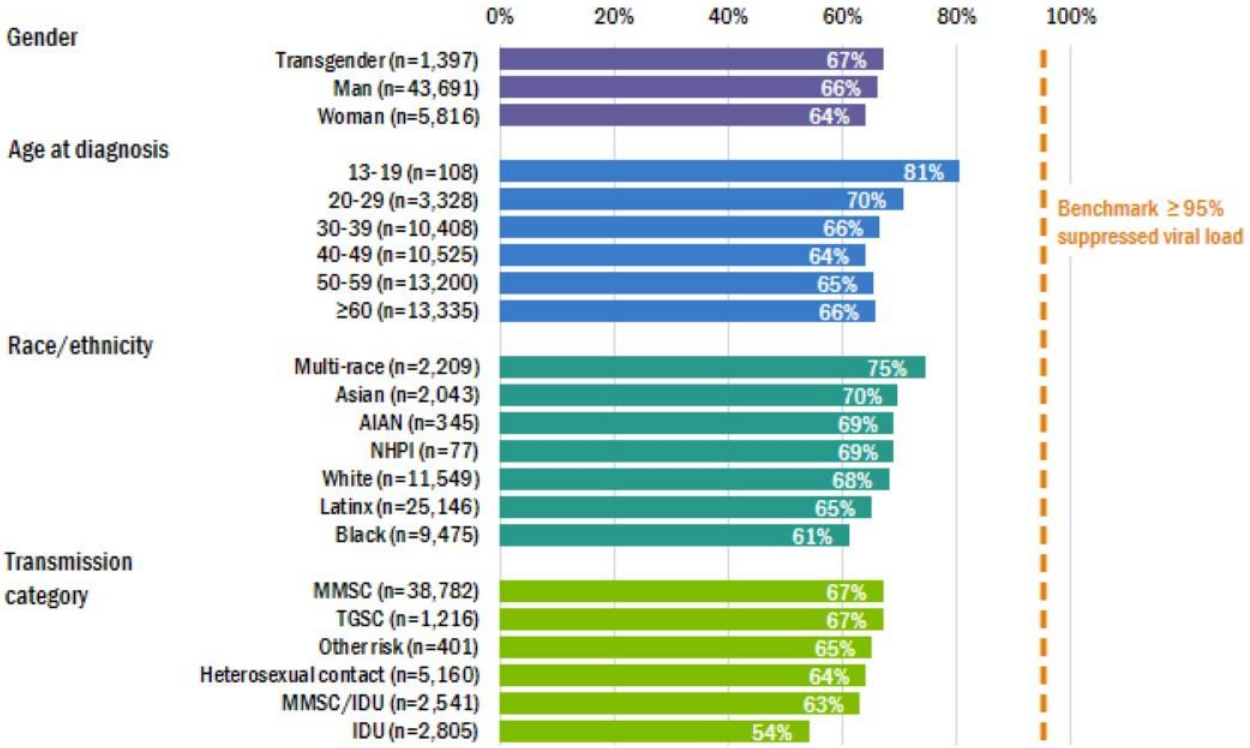
[1] Analysis includes persons newly diagnosed with HIV in each calendar year and living in LAC at the end of the following year. Numerator includes persons who achieved viral suppression within 3, 6, or 12 months of diagnosis. Denominator includes persons newly diagnosed with HIV in each calendar year, with or without a viral load test result in the observed months.

[2] Due to reporting delay, 2023 HIV data are provisional as indicated by the dashed line.

Source: HIV Surveillance data as of December 2024

LAC falls significantly short of reaching the 2025 goal of increasing the percentage of PLWDH who are virally suppressed to 95%. In 2024, the largest disparities were observed among women, persons aged 40-49 years, Black persons, and persons who inject drugs.

Suppressed viral load by selected demographic and risk characteristics among persons aged ≥ 13 years diagnosed through 2023 and living with diagnosed HIV (PLWDH) in LAC at year-end 2024, LAC 2024[1,2]



Abbreviations: AIAN = American Indian and Alaska Natives; NHPI = Native Hawaiian and Pacific Islanders; MMSC = male-to-male sexual contact; TGSC = transgender persons with sexual contact; IDU = injection drug use

[1] Suppressed viral load: numerator includes PLWDH whose last VL test in 2024 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence. PLWDH without a VL test in 2024 were categorized as having unsuppressed viral load.

[2] Other race/ethnicity includes American Indians and Alaska Natives, Native Hawaiian and Pacific Islanders, persons of multiple race/ethnicities, and persons with unknown race/ethnicity. Other risk includes perinatal exposure, hemophilia, coagulation disorder, blood transfusion, and risk factor not reported/identified.

Source: HIV Surveillance data as of December 2024

In 2024, no Health District in LAC achieved the EHE target for viral suppression (95% or higher with suppressed viral load). The Central Health District performed the poorest, with just over half (54%) of PLWDH achieving viral suppression in 2024. In Hollywood-Wilshire, the Health District with the largest number of PLWDH, only 67% of PLWDH were virally suppressed. Health Districts where viral suppression is lower are noted as high risk locations where higher levels of HIV transmission may be occurring.

Suppressed viral load by Health District among persons aged ≥ 13 years diagnosed through 2023 and living in LAC at year-end 2024, LAC 2024[1,2]

Abbreviation: EHE = Ending the epidemic; PLWDH = persons living with diagnosed HIV

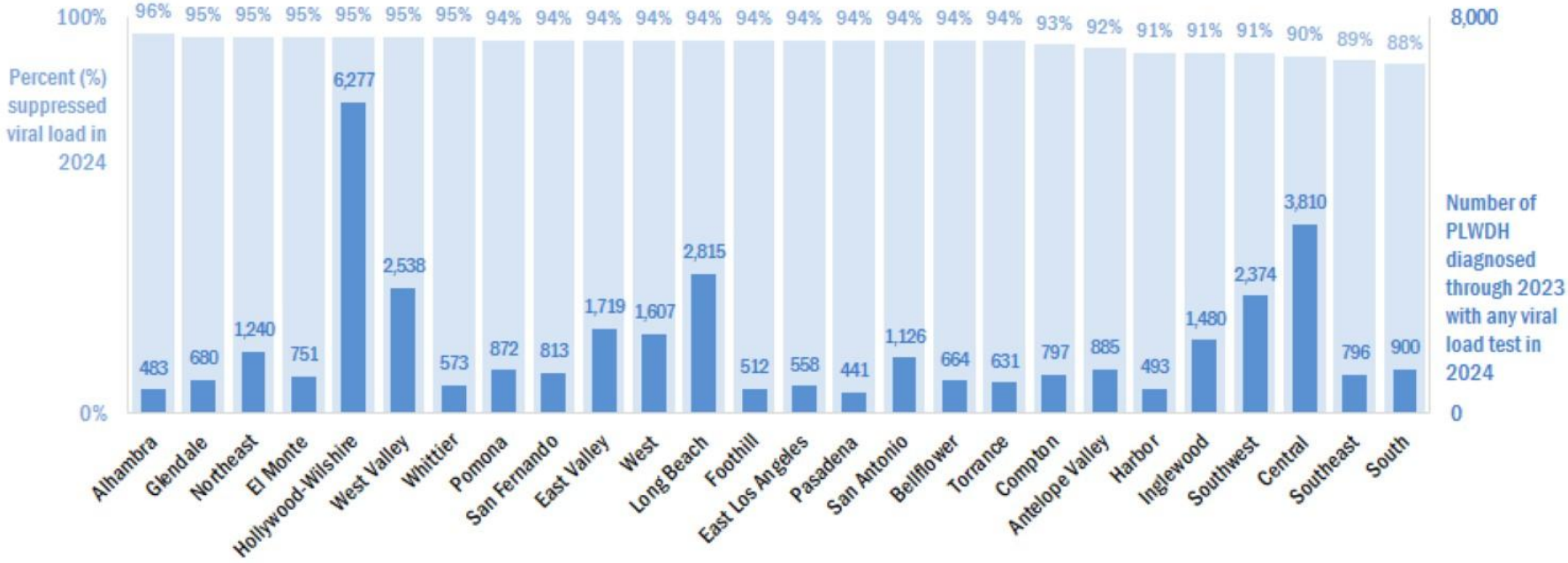
[1] Suppressed viral load: numerator includes PLWDH whose last VL test in 2024 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence. PLWDH without a VL test in 2024 were categorized as having unsuppressed viral load.

[2] Health Districts are based on 2023 boundaries. Persons are assigned a Health District using their geocoded residence at diagnosis joined to census tract 2020, followed by their ZIP Code if no valid residence at diagnosis was available. The correspondence tables were provided by LAC DPH Information Management and Analytics Office, Office of Health Assessment and Epidemiology, GIS Unit team.

Source: HIV Surveillance data as of December 2024

Once in care, the goal is for all PLWDH to achieve viral suppression as soon as possible. In 2024, most Health Districts had at least 90% of PLWDH within their boundaries who were virally suppressed. However, the South and Southeast Health Districts lagged behind, with the lowest viral suppression percentages among PLWDH in 2024 at 88% and 89%, respectively.

Suppressed viral load by Health District among persons aged ≥ 13 years receiving HIV care and who had a viral load test in 2024, LAC 2024[1,2]



Abbreviation: PLWDH = persons living with diagnosed HIV

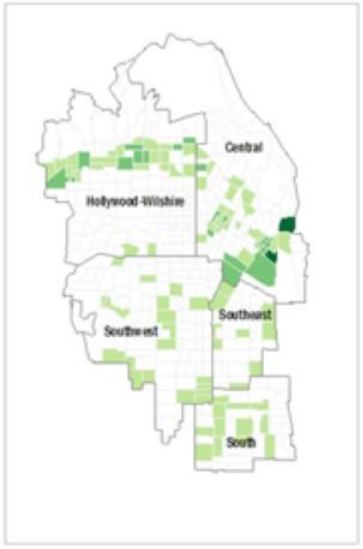
[1] Suppressed viral load: numerator includes PLWDH whose last VL test in 2024 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence who had any viral load test in 2024. PLWDH without a VL test in 2024 were categorized as having unsuppressed viral load.

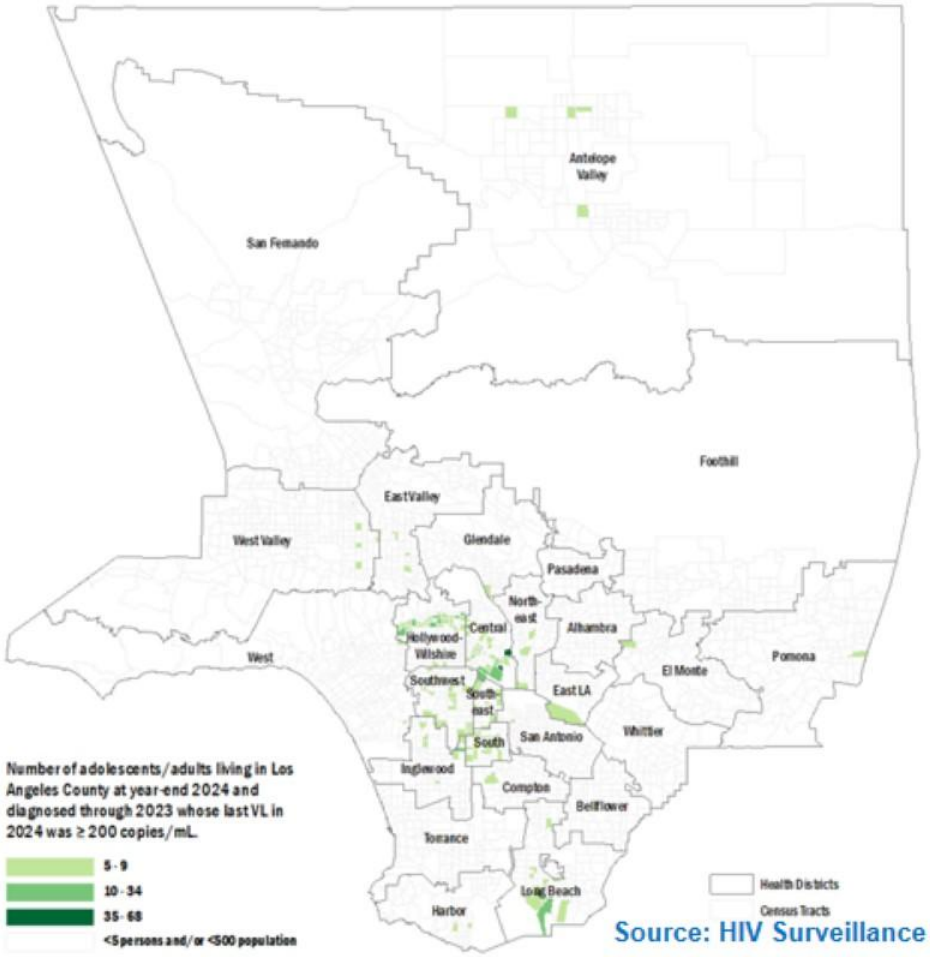
[2] Health Districts are based on 2023 boundaries. Persons are assigned a Health District using their geocoded residence at diagnosis joined to census tract 2020, followed by their ZIP Code if no valid residence at diagnosis was available. The correspondence tables were provided by LAC DPH Information Management and Analytics Office, Office of Health Assessment and Epidemiology, GIS Unit team.

Source: HIV Surveillance data as of December 2024

Census tracts located in the Central and Hollywood-Wilshire Health Districts had the highest levels of unsuppressed viral load. These are locations where a robust public health response is needed to 1) identify networks of ongoing transmission and 2) deploy rapid interventions to minimize transmission. Other emerging hotspots of transmission that require close monitoring are in the Southwest, Southeast, South, and Long Beach Health Districts. We have zoomed in on the six HDs with the highest levels of unsuppressed VL in the maps to the left.

Unsuppressed viral load by census tract among persons aged ≥ 13 years diagnosed through 2023 and living with diagnosed HIV in LAC at year-end 2024 (N=1,269), LAC 2024[1]

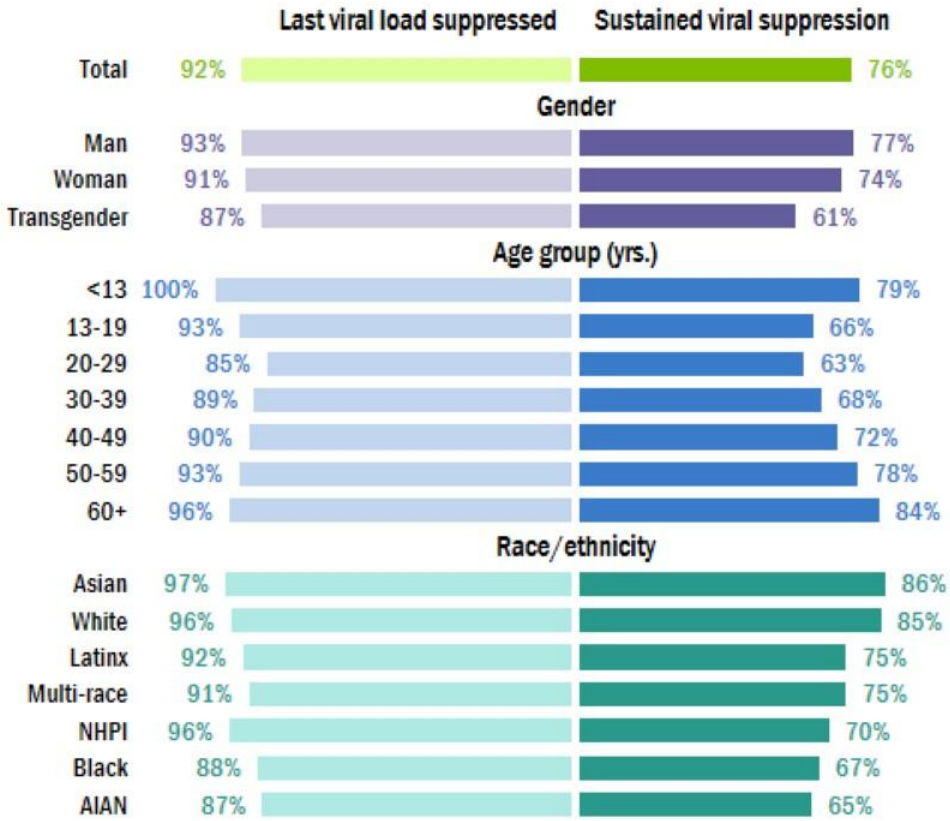




Source: HIV Surveillance data as of December 2024

Among PLWDH who had a viral load test done in 2022-2024, 76% achieved sustained viral suppression over this 3-year period. Transgender persons , younger persons (aged 13-39 years), and AIAN and Black persons had the lowest percentages of sustained viral suppression.

Viral load dynamics among persons living with diagnosed HIV and receiving HIV care, LAC 2022-2024[1]



Viral load dynamics: Among persons living with diagnosed HIV in LAC who are in care, if we only consider the last viral load test to determine viral suppression, the resulting viral suppression estimate is 92%. However, if we consider all of their viral load tests over the previous 3-years, the resulting sustained viral suppression estimate (i.e., all viral loads suppressed) is 76%. Sustained viral suppression offers a more robust and realistic assessment of treatment success. In this graph, we define sustained viral suppression based on a person's viral load results over a 3-year period while viral suppression is based only on a person's most recent viral load results in the relevant calendar year.

Abbreviations: AIAN = American Indian and Alaska Natives; NHPI = Native Hawaiian and Pacific Islanders

[1] Analysis includes 34,952 persons diagnosed with HIV through 2021, had ≥ 1 viral load test in 2022-2024 and living in LAC during 2022-2024. "Sustained viral suppression" is defined for any PLWDH included this analysis with all reported viral load test results as undetectable or <200 copies/mL during the 3-year period. The last graph shown does not include 17 persons whose racial/ethnic information is unknown.

Source: HIV Surveillance data as of December 2024

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