2024

Los Angeles County

Annual HIV Surveillance Report

Division of HIV and STD Programs
Department of Public Health
County of Los Angeles

County of Los Angeles
Public Health
Division of HIV and STD Programs

COUNTY OF LOS ANGELES
Public Health

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December 2025

Dear Colleague:

On June 5, 1981, more than forty-four years ago, the United States Centers for Disease Control and Prevention (CDC) published a *Morbidity and Mortality Weekly Report* that described a rare lung infection among a cluster of gay men in Los Angeles which would later be known as the first cases of Acquired Immune Deficiency Syndrome (AIDS), a disease caused by the Human Immunodeficiency Virus (HIV). Since then, HIV has ravaged the globe with devastating impact. Worldwide, an estimated 91.4 million people have been infected with HIV and nearly 44.1 million people have died from AIDS-related illness. In 2024, approximately 630,000 people died from HIV and an estimated 1.3 million people became newly infected with HIV.

Although the end of AIDS is within grasp, the trajectory remains uncertain. UNAIDS has argued that AIDS is currently at a crossroads, "as cuts in resourcing and a rising anti-rights push endanger the progress that has been made."

We are releasing the *2024 Los Angeles County Annual HIV Surveillance Report.* This report provides community and academic partners, public health planners, policymakers, and other stakeholders with insights into the evolving HIV epidemic in Los Angeles County. The report also describes achievements in our shared public health response to HIV, outlines opportunities for improving our response, and offers critical data points to facilitate decision-making to achieve our shared *Ending the HIV Epidemic* goals.

The report includes HIV surveillance data reported to the Department of Public Health since the beginning of the HIV epidemic through December 31, 2024. Also included are annual estimates of the number of people newly infected with HIV and the number of people living with HIV based on the CDC's CD4 depletion model.

The main findings from this report are outlined in an Executive Summary. Additional context for the epidemiologic and surveillance findings are described in detail in the various sections of the report. The *Data to Action* summary is presented at the end of each section to contextualize programmatic and policy implications for the local response to HIV.

Importantly, our surveillance data highlight disparities in HIV outcomes across race and ethnicity, age, gender, and key populations. These findings reinforce the need to better understand the social and structural drivers of these inequities to ensure that health systems are strengthened for populations that experience challenges in access to and use of healthcare services and who are at greatest risk for poor health outcomes.

The Division of HIV and STD Programs continues to work in full partnership with a broad cross-section of community partners and stakeholders to shape programs and services to meet the evolving needs of populations that are most vulnerable to HIV. These efforts are done in coordination and alignment with the goals for *Ending the HIV Epidemic* in Los Angeles County by 2030. The current program priorities include enhancing HIV testing and screening efforts to ensure that we diagnose all persons with HIV as early as possible; characterizing the intersections of HIV and STD disease to maximize prevention and care; providing rapid and high-quality treatment for all persons living with HIV so that they achieve sustained viral suppression; implementing high impact interventions to prevent new HIV transmissions, and; identifying and characterizing foci where HIV is being transmitted so that we can respond quickly and provide services to populations that need them the most.

The *2024 Los Angeles County Annual HIV Surveillance Report,* is available at: http://publichealth.lacounty.gov/dhsp/Reports/HIV/2024AnnualHIVSurveillanceReport.pdf under the Reports link. We hope that you find this report helpful and look forward to our continued collaboration and partnership to end the HIV epidemic in Los Angeles County.

Sincerely yours,

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This report is inclusive of all gender, age, and racial and ethnic categories in Los Angeles County (LAC). Due to small numbers of diagnosed HIV infections and/or small population sizes of some subgroups in LAC, (e.g. data for children aged <13 years, transgender persons, Native Hawaiians and Other Pacific Islanders, American Indians and Alaska Natives) the rates and percentages presented for these subgroups in this report may be unreliable. Furthermore, cell sizes of less than 5 are suppressed so as to protect the privacy of diagnosed HIV cases by minimizing the risk of re-identification.

Notice to Health Care Providers and Laboratories Responsible for Disease Reporting

California Code of Regulations, Title 17, Section 2500 requires that all diagnosed or suspected cases of AIDS as defined by CDC must be reported within seven (7) days to the Health Officer. California Code of Regulations, Title 17, Section 2600/2641.5-2643.20 require both health care providers and laboratories to report HIV cases by name to the Health Officer within seven (7) days. In addition, Senate Bill (SB) 1184 requires each clinical laboratory to report all CD4+ T-cell tests within seven (7) days of completing a CD4+ T-cell test. 17 CCR 2500(h) and (k).

Acute HIV Reporting: Effective June 2016, Title 17 CCR 2500(h) and (k) requires all health care providers report cases of acute HIV within one (1) working day to the local health officer of the jurisdiction in which the patient resides by telephone. If evidence of acute HIV is based on presence of HIV p24 antigen, providers shall not wait until HIV-1 RNA is detected before reporting to the local health officer. To report an acute HIV case, please call (213) 351-8516.

For more information on HIV reporting requirements, obtain a copy of HIV case report forms, or report an HIV case, please visit: http://publichealth.lacounty.gov/dhsp/ReportCase.htm#HIV_Reporting_Information or contact the Division of HIV and STD Programs, 600 South Commonwealth Avenue, Suite 1003, Los Angeles, CA 90005. Phone (213) 351-8516.

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AIAN	American Indian and Alaska Native
ART	Antiretroviral therapy
COVID-19	Coronavirus Disease 2019
CDC	Centers for Disease Control and Prevention
DHSP	Division of HIV and STD Programs
eHARS	Enhanced HIV/AIDS Reporting System
EHE	Ending the HIV Epidemic
HET	Heterosexuals at increased risk for HIV
HIV	Human Immunodeficiency Virus
HUD	U.S. Department of Housing and Urban Development
IDU	Injection Drug Use
LAC	Los Angeles County
Mpox	an infectious disease caused by the monkeypox virus
MMSC	Male-to-Male sexual contact
MSM	gay, bisexual, and other Men who have Sex with Men
NHBS	National HIV Behavioral Surveillance
NHPI	Native Hawaiian and Pacific Islander
OMB	Office of Management and Budget
PEP	Post-Exposure Prophylaxis
PLWH	Persons Living with HIV
PLWDH	Persons Living with Diagnosed HIV
PWDH	Persons with Diagnosed HIV
PrEP	Pre-Exposure Prophylaxis
PWID	Persons Who Inject Drugs
SPA	Service Planning Area
TDRM	Transmitted Drug Resistant Mutation
TG	Transgender Person(s)
TGSC	Transgender Persons with Sexual Contact
US	United States
VL	Viral load

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Executive Summary

The 2024 Los Angeles County Annual HIV Surveillance Report describes the status of the local HIV epidemic and demonstrates the use of HIV surveillance data to inform prevention, care, and treatment programs in Los Angeles County.

The report includes information on persons living with diagnosed HIV (PLWDH) collected from mandated HIV case reporting and population-based surveys conducted among key populations at increased risk for HIV or among PLWDH. HIV case reporting data reflect information from reports received by the Department of Public Health for PLWDH from the beginning of the HIV epidemic through December 31, 2024. Population-based surveys include Los Angeles County data collected for the CDC-funded HIV Behavioral Surveillance System from 2004 to 2024 and Medical Monitoring Project from 2015 to 2022 (collected from June 2015 through June 2023). The most notable change from prior reports is our approach to presenting data on HIV Transmission Categories. This year we have included an additional category "Transgender Persons with Sexual Contact" (TGSC). This category includes any individual who is documented as ever identifying as transgender and who reports ever having sex with another person, irrespective of the person's sex or gender. Prior to this addition, transgender persons were grouped into one of the following transmission categories (HET; Heterosexual Contact, IDU: Injection Drug Use, MSM: Men who have sex with Men, and MSM/IDU), based on their sex listed at birth and their reported sexual behavior and injection drug use. Note that due to data limitations, individuals who do not identify as transgender but have transgender sexual partners remain undifferentiated by our updated approach to presenting Transmission Categories.
Those who read our 2023 report will appreciate that we have once again included figures and tables that we limit to only LAC PLWDH who could reasonably be expected to be within the reach of our programs and services. These are cases who have interacted with the healthcare system at least once within the previous 10 years. This addition provides a juxtaposition to our historically conservative approach of including in our HIV outcome evaluations, persons who were diagnosed with HIV in LAC over a decade ago who have most likely left the US permanently or are deceased and as such cannot be reasonably expected to be impacted by our programs and services.

The report is divided into four sections: (1) HIV Epidemic Monitoring; (2) Vulnerable Populations; (3) HIV Surveillance to Partner Services Continuum; and (4) HIV Care Continuum. At the end of each section, a Data to Action summary is included to discuss program and policy implications for the data presented. We summarize key findings for the four sections below and provide hyperlinks to the referenced Tables and Figures.

Report changes

The 2024 Los Angeles County Annual HIV Surveillance Report includes new data reports on:

- Interest in and preferences for Long-Acting PrEP Modalities among HIV-Negative NHBS-MSM participants, LAC 2023 (**Figure 36**)
- Injection drug use behavior and sex exchange among NHBS-PWID participants by age group, LAC 2018, 2022 and 2024 (**Figure 42**)
- Factors associated with fentanyl injection in past 12 months among NHBS-PWID participants, LAC 2024 (**Figure 39**)
- HIV care and treatment among NHBS-Transgender women 2019 vs. 2023, LAC (**Figure 49**)
- Change in PrEP use among Latinx and Black NHBS-Transgender women, LAC 2019 vs. 2023 (**Figure 50**)
- Hormone Therapy and Gender Affirmation among NHBS-Transgender women by race/ethnicity, LAC 2023 (**Figure 51**)
- Lifetime prevalence of syphilis (**Figure 52**) and awareness of syphilis status among NHBS-Transgender women by race/ethnicity, LAC 2023 (**Figure 53**)

- Utilization of HIV/STD prevention services and awareness of Undetectable=Untransmittable (U=U) among sexually active PLWDH- Medical Monitoring Project, LAC 2018-2022 (**Figure 55**)
- Percentage of PLWDH reporting at least one unmet need within the past 12 months by category- Medical Monitoring Project, LAC 2018-2022 (**Figure 56a**)
- Percentage of PLWDH who received or had unmet needs for HIV support services, non-HIV medical services, subsistence services and additional local services within the past 12 months- Medical Monitoring Project, LAC 2018-2022 (**Figure 56b-55e**)
- Percentages of linkage to care within 1 month and viral suppression within 6 months of HIV diagnosis among adults aged ≥ 18 years, by federal poverty level, education level, median household income, health insurance coverage, and Gini Index—census tract level, LAC 2023 (**Figure 64**)

Key findings in HIV epidemic monitoring

- As of year-end 2024 there were a total 52,130 persons (adolescent, adult and pediatric cases) *living with diagnosed HIV* in LAC (**Figure 2**). This does not include *undiagnosed* persons living with HIV.
- As of year-end 2024 there were 52,112 persons aged ≥ 13 years living with diagnosed HIV in LAC (**Table A1.a**).
- Males are disproportionately impacted by HIV in LAC (**Figure 5**).
- In 2023, 1,635 persons aged 13 years and older were *newly diagnosed* with HIV, down from 1,649 persons in 2022 (**Table A3**). Nine percent of persons with a new HIV diagnosis in 2023 were classified as having acute HIV (i.e., infected within 60 days prior to HIV diagnosis). In contrast, 18% were classified as stage 3 (i.e., late stage HIV) at the time of diagnosis (**Table 3**).
- *An estimated 1,400 (95% confidence interval [CI]: 880 - 1,800) persons aged 13 years and older acquired HIV in 2023* (**Table 1**). New HIV infections, or "HIV incidence," is different from the number of people diagnosed with HIV during a year. Some people may have HIV but not know it (**Figure 13**). Notably, estimates are not considered true values and should be interpreted along with a range of values that are likely to contain the true value with a certain degree of confidence (such as a 95% confidence interval). In 2023, the 95% confidence interval for the estimated number of new infections ranged from a low of 880 infections to a high of 1,800 infections (**Table 1**).
- As of year-end 2023, an estimated 56,600 (95% CI: 54,900 – 58,400) persons aged 13 years and older were *living with HIV in LAC*. Among these, an estimated 4,900 (95% CI: 3,200 – 6,700) were *unaware of their infection* (**Figure 14**). As noted above, estimates are not true values and should be carefully considered with the 95% confidence interval in mind.
- There are disparities in HIV diagnosis by population and location. Rates of new HIV diagnosis are higher among males (34/100,000) than females (5/100,000) (**Figure 6**).
- Among males, the highest rates of HIV diagnoses were in Metro SPA, but rates were also elevated in South SPA. Among females, the highest rates were in Southwest Health District within South SPA and in Central Health District within Metro SPA (**Table A2.a, Table A2.b**). Among males, 2023 HIV diagnosis rates were highest in 20-39 year olds while among females rates were highest in 30-49 year olds. (**Figure 7**, **Figure 10**).
- Black persons had higher rates of HIV diagnosis compared with all other racial and ethnic groups (**Figure 8**, **Figure 11**).
- In 2023, 20% of newly diagnosed LAC HIV cases for whom eligible genotyping sequences were available exhibited laboratory evidence of resistance to one or more antiretroviral drugs. Of the three major drug classes, transmitted drug resistance continues to be highest in non-nucleoside reverse transcriptase inhibitors (NNRTI) (**Figure 19**).
- In 2023, 3% of people newly diagnosed with HIV in LAC were determined by molecular HIV surveillance to be part of a high priority transmission cluster where rapid HIV transmission could be occurring (**Figure 20**).

- Overall death rates for PLWDH have declined to 14 per 1,000 PWDH. Rates of death due to HIV have fallen below rates of death due to non-HIV-related causes for the past decade (**Figure 21**). In 2023, approximately three in four deaths among PLWDH were due to non-HIV related causes.

Key findings for vulnerable populations

- From 2023-2024, 92% of pregnant women living with diagnosed HIV received at least one form of ART during pregnancy and/or during labor and delivery (**Figure 25**). There have been 2 perinatally infected infants born in LAC since 2021 (**Figure 23**).
- Persons living with diagnosed HIV who are unhoused continue to experience suboptimal outcomes along the HIV care continuum. Compared with housed persons, unhoused persons had lower rates of receiving HIV care, retention in care, and achieving viral suppression in 2024 (**Figure 70**).
- HIV biobehavioral surveys in LAC confirm that in 2023 transgender (TG) women had the highest HIV prevalence (40%) compared with other populations at elevated risk for HIV. MSM also had high prevalence (17%) while persons who inject drugs (PWID) (3%) and heterosexual persons (HET) (<1%) had lower HIV prevalence (**Figure 28**).
- PrEP uptake within the previous 12 months among LAC MSM increased from 29% in 2017 to 50% in 2023, successfully meeting the EHE target of 50%. In 2023, among LAC MSM who reported being HIV-negative, 62% of White MSM reported taking PrEP compared with 48% of Black MSM and 45% of Latinx MSM (**Figure 30**); Among those who reported being on PrEP, adherence to daily PrEP was high, with 80% reporting fewer than 4 missed days of PrEP in the past 30 days (**Figure 33**).
- DoxyPEP, as a targeted intervention for bacterial STIs, has the potential to reduce STI acquisition and transmission. In a recent local study in 2024, 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, and 19% had used DoxyPEP in the 12 months prior to the interview (**Figure 34**).
- Among HIV negative NHBS-MSM participants in 2023 (n=444), over half (54%) were interested in taking Long-Acting PrEP and 2% reported they were already taking long-acting PrEP (**Figure 35**).
- From 2009 to 2024, the prevalence of methamphetamine injection among PWID increased significantly from 29% to 84%, surpassing heroin use in 2022 and continuing to rise (**Figure 37**). In the most recent PWID cycle in 2024, 41% of participants reported injecting fentanyl and 21% reported injecting xylazine in the past 12 months.
- Between 2022 and 2024 fentanyl use among PWID increased, with fentanyl injection rising from 24% to 41% and fentanyl smoking increasing from 38% to 55%. (**Figure 38**). Fentanyl injection was more prevalent among White and Latinx PWID and was strongly associated with syringe sharing, hepatitis C infection, and recent overdose (**Figure 39**). NHBS-PWID 2024 data also showed substantial overdose risks with 29% reporting opioid overdose, 42% stimulant overamping and 16% reporting both in the past 12 months (**Figure 41**).
- TG women disproportionately experience social marginalization and discrimination. Among 593 participants in the NHBS-Trans 2023 survey, 55% had experienced physical violence, verbal abuse or sexual assault within the past year. Sixty-five percent reported transgender specific discrimination. including employment discrimination (45%) and housing eviction or denial (17%).
- Over the past 5 years, PrEP use increased significantly among Latinx TG women (+61%) but declined among Black TG women (-11%), indicating growing racial disparities and highlighting the need for targeted interventions (**Figure 50**).
- Lifetime syphilis exposure among TG women is high (54%), especially among Black, HIV-positive, methamphetamine users, and those with hepatitis C (**Figure 52**). Alarmingly, 32% of those testing positive for syphilis were unaware of their infection status (**Figure 53**).

- Among a representative sample of PLWDH, most sexually active PLWDH did not commonly engage in high-risk sexual activity. The most utilized prevention strategy reported by this group was having sex while virally suppressed (**Figure 54**).
- Among a representative sample of PLWDH, 1 in 3 reported needing an HIV ancillary service within the past 12 months but did not receive it. The most commonly reported unmet needs were dental care (16%), shelter or housing services (9%), and mental health services (8%) (**Figure 56a-Figure 56e**).
- In 2023, 42% of people newly diagnosed with HIV were diagnosed with an STD in the same year as their HIV diagnosis (**Figure 59**). Co-infection with HIV and syphilis was more common than co-infection with HIV and gonorrhea or chlamydia (**Figure 60**).

Key findings in HIV surveillance to Partner Services continuum

- In 2023, 73% of persons newly diagnosed with HIV were assigned for a Partner Services index case interview and 74% of these persons were interviewed. Of all persons newly diagnosed with HIV in LAC in 2023, 54% completed an index case partner services interview (**Figure 65**).
- The Ending the HIV Epidemic (EHE) target for Partner Services is for 85% of newly diagnosed persons to be interviewed by Partner Services staff within 7 days of HIV diagnosis. Only 15% of persons newly diagnosed with HIV were interviewed within this 7-day window, while 64% were interviewed within 30 days and 86% were interviewed within 60 days (**Figure 66**).
- Of the partners that were named during the index case interview, 92% were located. Among those partners located, 44% were HIV-positive and 26% were HIV-negative. Unknown testing status accounts for the remaining 29% About half of HIV-positive partners had been previously diagnosed with HIV, and among those newly diagnosed with HIV through Partner Services, 53% were linked to care (**Figure 67**).

Key findings in the HIV care continuum

- The EHE target for linkage to care is that 95% of PLWDH are linked to care within 1 month of HIV diagnosis. In 2023, among persons aged ≥ 13 years with newly diagnosed HIV, 55% were linked to care within 7 days and 79% were linked within 1 month of diagnosis (**Figure 71**).
- Populations with the lowest linkage to care within 1 month were men, persons of "other" race/ethnicities, persons aged 50 to 59 years, and persons whose transmission risk was Injection Drug Use (**Figure 72**).
- Once people diagnosed with HIV are linked to HIV care, performance along the HIV care continuum leaves room for much improvement. In 2024, 7 in 10 PLWDH received care services, 5 in 10 were retained in care, and 6 in 10 were virally suppressed (**Figure 68**).
- Timeliness from HIV diagnosis to treatment initiation has improved over time but still needs improvement. Among persons newly diagnosed with HIV in 2023 with treatment information included in their case reports, 81% had initiated treatment within 1 month of diagnosis and 93% within 3 months of diagnosis (**Figure 77**).
- The time from HIV diagnosis to viral suppression has significantly improved over the past decade with the proportion of persons newly diagnosed with HIV in 2014 who had achieved viral suppression within 3 months of diagnosis improving from 25% in 2014 to 50% in 2023. (**Figure 79**).
- The lowest levels of viral suppression were among Black persons, women, persons aged 40-49 years, and persons whose transmission risk included injection drug use (**Figure 80**).
- By geographic area, suppressed viral load was lowest in the Central Health District, followed by the South, Southeast, Harbor, West, and Northeast Health Districts (**Figure 81**).
- In a representative sample of PLWDH, 100% ART adherence and sustained viral suppression were lower among younger age groups compared with older age groups, as well as lower in Black and Latinx PLWDH compared to White PLWDH (**Figure 78**).

Progress towards national Ending the HIV Epidemic goals

- **New HIV infections:** An estimated 1,400 new infections occurred in LAC in 2023. This highlights the significant gap between current levels and the 2025 EHE target of no more than 380 new infections per year (Table 1).
- It is important to note that the number of new diagnoses is expected to remain high until we have far fewer persons living with undiagnosed HIV and far fewer persons with newly acquired HIV each year. **New HIV diagnoses:** 1,635 persons were newly diagnosed with HIV in 2023 (Table 1).
- **Knowledge of HIV-positive status:** An estimated 91% of persons living with HIV were aware of their HIV status in 2023, which is 4 percentage points below the 2025 EHE target of 95% (Table 1).
- **Linkage to HIV care:** 79% of persons newly diagnosed with HIV in 2023 were linked to care within 1 month, falling 16 percentage points below the 2025 EHE target of 95% (Table 1).
- **Viral suppression:** Only 66% of PLWDH in 2024 were virally suppressed, falling 29 percentage points below the 2025/2030 EHE target of 95% (Table 1).
- PrEP use varied among different NHBS populations, with the highest uptake observed among MSM (50% in 2023 survey) (**Figure 30**) and the lowest among PWID (0.8% in 2022 survey) (not shown). Within the MSM group, PrEP use differed by race/ethnicity. Recent data shows that an estimated 62% of White MSM reported using PrEP, meeting the EHE benchmark for PrEP use. Separately, Black (48%) and Latinx (45%) MSM are showing promising progress towards reaching the 50% benchmark.

Ending the HIV Epidemic in Los Angeles County

Ending the HIV Epidemic in the US (EHE) is a federal plan, launched in 2020, that aims to reduce new HIV infections in the US by 75% by 2025 and by 90% by 2030 compared with 2017 levels. In February 2020, the US Department of Health and Human Services awarded 57 high burden states and counties, inclusive of LAC, with grants to expand HIV prevention and care activities to accelerate progress towards achieving the national EHE goals.

Ending the HIV Epidemic in LAC focuses on four key pillars of diagnosing, preventing, treating, and responding to HIV. Within these pillars, LAC Public Health is committed to a local response that is high quality and rapidly deployed, prioritizing the highest impact interventions to optimize performance along the steps of the HIV care continuum, and using local evidence at the most granular level possible to identify where and among whom HIV is transmitted so that we can then target interventions to where they are needed most.

In Table 1, we list the key metrics that are being tracked to measure progress towards targets in the EHE initiative and progress to date in LAC. The forthcoming sections in this annual report provide additional detail to contextualize LAC achievements and identify where we need to improve HIV prevention and care activities to meet our set targets, reduce HIV transmission, and ensure that all Angelenos living with HIV can live long and healthy lives.

Table 1: 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 1 month of diagnosis[2]	95%	95%	79% (2023)
Percentage of 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. Estimates are based on the CD4-Based Model v6.0 developed by CDC.

[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.

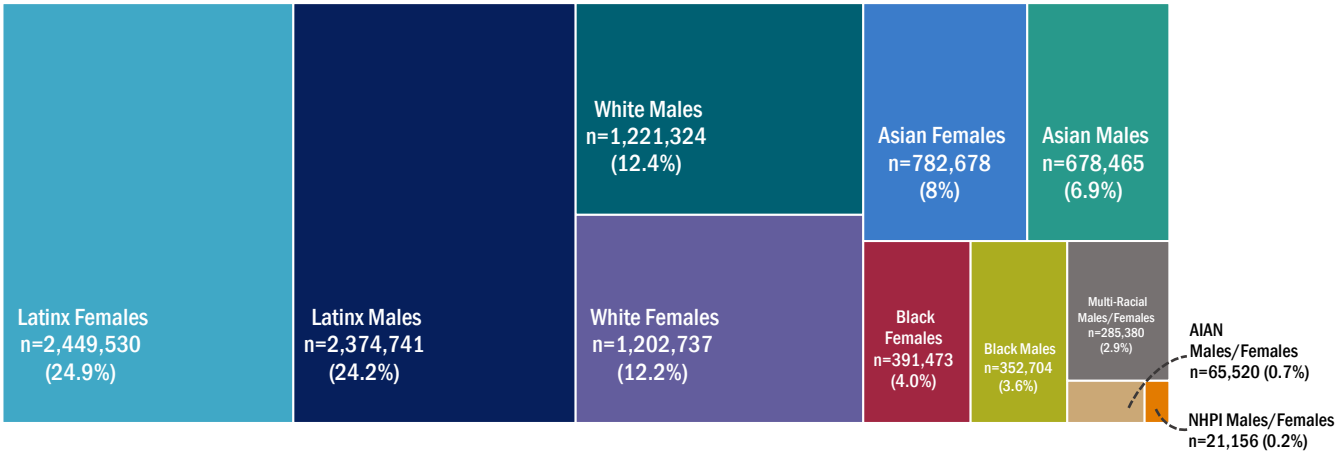
HIV Epidemic Monitoring

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

An estimated 9.8 million people resided in LAC in 2023. Latinx males and females represented 24% and 25% 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.

Figure 1: Distribution of sex listed at birth[4] and race/ethnicity[5] among LAC residents in 2023

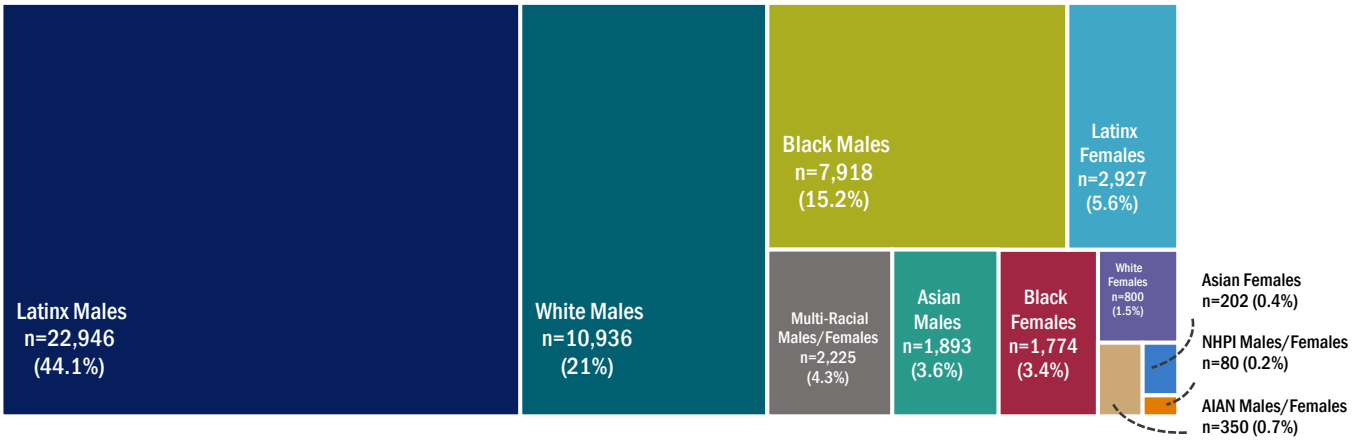
Population Size=9,825,708



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).

Figure 2: Distribution of sex listed at birth[4] and race/ethnicity[5] among persons living with diagnosed HIV at year-end 2024, LAC

PLWDH=52,130

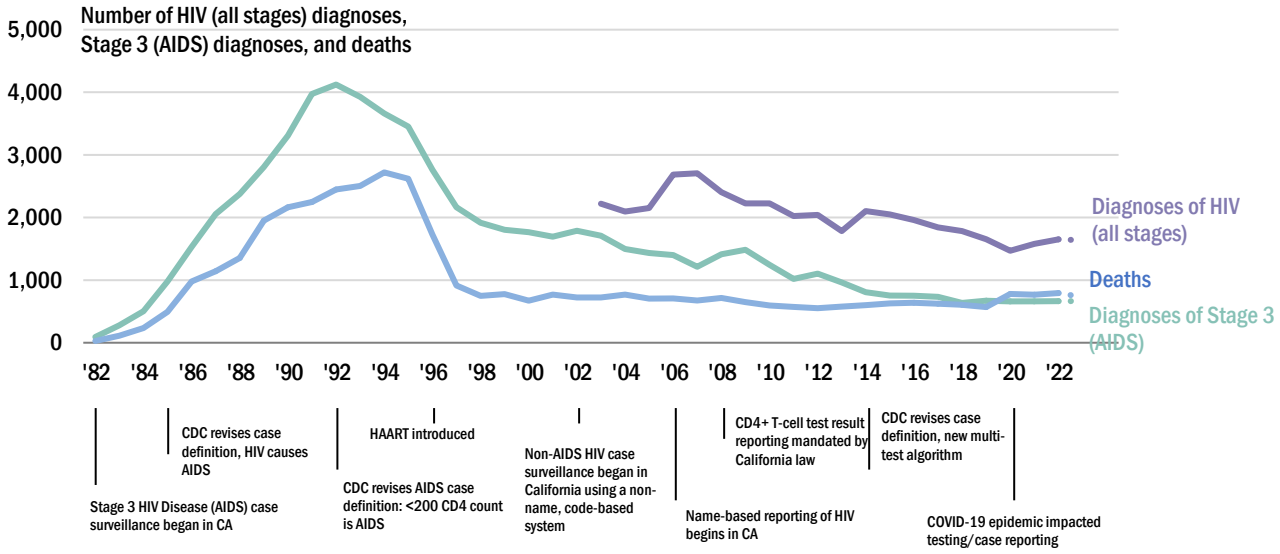


[4] Population estimates are not currently available for transgender persons, therefore male and female categories are based on sex listed at birth.
[5] See technical notes for adjusted racial/ethnic categories in these figures.

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.

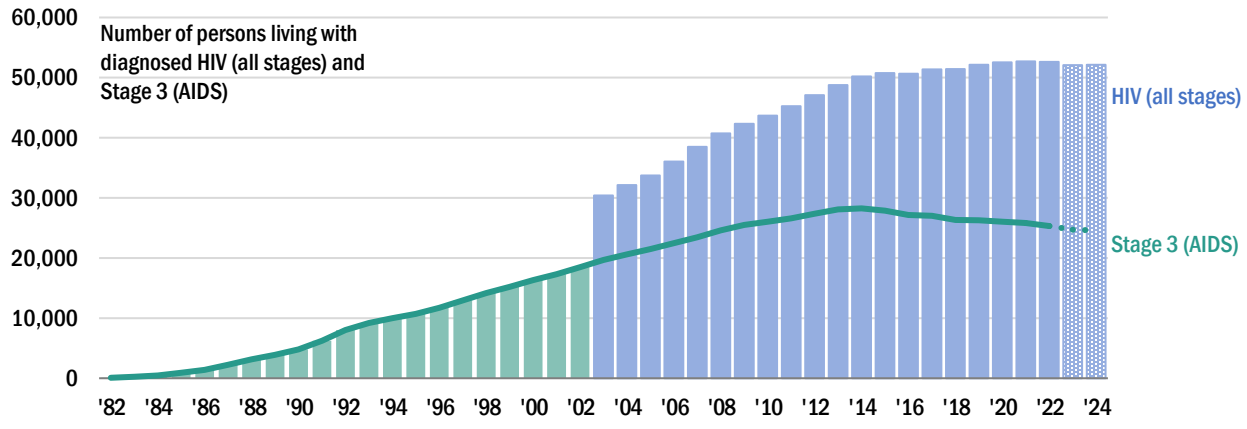
In the past decade, diagnosed cases of HIV, Stage 3 (AIDS), and deaths have gradually declined. The most recent increase in HIV diagnoses from 2020 to 2023 is likely due to the identification and reporting of missed diagnoses due to the impact of the COVID-19 pandemic.

Figure 3a: HIV diagnoses, AIDS diagnoses, and deaths among persons reported with HIV, LAC 1982-2023[6,7,8]



With prescribed antiretroviral therapy (ART), people with HIV can live long and healthy lives, leading to a steady rise in the prevalence of HIV over time, which has plateaued in recent years. The decrease in the prevalence of Stage 3 (AIDS) since 2014 may be due to earlier detection of HIV infection and treatment among persons with HIV or the reduced efforts in diagnosing and reporting of AIDS-related opportunistic infections/conditions in recent years.

Figure 3b: Persons living with diagnosed HIV and AIDS, LAC 1982-2024[7,8]

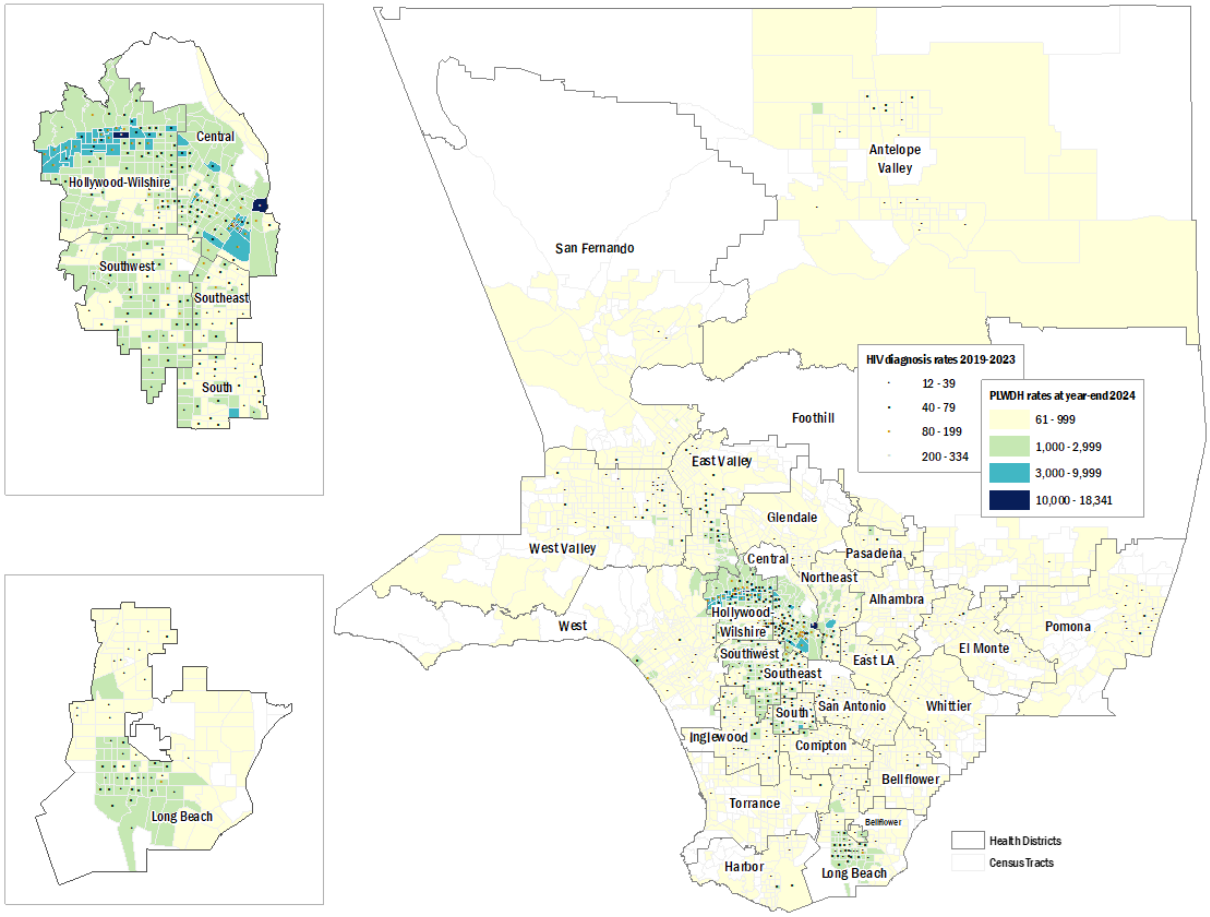


[6] Includes new diagnoses of HIV regardless of the disease stage at time of diagnosis.
[7] Includes persons whose residence at death was in LAC or whose most recent known address before death was in LAC, when residence at death is missing.
[8] 2023 data for diagnoses of HIV/AIDS and deaths and 2023/2024 data for persons living with HIV and AIDS are provisional as indicated by the dashed line and patterned bars. 2024 diagnoses of HIV/AIDS and deaths are underreported/unreliable due to significant reporting delay, and therefore are not shown.

Geographic distribution of HIV

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.

Figure 4: Geographic distribution[9] of rates per 100K population for PLWDH aged ≥13 years at year-end 2024 and persons newly diagnosed with HIV in 2019-2023, LAC



[9] See Technical Notes for detailed methodology and data definitions.

Trends in HIV diagnoses

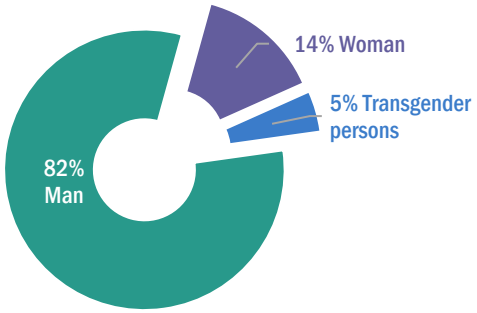
AT A GLANCE

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. Furthermore, all 2020-2022 data should be interpreted with caution due to the impact of the COVID-19 pandemic on HIV testing. For additional data on HIV diagnosis trends by health district, refer to **Table A4**.

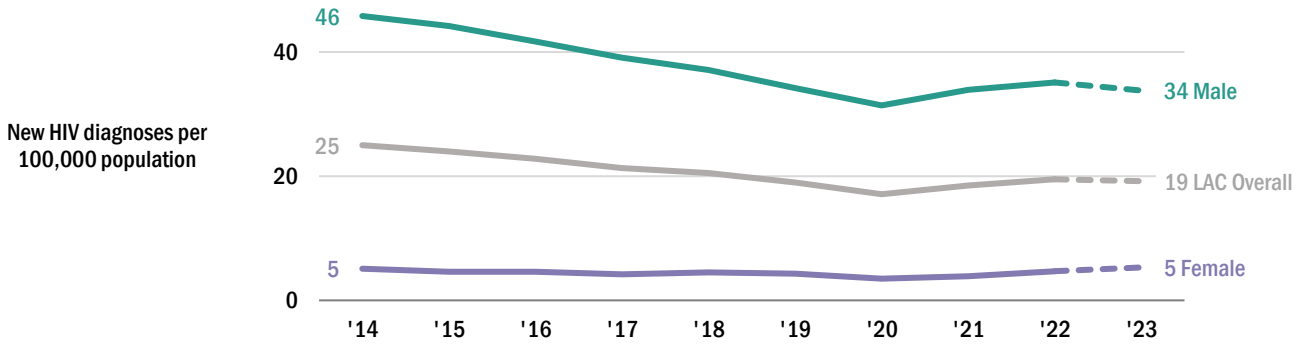
Consistent with prior years, men made up most of the HIV diagnoses in 2023 (n=1,333; 82%). Women represented 14% (n=229) and transgender persons 5% (n=73) of new HIV diagnoses in 2023.

Figure 5: HIV diagnoses by gender among persons aged ≥ 13 years, LAC 2023[10,11]



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.

Figure 6: HIV diagnoses rates by sex listed at birth[11] among persons aged ≥ 13 years, LAC 2014-2023[12,13]

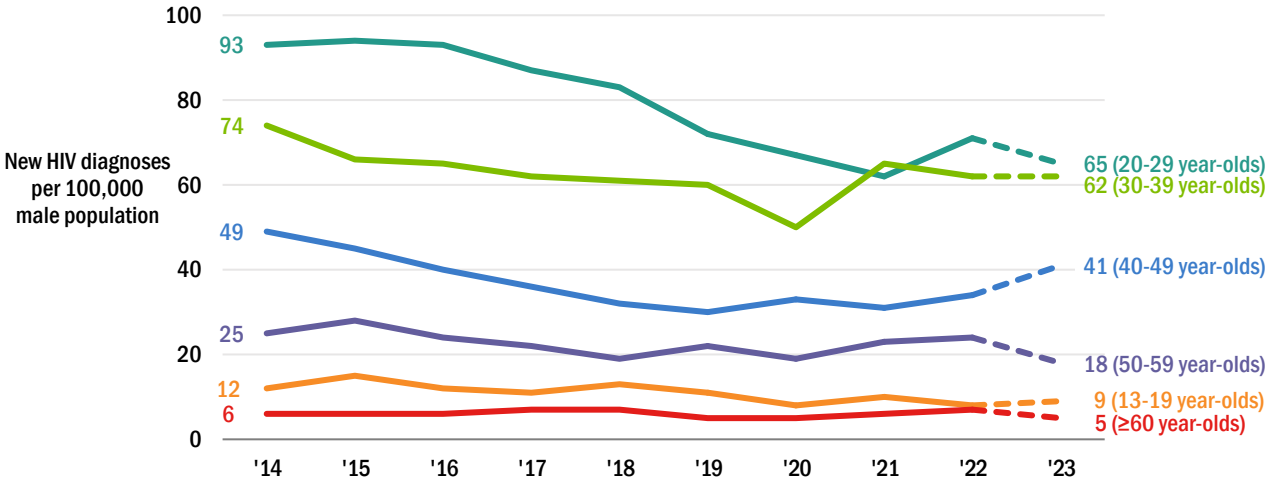


[10] Among the 73 transgender persons newly diagnosed with HIV in 2023, most identified as transgender women. Since transgender reporting relies on accurate gender classification from laboratories and health care providers, it is likely to be underreported.
[11] Rates are presented by sex listed at birth due to the unavailability of population size estimates in LAC by gender categories.
[12] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.
[13] 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.

Trends in HIV diagnoses among males[14]

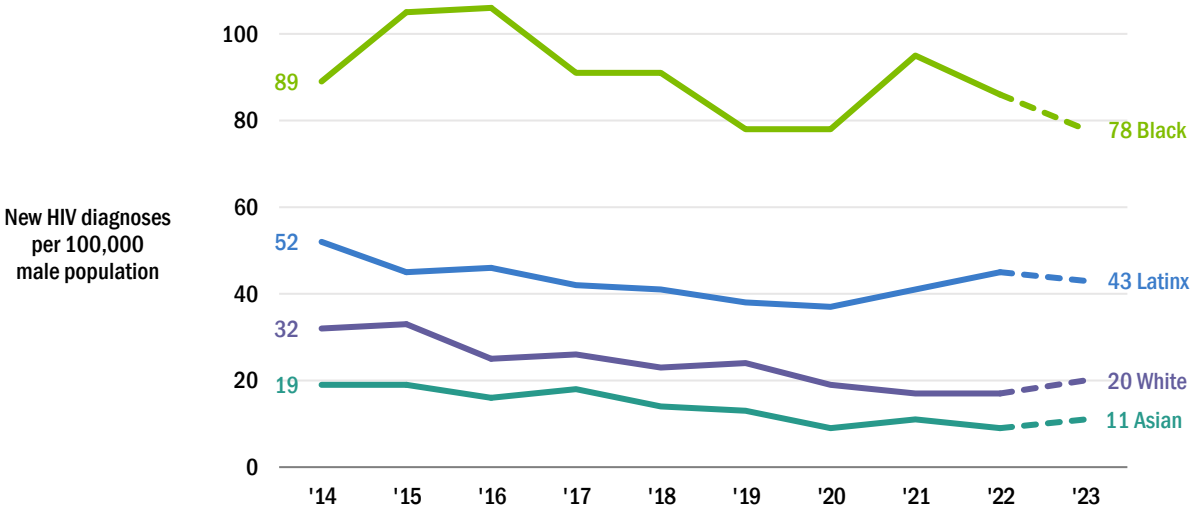
▶▶▶ Over the past decade, HIV diagnosis rates have declined among LAC males[14] across all age groups. However, males aged 20–29 years and 30–39 years continue to have significantly higher rates than other age groups.

Figure 7: HIV diagnoses rates among males (sex listed at birth)[14] aged ≥ 13 years by age group, LAC 2014-2023[15,16]



▶▶▶ Over the past decade, HIV diagnosis rates have declined among LAC males[14] across all race/ethnicity groups. However, stark disparities persist, with Black males experiencing significantly higher rates than other race/ethnicity groups.

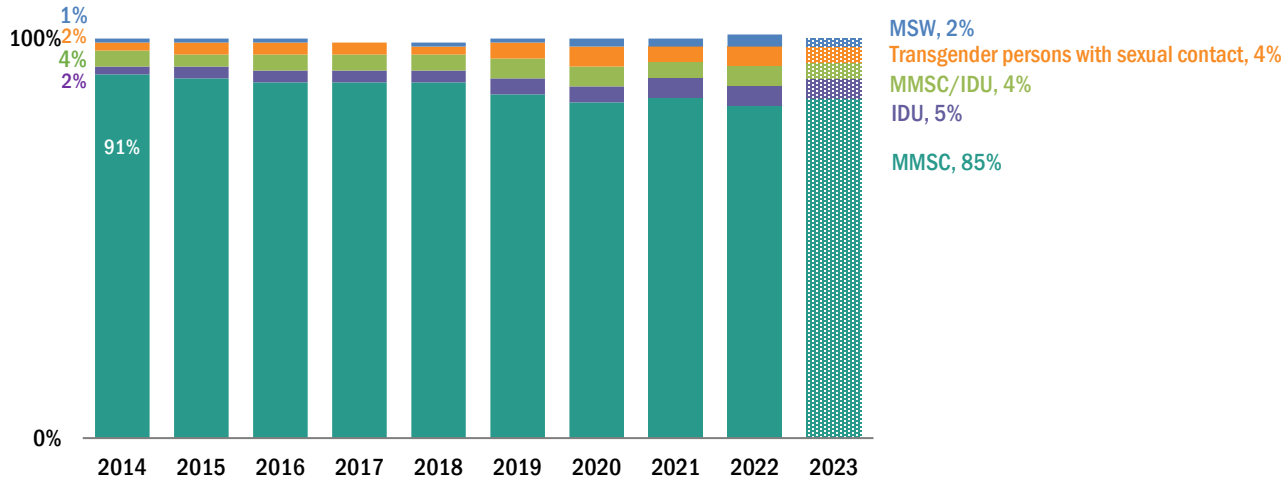
Figure 8: HIV diagnoses rates among males (sex listed at birth)[14] aged ≥ 13 years by race/ethnicity,[17] LAC 2014-2023[16]



[14] Based on sex listed at birth.
[15] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.
[16] 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.
[17] American Indians and Alaska Natives (AIAN), Native Hawaiian and Pacific Islanders (NHPI), and persons of multiple race/ethnicities were not included in the analysis due to small numbers. In 2023, AIAN, NHPI, and multi-racial persons represented 0.4%, 0.3%, and 1.3% of males newly diagnosed with HIV, respectively.

▶▶▶ The primary HIV transmission route among males[18] 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.

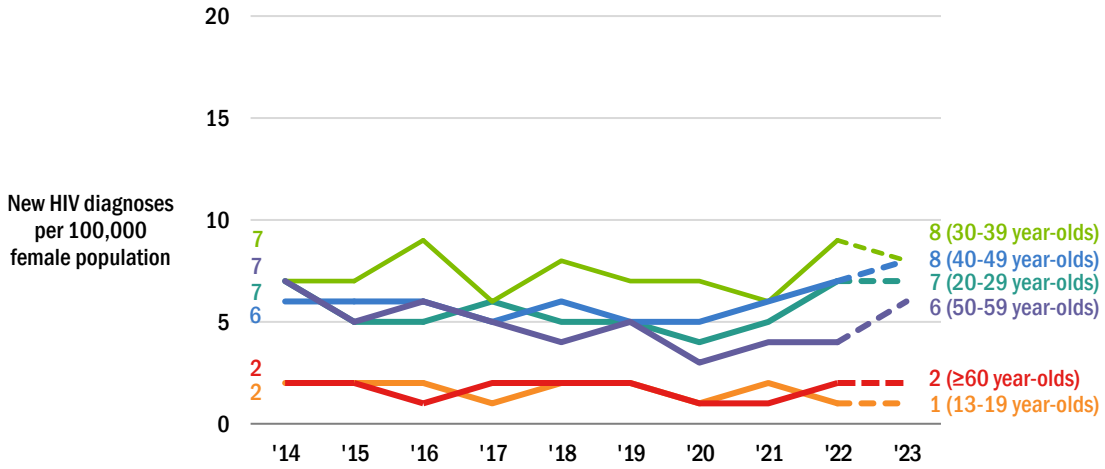
Figure 9: Transmission category[19] among males (sex listed at birth)[18] newly diagnosed with HIV, LAC 2014-2023[20]



Trends in HIV diagnoses among females[18]

▶▶▶ HIV diagnosis rates among females[18] 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.

Figure 10: HIV diagnoses rates among females (sex listed at birth)[18] aged ≥ 13 years by age group, LAC 2014-2023[20]

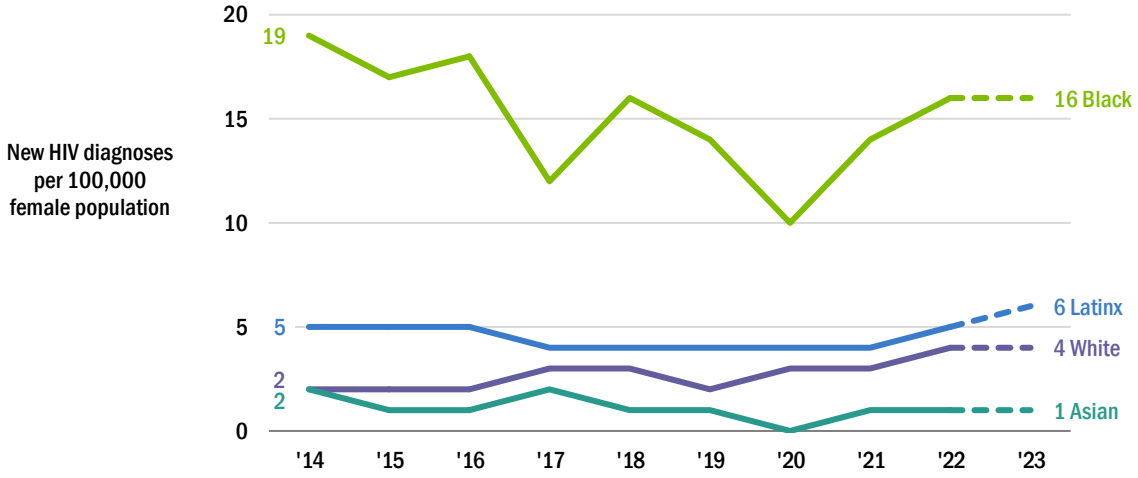


Compared with 2020, a year in which HIV laboratory surveillance data showed a decrease in HIV testing due to the COVID-19 pandemic, HIV diagnosis rates among females rose sharply in 2023 across most age groups. The initial drop in HIV testing was likely due to reduced healthcare access during the pandemic and was followed by a rebound in testing in 2021 and 2022, which may have contributed to the observed increase in diagnoses in 2023.

[18] Based on sex listed at birth.
[19] 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 (see Technical Notes).
[20] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the patterned bar and dashed line.

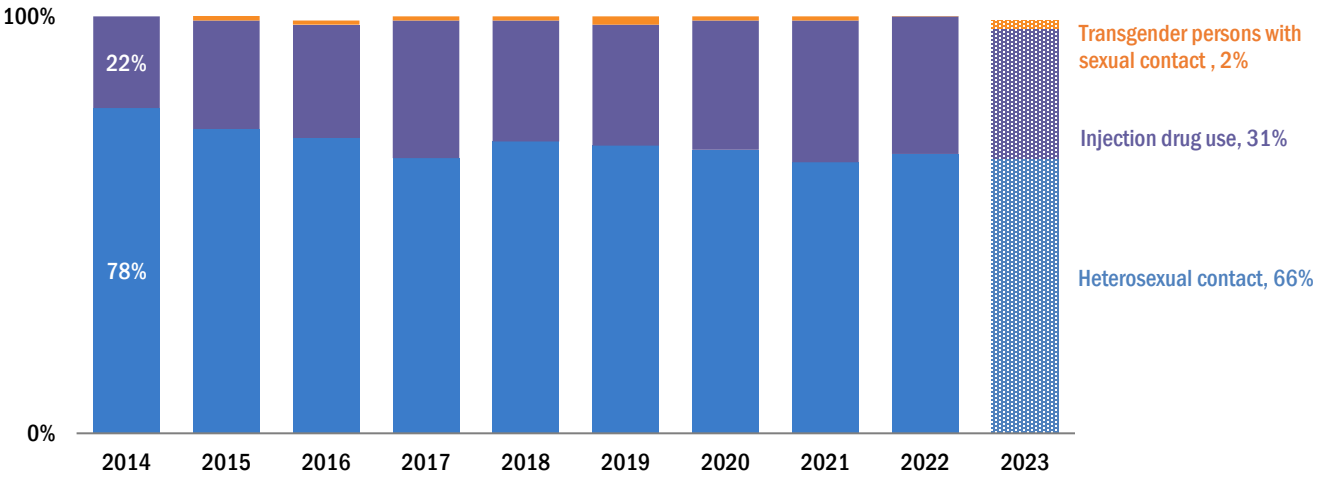
Over the past decade, HIV diagnosis rates have remained relatively low and stable among Latinx, White, and Asian females[21] in LAC. By contrast, rates for Black females have consistently remained higher than other racial/ethnic groups and have increased in recent years, reaching 16 per 100,000 in 2023.

Figure 11: HIV diagnoses rates among females (sex listed at birth)[21] aged ≥ 13 years by race/ethnicity, LAC 2014-2023[22,23,24]



From 2014 through 2023, the primary HIV transmission route among females[21] diagnosed with HIV was heterosexual contact, though it declined from 78% to 66%. By contrast, injection drug use rose from 22% to 31%, marking a steady upward trend.

Figure 12: Transmission category among females (sex listed at birth)[21] newly diagnosed with HIV, LAC 2014-2023[25]



[21] Based on sex listed at birth.
[22] American Indians and Alaska Natives (AIAN), Native Hawaiian and Pacific Islanders (NHPI), and persons of multiple race/ethnicities were not included in the analysis due to small numbers. In 2023, AIAN, NHPI, and multi-racial persons represented 1.7%, 0.4%, and 1.3% of females newly diagnosed with HIV, respectively.
[23] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line and patterned bar.
[24] 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.
[25] Not presented in this 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 (see Technical Notes).

HIV incidence and undiagnosed HIV

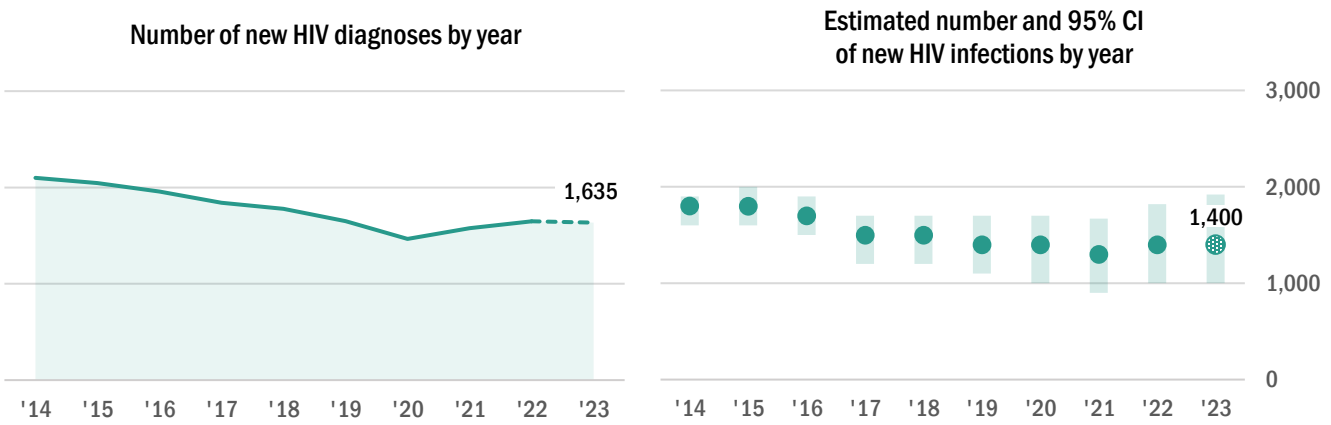
AT A GLANCE

Several indicators important for planning, monitoring, and evaluating the local HIV response are not directly measured through HIV surveillance. These include: (1) the number of persons who acquired HIV each year (i.e., new HIV infections), regardless of whether they received an HIV diagnosis and (2) 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.

Importantly, the model produces estimates (not true values). These, estimates are presented with 95% confidence intervals that show the range of values likely to contain the true value. Furthermore, these estimates are subject to periodic revisions because of updates to the surveillance data and methodological refinements in CDC's model. 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.

Figure 13: Number of persons newly diagnosed with HIV compared with the estimated number of persons with new HIV infection among PLWH aged ≥ 13 years, LAC 2014-2023[26]



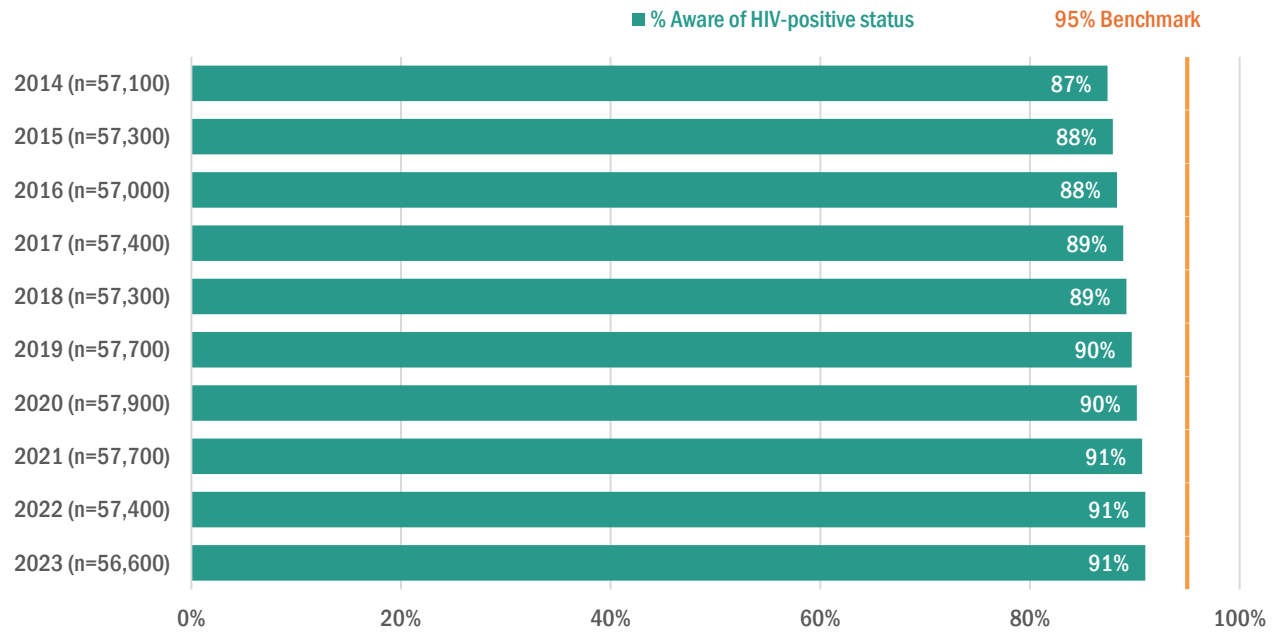
Note: The annual number of new HIV diagnoses is the number of PLWH who received an HIV diagnosis in a calendar year. This information is used to monitor trends in new HIV diagnosis and quantify the need for HIV care. A new HIV diagnosis is *not* equivalent to a new infection that was acquired in a calendar year. Many people live with HIV for years before they are diagnosed while some are diagnosed soon after acquiring HIV. Based on local data, the majority of new HIV diagnoses each year were infections acquired over a year ago.

The annual number of new HIV infections reflect infections acquired in a calendar year. Some new infections are diagnosed soon after acquiring HIV, but the majority are not. When the number of new HIV infections is high, HIV continues to spread because most people with a new infection are not aware they are living with HIV. New infections provide information on recent transmission and serve as a barometer to assess whether HIV prevention efforts are reducing transmission.

[26] 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.

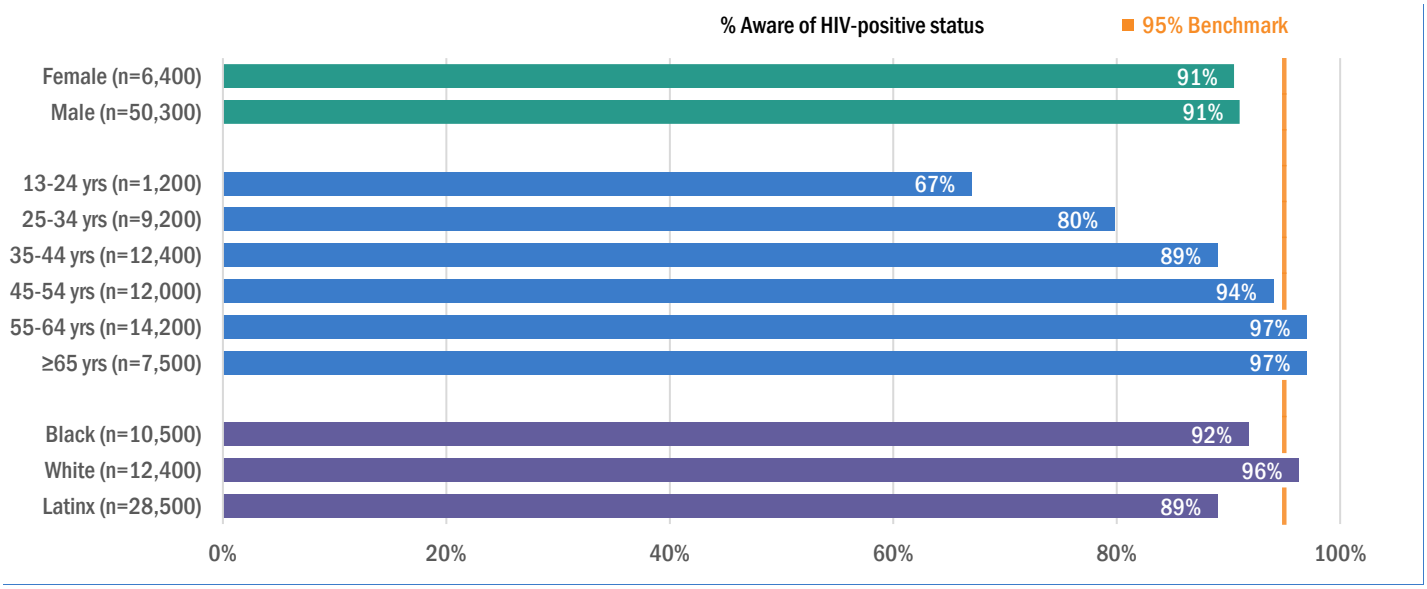
The percent of PLWH who are aware of their HIV-positive status has increased over the last 10 years from 87% to 91% but has yet to meet the EHE goal of 95% by 2025. In 2023, an estimated 4,900 PLWH remained unaware of their HIV-positive status.

Figure 14: Awareness of HIV-positive status among PLWH aged ≥ 13 years, LAC 2014-2023[27]



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

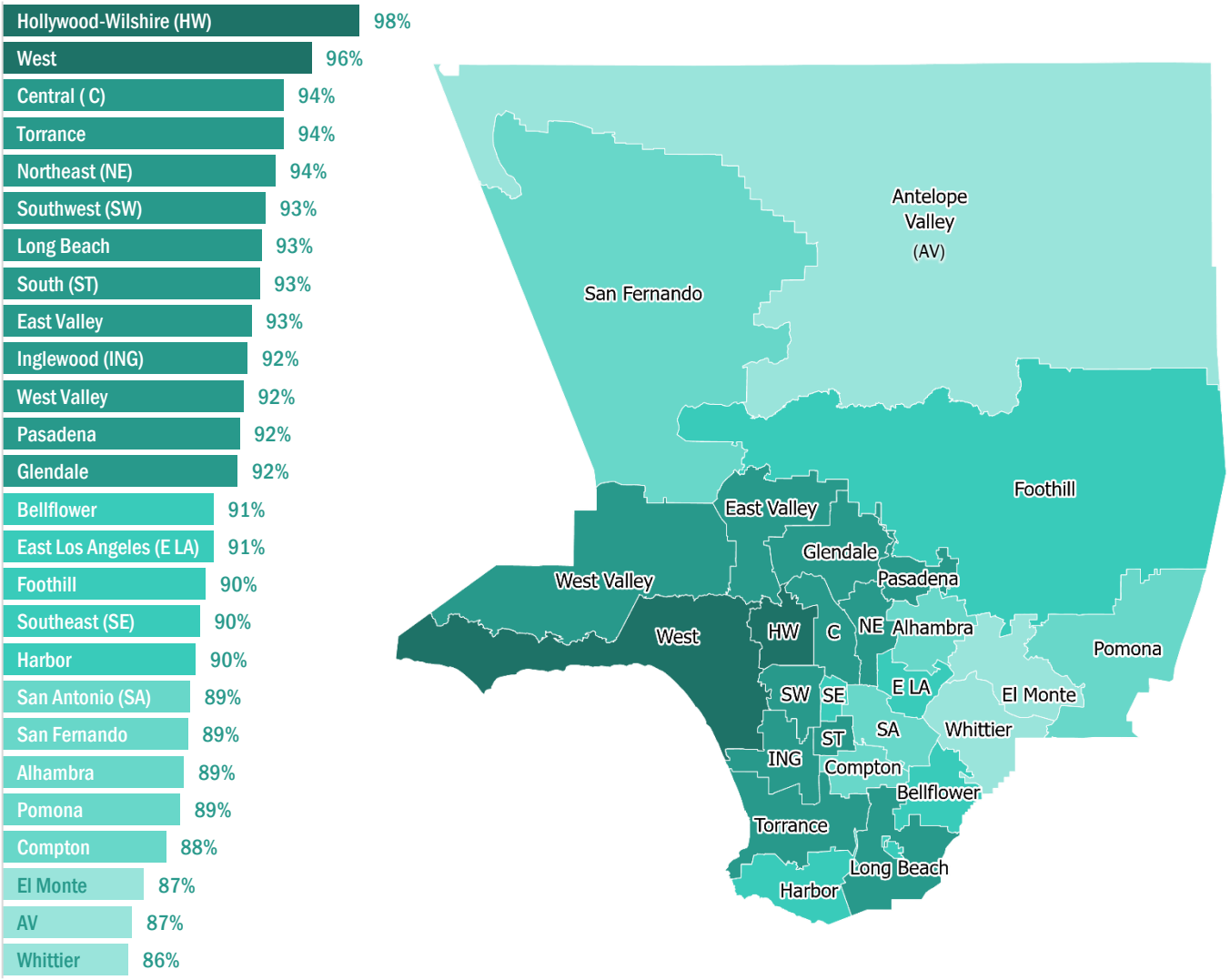
Figure 15: Awareness of HIV-positive status among PLWH aged ≥ 13 years by sex listed at birth, age group, and race/ethnicity, LAC 2023[27,28]



[27] 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.
[28] 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.

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%).

Figure 16: Percentage of PLWH aged ≥ 13 years who were aware of their HIV-positive status by Health District, LAC 2023[29,30 31]



[29] Based on HIV surveillance data as of December 31, 2024, for persons aged ≥ 13 years at year-end 2023.
[30] 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.
[31] AV=Antelope Valley

Stage of HIV disease at diagnosis

AT A GLANCE

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) as well as 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.

Table 2: HIV disease staging for surveillance purpose

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.[32] 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.[32] 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.

[32] 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.

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.

Table 3: HIV disease stage among persons ≥13 years newly diagnosed with HIV, LAC 2023

	New HIV Diagnoses	Stage 0 [33]				Stage 1 [34]		Stage 2 [35]		Stage 3 [36]		Unknown [37]	
		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 Person	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%

[33] 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 underestimated due to under-reporting of HIV-negative test results.
[34] The criterion for Stage 1 disease is CD4 ≥ 500 cells/μL within 90 days of diagnosis.
[35] The criterion for Stage 2 is CD4 between 200-499 cells/μL within 90 days of diagnosis.
[36] 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.
[37] Unknown stage includes persons without a CD4 test within 90 days of HIV diagnosis.

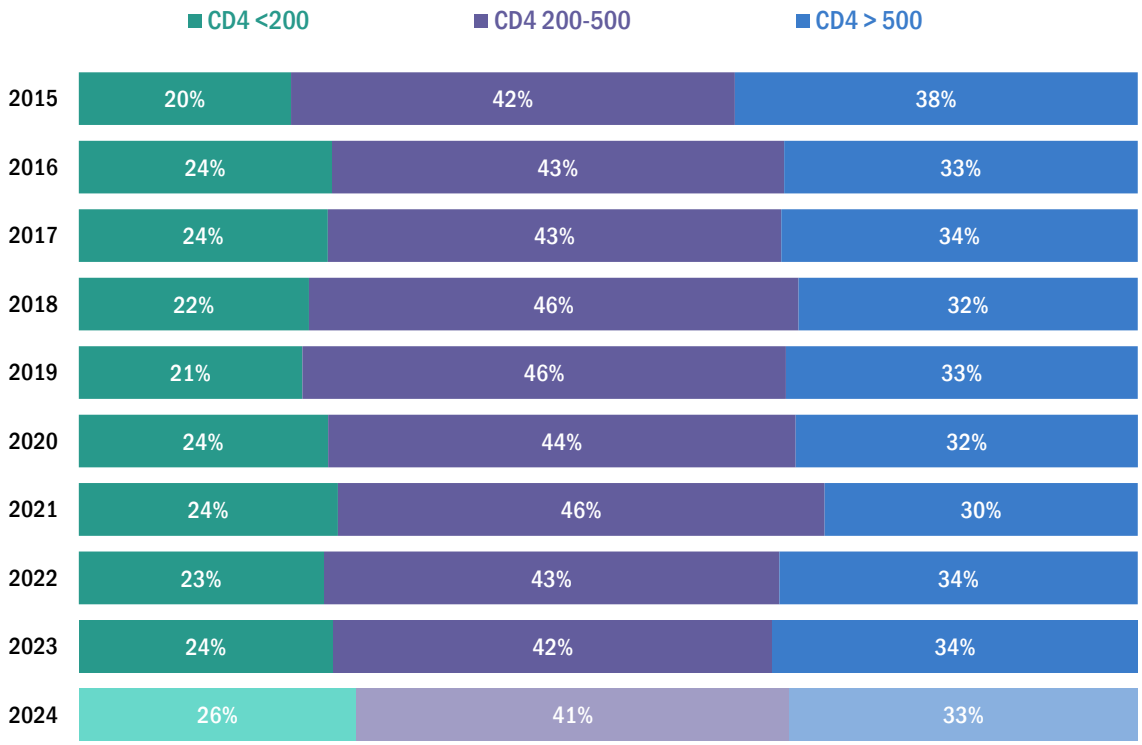
Monitoring trends in CD4 counts at diagnosis

AT A GLANCE

One way we evaluate the timeliness of a patient's HIV diagnosis is by assessing their CD4+ counts at the time of, or shortly after their HIV diagnosis. Patients with relatively low baseline CD4+ counts (CD4 < 200 cells/µL) within 1 month of diagnosis are defined as having late-stage disease while those with relatively high baseline CD4+ 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.

Figure 17: CD4+ T-cell count within 1 month of HIV diagnosis, LAC 2015-2024[38]



[38] 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.

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

AT A GLANCE

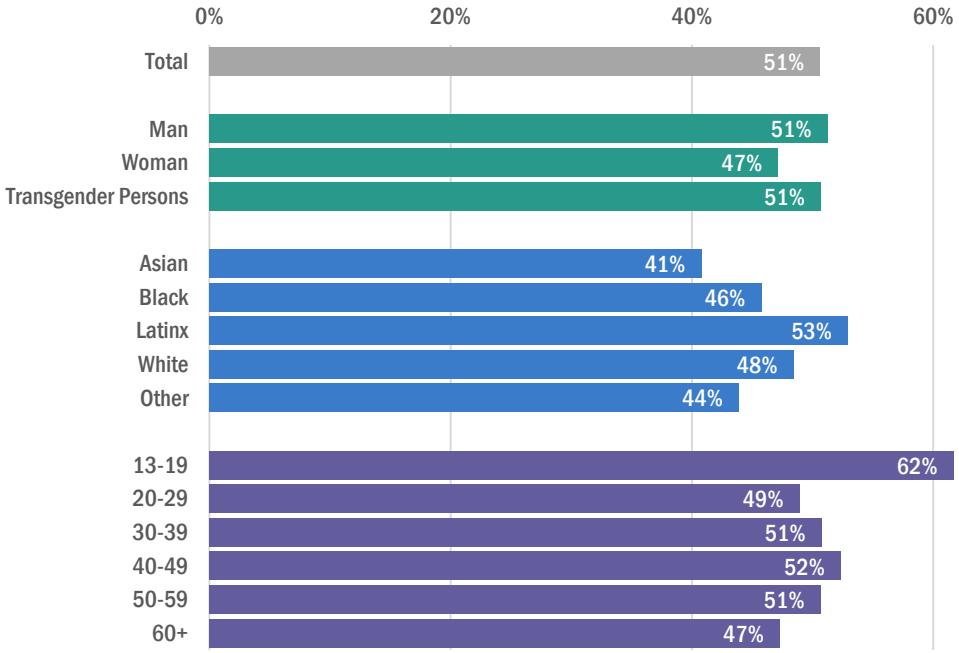
Federal guidelines for the care and treatment of PLWDH recommend HIV viral genotype testing at initiation of HIV care to determine whether an individual's HIV strain is resistant to certain anti-retroviral drugs. The genotype testing, which results in a genetic sequence report reflecting an individual's 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. 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.

Figure 18: Proportion of new HIV diagnoses[39] with a genotype resistance test within 90 days of HIV diagnosis,[40] LAC 2023

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

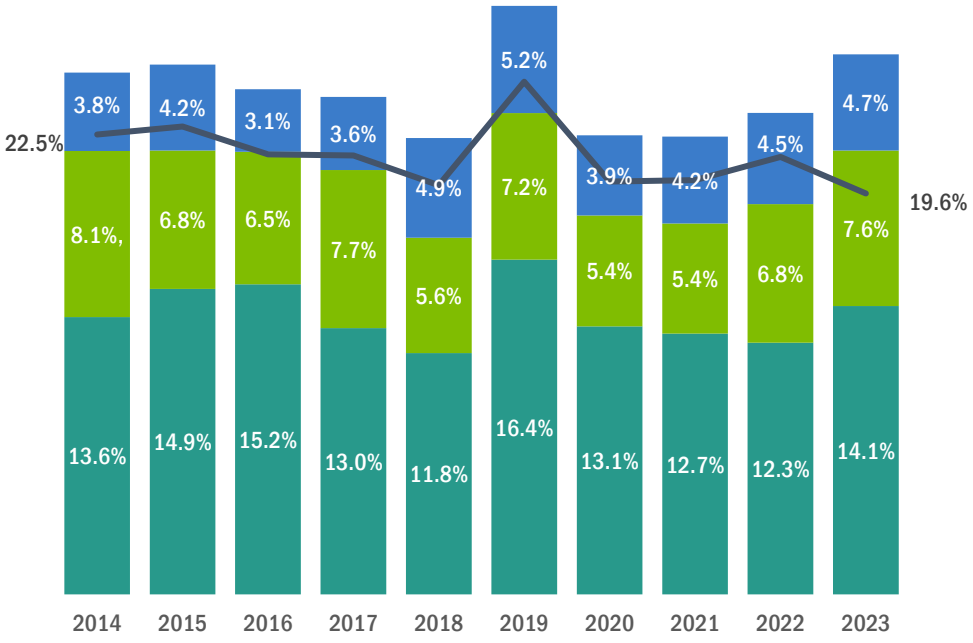


[39] Persons aged ≥ 13 years newly diagnosed with HIV in 2023. Data are provisional due to reporting delay.
[40] Race/ethnicity categories with fewer than 10 diagnoses (Native Hawaiian and Other Pacific Islander, American Indian/Alaska Native), Multi-race, and Unknown persons were included in Other.

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.

Figure 19: Proportion of transmitted drug resistance (TDR) by drug class[41] among persons aged ≥13 years newly diagnosed with HIV with an eligible sequence,[42] LAC 2014-2023

PI = Protease Inhibitors
NRTI = Nucleoside Reverse Transcriptase Inhibitors
NNRTI = Non-Nucleoside Reverse Transcriptase Inhibitors
% of new HIV diagnoses with a TDRM



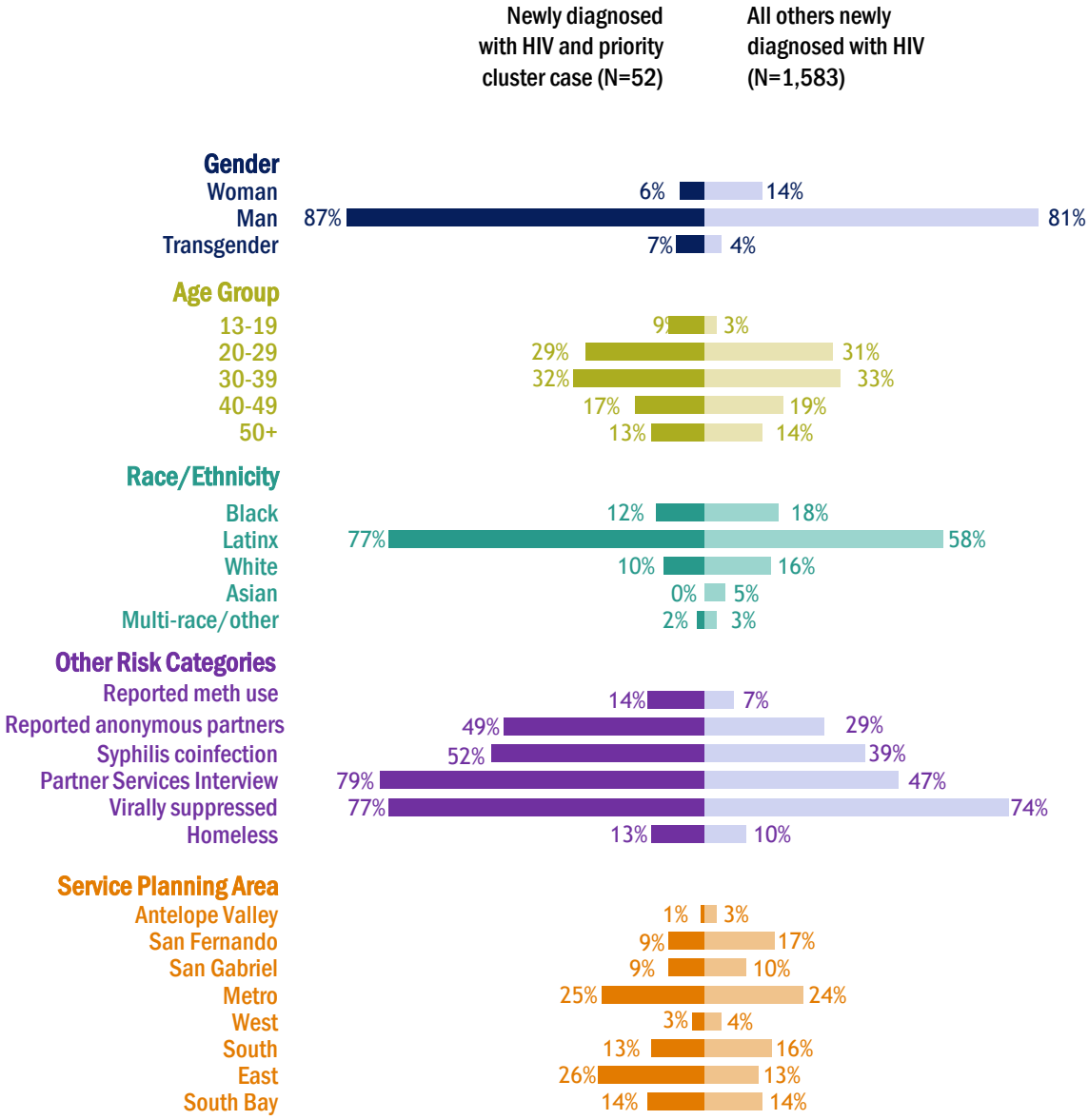
Notes: In 2023, 58% of people newly diagnosed with HIV had a sequence eligible for drug resistance analysis.

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

[41] 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.
[42] 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.

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 20-29 or 30-39 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.

Figure 20: Priority[43] cluster diagnoses compared to non-cluster diagnoses among those newly diagnosed with HIV by selected characteristics,[44] LAC 2023



DHSP's multi-disciplinary cluster detection and response workgroup reviews high priority clusters and cases in priority clusters monthly, and plans tailored HIV prevention, testing, and care and treatment services to respond to networks where rapid HIV transmission is occurring.

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

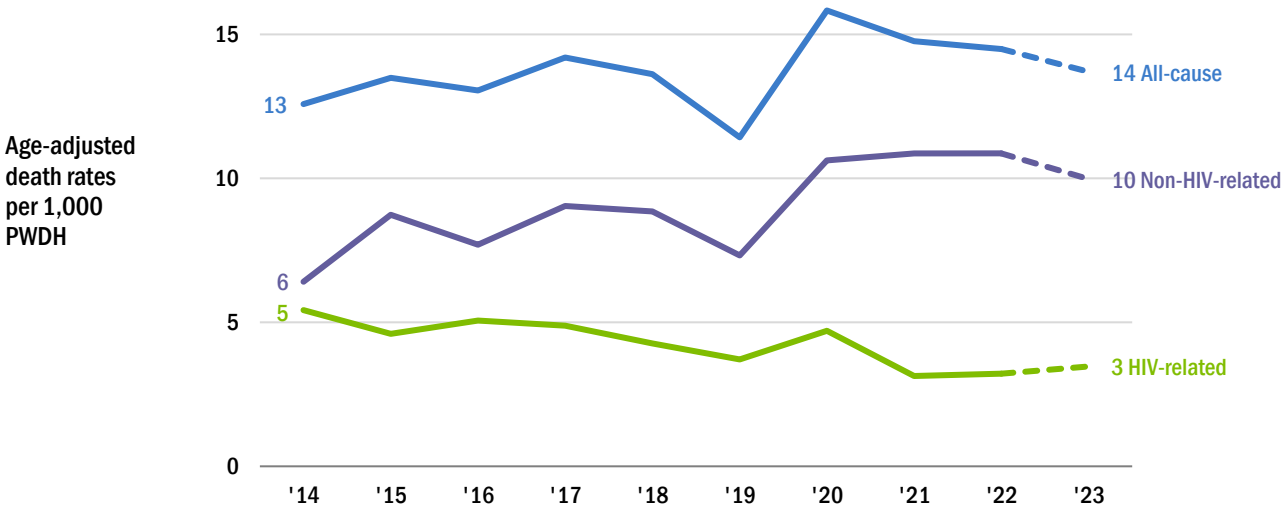
HIV mortality

AT A GLANCE

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 PWDH.

Between 2014 and 2019, age-standardized death rates among persons with diagnosed HV due to HIV-related, non-HIV related, and all-causes were 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.

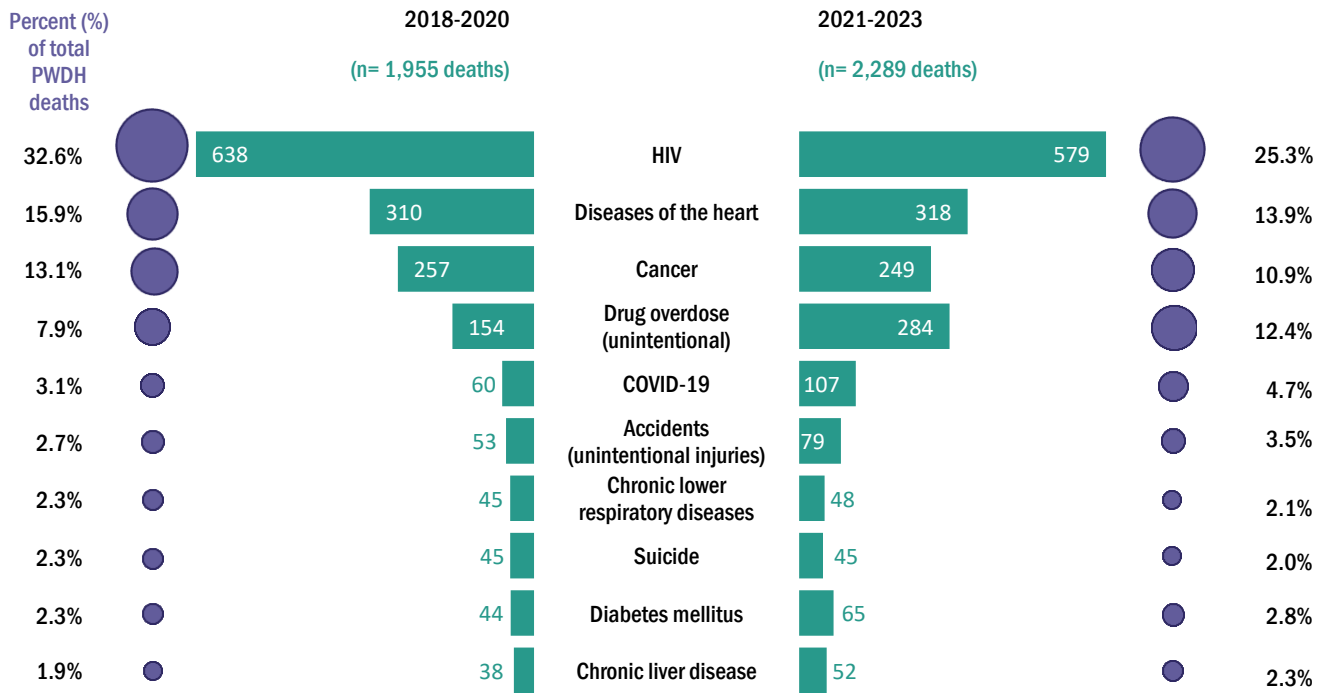
Figure 21: Age-adjusted death rates among persons aged ≥ 13 years with diagnosed HIV, by HIV-related and non-HIV related cause of death, LAC 2014-2023[45,46,47,48]



[45] Age-adjusted to the U.S. 2000 standard population.
[46] 2023 death rate data among PWDH are provisional due to reporting delay as indicated by the dashed line.
[47] For each calendar year in which the deaths occurred, PWDH includes persons living with HIV at the beginning of the calendar year plus persons newly diagnosed in the calendar year (see Technical Notes).
[48] 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).

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 COVID-19 pandemic to nearly 800 deaths per year. 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.

Figure 22: Underlying causes of death[49] among persons aged ≥ 13 years with diagnosed HIV, LAC 2018-2020, 2021-2023[50]



[49] 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.
[50] Annual percentages may not add up to 100% due to rounding error.

Data to Action

Progress and Opportunities in HIV Epidemic Monitoring

- In LAC, as of year-end 2023, approximately 56,600 persons aged ≥ 13 years are living with HIV, and an estimated 4,900 of these persons have not yet been diagnosed. With improved HIV survival and accelerated HIV case finding efforts to identify all undiagnosed PLWH, the number of diagnosed PLWH who require high quality HIV care will continue to grow.

- HIV epidemic control occurs when the number of new HIV infections falls below the number of deaths among PLWH. Approximately 1,400 new infections and 600 deaths among persons with HIV occur each year, signaling that LAC is far from reaching "HIV epidemic control." To turn the tide, high impact evidence-based prevention interventions, such as PrEP and partner services, will need to be more focused, accessible, and tailored to the specific needs of the populations and locations that need them most.

- The significant jump in HIV diagnosis rates from 9 per 100,000 in 13–19-year-old males to 65 per 100,000 in 20–29-year-old males highlights an inflection point where public health must intervene to prevent large numbers of young men from acquiring HIV. In addition, HIV diagnosis rates among adults aged 40-49 years, both males and females, have also shown a rising trend in recent years. Public health efforts and prevention strategies should be broadened and tailored to middle-aged adults as well.

- Among PLWH, persons younger than 35 years of age, Black, and Latinx persons had lower awareness of their HIV-positive status compared with their counterparts (Figure 15). These are the groups where capacity for HIV testing programs should expand to improve testing access and early HIV diagnosis.

- Almost half of people with a new HIV diagnosis were diagnosed late (Stage 2 and beyond) in their disease stage. Women, Latinx persons, persons aged 40 years or older, and persons reporting injection drug use risk were more likely to have delayed diagnoses than other groups (Table 3). HIV screening programs should be tailored to the needs of these populations to ensure that HIV care and treatment interventions are not delayed.

- HIV drug resistance testing is important to ensure that ART is effective among PLWDH initiating treatment. Over 40% of new HIV diagnoses did not receive a timely HIV genotype in 2023, highlighting a gap between recommendations and current practice. This also limits our ability to detect rapid HIV transmission clusters.

- Cluster response continues to serve as an important tool to laser focus the public health response on locations and network contacts where recent and rapid transmission may be occurring.

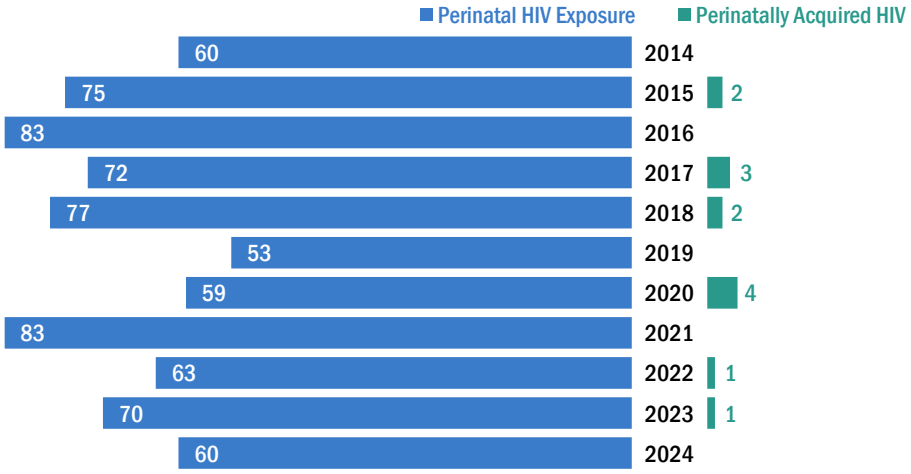
- As increasingly more people with HIV live long lives and ultimately succumb to non-HIV-related causes, there is a need to evolve HIV services into an integrated disease management model that provides comprehensive health services for persons living with HIV throughout their life course.

Vulnerable Populations

HIV among Infants

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

Figure 23: Number of infants with perinatal HIV exposure vs. Number of infants with perinatally acquired HIV, LAC 2014-2024[51,52]



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

Table 4: HIV incidence and perinatal transmission among infants aged <18 months, LAC 2013-2023[53]

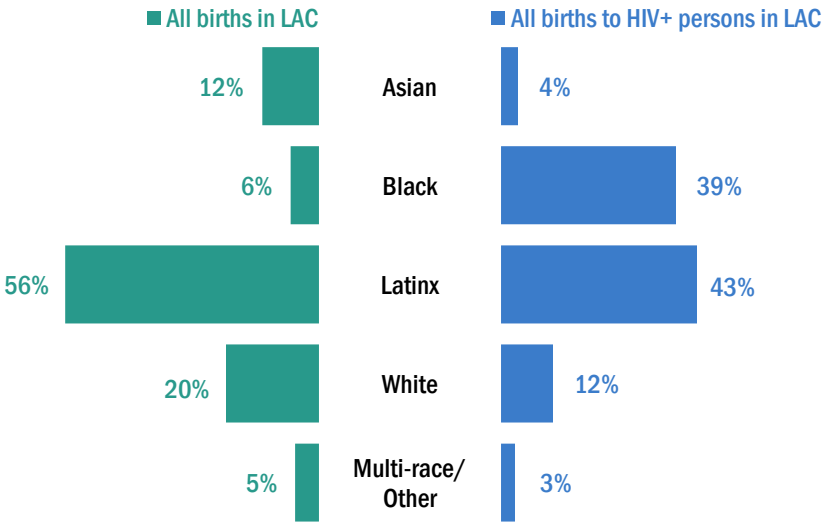
Birth Year	Number of infants newly diagnosed with HIV	Live Births	Number of HIV-exposed infants	Perinatal HIV incidence rate per 100,000 live births	Perinatal HIV transmission rate per 100 HIV-exposed infants
2014	0	130,150	60	0	0
2015	2	124,438	75	1.6	2.7
2016	0	123,092	83	0	0
2017	3	116,850	72	2.6	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	94,886	70	1.1	1.4
2024	0	94,779	60	0	0

National targets for elimination of mother-to-child transmission of HIV are perinatal HIV incidence < 1 per 100,00 live births, and a perinatal transmission rate <1 per 100 HIV-exposed infants.

[51] Due to reporting delay, 2023 and 2024 HIV data are provisional.
[52] 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.
[53] 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.

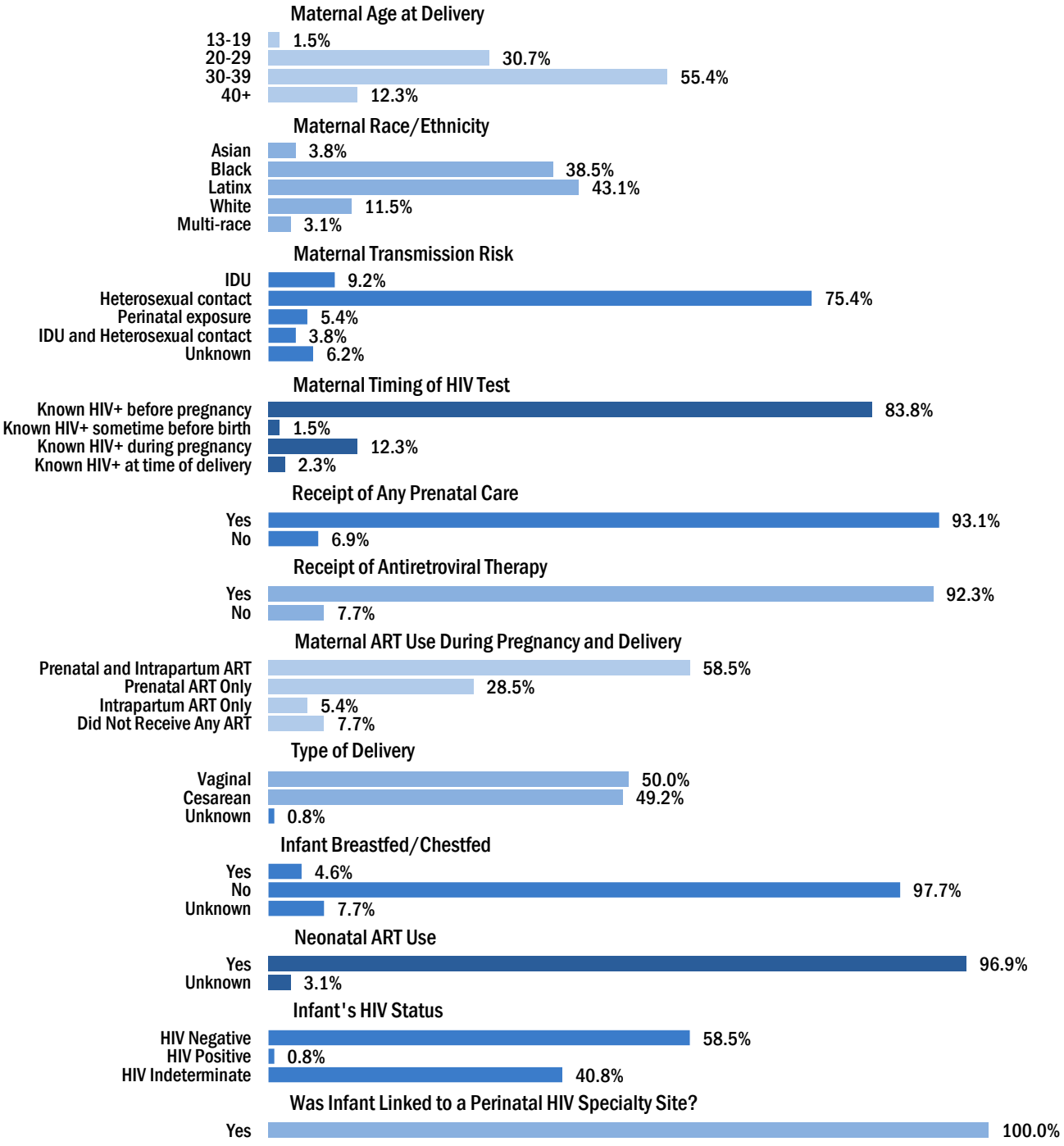
Black persons are disproportionately impacted by perinatal HIV risk. Black infants accounted for 6% of all births in the general LAC population but made up 39% of all HIV-exposed births in 2023–2024.

Figure 24: Rate of all LAC births vs perinatal HIV-exposed births in LAC by race/ethnicity, 2023-2024



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

Figure 25: Demographic and clinical characteristics of pregnant persons with diagnosed HIV and exposed infants, LAC 2023-2024[54,55]

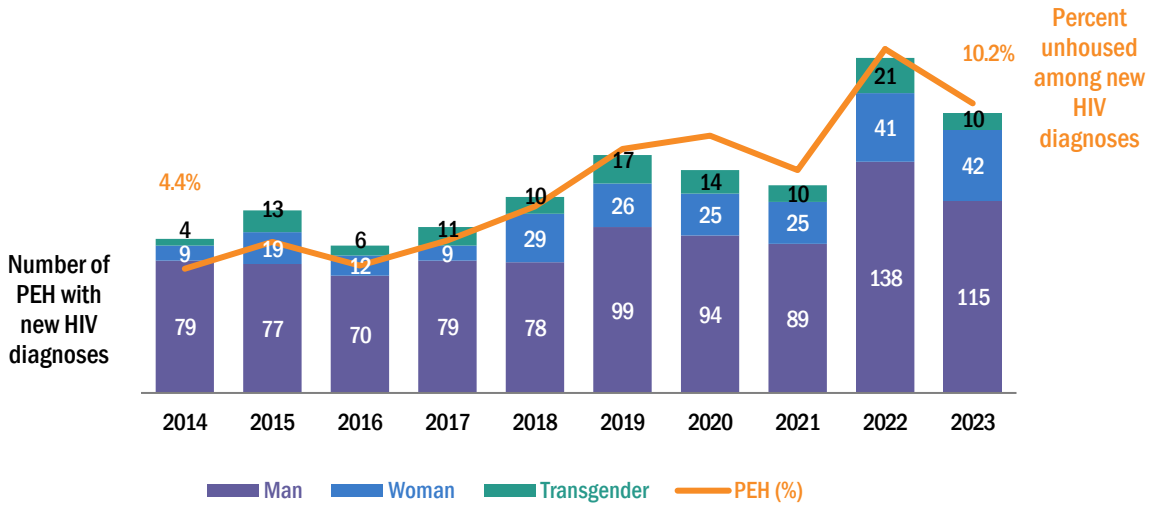


[54] Data are provisional due to reporting delay
[55] Due to rounding, totals may not equal 100%

HIV among persons experiencing homelessness (PEH)

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.

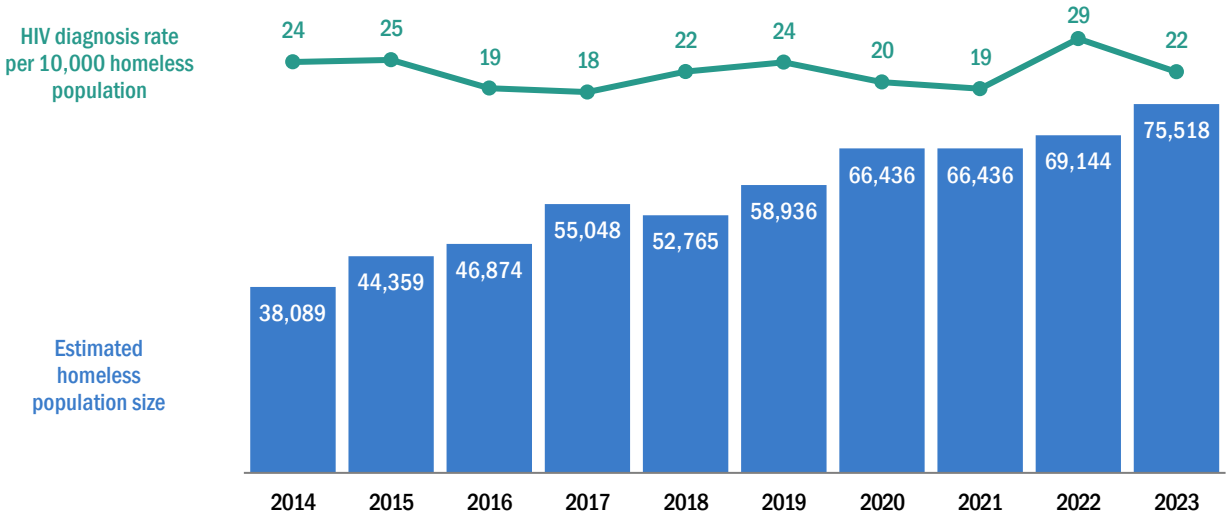
Figure 26: Number and percent of persons aged ≥ 13 years newly diagnosed with HIV who experienced homelessness within 6 months of diagnosis[56] by gender, LAC 2014-2023



The HIV transmission risk profile among PEH newly diagnosed with HIV differs from the overall population of new HIV diagnoses, with a lower proportion of MMSC (50% versus 73% overall) and higher proportion of heterosexual contact (14% versus 11% overall) and IDU (21% versus 8% overall).

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.

Figure 27: HIV diagnoses rates among persons aged ≥ 13 years experiencing homelessness, LAC 2014-2023[57]



[56] 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

[57] 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.

HIV among transgender people

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).

Table 5: Transgender people aged ≥ 13 years diagnosed in 2021-2023 and living with diagnosed HIV at year-end 2024 by gender and age group,[58] race/ethnicity,[59] transmission category,[60] diagnosed while incarcerated,[61] PEH,[62] and viral suppression,[63] 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)

[58] Age groups for new diagnoses are based on age at the time of initial HIV diagnosis and age groups for persons living with diagnosed HIV are based on age as of 2024.
[59] Other race/ethnicity includes American Indian and Alaska Native (AIAN), Native Hawaiian and Pacific Islander (NHPI), persons of multiple races and unknown race/ethnicity.
[60] Persons without an identified transmission category were assigned a transmission category using CDC-recommended multiple imputation methods; TGSC = Transgender persons with sexual contact; IDU = Injection drug use; other transmission categories include perinatal exposure, recipient of clotting factor, transfusion, or organ transplant, and transmission category not reported/identified.
[61] Diagnosed while incarcerated includes persons who were diagnosed and reported by a city or county jail, juvenile hall, regional correctional center, or state and federal adult correctional facilities (confinement and community-based). Excludes persons diagnosed at facilities whose only function is temporary holding.
[62] PEH includes persons who have experienced homelessness within 6 months of diagnosis for HIV diagnosis in 2021-2023, while PEH among PLWDH in 2024 includes persons who have ever experienced homelessness, if reported. PEH can be housed or unhoused.
[63] Among persons newly diagnosed in 2021-2023, viral suppression (< 200 copies/mL) is defined as ≥ 1 suppressed viral load test within 6 months of diagnosis. For PLWDH, viral suppression is defined as the last VL test in 2024 being <200 copies/mL. The denominator for viral suppression within 6 months of diagnosis includes only persons reported with a new HIV diagnosis in 2021–2023 and does not include estimated persons unaware of their HIV infection. The VLS denominator among PLWDH includes persons diagnosed through 2023 and living in LAC at year-end 2024, based on most recent residence. Persons without a viral load test are considered not virally suppressed.

HIV biobehavioral surveillance

AT A GLANCE

HIV biobehavioral surveys are surveillance tools that use probability-based sampling methods to estimate HIV prevalence and assess relevant behavioral and clinical indicators within specific populations. Information from biobehavioral surveys helps us better understand factors that may be associated with behavioral and clinical outcomes in vulnerable populations who are at increased risk for HIV or are living with HIV.

The National HIV Behavioral Surveillance (NHBS) is an HIV surveillance activity that enables state and local health departments to monitor HIV prevalence and associated risk behaviors among select populations at elevated risk for HIV. These populations include gay, bisexual and other 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 another CDC-funded HIV surveillance activity that provides national and local data on behavioral and clinical outcomes in a representative sample of PLWH. MMP uses a 2-stage sampling strategy to select a sample of persons from which nationally and locally representative data are derived.

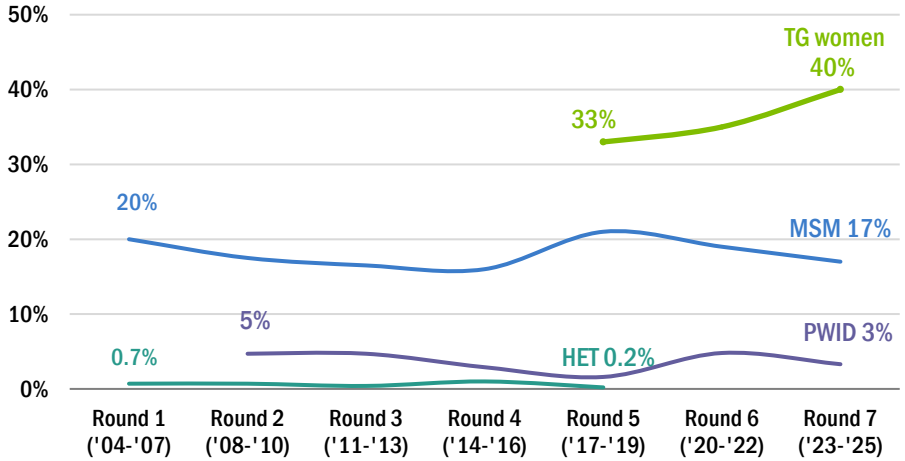
This section highlights key findings from NHBS (Figure 28-Figure 53) and MMP (Figure 54-Figure 58) efforts in LAC. While these data provide the best available estimates for the populations presented, they are estimates (not true values), and thus any generalizations to broader population groups represented 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.

Figure 28: Trends in HIV prevalence[64] by NHBS population, LAC 2004-2024[65,66]

In the most recent NHBS surveillance period, TG women had the highest HIV prevalence across the 4 surveyed populations. HIV prevalence was also high among MSM. By contrast, HIV prevalence among PWID and HET was low.

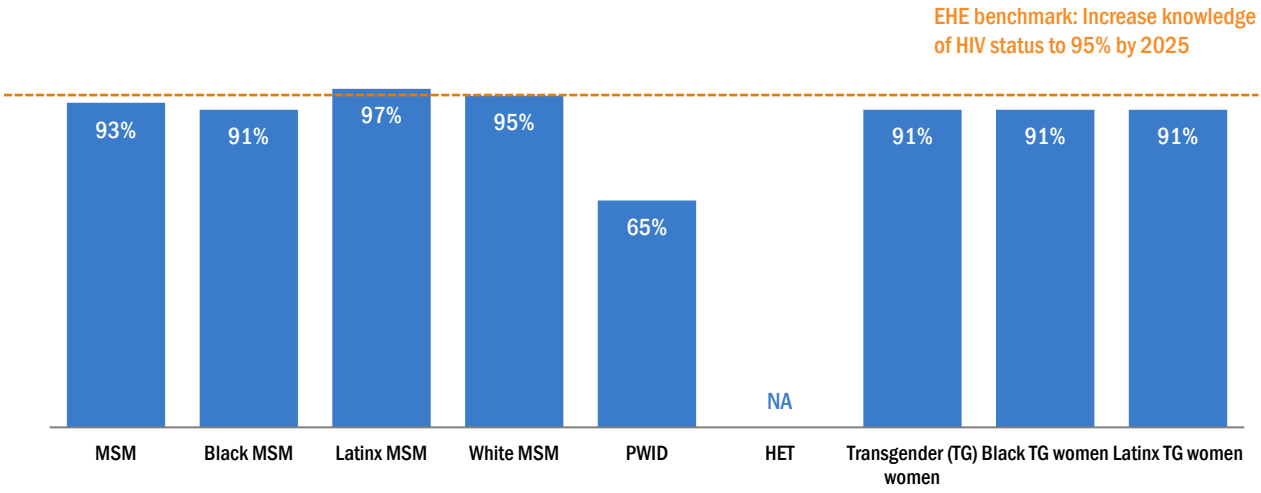
Note: Testing frequency among MSM and TG women was high compared with PWID and HET. MSM (85%) and TG women (86%) reported high levels of HIV testing in the past year. By contrast, only 45% of PWID and 31% of HET reported testing for HIV in the past year.



[64] "HIV Prevalence" refers to the percentage of participants with a confirmed positive HIV test result among the total number of participants tested in NHBS.
[65] 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 in 2019 and Round 7 in 2023.
[66] In PWID cycle in 2024, it was found that 14% of male PWID were sexually active MSM, and the HIV prevalence among this group was 24%, which is notably higher than the prevalence among non-MSM male PWID (approximately 0.7%).

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.

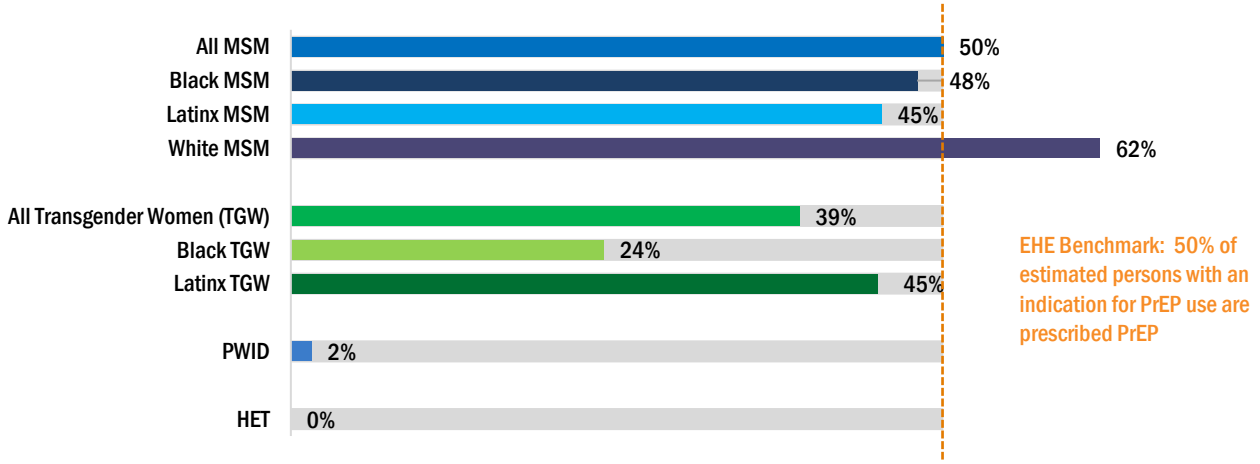
Figure 29: Awareness of HIV-positive status among participants aged ≥ 18 years living with HIV by NHBS population and race/ethnicity, LAC 2017-2024[67,68,69]



It is noteworthy that among NHBS MSM participants living with HIV, over 95% of Latinx MSM and White MSM were aware of their HIV status.

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.

Figure 30: PrEP Use during the past 12 months among NHBS Populations with a negative HIV test result, LAC 2019-2024[70]

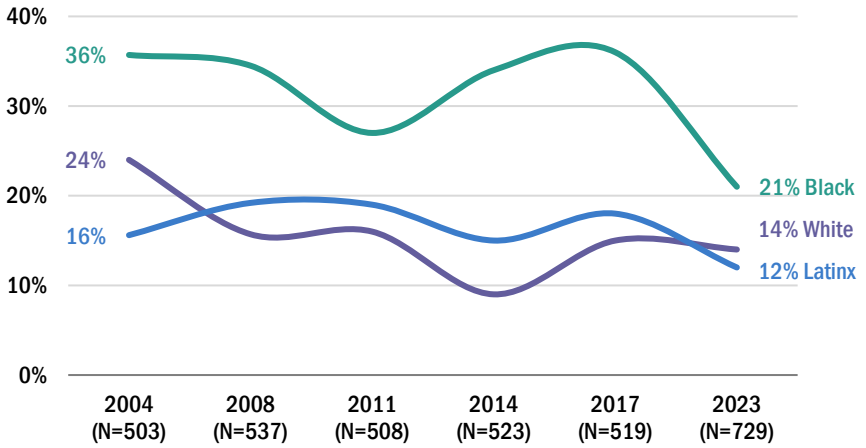


[67] **MSM**: Gay, bisexual and other men who have sex with men in the past 12 months. The NHBS-MSM cycle collects information on persons who report sex with a male partner in the 12 months before interview. A total of 729 MSM participated in NHBS-MSM in 2023, including 309 Black MSM, 243 Latinx MSM, and 133 White MSM.
PWID: Persons who inject drugs; A total of 513 PWID participated in NHBS-PWID in 2024;
HET: Heterosexually active persons at increased risk for HIV infection; A total of 509 HET participated in NHBS-HET in 2019;
Transgender (TG) women: 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 596 transgender women enrolled in NHBS-Trans in 2023.
[68] Awareness of HIV infection among PWID (11/17) and HET is unstable due to small numbers.
[69] Data on HIV testing in the past 12 months excludes participants diagnosed with HIV >12 months prior to the survey interview.
[70] **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;

Gay, bisexual, and other men who have sex with men (MSM)

▶▶▶ Since 2004, HIV prevalence has been declining among MSM in LAC across all race/ethnicity groups. However, Black MSM have consistently experienced higher HIV prevalence than other race/ethnicity groups.

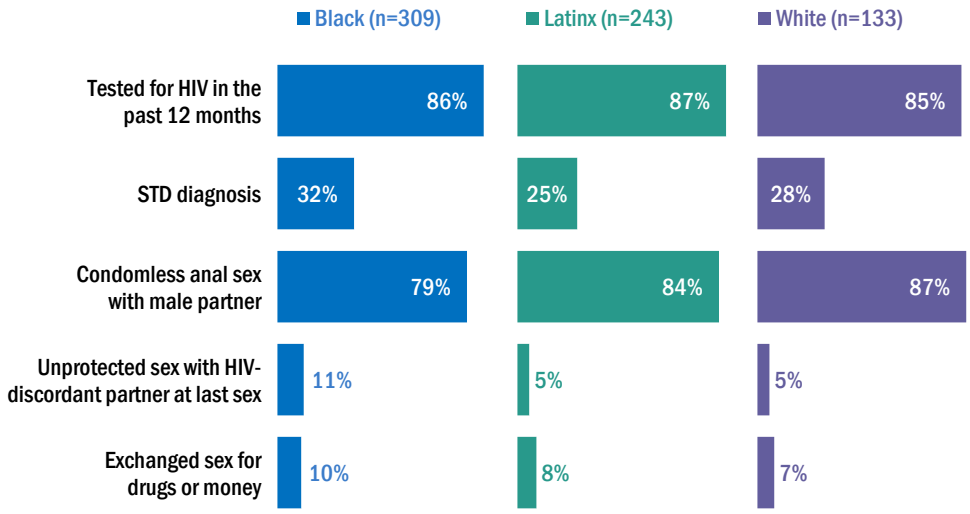
Figure 31: Trends in HIV prevalence among NHBS-MSM participants by race/ethnicity, LAC 2004-2023



HIV prevalence among Black MSM has consistently been higher compared to White and Latinx MSM over the years. While prevalence rates have varied over time for all racial/ethnic groups, there has been a notable overall decline by 2023. In the most recent surveillance round, 21% of Black MSM were living with HIV compared with 14% of White MSM and 12% of Latinx MSM. Changes in influential characteristics within the Latinx and White MSM participants may have affected the observed relative prevalence of HIV between the two groups, particularly as White MSM have now surpassed Latinx MSM in HIV prevalence.

▶▶▶ 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

Figure 32: HIV testing behavior, STD diagnosis, and sexual behavior among NHBS-MSM participants by race/ethnicity, LAC 2023[71]



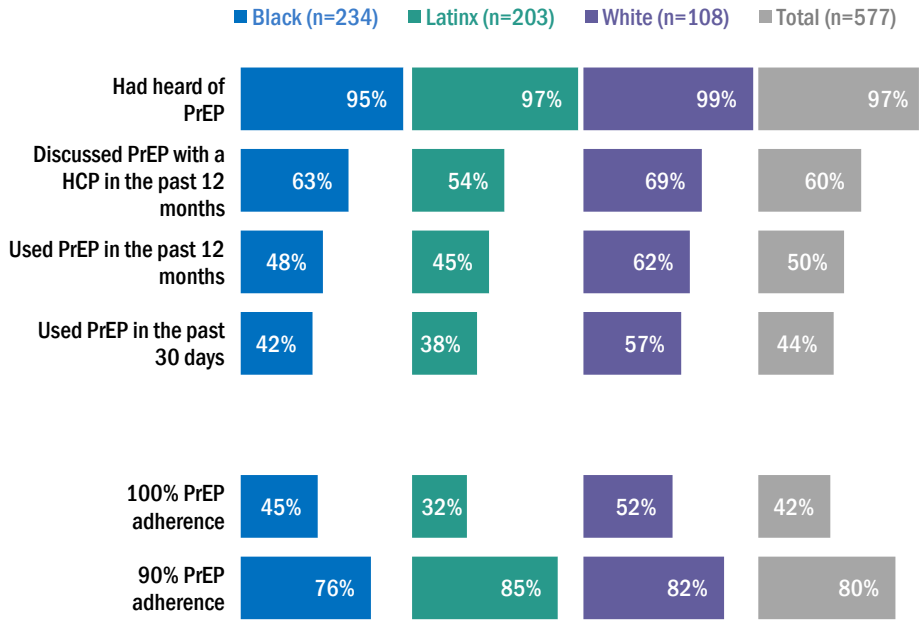
In 2023, HIV testing within the previous 12 months was high among MSM of all racial and ethnic groups. The high proportion of MSM who engaged in condomless sex underscores the importance of using evidence-based HIV/STD prevention strategies among MSM at increased risk for HIV. These strategies include access to and use of condoms, PrEP, DoxyPEP and risk-reduction counseling.

[71] 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.

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

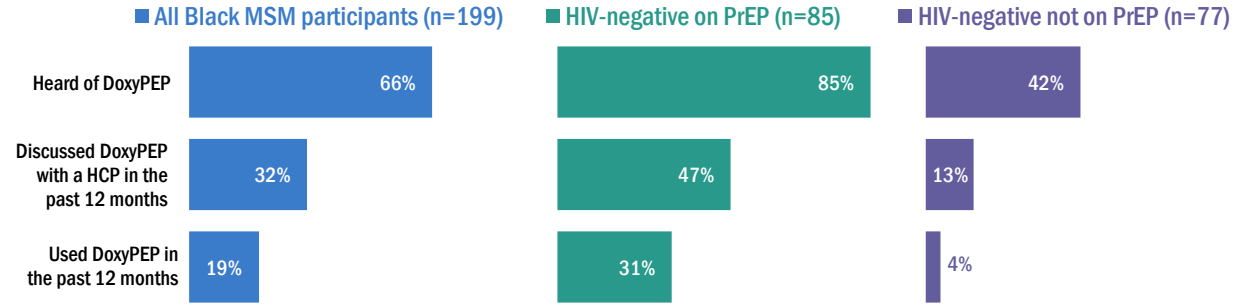
Figure 33: PrEP use among NHBS-MSM participants who reported as HIV-negative status, by race/ethnicity, LAC 2023[72]

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. Of those who reported PrEP use in the past 30 days, 42% reported they had taken all PrEP medicine (100% adherence); An additional 38% reported missing three days or fewer (90% adherence). 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.



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

Figure 34: Doxycycline Post-Exposure Prophylaxis (DoxyPEP) knowledge and uptake among a sample of black MSM, NHBS-MSM, LAC, Jan-March 2024[73]



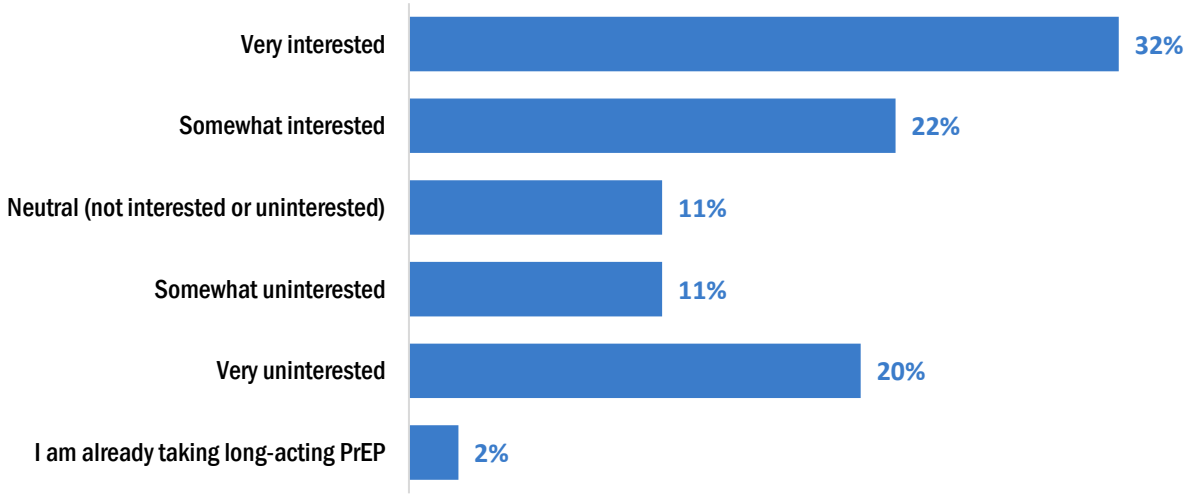
DoxyPEP, as a targeted intervention for bacterial STIs, has the potential to reduce STI acquisition and transmission. In a recent local study, we examined DoxyPEP awareness and uptake among a sexually active Black MSM community. Overall, 66% reported having heard of DoxyPEP, and a third had discussed 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.

[72] 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.
[73] 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.

Interest in and Preferences for Long-Acting PrEP Modalities among NHBS -MSM

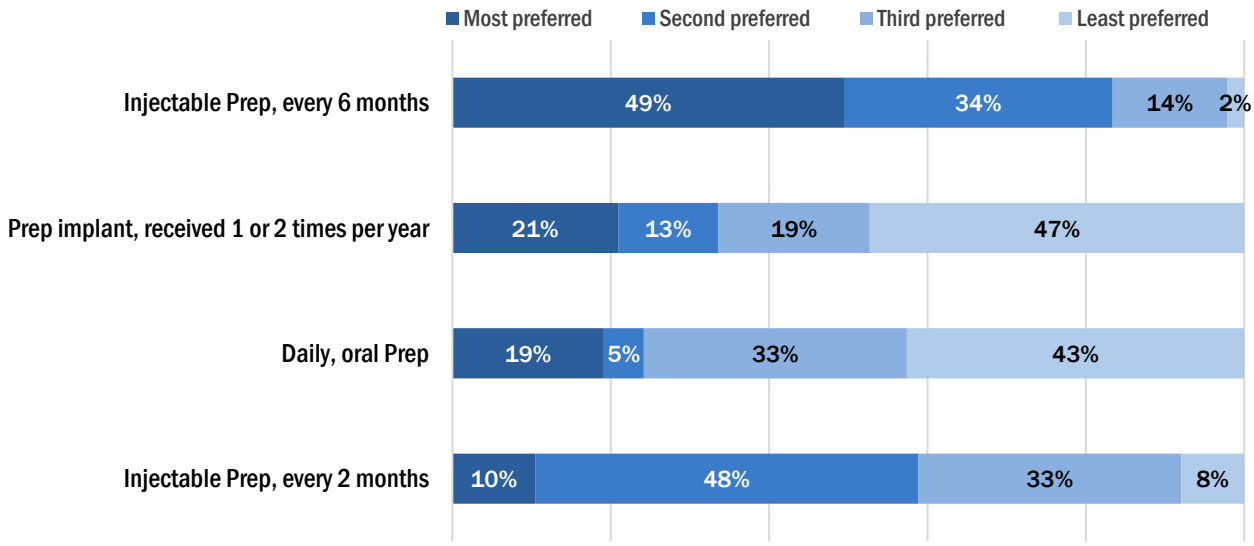
Among HIV negative NHBS-MSM participants (n=444), over half (54%) were interested in taking Long-Acting PrEP and 2% reported they were already taking long-acting PrEP

Figure 35: "How interested are you in taking long-acting PrEP?" Among HIV negative NHBS-MSM participants (n=444), Los Angeles County, 2023



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%).

Figure 36: 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

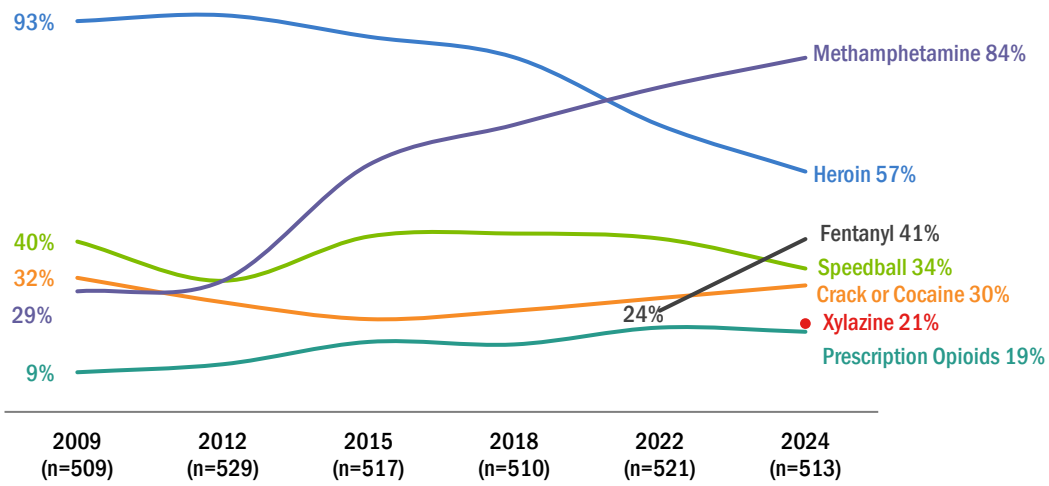


Persons who inject drugs (PWID)

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

Figure 37: Drugs injected in the past 12 months among NHBS-PWID participants, LAC 2009-2024[74]

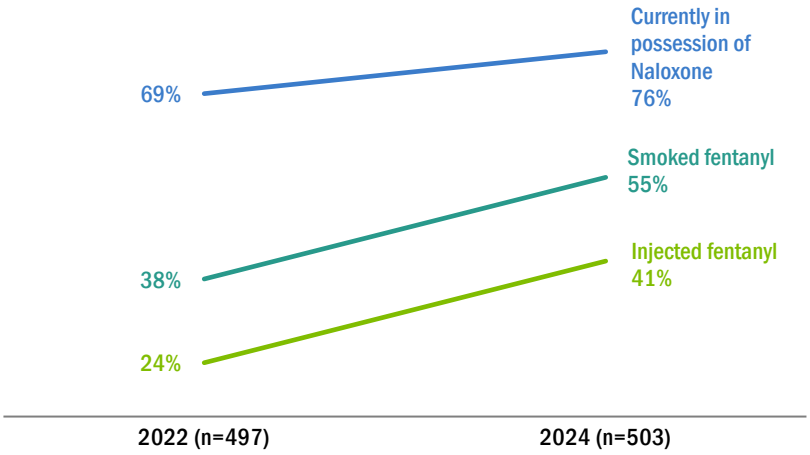
The prevalence of past-year methamphetamine use by injection among PWID increased steadily from 29% in 2009 to 84% in 2024, overtaking heroin in 2022 and continues to rise. Among those reporting past-year methamphetamine injection, 56% reported injecting it daily (data not shown). In the most recent PWID cycle in 2024, **41%** of participants reported injecting fentanyl and **21%** reported injecting xylazine in the past 12 months.



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

Figure 38: 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 injection and smoking of 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.

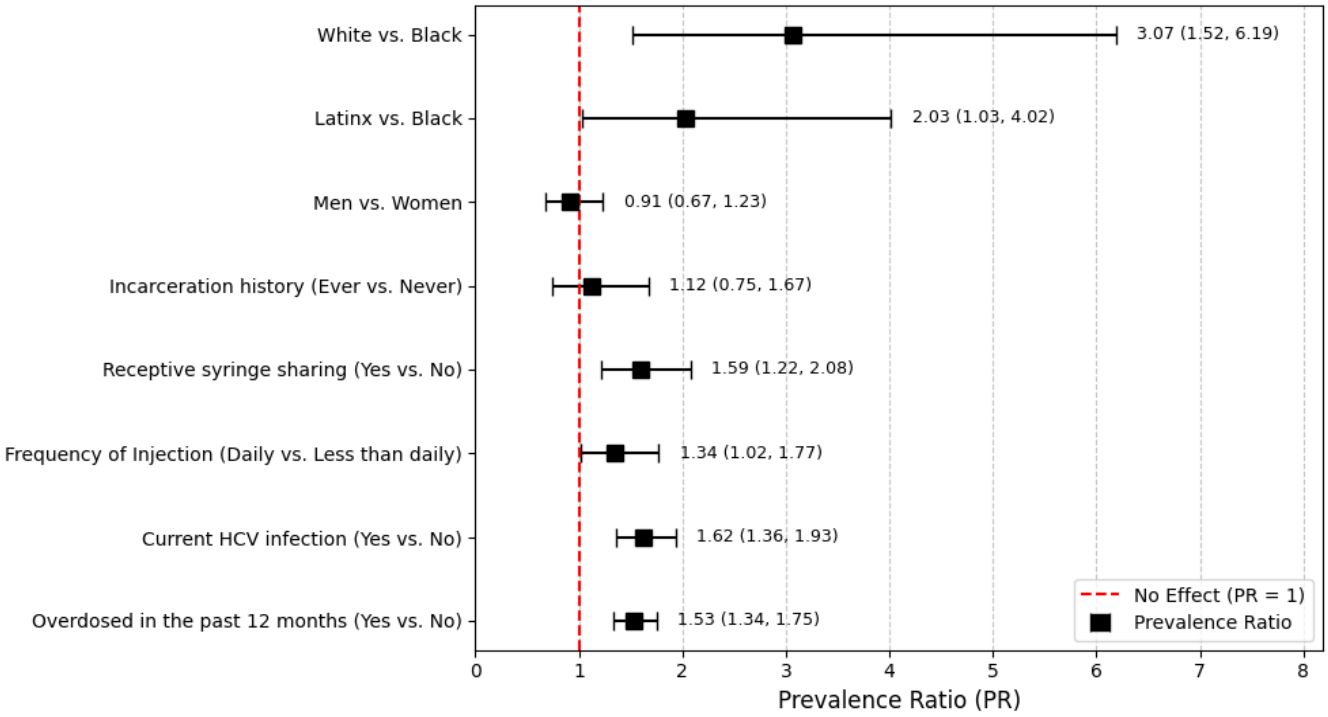


Naloxone can effectively reverse opioid overdoses, including those involving synthetic opioids like fentanyl, and can prevent overdose-related deaths. Among survey participants, 76% reported having naloxone on hand at the time of the interview, higher than in the PWID 2022 cycle. This data suggest that local harm reduction programs should continue scaling naloxone distribution and training, and provide safer smoking supplies to reduce injection-related harms.

[74] Speedball is a polydrug mixture of Heroin and Cocaine.

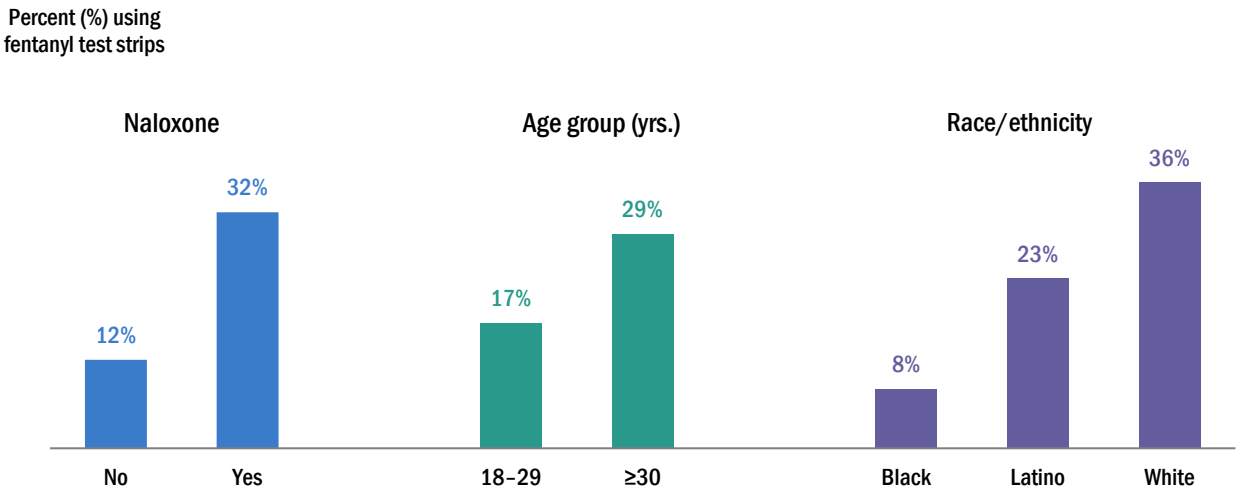
NHBS-PWID 2024 data indicate that fentanyl injection is more common among White or Latinx PWID compared with Black PWID. Syringe sharing is strongly associated with fentanyl injection, likely driven by fentanyl's short duration of effect, which leads to more frequent injecting and more frequent reuse of injecting equipment. This behavioral pattern elevates both the risk of hepatitis C transmission and overdose risk.

Figure 39: Factors associated with fentanyl injection in past 12 months among NHBS-PWID participants, LAC 2024



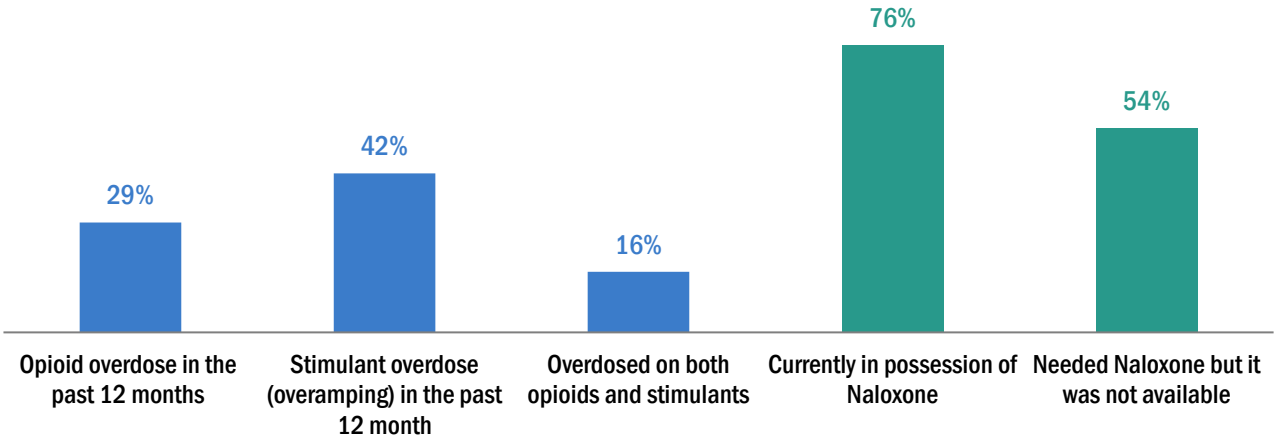
Fentanyl test strips are a tool to help prevent overdoses. In NHBS- PWID 2024, fentanyl test strips were used more often among PWID who routinely carry naloxone, but fentanyl test strips were used less often among younger PWID (aged 18–29 years) and among Black PWID.

Figure 40: Fentanyl Test Strip Use by Naloxone Access, Age or Race/Ethnicity, among NHBS-PWID participants, LAC 2024



The NHBS-PWID2024 survey highlights the burden of opioid and stimulant overdoses among local PWID and indicates an unmet need in overdose prevention.

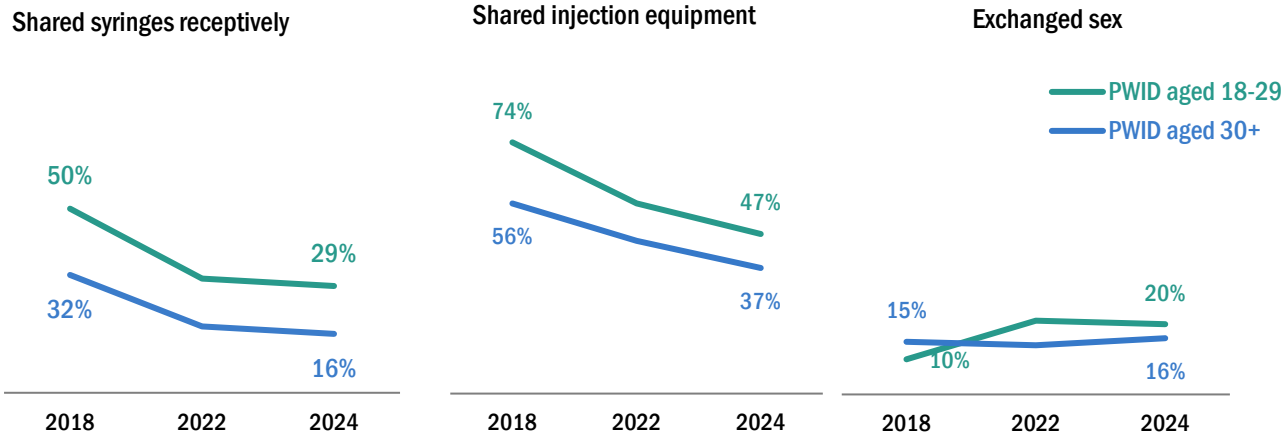
Figure 41: Non-fatal opioid heroin overdose, stimulant overdose, possession of naloxone and unmet naloxone need among LAC NHBS-PWID participants, LAC 2024, n=503



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; however, 54% had experienced situations when naloxone was needed but unavailable, indicating a significant unmet need for naloxone access.

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.

Figure 42: Injection drug use behavior and sex exchange among NHBS-PWID participants by age group, LAC 2018, 2022 and 2024[75]

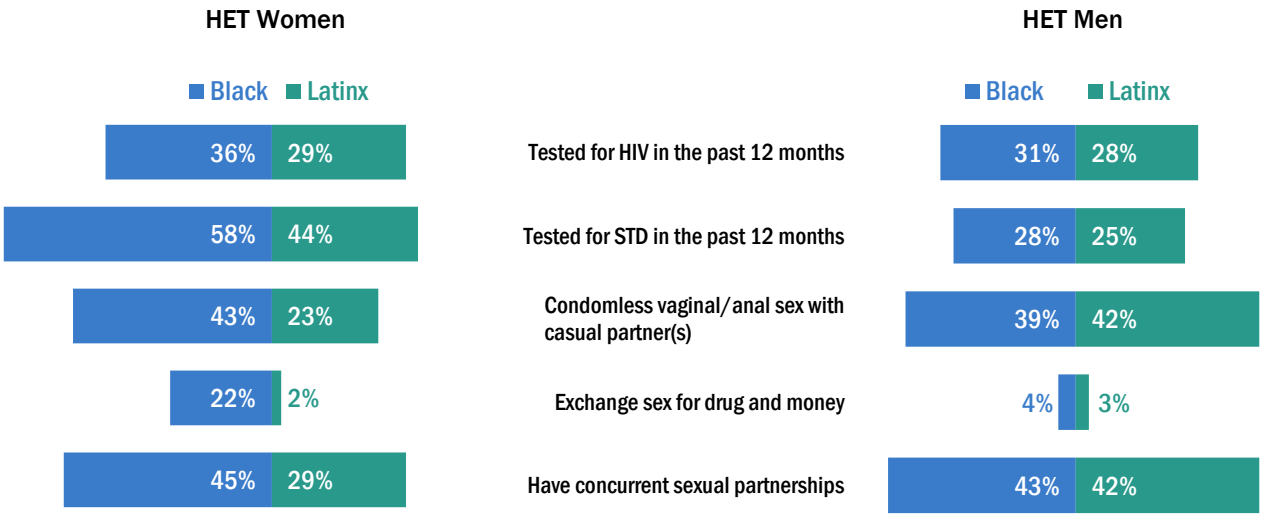


[75] Receptive sharing of syringes or injection equipment refers to using a syringe or injective equipment that has already been used by someone else. All injection and sexual behavior indicators reflect behavior in the 12 months prior to the survey interview.

Heterosexually active persons at increased risk for HIV infection

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

Figure 43: Testing and sexual behavior among NHBS heterosexuals at increased risk of HIV (HET) by sex and race/ethnicity, LAC 2019[76]



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.

[76] 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?"

Women of trans experience & transfeminine people (TG women)

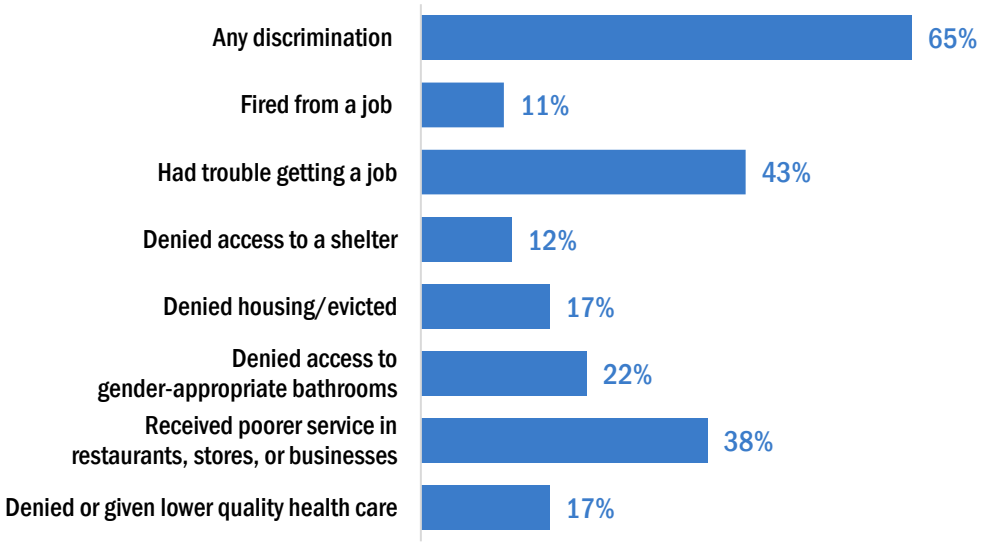
▶▶▶ Among the 593 TG women surveyed in the 2023 NHBS-Trans cycle, many reported experiences that make it difficult to access & use HIV prevention and care services.

Figure 44: Social determinants of health, NHBS-Trans, LAC 2023 (n=593)[77]

* 12 months prior to interview

▶▶▶ 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.

Figure 45: Transgender-specific discrimination among NHBS-Transgender women, LAC 2023[78]

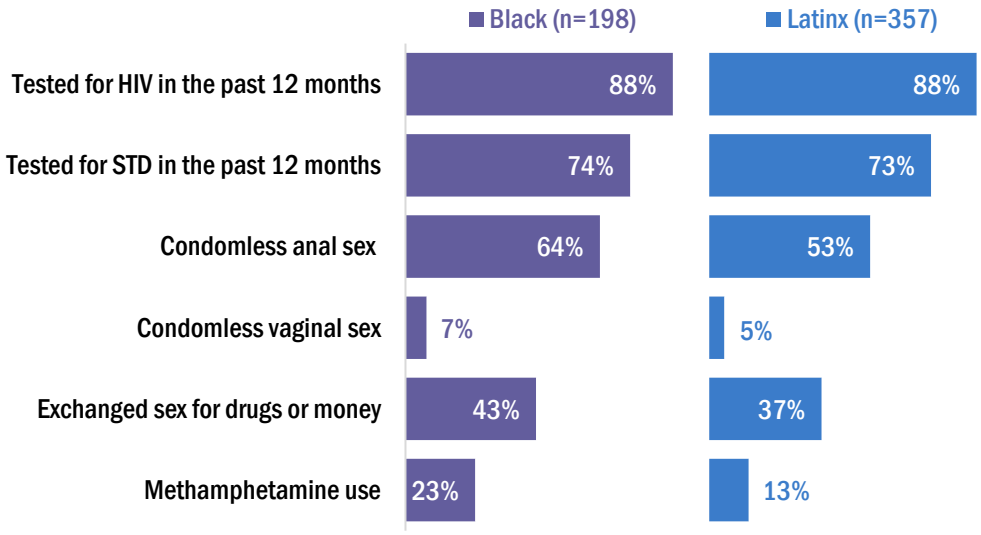


Overall, **65%** reported experiencing at least one type of transgender-specific discrimination (employment, housing, bathroom, businesses, health care): **45%** were either fired from employment or had trouble getting a job, and **17% had** been evicted or denied housing during the past 12 months because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

[77] 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)
[78] Denied access to bathrooms that were appropriate to your gender identity or self-expression.

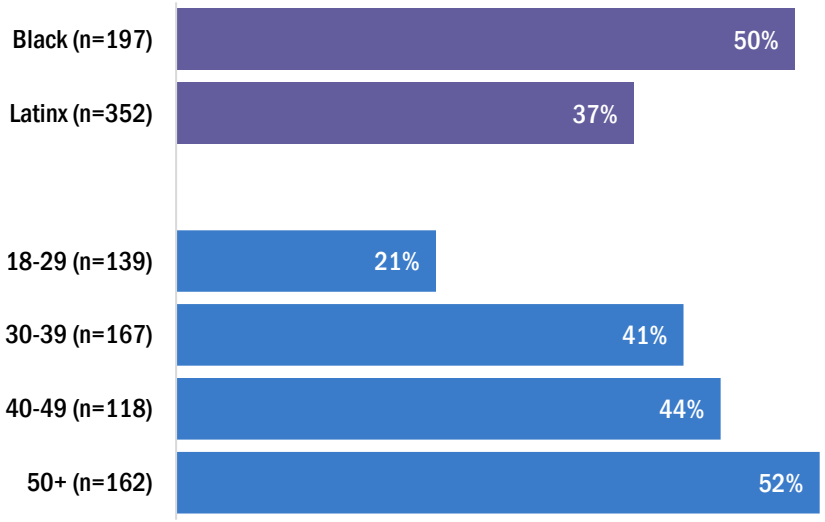
Economic hardship (Figure 44) and employment discrimination (Figure 45) can increase the need for alternate means of survival. More Black TG women reported engaging in condomless anal sex, exchanging sex for drugs or money, and using methamphetamine compared to their Latinx counterparts.

Figure 46: Sexual behavior and drug use among NHBS-Transgender women by race/ethnicity, LAC 2023[79,80]



TG women, particularly those from marginalized racial and ethnic groups, continue to experience disproportionately high rates of HIV. Four in 10 (40%, 234/586) NHBS -Trans2023 participants tested positive for HIV; specifically, 50% of Black and 37% of Latinx TG women surveyed had HIV.

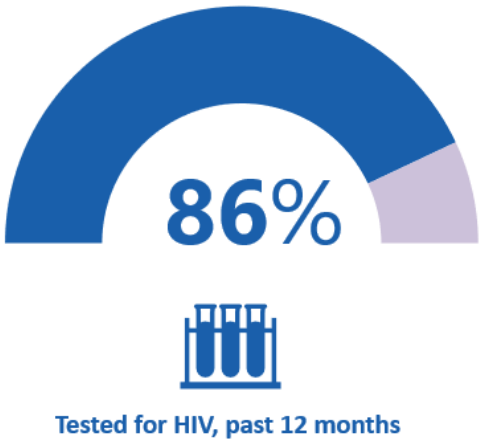
Figure 47: HIV prevalence among NHBS-Transgender women by race/ethnicity, age, LAC 2023



[79] 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.
[80] Estimates for white transgender women were not reported due to their small numbers.

▶▶▶ All Transwomen should get tested for HIV annually.[81]

Figure 48: HIV testing history and locations of their most recent HIV test among TG women, 2023, LAC



Ever tested for HIV among TG women: 97%

Tested for HIV in 12 months: 86%

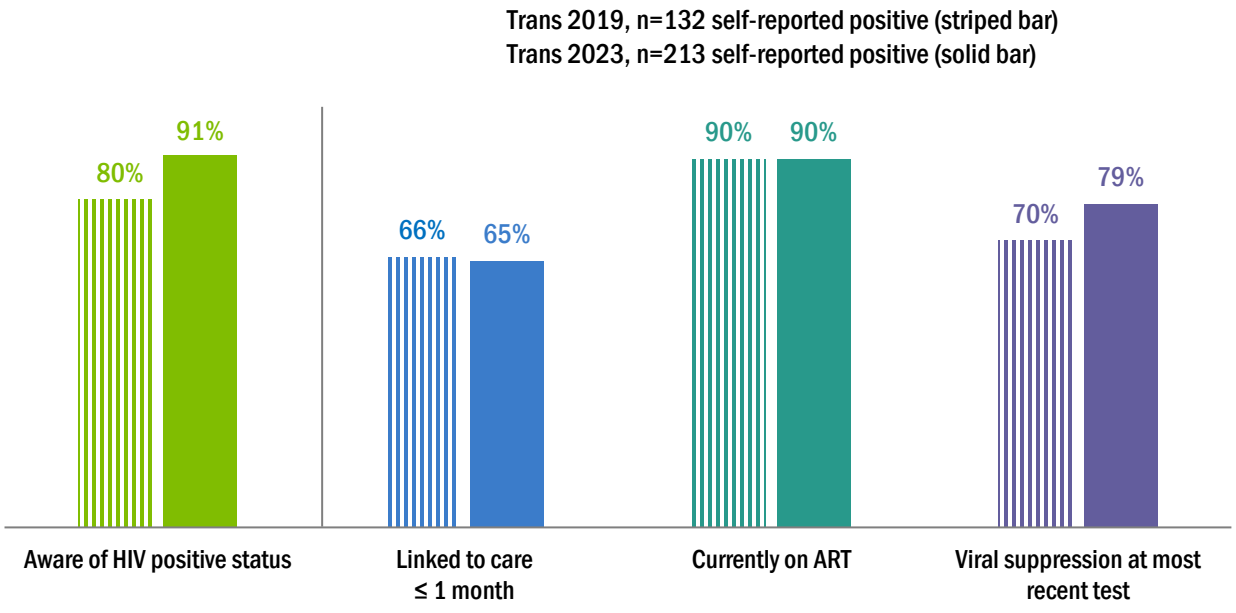
Location of their most recent HIV test among TG women participants who reported being tested for HIV in the 12 months:

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%).

▶▶▶ From 2019 to 2023, HIV care for TG women improved as awareness of HIV status increased from 80% to 91% and viral suppression increased from 70% to 79%.

Figure 49: HIV care and treatment among NHBS-Transgender women 2019 vs. 2023, LAC[82]

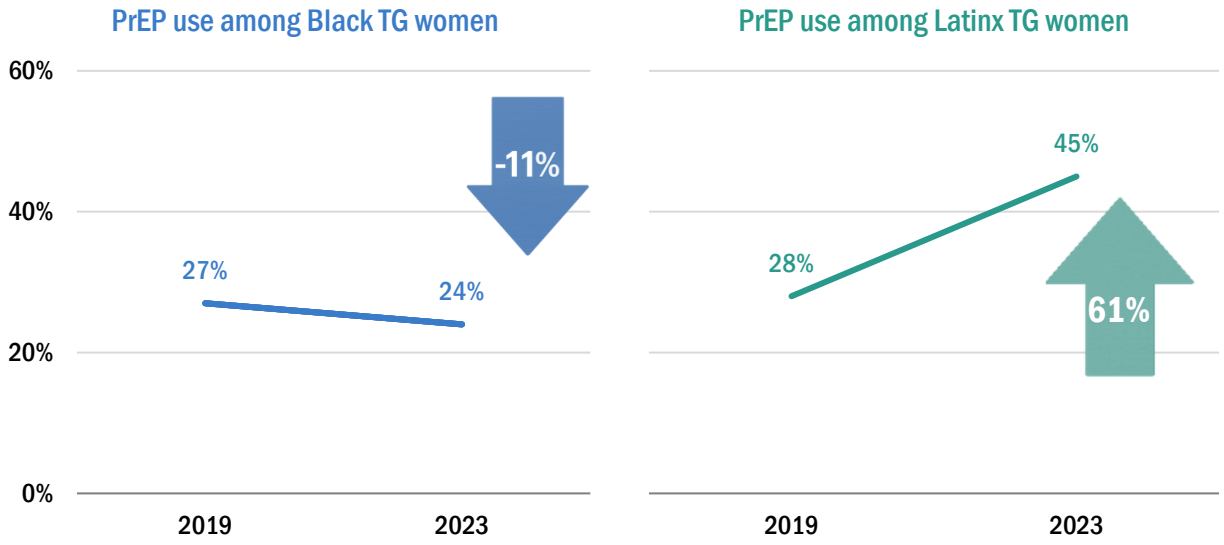


Nine in 10 HIV-positive TG women in the 2023 survey reported currently taking antiretroviral treatment (ART) and 8 in 10 are virally suppressed, which allows them to stay healthy and prevent transmitting HIV to others.

[81] Tested for HIV in the past 12 months excluded participants who reported being diagnosed with HIV more than 12 months prior to the interview.
[82] Viral suppression: undetectable viral load based on most recent test in the past 12 months.

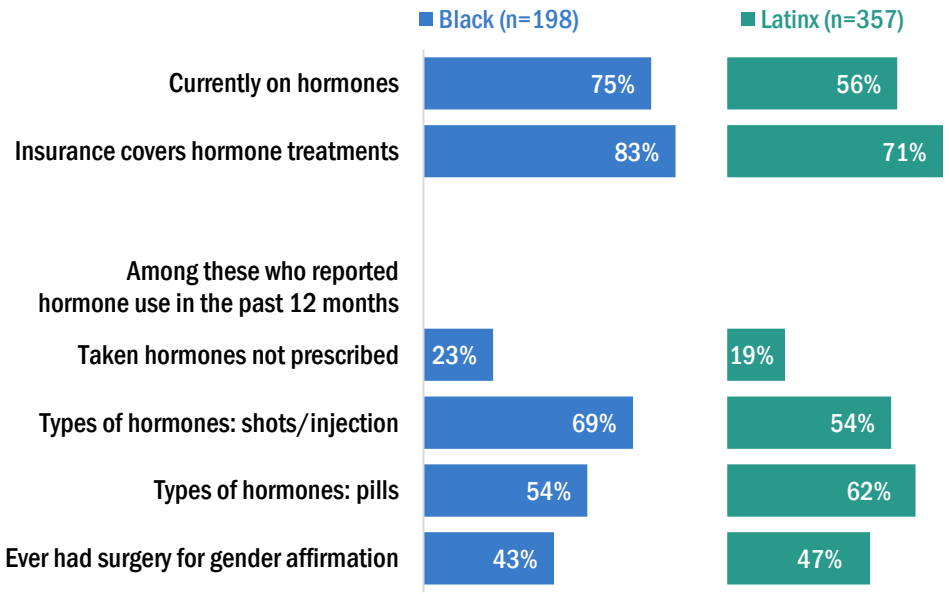
PrEP use increased significantly among Latinx TG women (+61%) but declined among Black TG women (-11%) in Los Angeles County from 2019 to 2023, indicating a growing racial disparity. The lack of progress among Black TG women points to the urgent need for more racially and culturally tailored interventions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

Figure 50: Change in PrEP use among Latinx and Black NHBS- Transgender women, LAC 2019 vs. 2023[83]



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

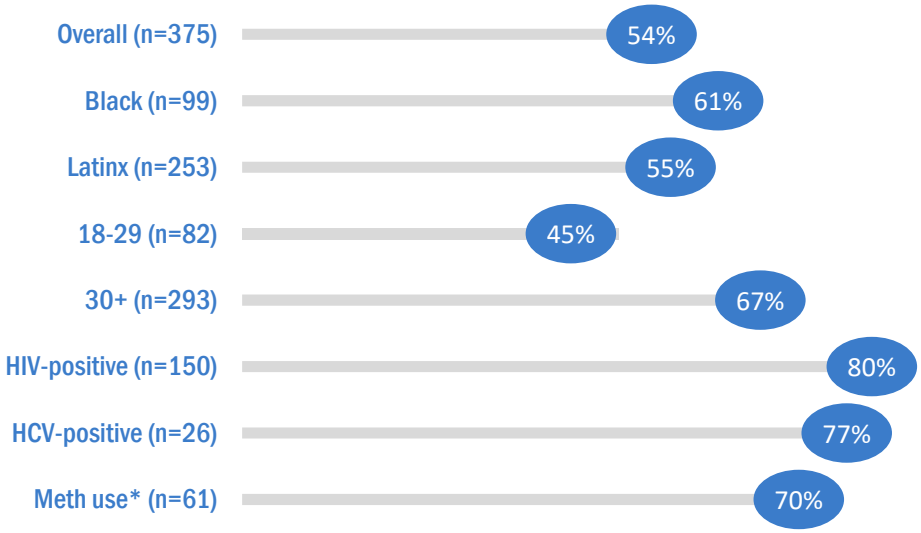
Figure 51: Hormone Therapy and Gender Affirmation among NHBS-Transgender women by race/ethnicity, LAC 2023



[83] 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.

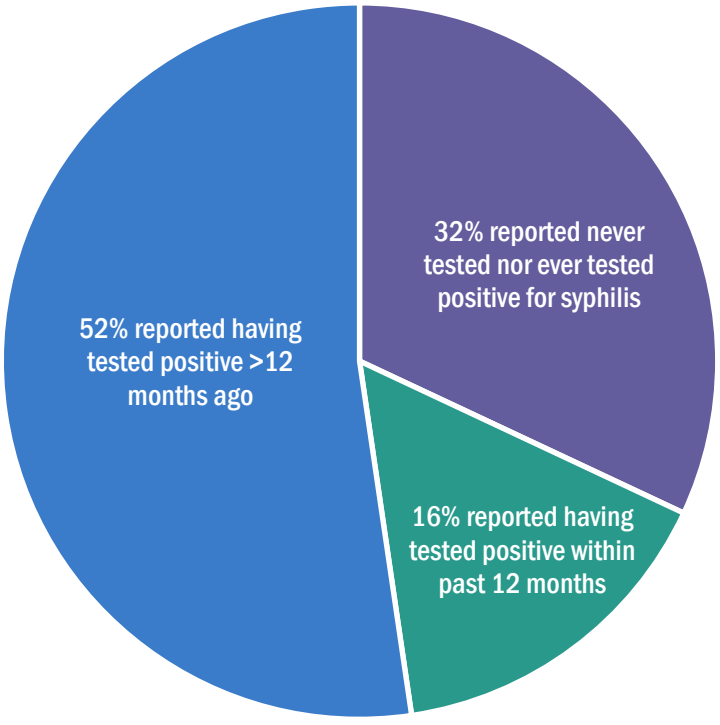
▶▶▶ About half of NHBS-Trans participants (54%) had been exposed to syphilis at some point in their lives. The prevalence was higher among Black TG women, people living with HIV, those with HCV antibodies, or those who reported methamphetamine use in the past 12 months.

Figure 52: Lifetime prevalence of syphilis among NHBS-Transgender women by race/ethnicity, LAC 2023[84]



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

Figure 53: Awareness of syphilis status among NHBS-Transgender women by race/ethnicity, LAC 2023

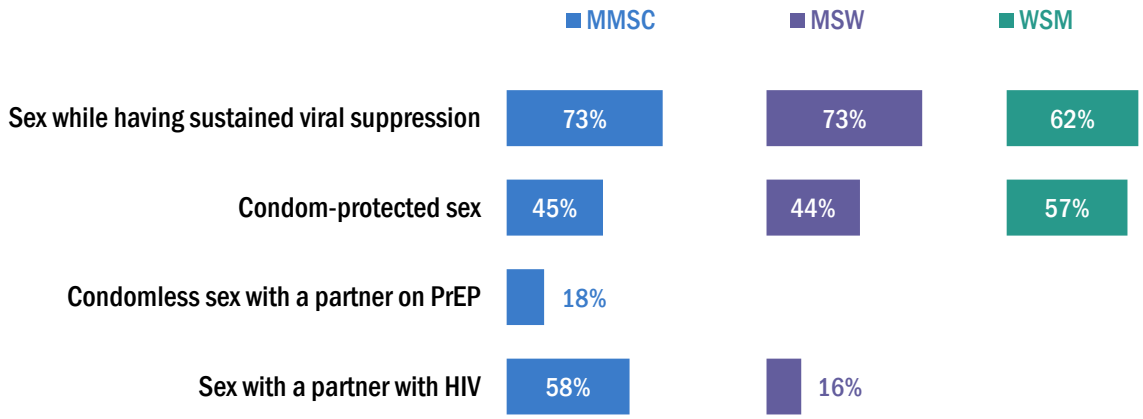


[84]Denominator: Persons with a valid Lab based syphilis treponemal test result. *Methamphetamine use in the past 12 months

Sexual behavior, HIV/STD prevention and awareness among sexually active PLWDH

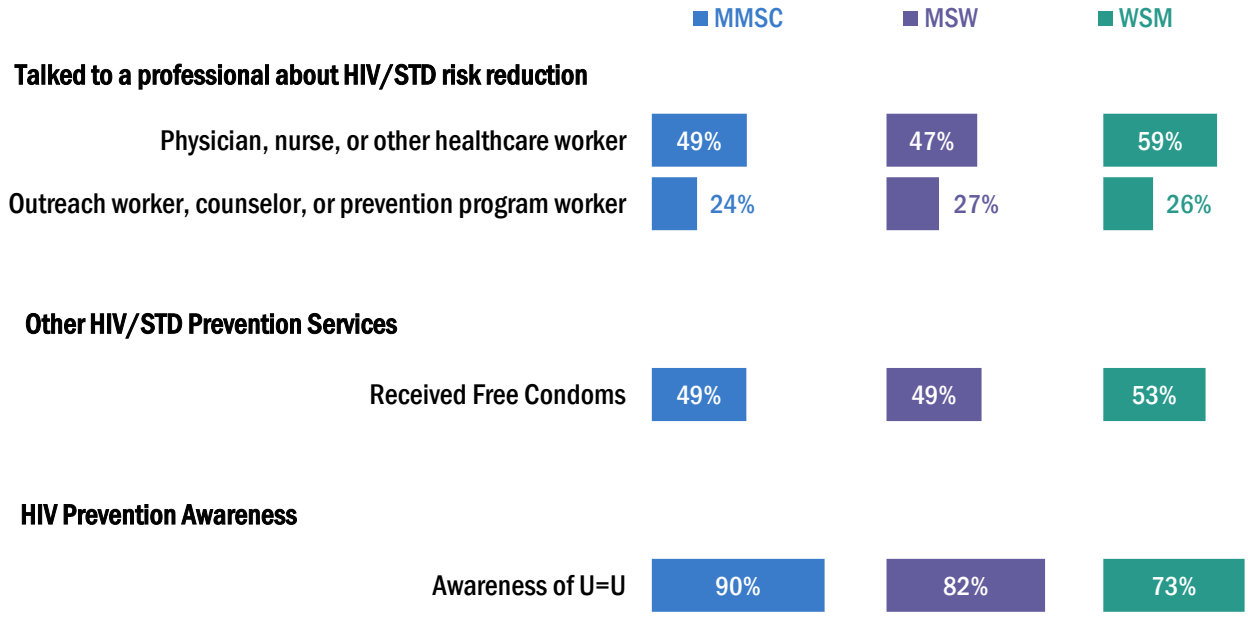
Having sex while having sustained viral suppression was the most common HIV prevention strategy utilized by sexually active PLWDH.

Figure 54: Sexual behavior among sexually active PLDWH—Medical Monitoring Project, LAC 2018-2022[85,86,87,88]



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.

Figure 55: Utilization of HIV/STD Prevention Services and Awareness of Undetectable = Untransmittable (U=U) Among Sexually Active PLWDH—Medical Monitoring Project, LAC 2018-2022[89,90]



[85] Sexual behavior pertains to the past 12 months prior to the interview.
[86] 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.
[87] Condom-protected sex is when condoms were consistently used with at least 1 vaginal or anal sex partner.
[88] PREP use was only measured among the 5 most recent partners and was reported by the participant.
[89] Utilization and/or receipt of prevention services pertain to the past 12 months prior to the interview.
[90] 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.

Met and unmet needs for HIV ancillary services among PLWDH

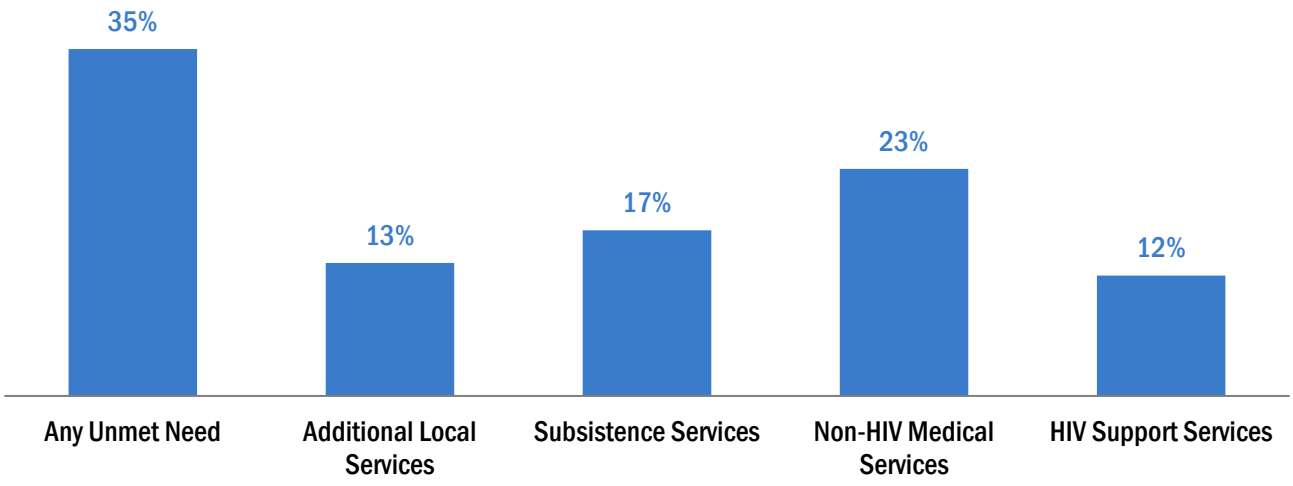
Ancillary HIV care services refer to a wide array of services that support the receipt and retention of HIV care to achieve viral suppression. Across all project areas, MMP ubiquitously collects data regarding the receipt and unmet needs of a host of ancillary services within the past 12 months. The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

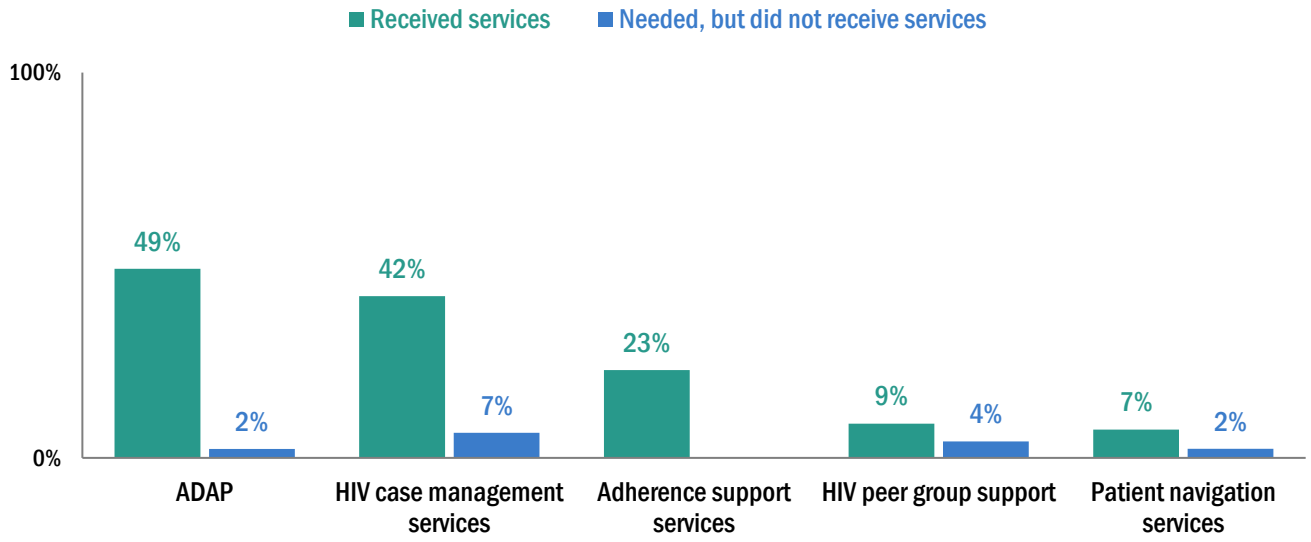
Figure 56a: Percentage of PLWDH reporting at least one unmet need within the past 12 Months by category—Medical Monitoring Project, LAC 2018-2022[91,92]



[91] Unmet need is defined as needing, but not receiving a service within the past all 12 months among all PLWDH.
[92] 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.

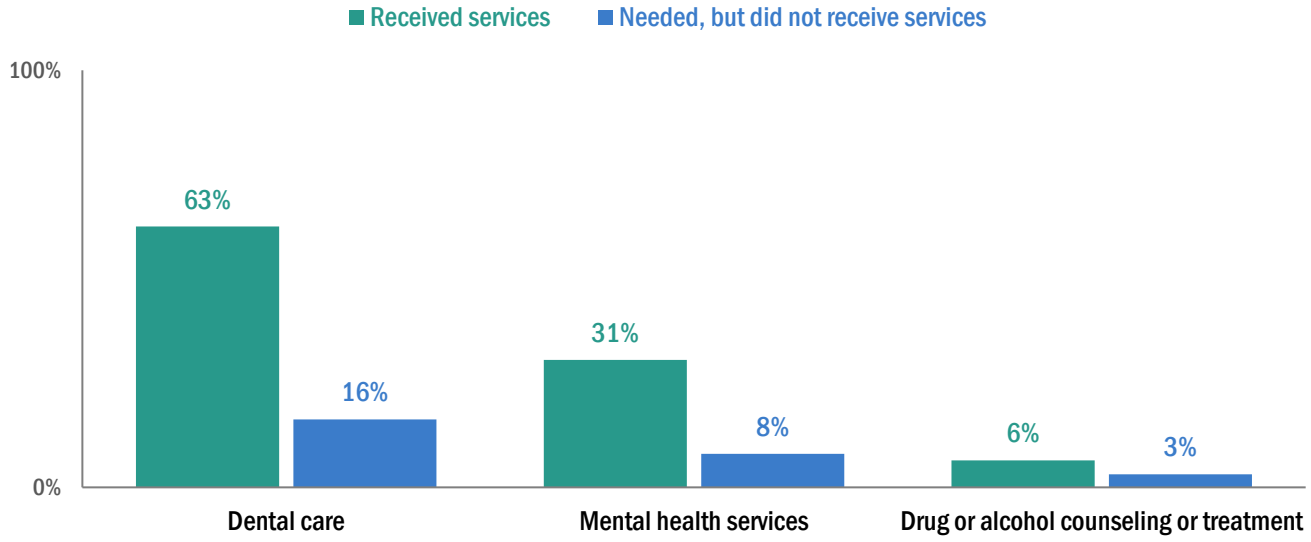
AIDS Drug Assistance Program (49%) and HIV case management services (42%) were the most frequently received HIV support services. Meanwhile, HIV case management services (7%) and HIV peer group support (4%) were the most reported unmet HIV support services.

Figure 56b: Percentage of PLWDH who received or had unmet needs for HIV support services within the past 12 months—Medical Monitoring Project, LAC 2018-2022



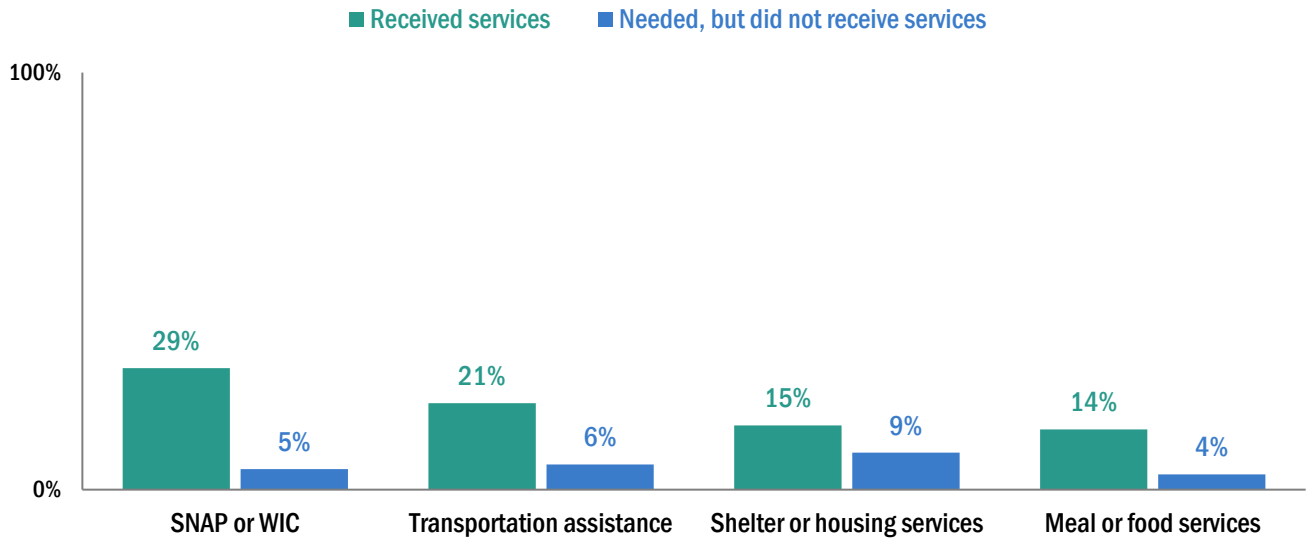
Dental care (63%) and mental health services (31%) were the most commonly received non-HIV medical services, as well as the services that PLWDH reported having the most unmet needs for.

Figure 56c: 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



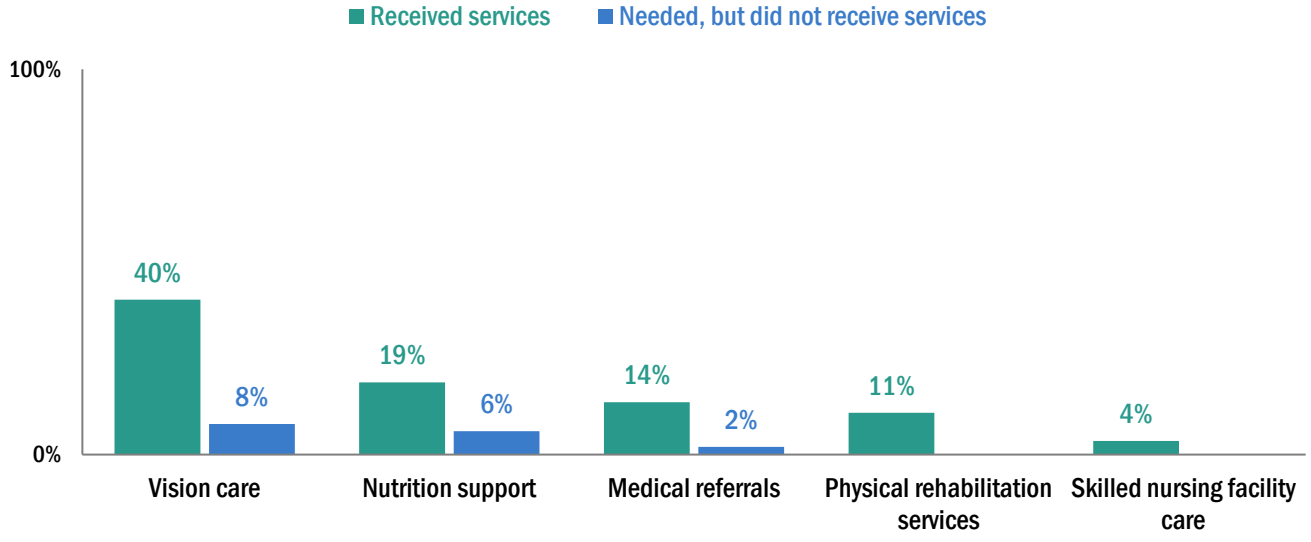
SNAP (also known as CalFresh) or WIC (29%) and transportation assistance (21%) were the most received subsistence services. About 1 in 11 PLWDH reported needing but not receiving shelter or housing services.

Figure 56d: Percentage of PLWDH who received or had unmet needs for subsistence services within the past 12 months—Medical Monitoring Project, LAC 2018-2022[93]



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.

Figure 56e: Percentage of PLWDH who received or had unmet needs for additional local services within the past 12 months—Medical Monitoring Project, LAC 2018-2022[94]

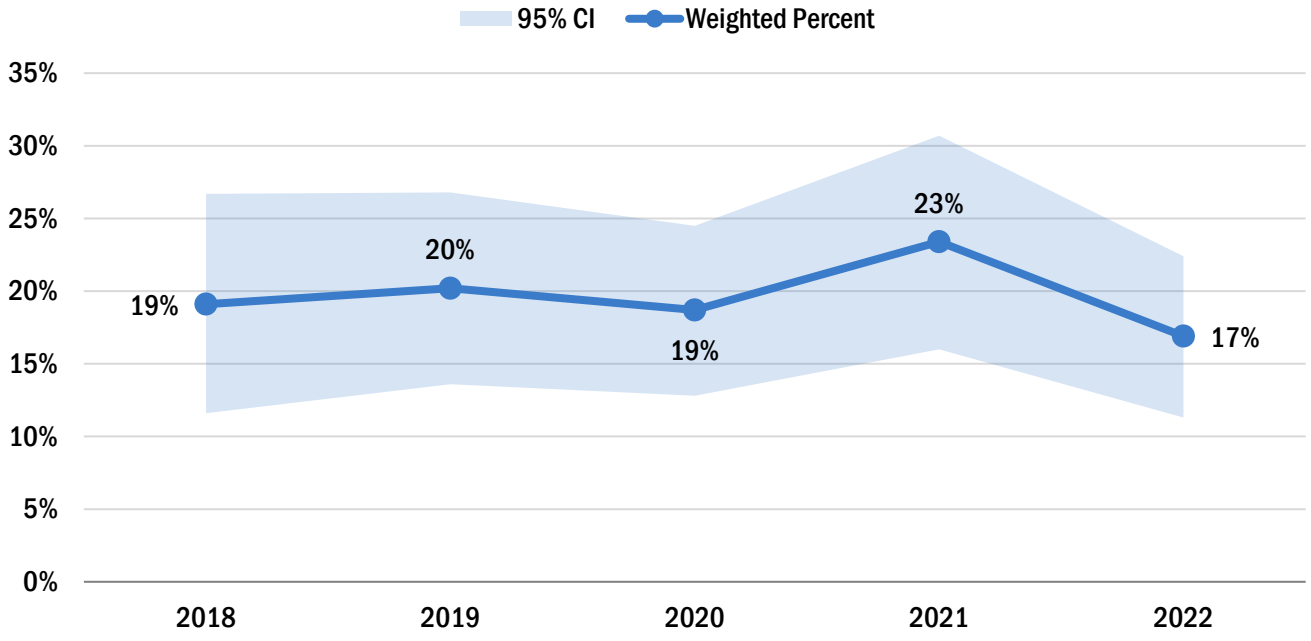


[93] Meal or food services includes services such as soup kitchens, food pantries, food banks, church dinners, or food delivery services.
[94] Nutrition support refers to support provided by a nutritionist who evaluates diets, provides nutritional counseling, and/or recommends supplements to improve health.

Unstable housing or homelessness among PLWDH

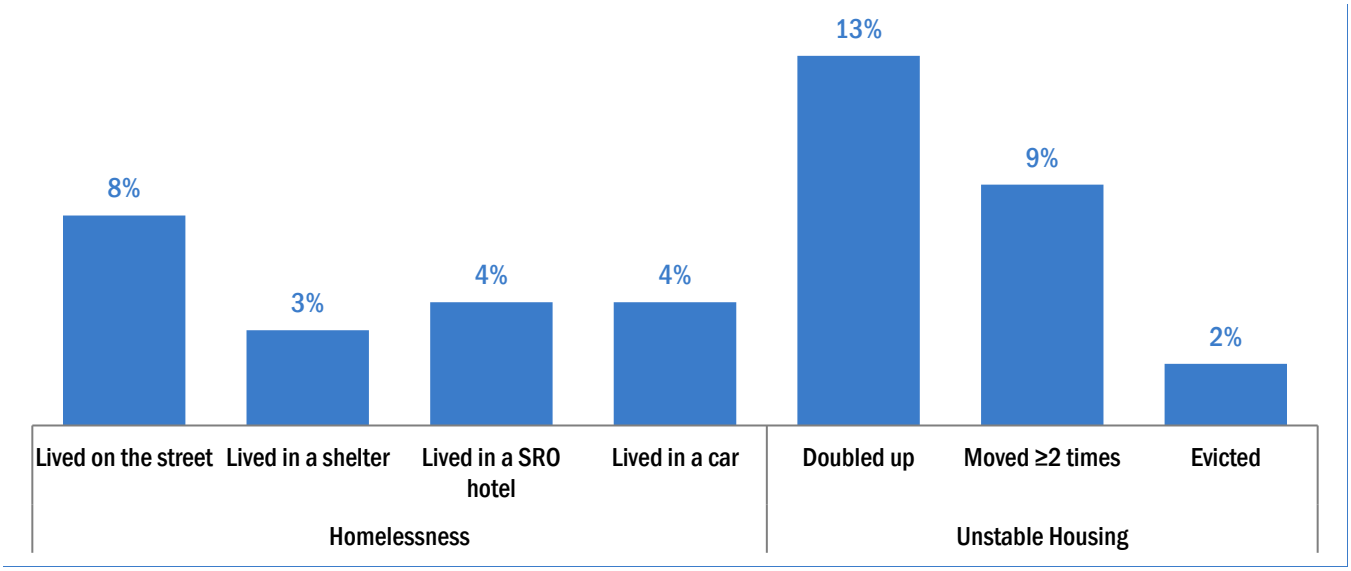
From 2021 to 2022, the prevalence of PLWDH reportedly experiencing homelessness or unstable housing within the past 12 months dropped from 23% to 17%, the lowest since 2018.

Figure 57a: Prevalence of unstably housed PLWDH by year—Medical Monitoring Project, LAC 2018-2022[95]



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%).

Figure 57b: Forms of unstably housing within the past 12 months, reported by PLWDH—Medical Monitoring Project, LAC 2018-2022[95, 96]

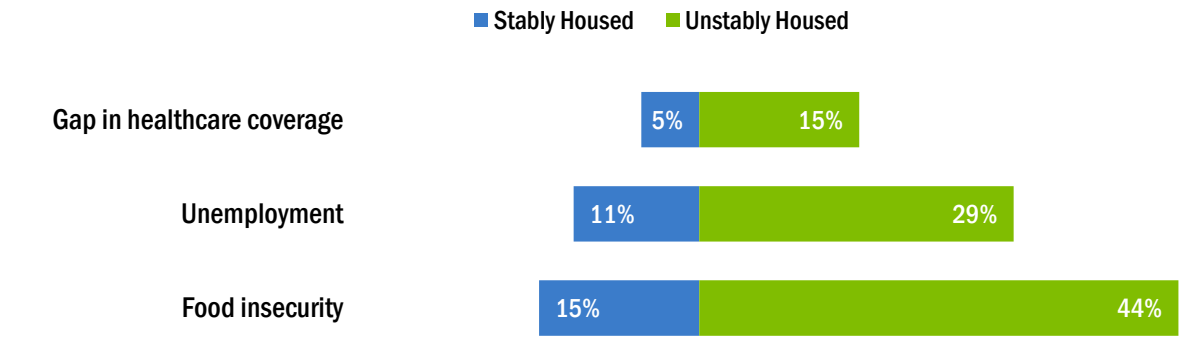


[95] Unstably housing includes experiencing unstable housing (i.e., moving in with others due to financial issues, moving 2 or more times, or being evicted at any time) or homelessness (living on the street, in a shelter, in a single-room-occupancy (SRO) hotel, or in a car at any time) during the past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

[96] Doubled up is defined as having moved in with others due to financial issues.

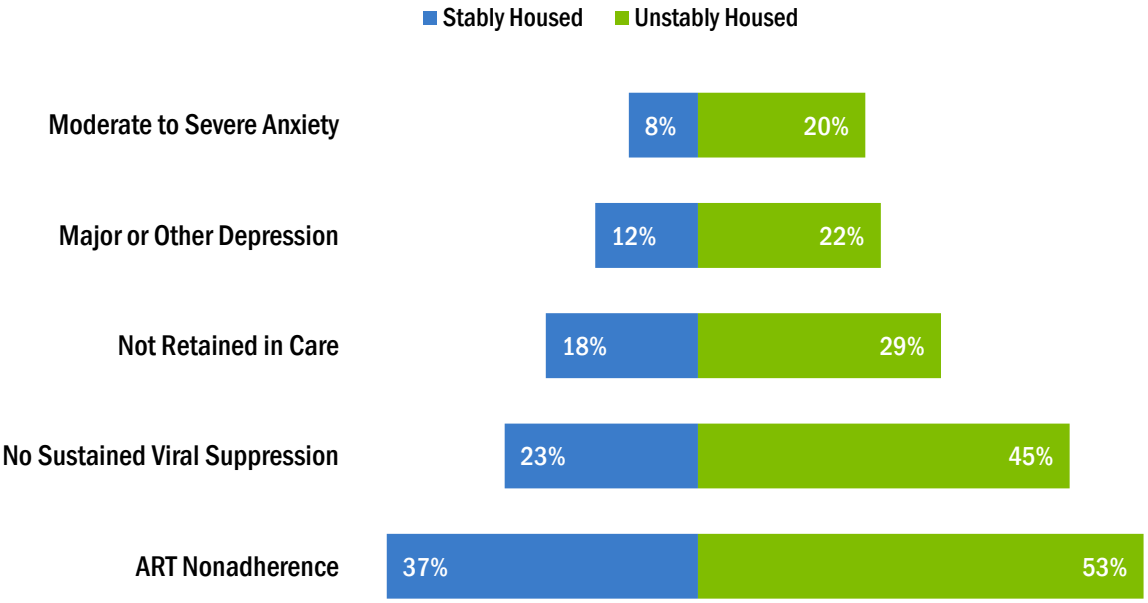
Higher proportions of unstably housed PLWDH reported adverse social indicators such as gaps in healthcare coverage, unemployment, and food insecurity within the past 12 months compared to their stably housed counterparts.

Figure 58a: Select social indicators by housing status—Medical Monitoring Project, LAC 2018-2022[97, 98, 99]



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

Figure 58b: Select clinical and health indicators by housing status—Medical Monitoring Project, LAC 2018-2022[100, 101, 102, 103]



[97] 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.
[98] Unemployment refers to participants who report being unemployed at the time of interview, excluding persons who were unable to work.
[99] Food insecurity is defined as going without food due to lack of money during the past 12 months.
[100] 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.
[101] Retained in care is defined as having two elements of outpatient care HIV care at least 90 days apart within the past 12 months.
[102] 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.
[103] ART nonadherence is defined as missing one or more doses of HIV medicines within the past 30 days.

HIV co-infected populations

STD and HIV co-infection[104]

AT A GLANCE

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.

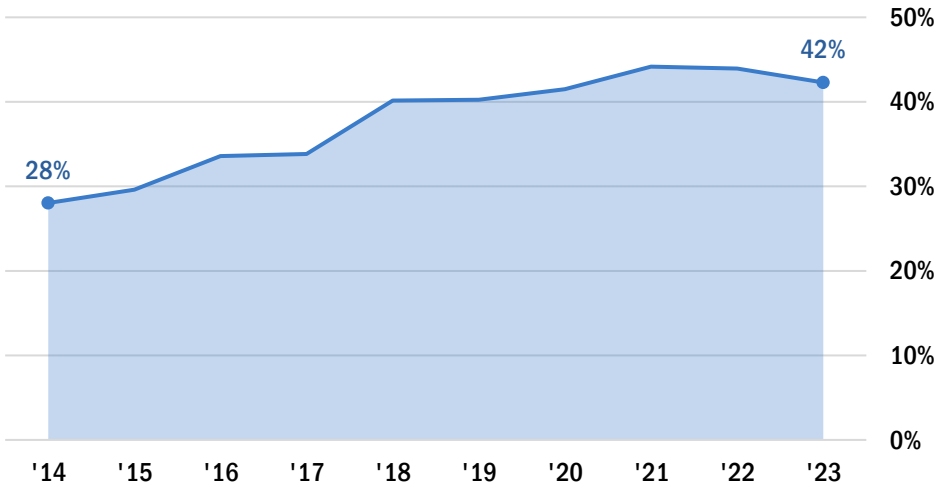
We examined the percent of persons newly diagnosed with HIV who also received an STD diagnosis in the same calendar year. This approach attempts to approximate the percentage of HIV-STD co-infections around the time of HIV diagnosis. Note that a person may be living with HIV for months or years before 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%.

Figure 59: Percentage of persons newly diagnosed with HIV aged ≥ 13 years who are also diagnosed with syphilis, gonorrhea, and/or chlamydia in the same calendar year as their HIV diagnosis, LAC (excluding Long Beach and Pasadena), 2014-2023[105,106,107,108]

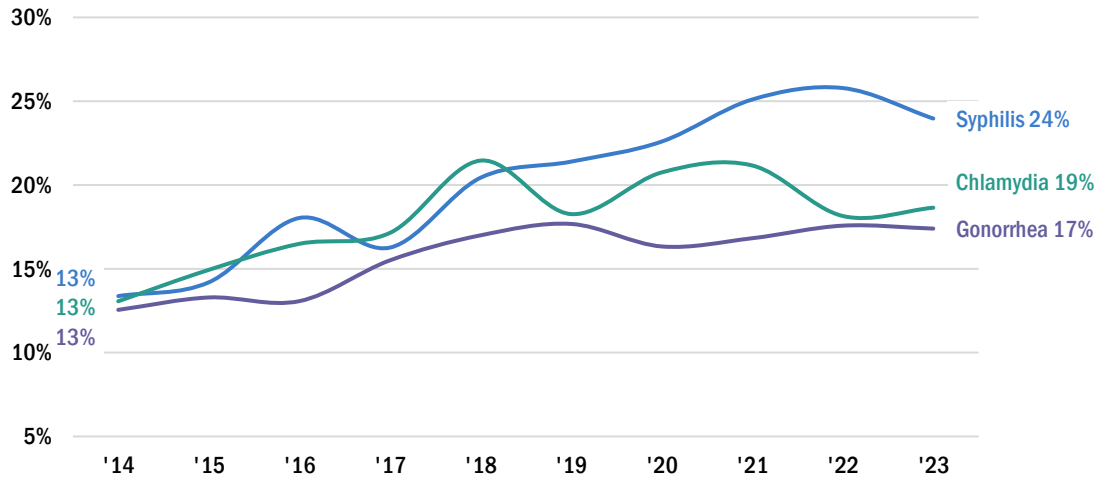
The observed increase in persons co-infected[104] with HIV and STDs in LAC reflects the rise in total STD cases over the same time period.



[104] 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.
[105] PLWDH with more than one STD case per year are counted only once.
[106] DHSP prioritizes HIV, syphilis, and congenital syphilis cases for investigation.
[107] STD cases in the cities of Long Beach and Pasadena are reported to their respective health departments.
[108] Due to reporting delay and time needed for case investigations, data are shown through 2023 instead of 2024.

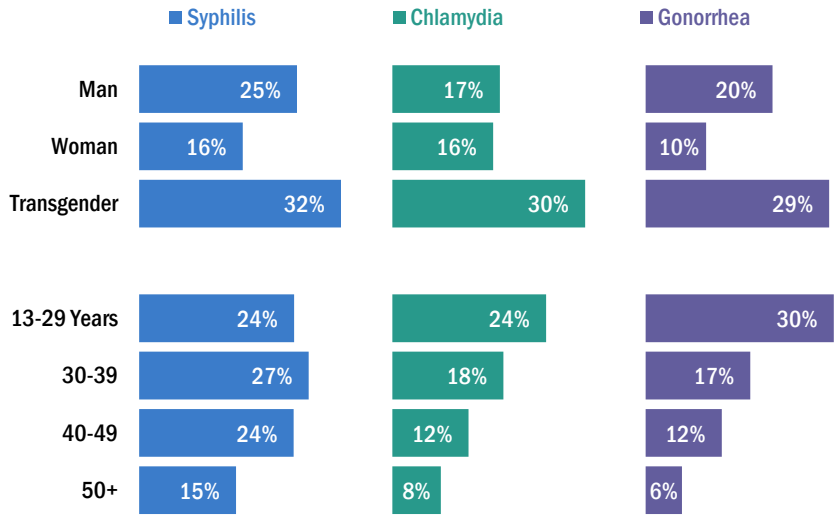
HIV co-infections[109] with syphilis, chlamydia, and gonorrhea have increased over the last 10 years. In 2023, syphilis co-infection[109] was highest, followed by chlamydia and gonorrhea.

Figure 60: Percentage of persons newly diagnosed with HIV aged ≥ 13 years who were diagnosed with syphilis, gonorrhea, or chlamydia in the same calendar year as their HIV diagnosis by STD, LAC (excluding Long Beach and Pasadena), 2014-2023[110,111,112]



Syphilis co-infection[109] at the time of HIV diagnosis was higher than other STDs.
Syphilis co-infection[109] was highest among transgender people newly diagnosed with HIV.
Syphilis co-infection[109] was higher among people aged 49 years and younger compared with those aged 50 and older.

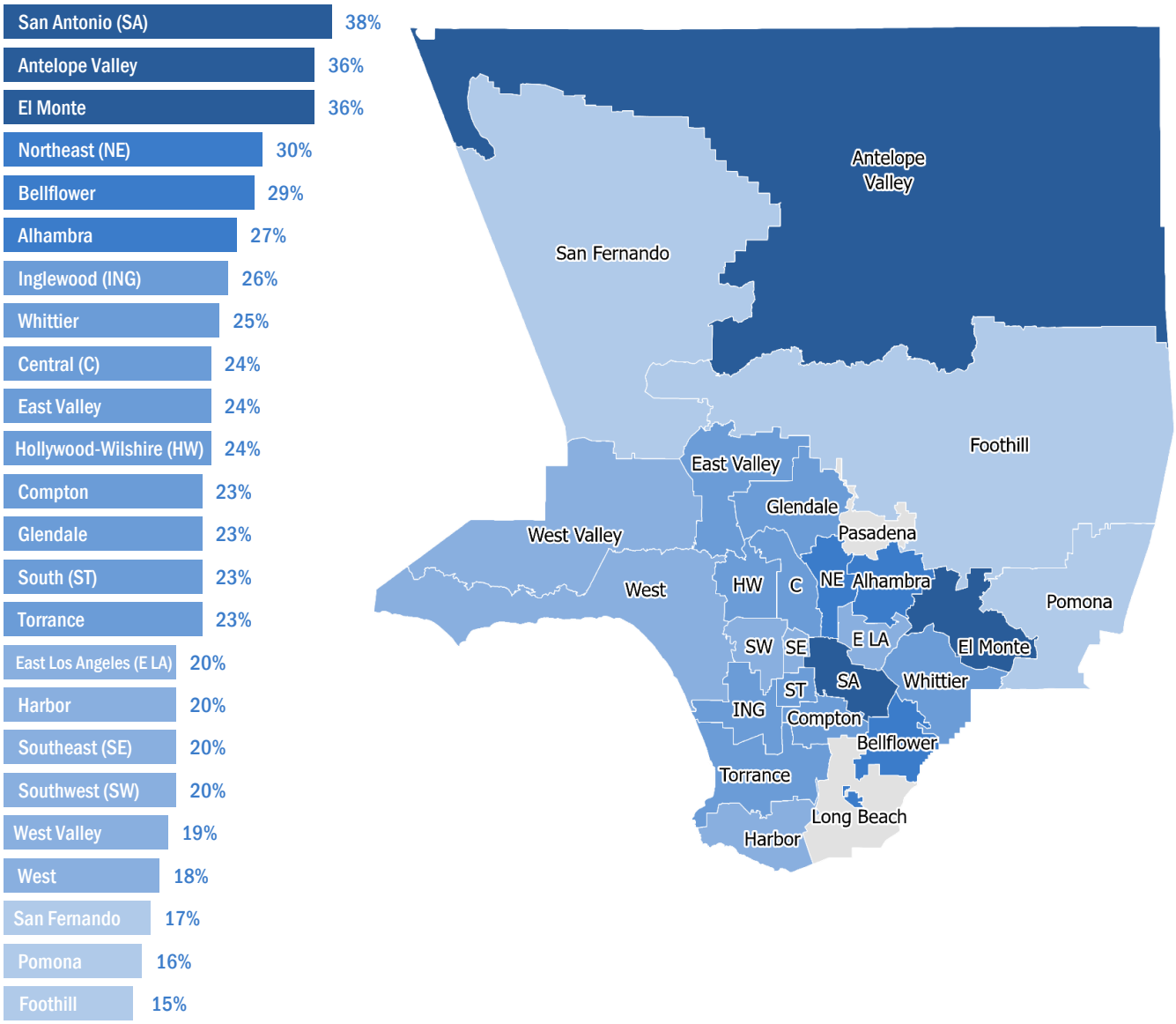
Figure 61: Percentage of persons newly diagnosed with HIV aged ≥ 13 years who had syphilis, gonorrhea, or chlamydia in the same calendar year as HIV diagnosis by STD, gender, and age group, LAC (excluding Long Beach and Pasadena), 2023[110,111,112]



[109] 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.
[110] DHSP prioritizes HIV, syphilis, and congenital syphilis cases for investigation.
[111] STD cases in the cities of Long Beach and Pasadena are reported to their respective health departments.
[112] Due to reporting delay and time needed for case investigations, data are shown through 2023 instead of 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[113] in 2023.

Figure 62: 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[114,115,116]



[113] 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.
[114] DHSP prioritizes HIV, syphilis, and congenital syphilis cases for investigation.
[115] STD cases in the cities of Long Beach and Pasadena are reported to their respective health departments.
[116] Due to reporting delay and time needed for case investigations, 2023 is shown as the latest year.

Mpox and HIV co-infection

AT A GLANCE

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.

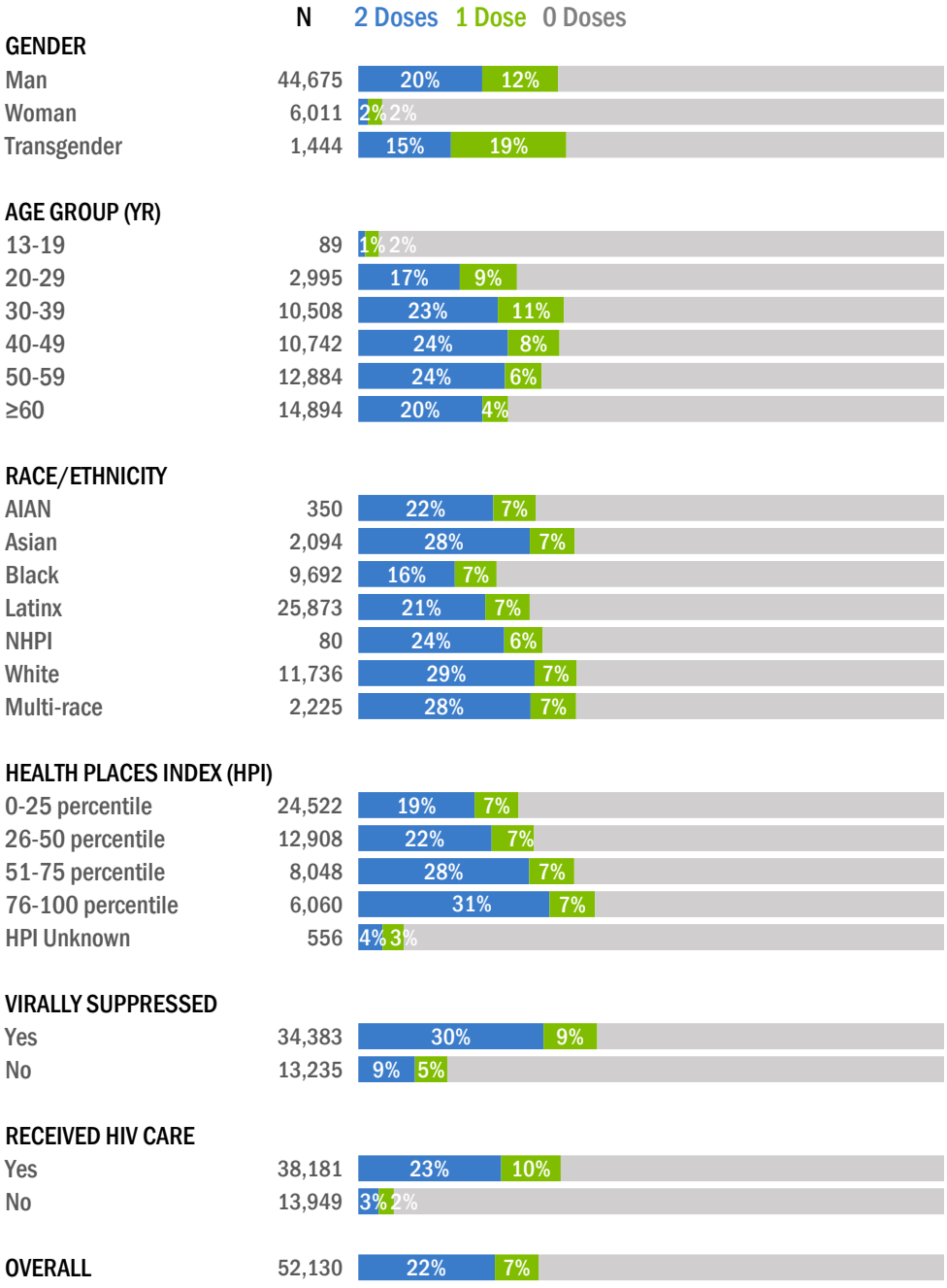
Using surveillance data on persons living with diagnosed HIV through December 2024 and newly diagnosed cases of mpox infection from the onset of the outbreak (May 2022) through end of year 2024, we calculated the HIV co-infection rate among mpox cases. CDC recommends that anyone with HIV be vaccinated 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.

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 who are not virally suppressed and those who have not received HIV care in the last 12 months.

Figure 63: JYNNEOS vaccination dose among PLWDH aged ≥ 13 years by gender, age, race/ethnicity, Healthy Places Index (HPI),[117] and HIV care status, LAC 2024[118]

Note: The California Healthy Places Index (HPI), developed by the Public Health Alliance of Southern California, combines 25 community characteristics, like access to healthcare, housing, education, and more, into a single indexed HPI score. The healthier a community, the higher the HPI score.



[117]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

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

Census tract characteristics and HIV

Social determinants of health (SDOH) and HIV care outcomes

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.

Figure 64: Percentages of linkage to care within 1 month[119] and viral suppression within 6 months[120] of HIV diagnosis among adults aged ≥ 18 years, by federal poverty level, education level, median household income, health insurance coverage, and Gini Index—census tract level,[121] LAC 2023

[119] 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.
[120] Viral suppression: numerator includes persons newly diagnosed with HIV in 2023 who achieved viral suppression (HIV-1 RNA < 200 copies/mL) within 6 months of HIV diagnosis; denominator includes persons who were diagnosed with HIV in 2023.
[121] Census tract characteristics are based on 2019–2023 ACS estimates, which were linked to the residential addresses of persons diagnosed with HIV in LAC in 2023. The median was determined across LAC census tracts. Not all persons were assigned an SDOH indicator, either because they resided in a census tract for which a SDOH measure was not available or because their residence at diagnosis was not geocoded to the census tract level (see Technical Notes).

Data to Action

Progress and Opportunities Among Vulnerable Populations

- HIV prevalence and high-risk sexual behavior are high among MSM and transgender women, especially Black/African-American persons. Persons who identify as MSM or TG women should be tested at least annually as part of routine health care and, if tested HIV-positive, immediately linked to HIV care and educated on strategies to prevent transmission of HIV to their partners.

- Though the prevalence of HIV is relatively low among persons who inject drugs (PWID), high risk injection behavior in this population is concerning, particularly among younger PWID. As shown in the next section, PWID also have the poorest outcomes across the HIV continuum of care. Current HIV prevention, testing, and care services for PWID should be evaluated to assess whether the needs of PWID are incorporated to successfully prevent and manage disease.

- While the increase in HIV diagnoses among PEH may not be attributable to increasing transmission rates in this population but rather increases in the number of LAC residents sliding into homelessness, the result is still an increasing number of PLWDH in LAC who need resource intensive services. People with HIV experiencing homelessness are more likely to delay entering HIV care, have reduced access to regular HIV care, and have poorer adherence to antiretroviral treatment. Addressing the needs of PEH with HIV will require implementing integrated solutions that address the comprehensive health, social services, and housing needs of these vulnerable populations so they can stay healthy and prevent further HIV transmission.

- PrEP use is a biomedical intervention that can minimize the risk of acquiring HIV among HIV-negative persons. Despite its promise, PrEP use in populations at highest risk for HIV, including MSM and TG women, remains low. We must continue to strengthen partnerships with heath care providers and programs that serve vulnerable populations to ensure that PrEP is discussed and offered to all persons at high risk of acquiring HIV.

- Prevention strategies among PLWDH are working. The vast majority of sexually active PLWDH are not engaging in high-risk sex but practicing safe sexual behavior with their partners. These best practices should be shared with the broader community through sex positive education programs and communication messages.

Data to Action (continued)

Progress and Opportunities in Vulnerable Populations

- An integrated disease surveillance system that concurrently reports and investigates multiple diseases, including HIV, will advance disease co-infection surveillance and facilitate a comprehensive response for coinfected individuals.
- The public health response to HIV should include STD prevention and care. All persons with a new HIV diagnosis should be screened for syphilis, and all persons with a new syphilis diagnosis should be screened for HIV. Syphilis infection should be considered an indication for starting PrEP among HIV-negative persons.
- Persons with HIV infection were disproportionately affected by the mpox outbreak in 2022. While mpox cases declined dramatically in 2023 and 2024, the data illustrates the importance of continuing to increase access to mpox vaccination, diagnosis, and treatment among persons with HIV. Additional efforts are needed to improve mpox vaccine confidence and access among PLWH, especially among those who are <30 years old, persons of color, persons residing in areas with a low HPI score, and/or out of HIV care.
- HIV surveillance data among populations at high risk for HIV highlight disparities in HIV outcomes and access to prevention services among the Black population and young PWID. Further investigation is needed to identify underlying socio-economic, social determinants of health, and structural factors, including racism and other forms of stigma and discrimination, that may be driving these health inequities. Addressing these root causes will help to establish stronger systems of care to better support these populations.

HIV Surveillance to Partner Services Continuum

AT A GLANCE

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.

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.

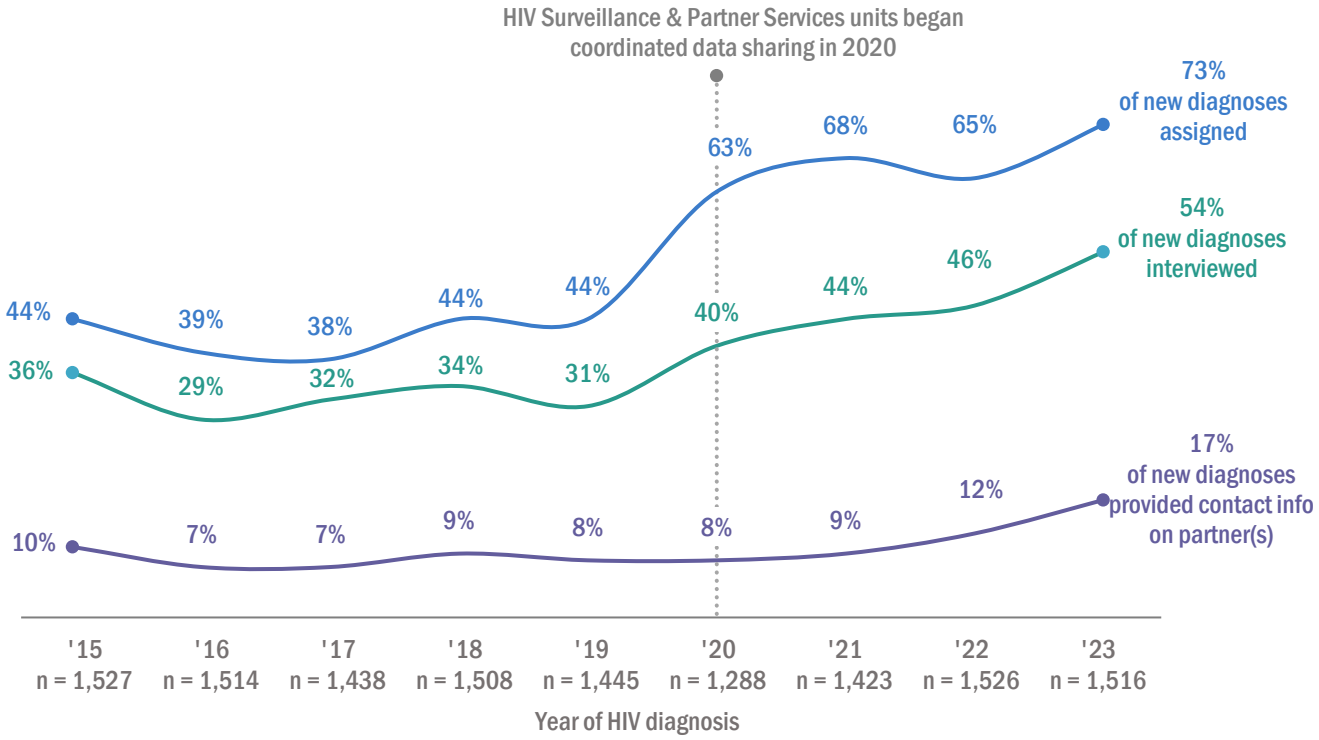
EHE Partner Services Targets

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.

Trends in the HIV Partner Services Continuum

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.

Figure 65: HIV Partner Services continuum among new HIV diagnoses by year, LAC (excluding Long Beach and Pasadena) 2015 – 2023[122,123,124,125]

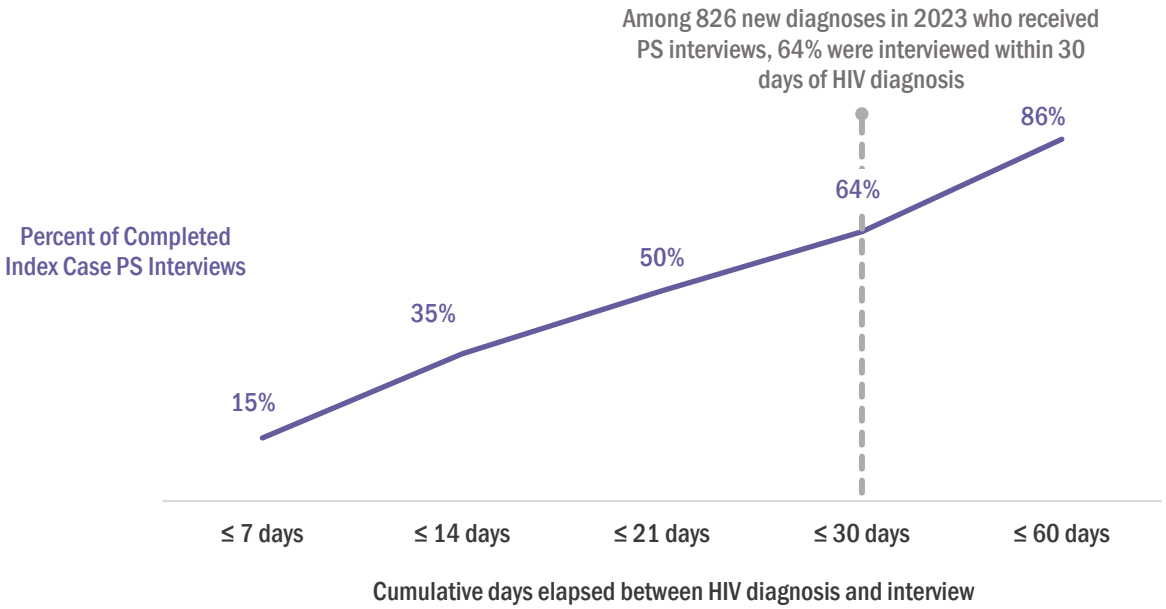


In 2023, 73% of newly diagnosed HIV-positive persons in LAC were assigned for a Partner Services interview and 74% of those persons assigned for Partner Services were interviewed. Of all new HIV diagnoses, 54% were interviewed and 17% provided contact information of sexual and/or needle sharing partners.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

[122] Denominator is persons in LAC newly diagnosed with HIV in 2023 and reported to Surveillance within 12 months of HIV diagnosis.
[123] **Assigned:** New HIV diagnoses assigned for partner services within 12 months of report among LAC HIV diagnoses (excluding Long Beach and Pasadena).
[124] **Interviewed:** New HIV diagnoses interviewed by public health investigators among new LAC HIV diagnoses (excluding Long Beach and Pasadena).
[125] **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).

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.

Figure 66: 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 [126]



The time lag between diagnosis and PS interviews is largely attributable to delays in reporting and assignment for follow-up. The surveillance and case-management systems are not integrated and rely on manual processes for case assignment.

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

Elicited Contacts

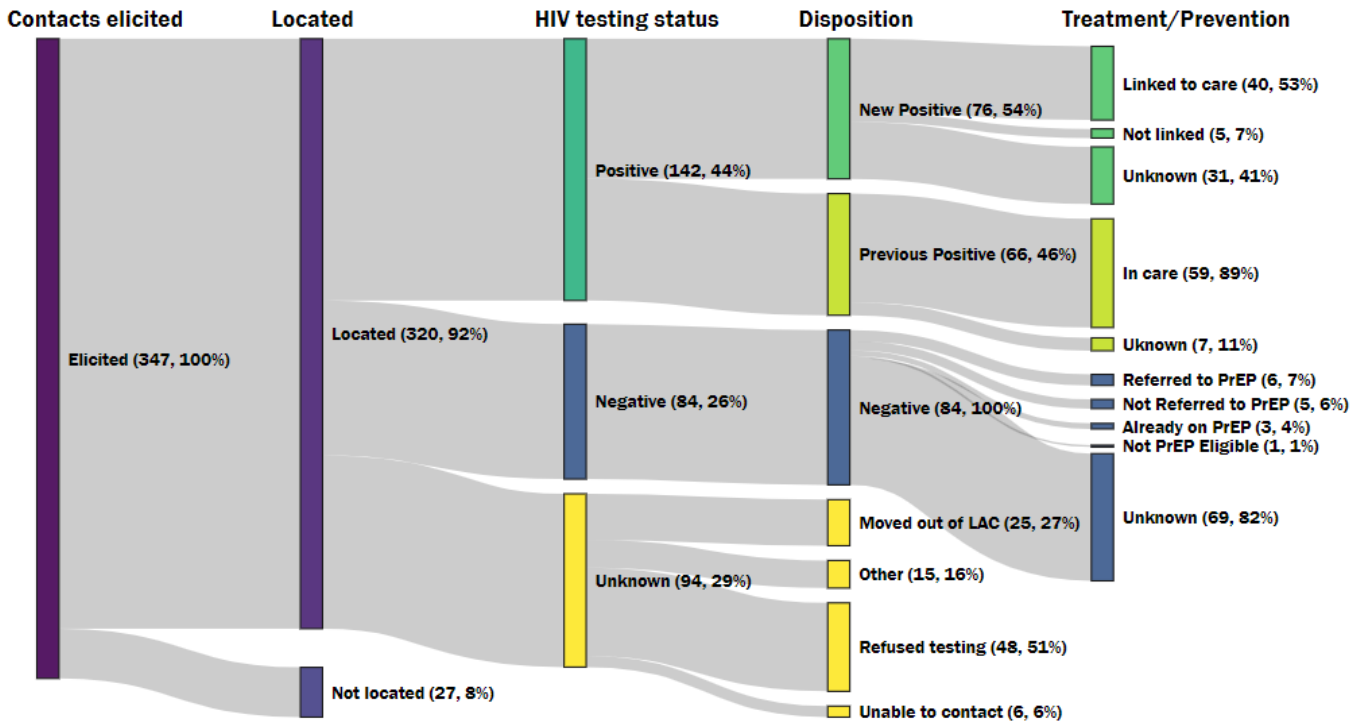
AT A GLANCE

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 that 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.

Figure 67: HIV Partner Services continuum[127] among named contacts, LAC (excluding Long Beach and Pasadena) 2023[128,129,130]



This Sankey diagram depicts the flow of clients in each step of the HIV PS cascade. Each column represents a step in the cascade. Within each step, clients are grouped into categories represented by the colored rectangles (nodes). The gray lines show the proportion of clients moving from one node to the next.

In 2023, 347 named contacts of persons newly diagnosed with HIV were elicited. Most contacts were located (92%). Of those located, many tested HIV positive (44%), followed by unknown status (i.e., refused testing, 29%) and HIV negative (26%). Fifty-three percent of contacts who tested newly positive for HIV were linked to care and 89% of previously diagnosed contacts were engaged in HIV care at the time of this assessment.

[127] 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.
[128] 348 contacts named by 253 index cases newly diagnosed with HIV in 2023.
[129] 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.
[130] PrEP information is unknown for clients without comorbid STD.

Data to Action

Progress and Opportunities in the HIV Partner Services Continuum

- Partner Services is key to the delivery of life-saving HIV interventions and prevention strategies for PLWDH and their partners. The program's role in ending the HIV epidemic in Los Angeles County is critical; however, the current program infrastructure is not sufficient to meet the high demands of both the HIV and STD program priorities for preventing and controlling disease. Significant resources, policy changes, and greater acceptance and compliance are urgently needed for Partner Services to have its intended impact. Human resources to implement expanded PS activities are needed. The realignment of PS training, use of communication and information technology tools, and modernization of data systems are also needed to successfully implement, monitor, and evaluate PS program goals.

- Important strides have been made to strengthen coordination between HIV Surveillance and Partner Services teams to ensure that Partner Services personnel have the information they need to respond to new HIV diagnoses and persons who are not virally suppressed. Nonetheless, at 15%, LAC remains far below the EHE target of 85% of PLWDH having been interviewed by a Partner Services staff within 7 days of diagnosis. HIV Surveillance staff must work closely with diagnosing laboratories and providers to ensure that case reports are received within 24 hours of HIV diagnosis. Secondly, once case reports are received, we must accelerate referral of newly diagnosed HIV cases and persons with unsuppressed viral load to Partner Services within 24 hours of receiving the case report.

- Many sexual and drug using partners are refusing HIV testing offered by the Partner Services program. Partner testing strategies must include approaches for addressing testing hesitancy, addressing stigma and fear with accessing HIV testing among vulnerable populations, and incentives to improve testing uptake for those that do not have a prior diagnosis of HIV.

- Surveillance and Partner Services data systems must include outcomes measures. At minimum, outcomes for index patients should include rates tied to linkage to care, re-engagement to care, treatment status, viral suppression, STI testing, and partner notification. Outcomes for partners should include rates tied to HIV and STI testing. Outcomes for HIV-positive partners should include rates tied to linkage to care, care and treatment status, relinkage to care, and viral suppression. Finally, outcomes for HIV-negative partners should be tied to rates of PrEP referral and PrEP use.

HIV Care Continuum

AT A GLANCE

The HIV care continuum is a public health model that outlines the steps or stages that a person living with HIV goes through from an HIV-positive diagnosis through the achievement of viral suppression. By monitoring these steps at a population level, we can help 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 continuum 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.

The HIV care continuum includes the 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 1 month of diagnosis (defined as ≥ 1 CD4 or VL or Genotype test reported within 1 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 or VL or 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).

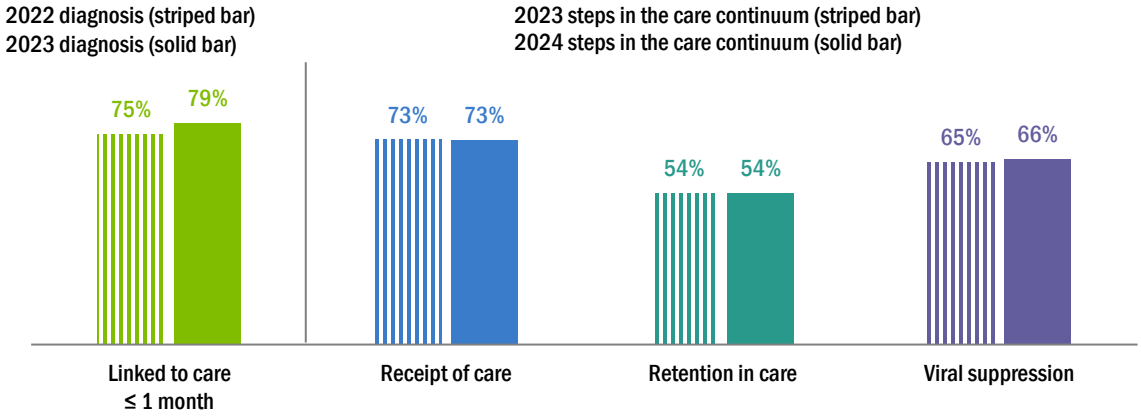
The base population for measuring linkage to HIV care is persons who received an HIV-positive diagnosis in a given calendar year, whereas the base population for the downstream steps in the continuum of care is all persons who were diagnosed with HIV through the prior calendar year and living in LAC 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. For additional data on the HIV care continuum by demographic variables, transmission risk categories, and health district, refer to **Table A5.a-b** and **Table A6.a-b**.

EHE HIV Care Continuum Targets

- Increase the percentage of newly diagnosed persons linked to care within 1 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

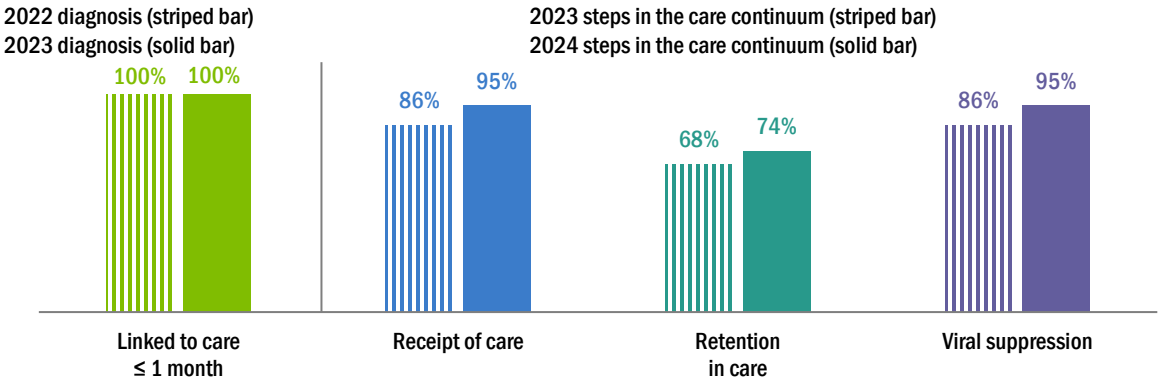
In 2023, 79% of persons diagnosed with HIV were linked to care within 1 month of diagnosis. All key steps along the HIV care continuum remained largely unchanged in 2024 compared with 2023.

Figure 68: HIV care continuum[131] among persons aged ≥ 13 years, LAC 2022-2023[132] and 2023-2024[133]



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 with 2023.

Figure 69: HIV care continuum[131] among children aged <13 years, LAC 2022-2023[132] and 2023-2024[133]



[131]The HIV care continuum includes the following steps: 1) the percentage of people 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 people 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.

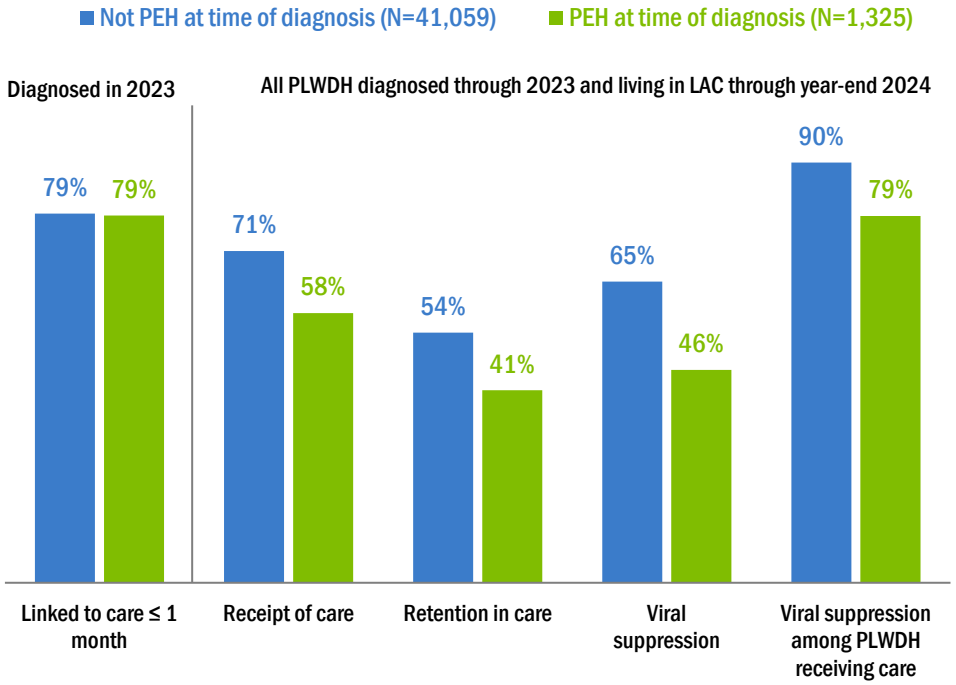
[132] The 2022-2023 HIV care continuum denominator includes persons diagnosed in 2022 to calculate linkage to care ≤ 1 month of diagnosis, and all persons living with diagnosed HIV diagnosed through 2022 and living in LAC at year-end 2023 to calculate receipt of care, retention in care, and viral suppression.

[133] The 2023-2024 HIV care continuum denominator includes persons diagnosed in 2023 to calculate linkage to care ≤ 1 month of diagnosis, and all persons living with diagnosed HIV diagnosed through 2023 and living in LAC at year-end 2024 to calculate receipt of care, retention in care, and viral suppression.

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

Figure 70: HIV care continuum among persons aged ≥ 13 years by PEH status at the time of HIV diagnosis, LAC 2022-2023[134]

Note: In LAC there are robust support services in place to facilitate linkage to care after diagnosis, facilitated by HIV testing providers, Partner Services, linkage and retention programs, and community embedded Disease Intervention Specialists. However, the complexities of a person's life circumstances may present barriers along subsequent steps in the care continuum.



[134] 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.

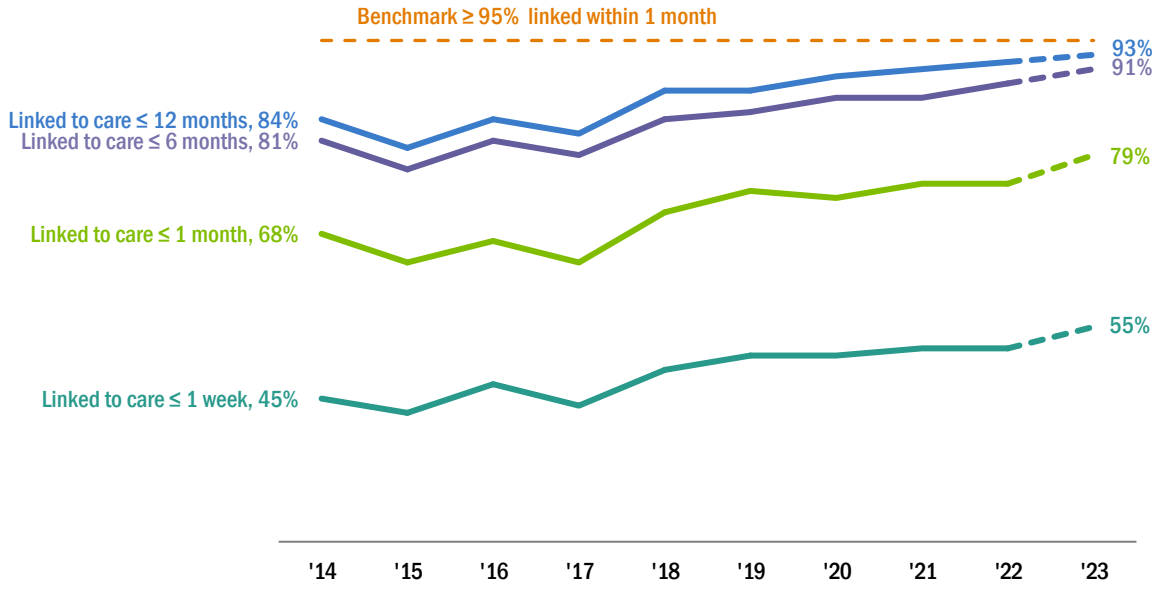
Linkage to HIV care

AT A GLANCE

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 1 month of HIV diagnosis. However, 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, 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.

Figure 71: 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[135,136]

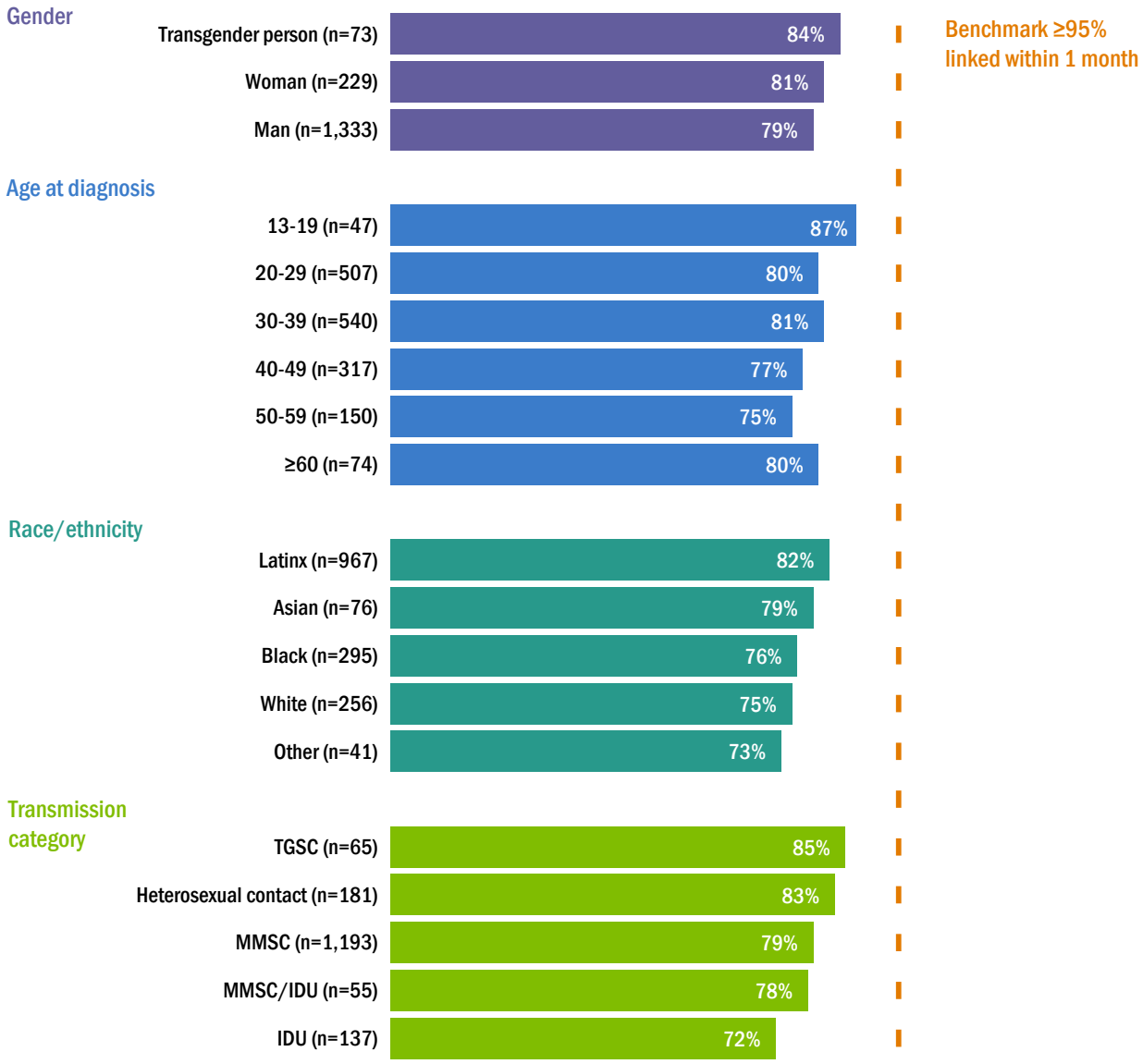


[135] Includes persons diagnosed with HIV in each calendar year with ≥1 CD4/VL/Genotype test reported within 1 week, as well as 1, 6, and 12 months of diagnosis.
[136] Due to reporting delay, 2023 HIV linkage to care data are provisional as indicated by the dashed line.

The next two figures describe specific populations of PLWDH who were linked to HIV care within 1 month of diagnosis and help gauge where strategies for linkage to HIV care may require re-direction.

▶▶▶ None of the groups identified below 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.

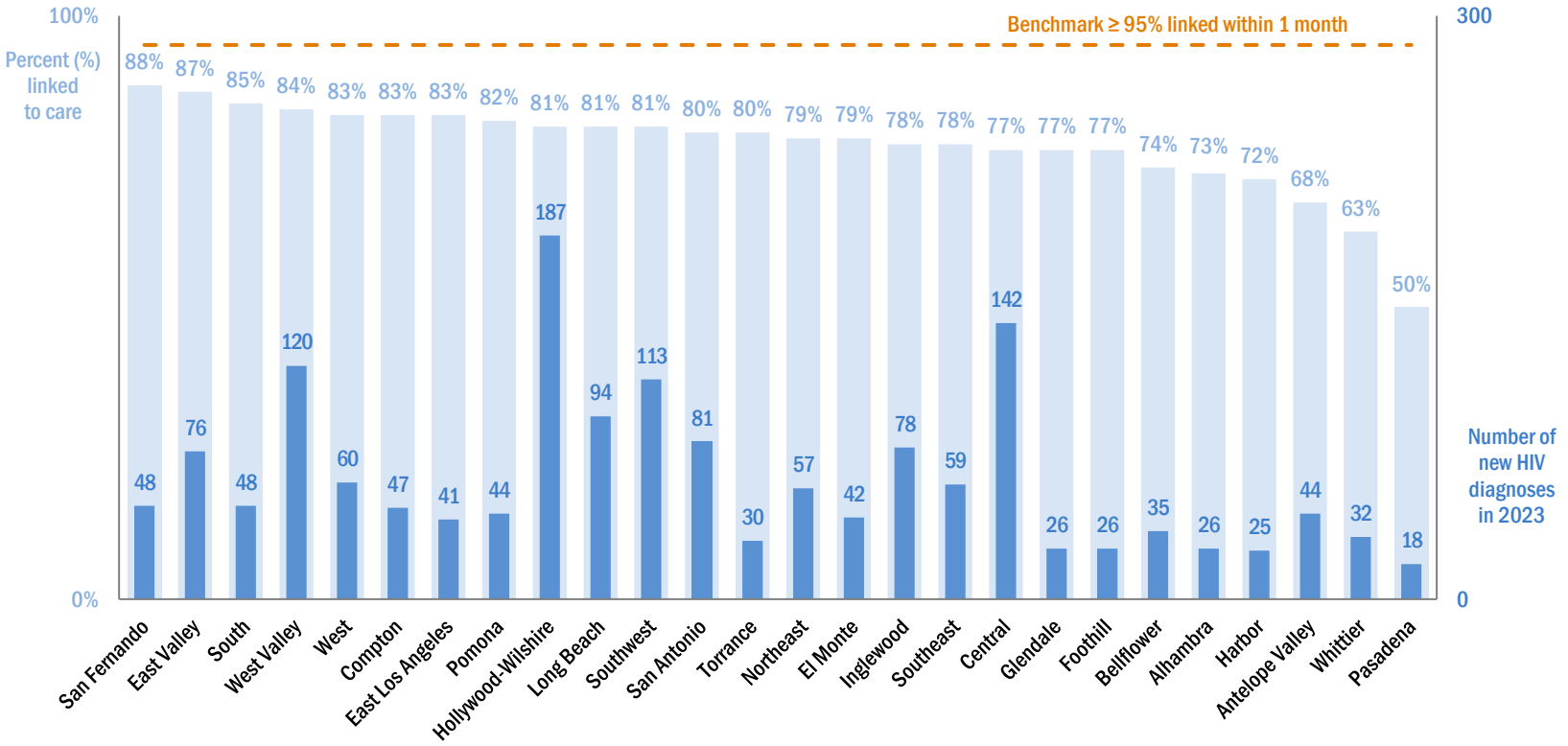
Figure 72: Persons aged ≥ 13 years newly diagnosed with HIV and linked to care within 1 month of diagnosis[137] by select demographic[138] and risk[139] characteristics, LAC 2023



[137] 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.
[138] 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.
[139] Other risk includes risk factors not reported/identified and is not shown due to small numbers. Persons without an identified risk factor were assigned a risk factor using CDC-recommended multiple imputation methods (see Technical Notes).

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.

Figure 73: Persons aged ≥ 13 years newly diagnosed with HIV and linked to care within 1 month of diagnosis by Health District, LAC 2023[140,141]



[140] 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.
[141] Health Districts are based on 2022 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.

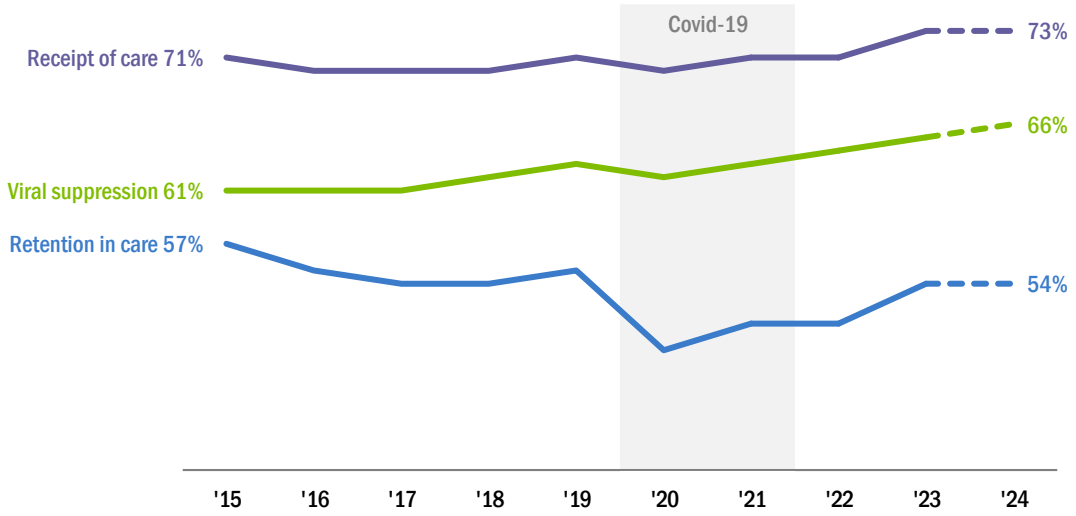
Receipt of care, retention in care, and viral suppression

AT A GLANCE

Entering and staying in HIV care is necessary to ensure that adherence to HIV treatment occurs and viral suppression is achieved. The figures in this section track how LAC performed with respect to receipt of care, retention in care, and viral suppression in 2024 across different populations of PLWDH. 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.

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.

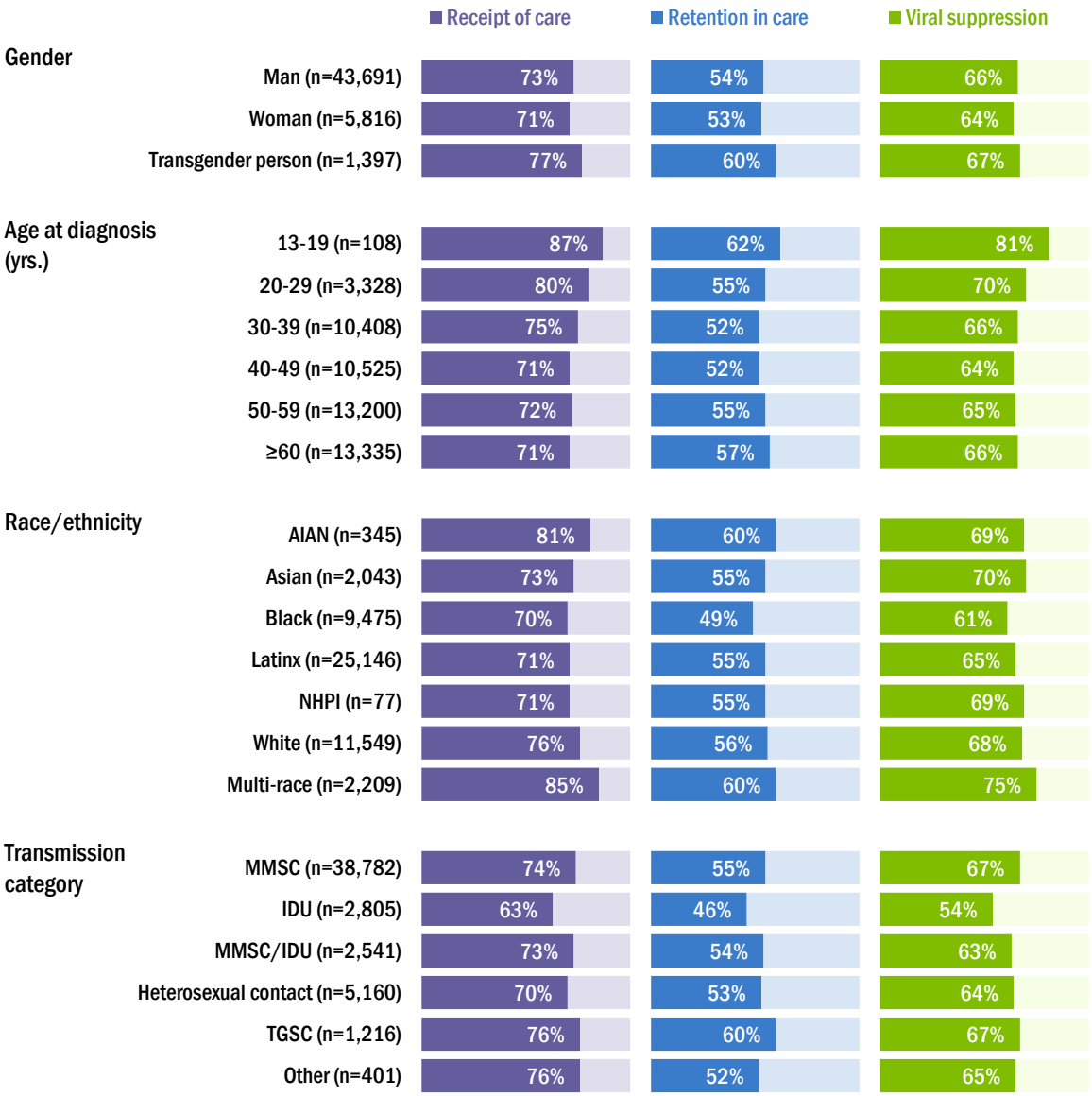
Figure 74: Trends in receipt of HIV care, retention in care, and viral suppression for PLWDH aged ≥ 13 years living in LAC at calendar year-end and diagnosed with HIV through the previous calendar year, LAC 2015-2024[142,143]



[142] 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 3 months apart in 2024; denominator includes PLWDH diagnosed through 2023 and living in LAC at calendar year-end 2024 on most recent residence. Viral suppression: numerator includes PLWDH whose last VL test in the calendar year 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.
[143] Due to reporting delay, 2024 HIV data are provisional as indicated by the dashed line.

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

Figure 75: Receipt of HIV care, retention in HIV care, and viral suppression by gender, age group, race/ethnicity, and transmission category[144] among PLWDH aged ≥ 13 years diagnosed through 2023 and living in LAC at year-end 2024, LAC 2024[145]

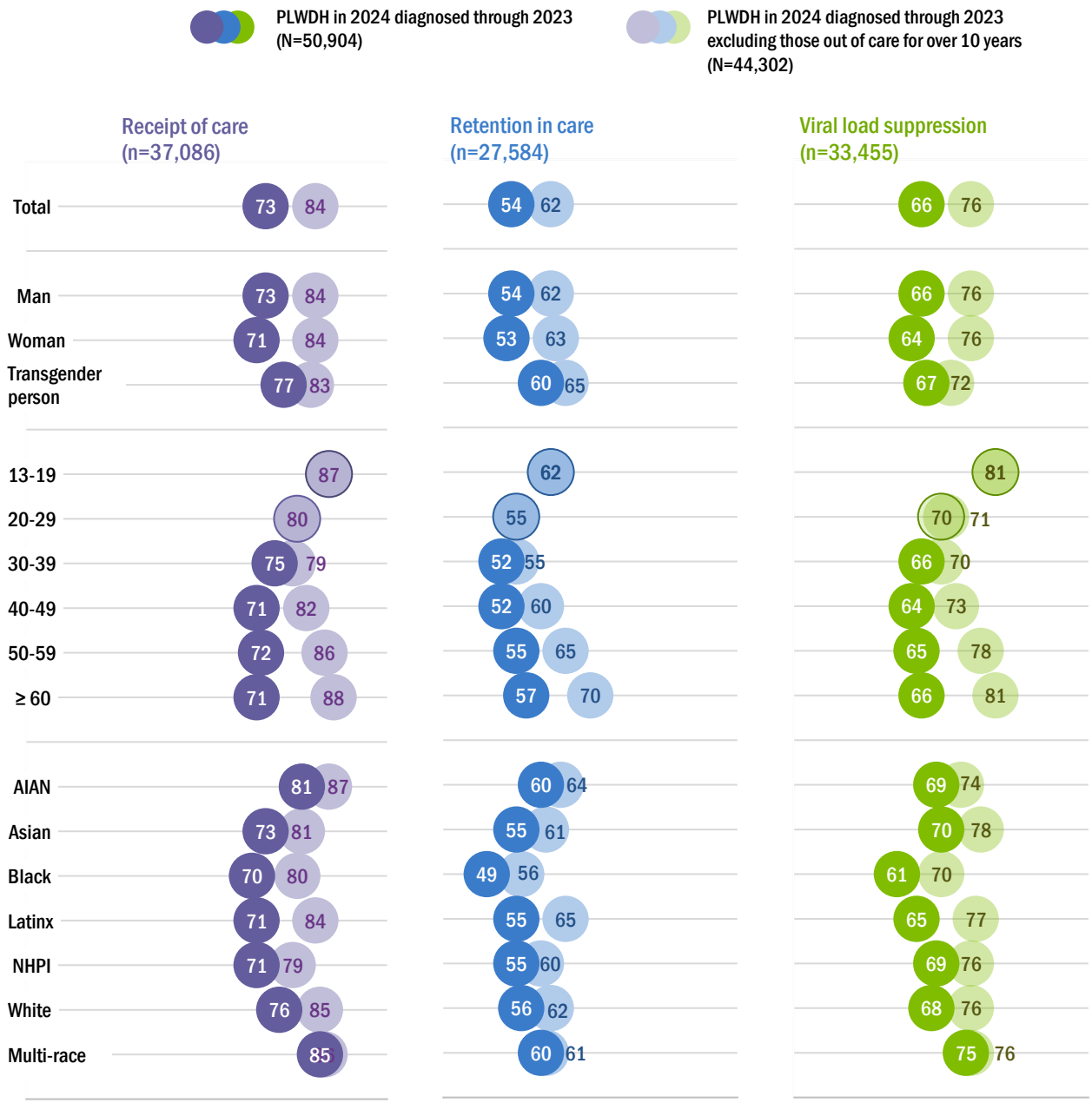


[144] Other transmission risk includes perinatal, hemophilia, coagulation disorder, blood transfusion, and risk factor not reported/identified. Persons without an identified risk factor were assigned a risk factor using CDC-recommended multiple imputation methods (see Technical Notes).

[145] 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 3 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.

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.

Figure 76: 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[146,147]



[146] The denominator for all three indicators includes PLWDH diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence. The numerator for receipt of care includes PLWDH with ≥1 CD4/VL/Genotype test in 2024 and for retention in care ≥2 CD4/VL/Genotype tests at least 3 months apart in 2024. The numerator for viral suppression includes PLWDH whose last VL test in 2024 was suppressed (HIV-1 RNA < 200 copies/mL) whereby PLWDH without a VL test in 2024 were categorized as having unsuppressed viral load.

[147] Out of care: no HIV care lab test (viral load, CD4+ T-cell, or genotype test) reported within past 10 years, or if no care labs were reported, diagnosed over 10 years ago.

HIV treatment

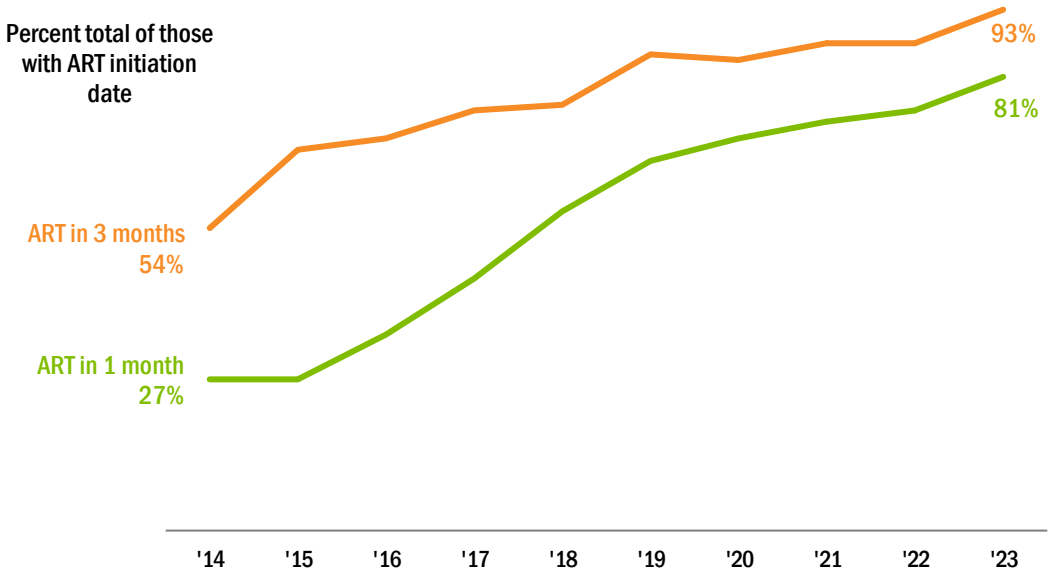
AT A GLANCE

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. Below 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.

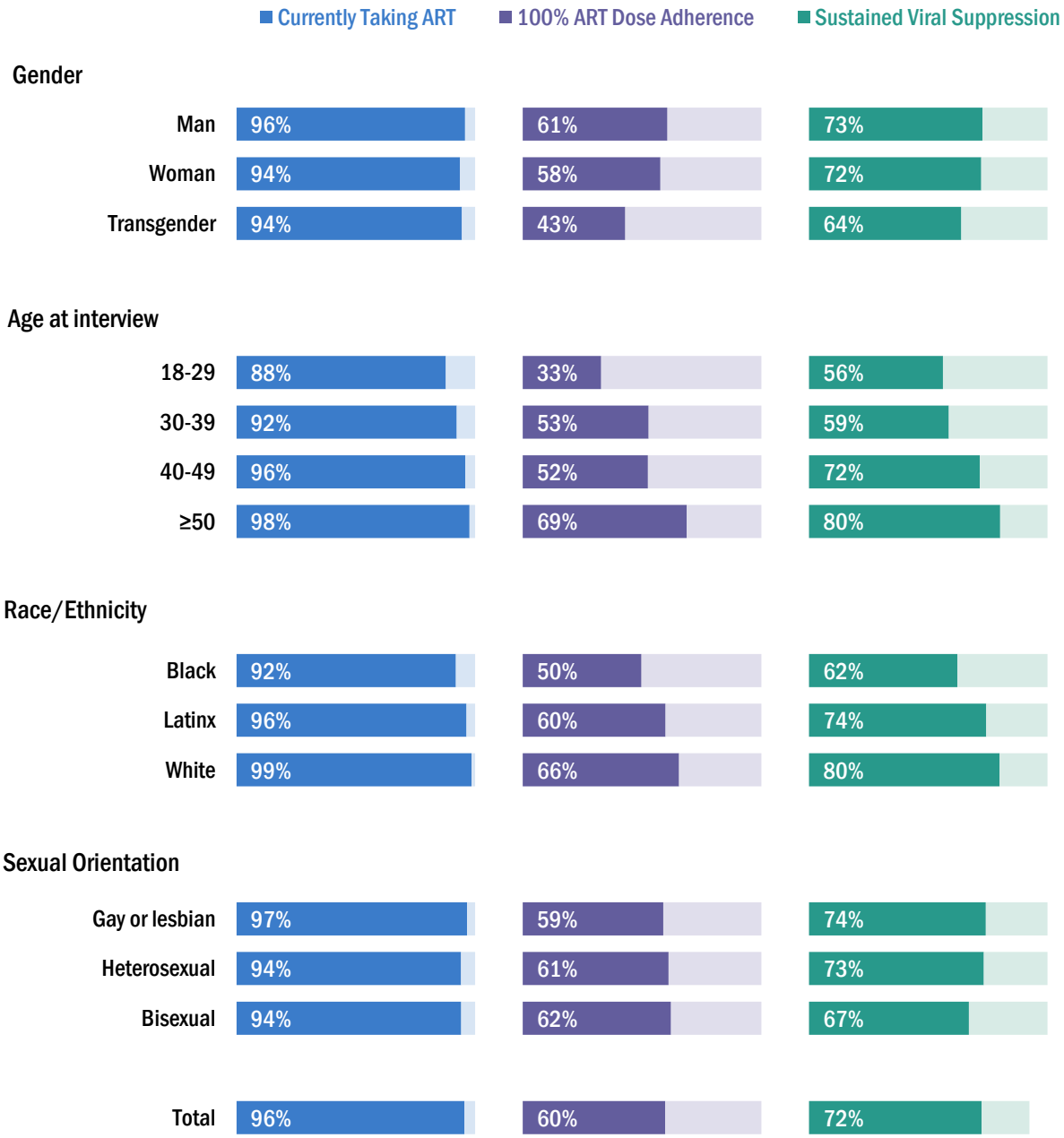
Figure 77: Time from HIV diagnosis to treatment initiation among persons aged ≥ 13 years newly diagnosed with HIV by year of diagnosis,[148] LAC 2014-2023



[148] 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.

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.

Figure 78: Antiretroviral therapy (ART) utilization, ART dose adherence, and sustained viral suppression among PLWDH by selected characteristics—Medical Monitoring Project, LAC 2018-2022[149,150]



[149] 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.
[150] 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.

Viral load monitoring

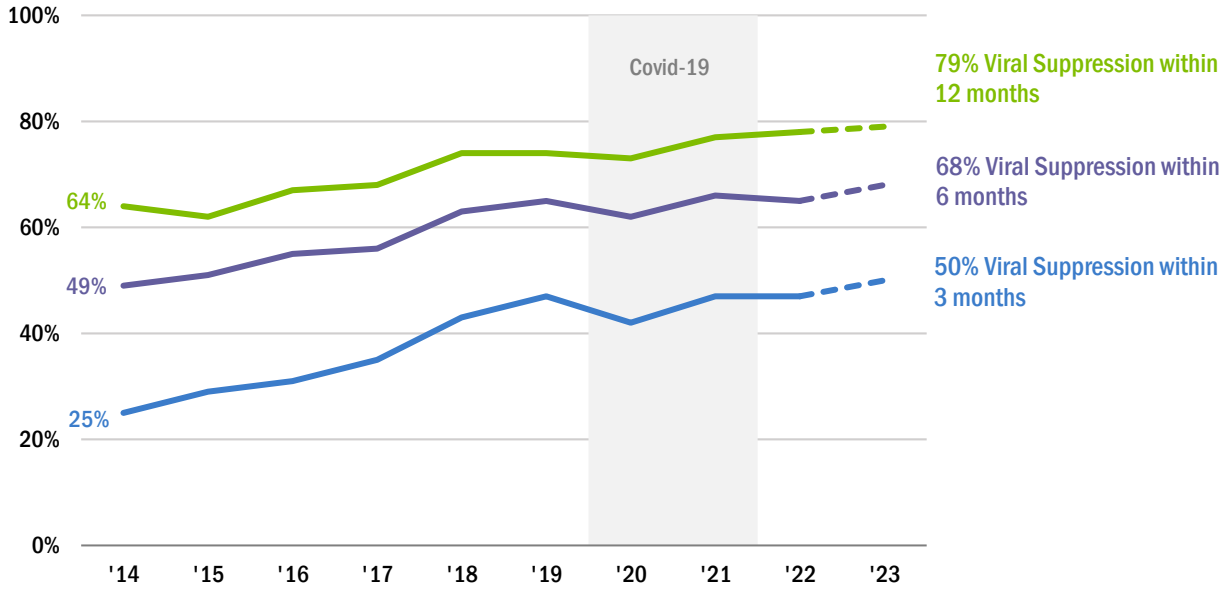
AT A GLANCE

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.

Figure 79: Time from diagnosis to viral suppression among persons diagnosed with HIV by year of HIV diagnosis, LAC 2014-2023[151,152]

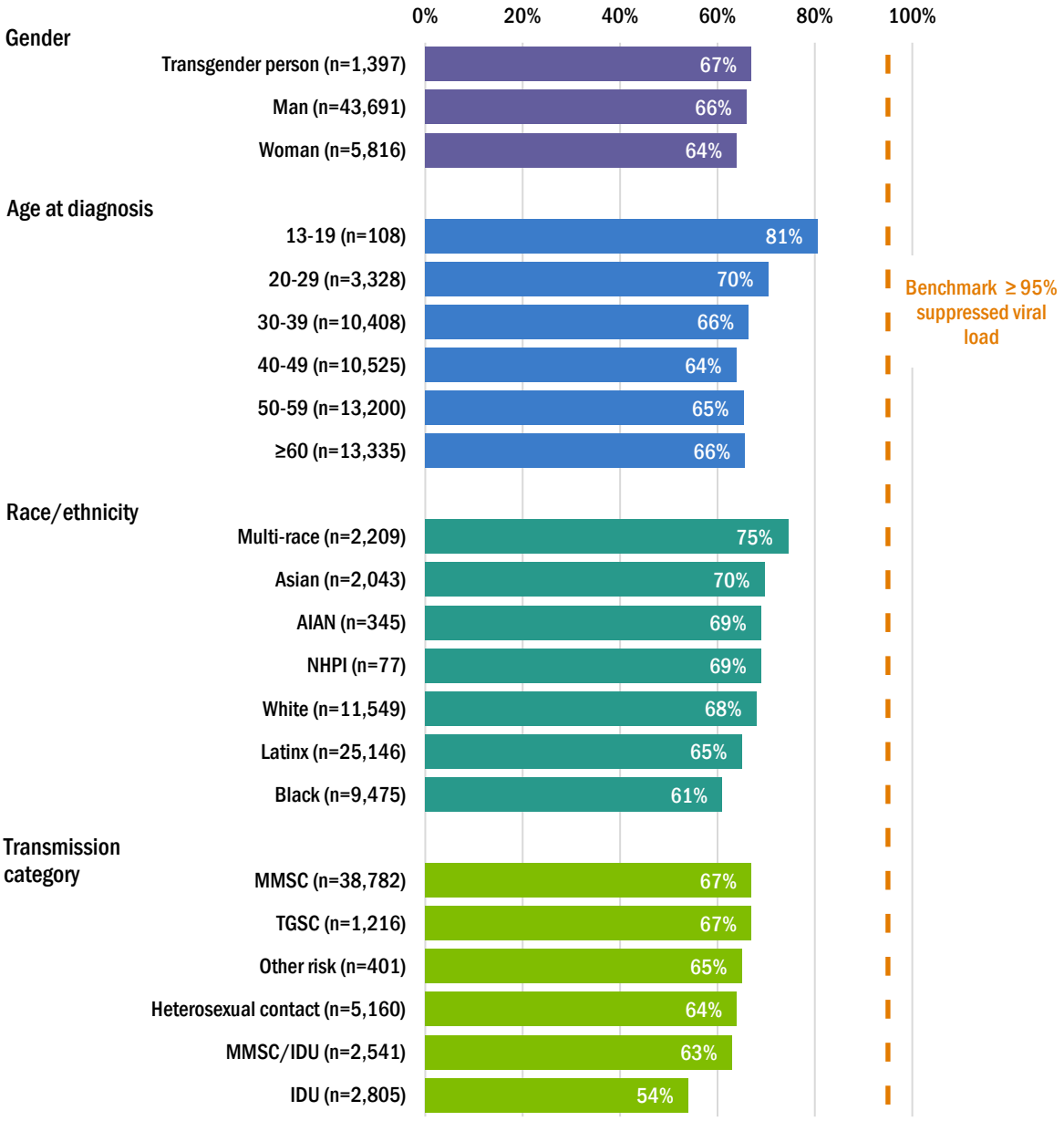


[151] Analysis includes persons newly diagnosed with HIV in each calendar year and living in LAC at the end of the following year. Numerator includes persons who achieved viral suppression within 3, 6, or 12 months of diagnosis. Denominator includes persons newly diagnosed with HIV in each calendar year,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

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

Persons living with diagnosed HIV in LAC: 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 whose transmission category is injection drug use.

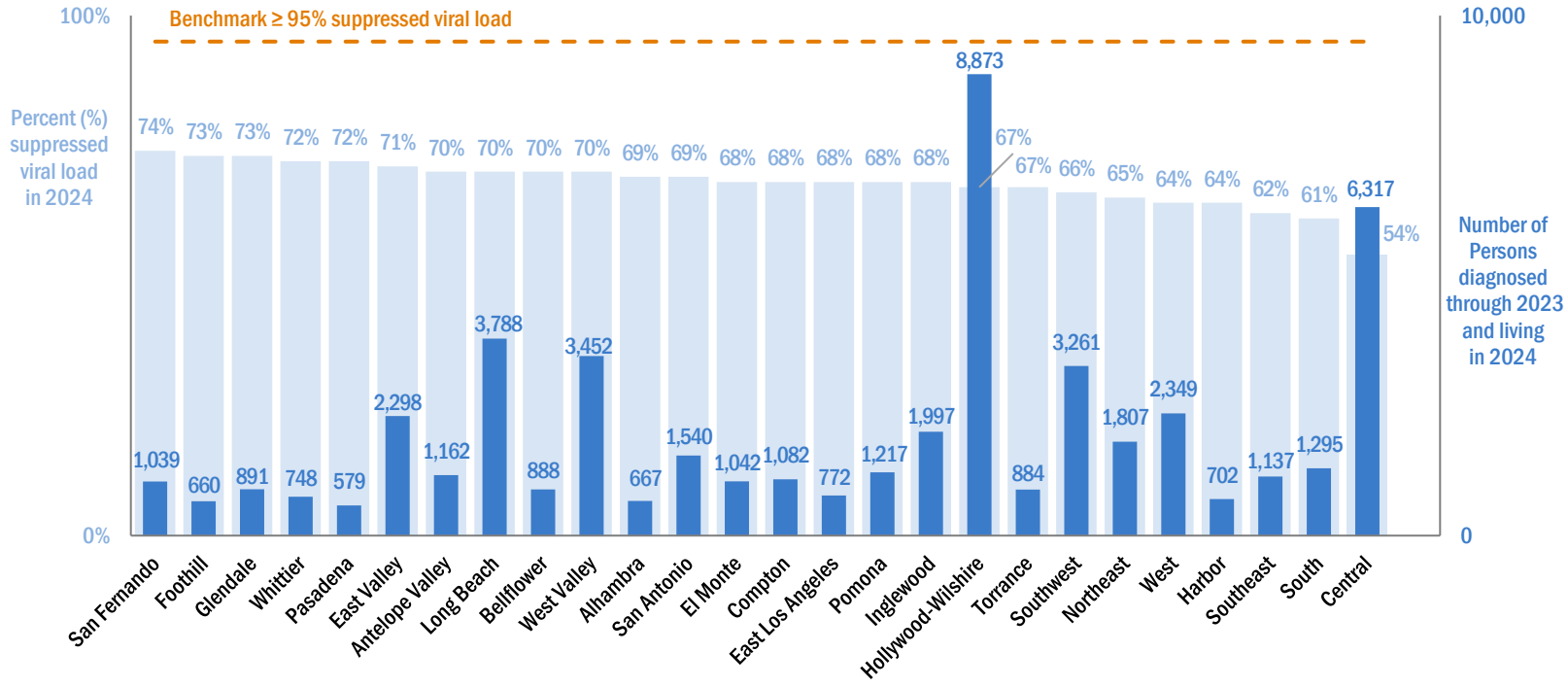
Figure 80: Suppressed viral load by selected demographic and risk characteristics among persons aged ≥ 13 years diagnosed through 2023 and living in LAC at year-end 2024, LAC 2024[153,154]



[153] 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.
[154] Persons with unknown race/ethnicity and are not shown. Other risk includes perinatal exposure, 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 (see Technical Notes).

Persons living with diagnosed HIV in LAC: 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.

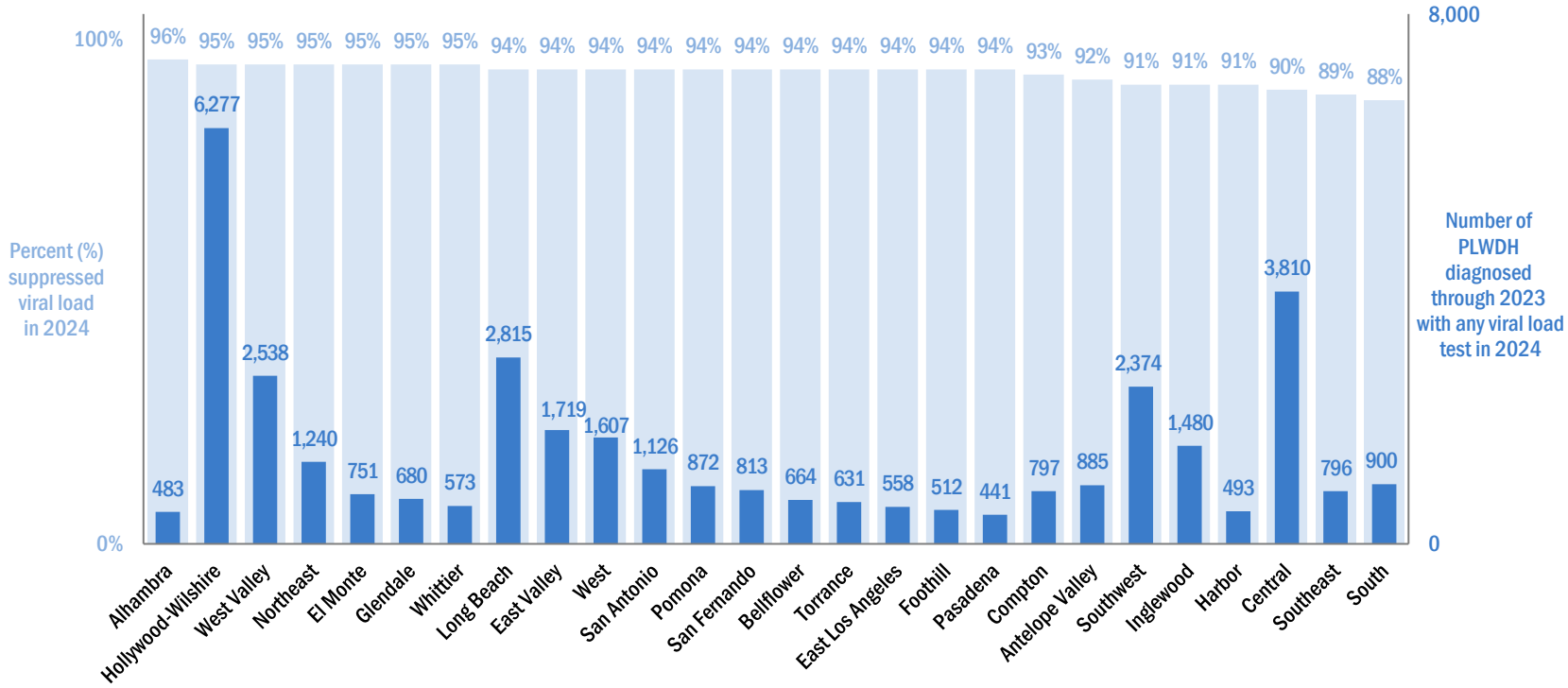
Figure 81: Suppressed viral load by Health District among persons aged ≥ 13 years diagnosed through 2023 and living in LAC at year-end 2024, LAC 2024[155,156]



[155] 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.
[156] Health Districts are based on 2022 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.

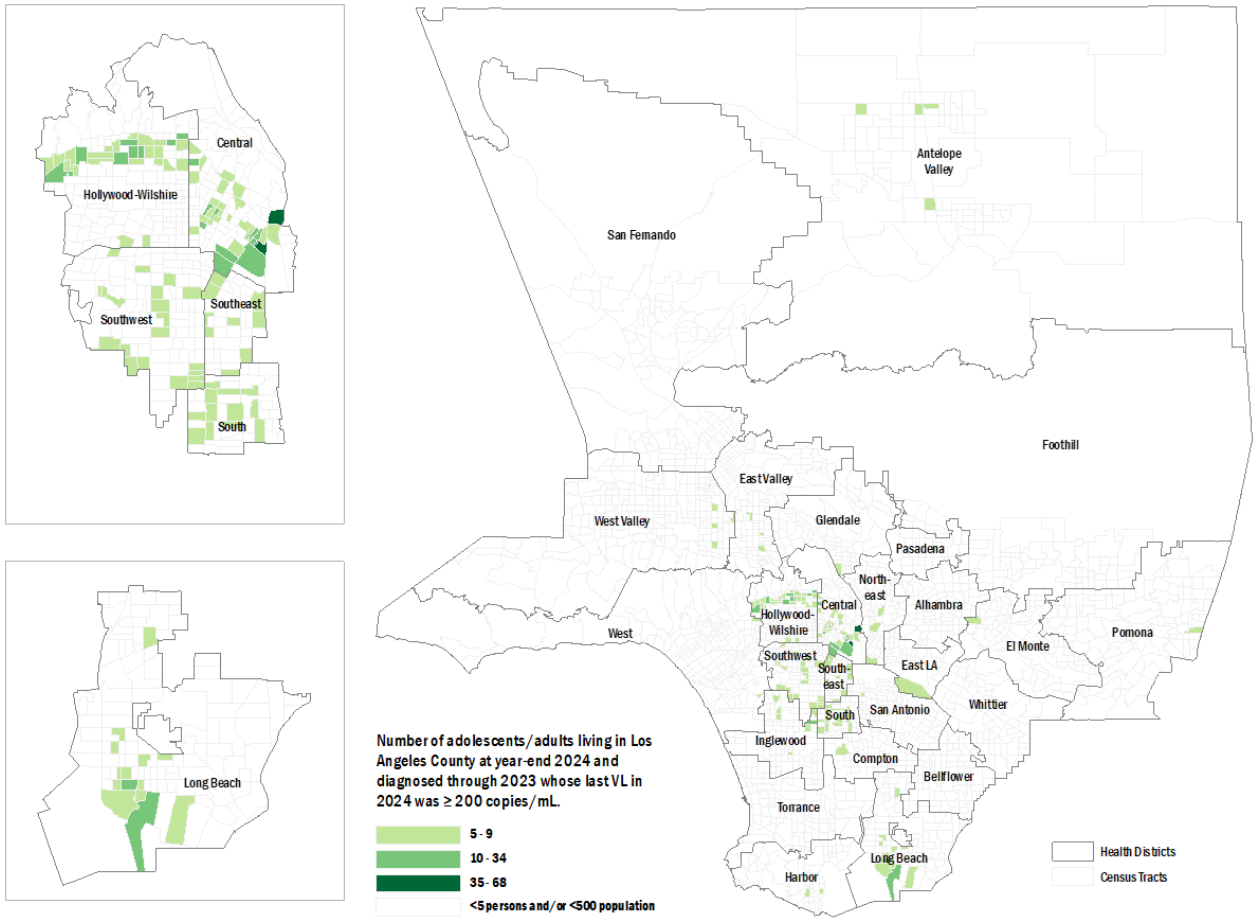
Once in care, the goal is for all PLWDH to achieve viral suppression as soon as possible. In 2024, most Health Districts had at least 90% of PLWDH within their boundaries who were virally suppressed. However, the South and Southeast Health Districts lagged behind, with the lowest viral suppression percentages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

Figure 82: Suppressed viral load among persons aged ≥ 13 years receiving HIV care and who had any viral load test in 2024 by Health District, LAC 2024[157,158]



[157] 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.
[158] Health Districts are based on 2022 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.

Figure 83: Unsuppressed viral load by census tract among persons aged ≥ 13 years diagnosed through 2023 and living in LAC at year-end 2024 (N=1,269), LAC 2024[159]

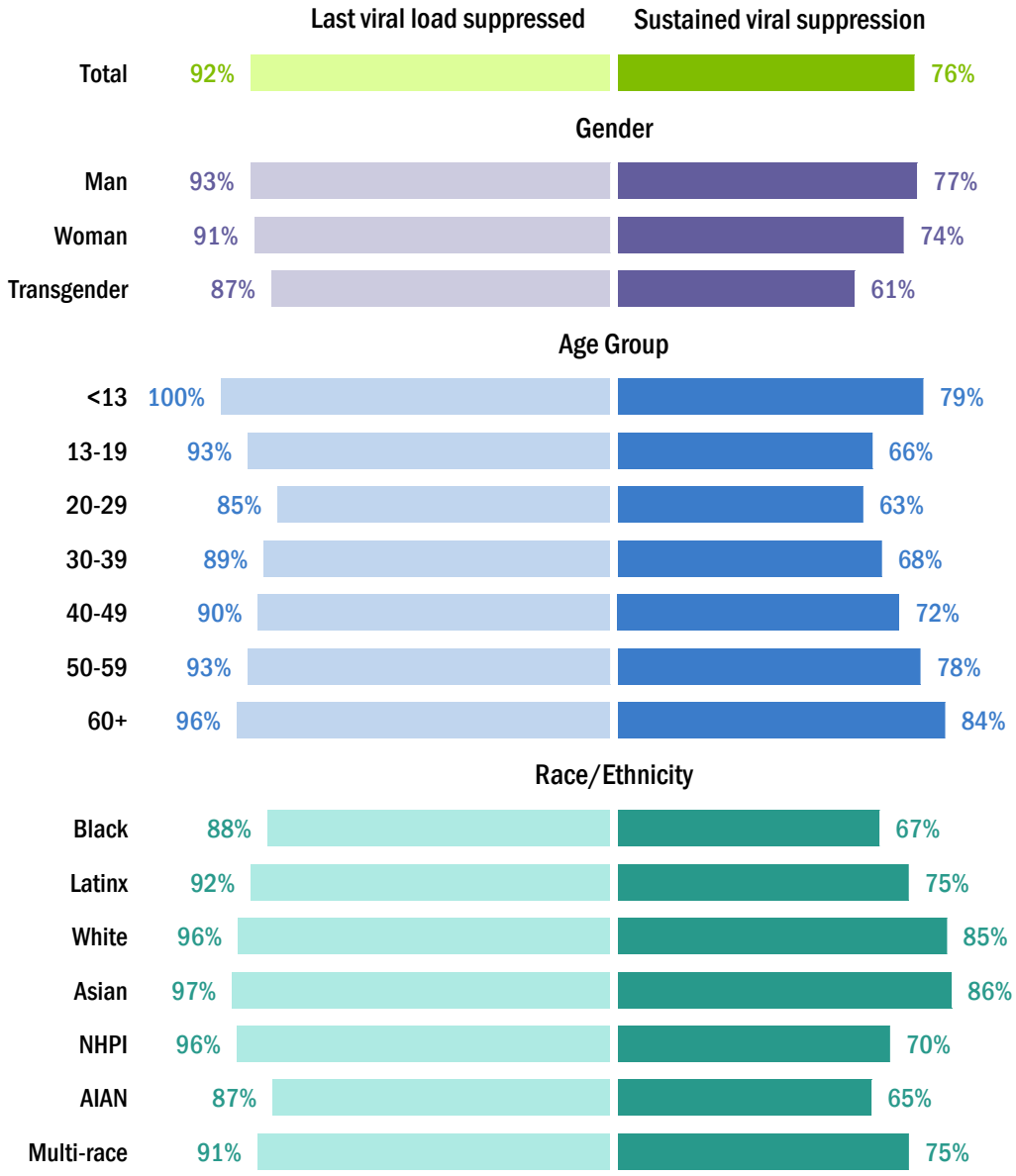


Census tracts located in the Central and Hollywood-Wilshire Health Districts had the highest levels of unsuppressed viral load. These are locations where a robust public health response is needed to 1) identify networks of ongoing transmission and 2) deploy rapid interventions to minimize transmission. 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.

[159] Unsuppressed viral load: Includes PLWDH whose last VL test in 2024 was unsuppressed (HIV-1 RNA ≥ 200 copies/mL) among 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 considered virally unsuppressed. Analysis excludes PLWDH diagnosed through 2023 and living at year-end 2024 who (1) had missing census tract information, (2) were receiving care but never had a viral load test, (3) were not receiving care for >12 months at year-end 2024, or (4) were in census tracts with small sample sizes (<5 persons with unsuppressed viral load or population size <500 persons). Exclusions represented 74% of PLWDH diagnosed through 2023 and living in 2024 whose last viral load was unsuppressed. Sources: County of Los Angeles, Internal Services Department Enterprise GIS Section. 2023. 2020 Census Tracts. County of Los Angeles, California, Enterprise GIS Repository. Accessed 03/01/2024. https://egis-lacounty.hub.arcgis.com/datasets/lacounty::2020-census-tracts-4/about; County of Los Angeles, Department of Public Health. 2022. Health Districts 2022 (view). County of Los Angeles, California, Enterprise GIS Repository. Accessed 03/21/2023. https://egis-lacounty.hub.arcgis.com/datasets/health-districts-2022-view/.

▶>> 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.**

Figure 84: Viral load dynamics among persons living with diagnosed HIV and receiving HIV care, LAC 2022-2024[160]



Transgender persons, persons aged 20-29 years, American Indians and Alaska Natives (AIAN), and Black persons had the lowest levels of sustained viral suppression.

[160] 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.

Data to Action

Progress and Opportunities in the HIV Care Continuum

- The COVID-19 pandemic impacted health service delivery in 2020 with a subsequent reduced provision of and access to HIV care services. Sustained reduction in retention in HIV care may reflect clinical trends toward less frequent visits.

- Only 79% of PLWDH were linked to HIV care within 1 month of diagnosis, falling below the EHE target of 95% linked to care within 1 month. More work is needed to improve mechanisms to ensure that newly diagnosed persons are promptly linked to HIV care at the time of diagnosis.

- Gaps in linkage to care within 1 month of diagnosis are particularly high among persons whose race/ethnicity category is 'Other,' persons aged 50-59 years, and persons whose transmission category was injection drug use. Targeted interventions are needed to link these populations immediately to care after HIV diagnosis. Special attention is needed in the Pasadena Health District where linkage rates are very low despite low burden of HIV disease.

- Across the care continuum, the levels of receipt of care, retention in care, and viral suppression was low in 2024. Groups with greatest disparities in the HIV care continuum are unhoused persons, those with injection drug use risk, and Black persons. Person-centered interventions that respond directly to the challenges and needs of these populations continue to be necessary.

- Of concern is that only 8 in 10 PLWDH were estimated to be on treatment and 5 in 10 had 100% adherence to their ART doses in the past 30 days, based on a representative survey of PLWDH. Delayed treatment and suboptimal adherence have hindered progress towards achieving viral suppression among PLWDH. More work is needed to ensure that treatment is started immediately after HIV diagnosis. Rapid ART programs should be scaled across the County and prioritized for subgroups of PLWDH with the lowest treatment coverage rates (e.g., Black and young PLWDH).

- Viral suppression is measured using the last viral load test for PLWDH in HIV care but this does not consider how soon after an HIV diagnosis PLWDH are reaching viral suppression nor whether suppression is maintained over time. Viral suppression is measured using the last viral load test for PLWDH in HIV care, but this does not consider how soon after an HIV diagnosis PLWDH are reaching viral suppression nor whether suppression is maintained over time. Sustained viral suppression (76%) is 16 percentage points lower than viral suppression (92%) based on the last viral load. Interventions to improve sustained viral suppression will be critical to ending the HIV epidemic.

- Hollywood-Wilshire Health District had the highest counts of unsuppressed viral load, followed by Central, Long Beach, and West Valley Health Districts. The response must be more intensive in these areas to ensure that all PLWDH are linked and all out-of-care PLWDH are re-linked, so that viral suppression can be achieved.

Data to Action (continued)

Progress and Opportunities in the HIV Care Continuum

- Among PLWDH in care, lower levels of viral suppression are disproportionately occurring in low-income areas, with the lowest levels of viral suppression in the South and Southeast Health Districts. In-depth assessments at the Heath District level are needed to understand the social and structural barriers that may be impacting access to and use of health services so that stronger systems of HIV care can be established for PLWDH, particularly for those residing in low-income areas.

- The HIV Surveillance data reported by HIV service providers offers direct information on care services for HIV patients. More attention is requested from providers to document complete information on patient visits, including treatment information, when reporting to Public Health. This will improve our understanding and response to the HIV care continuum among persons living with HIV.

- Outcomes in the HIV care continuum rely on availability and access to laboratory testing to measure linkage to HIV care, receipt of care, retention in care, and viral suppression among PLWDH. The availability of laboratory testing for PLWDH may have been reduced because of the COVID-19 pandemic on health services delivery, although the impact of this bias is not yet known. Nonetheless coordination should be strengthened with laboratory partners to ensure that reported laboratory data are timely, complete, and of high quality.

- Health information systems should be leveraged to routinely monitor and evaluate the quality of HIV services provided to PLWDH receiving care, inform quality management of services, and evaluate the impact of quality services on HIV survival.

Technical Notes

Surveillance of HIV in Los Angeles County

Surveillance of HIV, including AIDS in Los Angeles County (LAC), is conducted through active and passive surveillance as well as electronic case reporting to identify and collect information on persons with newly diagnosed HIV at hospitals, clinics, private physician offices, laboratories, community-based organizations, and hospices. Active HIV surveillance requires staff to routinely contact and visit sites to facilitate the completion of HIV case reports. Providers participating in passive HIV surveillance submit case reports to the LAC Department of Public Health (DPH) Division of HIV and STD Programs (DHSP). Among HIV cases diagnosed in 2023, 56% of LAC's case reports for newly diagnosed HIV were collected through active surveillance activities. Comparatively, 32% were collected through electronic case reporting process involving major healthcare providers. 12% were passive case reports by other providers, either by mail or through the LAC designated HIV case reporting phone line.

HIV surveillance database

The Enhanced HIV/AIDS Reporting System (eHARS) is a CDC-developed information system for collecting, storing, and retrieving HIV surveillance data. Case definitions are based on CDC documents "Stage-3-Defining Opportunistic Illnesses in HIV Infection" and "Revised Surveillance Case Definition for HIV Infection — United States, 2014".[161]

Reporting delay

HIV reporting delay is defined as the time interval between HIV diagnosis or death and the reporting of HIV diagnosis or death to the Public Health department. An evaluation of HIV surveillance data (2019–2023 diagnoses) in LAC found that, on average, approximately 71% of HIV diagnoses were reported to LAC DPH during the year of diagnosis and approximately 93% of HIV diagnoses were reported to LAC DPH by the end of the following year.

Thus, the HIV diagnosis data presented in this report are limited to the year 2023. All data presented in this report are considered provisional and subject to change as additional reports of HIV cases and deaths may be submitted later than the date of the report. In addition, the interstate deduplication and data validation activities may also provide more updated data. Because reporting delays can impact the reliability of data presented in this report, caution should be applied when interpreting the results.

Underreporting

HIV surveillance data may not be representative of all persons living with HIV (PLWH) because not all persons are aware of their infection or have been reported to the Public Health department. Many factors, such as the extent to which testing is routinely offered to specific groups and the accessibility and availability of medical care and testing services, may influence HIV testing patterns. Additionally, the results of anonymous tests are not required to be reported in California. As such, LAC HIV surveillance data likely underestimate the true numbers of all PLWH in LAC.

Population rates

All population rates presented in this report are per 100,000 population, except for HIV diagnoses rates among persons experiencing homelessness (PEH), which are presented per 10,000 homeless population. The population denominators used to compute the rates in the general population were based on 2014-2023 estimates provided by LAC Internal Services Department and contracted through Hedderson Demographic Services, with SPA and HD geographies integrated in by Population Health Assessment Team, Office of Health Assessment and Epidemiology (OHAE). Rates for 2024 are based on the 2023 population

[161] CDC. Revised Surveillance Case Definition for HIV Infection – United States, 2014. *MMWR* 2014; 63(No. RR03):1-10.

estimates released in March 2024. In Figure 1, Appendix Tables A1.a, A1.b, and A3, the numerators and denominators for AI/AN data account for all non-Latinx persons with any mention of AI/AN race.[162] Population denominators for persons experiencing homelessness were derived from the Greater Los Angeles County Homeless Count, 2024 Results (https://www.lahsa.org/documents?id=8164-2024-greater-los-angeles-homeless-count-results-long-version-.pdf; accessed 07/29/2024).

All rates are subject to random variation. This variation is inversely related to the number of cases, meaning a small number of cases can result in unstable rates. Conforming to standard criterion used by the National Center for Health Statistics, rates presented in this report were considered unreliable when the relative standard errors were greater than or equal to 30%, which corresponds to rates based on 12 or fewer observations.

Geographic information

Residence at HIV diagnosis was used to determine the geographic location of persons newly diagnosed with HIV. Similarly residential information at the time of AIDS diagnosis was used to determine the geographic location for AIDS diagnoses.

For persons living with diagnosed HIV data, the area of residence was based on a person's most recent known address at the end of each calendar year. A CDC SAS program was used to calculate last known residence at each specified year-end.

For death data, a person's geographic location was based on their residence at death, and when missing, on their most recently known address.

When street address was missing, then ZIP Code, city, and/or county fields were used. Geographic breakdowns by SPA, HD, and census tract are limited to persons with at least ZIP Code level information. Census tract and ZIP Code to SPA and HD correspondence tables were provided by LAC DPH Information Management and Analytics Office, GIS Unit team. Caution should be used when interpreting geographic level case counts and rates because these values are inclusive of correctional populations and may be artificially inflated.

Maps

Los Angeles County is divided into 26 Health Districts (HD)[163] and 2,496 census tracts.[164] All HD related maps are based on the 2022 boundary definitions and census tract maps are based on the Census 2020 census tract definition.

For 5-year HIV diagnoses (2019-2023), the census tract was assigned based on projected geo-coordinates (X, Y) of the person's address at diagnosis. When a detailed street address was not available, the ZIP Code was used to assign a census tract using the U.S. Department of Housing and Urban Development (HUD) United States Postal Service ZIP Code Crosswalk Files, 4th quarter 2023.[165] Rates are based on July 1, 2021 Population Estimates, prepared by Hedderson Demographic Services for Los Angeles County Internal Services Department, released March 2024. [166]

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[162] Adjusted Population Estimates for 2014-2023 prepared by County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section. Original estimates were adjusted to reflect AIAN alone and in combination with other race using U.S. Census Bureau American Community Survey PUMS 1-year estimates for 2014-2023. Adjusted estimates were produced by LAC DPH OHAE, Vital Records and Demography Unit.

[163] County of Los Angeles, Department of Public Health. 2022. Health Districts 2022 (view). County of Los Angeles, California, Enterprise GIS Repository. Accessed 03/21/2023. https://egis-lacounty.hub.arcgis.com/datasets/health-districts-2022-view/.

[164] County of Los Angeles, Internal Services Department Enterprise GIS Section. 2023. 2020 Census Tracts. County of Los Angeles, California, Enterprise GIS Repository. Accessed 03/01/2024. https://egis-lacounty.hub.arcgis.com/datasets/lacounty::2020-census-tracts-4/about.

[165] U.S. Department of Housing and Urban Development (HUD), Office of Policy Development and Research (PD&R). 2024/2025. HUD United States Postal Service ZIP Code Crosswalk Files, ZIP-TRACT 4th Quarter 2023 Accessed 01/29/2024 and 4th Quarter 2024 Accessed 02/24/2025. https://www.huduser.gov/portal/datasets/usps_crosswalk.html.

[166] County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section, July 1, 2021 and July 1, 2023, Population Estimates for Los Angeles County Tract-City and Countywide Statistical Area Splits by Age, Sex and Race/Ethnicity, Los Angeles, CA, March 2024. SPA, HD, and SD geographies integrated in by Population Health Assessment Team, Office of Health Assessment and Epidemiology.

For PLWDH at year-end 2024, the census tract was assigned based on projected geo-coordinates (X, Y) of the most current residential information. When a detailed street address was not available, the ZIP Code of the most current residence was used to assign a census tract using the U.S. Department of Housing and Urban Development (HUD) United States Postal Service ZIP Code Crosswalk Files, 4th quarter 2024.[165] Rates are based on July 1, 2023 Population Estimates, prepared by Hedderson Demographic Services for Los Angeles County Internal Services Department, released March 2024.[166]

For persons whose last viral load in 2024 was ≥ 200 copies/mL, the census tract was assigned based on projected geo-coordinates (X, Y) of the most current residential information.

The following criteria were applied to the data presented in maps to protect the confidentiality, privacy, and security of PLWDH in LAC. If the estimated population within a census tract was less than 500 persons or the counts of the outcome of interest was less than 5 observations in a census tract, then the count was set to missing.

Gender and sex listed at birth

Surveillance collects and presents data by the assigned sex category at birth ("sex listed at birth") and individuals' gender identity ("gender"). Sex-specific population estimates are used to calculate rates by sex listed at birth. Rates are not calculated for data by gender since the associated population estimates in LAC is not available. The following gender categories are included in this report: men, women, and transgender persons. Transgender individuals are people who have ever identified as trans women or trans men or whose reported gender identity differs from their sex listed at birth. Persons who are reported as female at birth and have no other gender identity noted are classified as females/women. Persons who are reported as male at birth and have no other gender identity noted are classified as males/men. This report likely underestimates the number of transgender persons affected by HIV because gender status information is often incomplete in HIV case reports.

Race and ethnicity

Mandated collection of race and ethnicity information for persons diagnosed with HIV was implemented on January 1, 2003, as per OMB Statistical Policy Directive 15. A minimum of 5 race categories are collected for HIV surveillance including: American Indian and Alaska Native, Asian, Black, Native Hawaiian and Pacific Islander, and White. Additionally, systems must be able to retain information when multiple racial categories are reported.

Race and ethnicity in this report were grouped using the following criteria exclusively: A person was considered 'Latinx' if indicated 'Latino' or 'Latina' in the race or ethnicity field, regardless of any other race information found for the person. When not indicated as 'Latino' or 'Latina', a person is considered 'American Indian and Alaska Native (AIAN)' if the race field contained AIAN information, regardless of any other race information found for this person. Asians and Pacific Islanders are categorized into two separate groups: Asian or Native Hawaiian and Pacific Islander (NHPI). When the reported information is insufficient to categorize between these two groups, it is determined through record reviews among available reporting sources, including electronic medical records, original case report forms, Ryan White client registry, and STD Case Watch, as well as the reported information on extended race, country of birth, and full name. Persons identified with presumed NHPI race are included in the NHPI group regardless of their identification of Asian race in the records. Except for AIAN and NHPI groups, a person is categorized as 'Multi-racial' when two or more races are reported in the above race fields. All other persons reported with only one single race are placed in the corresponding race/ethnicity category.

Transmission categories

For surveillance purposes, 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 sexual contact among males (listed at birth), regardless of gender, with injection drug use; this combination makes up a separate transmission category.

Male-to-male sexual contact (MMSC): sexual contact among males (listed at birth), regardless of gender. Transgender persons with sexual contact (TGSC): sexual contact among transgender persons and persons of any sex and gender. Injection drug use (IDU): non-prescription drug use, including TGSC/IDU. MMSC/IDU: sexual contact among males (listed at birth), regardless of gender, as well as non-prescription drug use. Heterosexual contact: heterosexual contact with a cisgender person known to have, or with certain risk factors, for HIV (e.g., a person who injects drugs). Hemophilia or Transfusion: receipt of a blood transfusion no later than 1985 or investigated and confirmed as having received a transfusion of contaminated blood after 1985. Perinatal transmission: also known as vertical transmission or mother-to-child transmission (MTCT), refers to the passage of HIV from a person living with the virus to their child during pregnancy (in utero), labor and delivery (intrapartum), or breastfeeding (postpartum).

Newly diagnosed HIV cases reported without a transmission category were classified as "undetermined" or "unknown" transmission category. These included cases that were under investigation by LAC staff; cases whose risk factor information was missing because they died, declined to be interviewed, were lost to follow-up; or persons with a lack of exposure information in their medical chart; and cases who were interviewed or for whom other follow-up information was available, but no risk factor was identified.

Because a substantial proportion of persons newly diagnosed with HIV are reported without an identified risk factor, multiple imputation was used to assign a transmission category for persons aged ≥13 years.[167] Multiple imputation is a statistical approach in which each missing transmission category is replaced with a set of plausible values that represent the uncertainty about the true, but missing value[168]. The plausible values were analyzed by using standard procedures, and the results from these analyses were combined to produce the final estimates.

Estimates HIV incidence and undiagnosed HIV

HIV incidence and undiagnosed HIV are approximated using CDC's CD4 depletion model.[169] The CD4-based model uses HIV surveillance data and the first CD4 value after HIV diagnosis to estimate HIV incidence (diagnosed and undiagnosed persons infected with HIV), HIV prevalence (diagnosed and undiagnosed persons living with HIV), and percentage of undiagnosed HIV. The date of HIV acquisition is estimated for each person with a CD4 test using the model. To account for persons without a CD4 test result, persons with CD4 test results are assigned a weight based on the year of HIV diagnosis, sex, race/ethnicity, transmission category, age at diagnosis, disease classification, and vital status at the end of the specified year.

Based on the estimated time from HIV infection to diagnosis, the diagnosis delay distribution can be estimated by using standard survival analysis for right truncated data and used to estimate annual HIV incidence. HIV prevalence, which represents counts of persons with diagnosed or undiagnosed HIV at year-end each year, is estimated by subtracting reported cumulative deaths from cumulative infections. The number of persons with undiagnosed HIV is estimated by subtracting the number of persons living with diagnosed HIV from total prevalence. The percentage of diagnosed (or undiagnosed) HIV is determined by dividing the number of persons living with diagnosed (or undiagnosed) HIV by the total prevalence for each year.

[167] Harrison KM, Kajese T, Hall HI, Song R. Risk factor redistribution of the national HIV/AIDS surveillance data: an alternative approach. Public Health Rep 2008;123(5):618–627.
[168] Rubin DB. Multiple Imputation for Nonresponse in Surveys. New York: John Wiley & Sons Inc; 1987.
[169] Song R, Hall HI, Green TA, Szwarcwald CL, Pantazis N. Using CD4 Data to Estimate HIV Incidence, Prevalence, and Percent of Undiagnosed Infections in the United States. J Acquir Immune DeficSyndr. 2017; 74(1):3-9.

The CD4 model relies on a series of assumptions: (1) the CD4 depletion model is accurate; (2) persons received no treatment before the first CD4 test; (3) all data adjustments (e.g., multiple imputation for missing values of transmission category, weighting to account for cases without a CD4 test) are unbiased; and (4) a person's infection, diagnosis, and death occur in a "closed" population (no migration) or balanced population (approximately the same number of infected people moved into or out of the area under consideration). Of note, the model estimates are impacted by a 12-month reporting delay.

In this report, estimates from the CD4 model are presented through 2023 using results from the CD4-based model v6.0. This version of the model adjusts the monthly distribution of diagnoses used in the model that were reported during years 2020-2022 to account for the impact of the COVID-19 pandemic on HIV diagnoses in the US.

National HIV Behavioral Surveillance

The National HIV Behavioral Surveillance (NHBS) system was a national behavioral surveillance system designed to generate estimates of HIV prevalence and behavioral indicators in priority populations through nationally representative surveys in these populations. These surveys are funded by the US Centers for Disease Control and Prevention and implemented by local health departments. Time location sampling, a method of recruiting participants from venues where eligible participants are known to socialize during specific time periods, was used to recruit MSM participants. Respondent driven sampling, a peer-driven chain-referral sampling method, was used to recruit PWID, heterosexual persons at elevated risk for HIV (HET) and Transgender women participants. In addition to population specific eligibility criteria, NHBS participants were residents of LAC and at least 18 years of age. Participants who provided informed consent completed an interviewer-administered, anonymous standardized questionnaire about HIV-related behaviors and underwent rapid HIV and standard Hepatitis B and C testing. All testers received HIV counseling and referrals for social and medical services as needed. Data presented under NHBS section are unweighted.

Medical Monitoring Project

The Medical Monitoring Project (MMP) is a national HIV surveillance system funded by the US Centers for Disease Control and Prevention and implemented by local health departments. The aim of MMP is to provide locally and nationally representative data on behavioral and clinical outcomes in a sample of persons living with diagnosed HIV. MMP uses a two-stage probability-based sampling strategy that draws from the National HIV Surveillance System (NHSS) to select survey participants. The first stage is selecting the geographic areas to participate, and the second stage is selecting adults diagnosed with HIV and reported to NHSS within those participating areas.

Sampled persons were recruited to participate in person, by telephone, or by mail. To be eligible for MMP, the person had to be living with diagnosed HIV, aged ≥18 years, and residing in an MMP project area. A trained interviewer conducted either a computer-assisted telephone interview or an in-person interview. Persons who provided informed consent and agreed to participate were interviewed over the telephone or in a private location, as well as had the past 2 years of their medical records abstracted by a trained medical record abstractor. The interview included questions about demographics, health care use, met and unmet needs for ancillary services, sexual behavior, depression and anxiety, gynecologic and reproductive history (females only), drug and alcohol use, and utilization of HIV/STD prevention services.

Procedure for obtaining MMP weights: To generate locally and nationally representative data, survey data are weighted using base weights that reflect individuals' probability of selection at the national level and within each project area. Unique national and project area base weights were calculated for all 9,700 sampled cases. For a small group of cases, the base weights were adjusted for multiplicity. The weights were adjusted for nonresponse based on the national, city-state combination, or project area nonresponse analysis. The national nonresponse-adjusted weights were post stratified to national population totals, and each project area and city-state combinations were post stratified to project area and city-state specific

population totals. In 2019, no trimming was required for the post stratified weights at the national, city-state combination or project area level. Thus, the post stratified weight was the final MMP weight.

The national and city-state combination design variables were constructed ensuring that each design stratum had at least two clusters to calculate variances. The report also presented weight statistics and variance estimates that reflected the complex sampling design, and these were reviewed as part of the quality assurance process.

HIV Care Continuum

LA County has aligned with the targets set in the Ending the HIV Epidemic (EHE) in the US initiative to track progress along the HIV care continuum, which includes increasing the proportion of newly diagnosed patients linked to clinical care within one month of their diagnosis to 95% by 2025 and increasing the proportion of persons with diagnosed HIV who are virally suppressed to 95% by 2025.

Biomarkers such as HIV viral load (VL), CD4+ T-cell counts, and HIV genotype tests are used as markers to approximate early HIV infection and track outcomes along the HIV care continuum. Since the start of mandatory name-based HIV reporting in California in 2006, laboratories have been required to report "all tests that are indicative of HIV, including tests for HIV diagnosis, a component of HIV, or antibodies to or antigen of HIV (Title 17 CCR 2641.30)" to their local health department. In 2008, the reporting of all CD4 tests was mandated in California. These laboratory tests are used to estimate early HIV infection and initial linkage to care for persons newly diagnosed with HIV and to monitor receipt of care, retention in care, and degree of viral suppression among PLWDH in care. Caution should be exercised when interpreting these results because not all CD4/VL results were reported to the health department. This was especially the case when a PLWDH received care outside the local jurisdiction or moved out of state or to another country. This limitation may have resulted in underestimates of one or more of the outcomes along the HIV care continuum.

Stage 0 HIV disease: Stage 0 is designed to capture early HIV infection, which includes acute HIV and infections within 180 days before HIV diagnosis. Stage 0 infection is based on a sequence of discordant HIV test results in which a negative or indeterminate result was within 180 days of a positive result. The date of the negative HIV test is based on laboratory documentation and, for this analysis, the patient's self-report of last negative test was used in the absence of laboratory documentation. Stage 0 cases are likely underestimated due to the under-reporting of HIV negative test results.

Linkage to care: Linkage to care was defined as having a viral load, CD4, or HIV genotype test performed within 1 week, 1 month, 6 months, or 12 months after a new HIV diagnosis.

Receipt of care: Receipt of care was defined as having at least one viral load, CD4, or HIV genotype test reported during a twelve-month period.

Retention in care: Retention in care was defined as two or more viral load, CD4, or HIV genotype tests performed at least three months apart during a twelve-month period.

HIV viral suppression: Viral suppression was defined as having a viral load result of < 200 copies per milliliter (copies/mL). It is based on a person's most recent viral load test result within the specified calendar year. Persons who had no viral load tests reported in the specified calendar year were presumed to be virally unsuppressed.

Sustained viral suppression: Sustained viral suppression was defined as having all viral load results of < 200 copies per milliliter (copies/mL) over a period of at least 1 year. In this report, sustained viral load is defined using either a one-year or three-year period.

Persons living with diagnosed HIV: Because of the need for at least 12 months of follow-up to monitor achievements in the HIV care continuum after linkage to care, the denominator used to calculate receipt of care, retention in care, and viral suppression was restricted to persons diagnosed with HIV through 2023 and living in LAC as of December 31, 2024.

HIV and STD Co-Infection

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.

Death information ascertainment

Death information among persons living with diagnosed HIV is obtained through medical chart review, provider reports, autopsy reports by the Los Angeles County Department of Medical Examiner, and routine record linkages with Los Angeles County/California Vital Statistics registry, Social Security Death Master File (SSDMF), and National Death Index (NDI). Caution should be applied when interpreting trends based on reported deaths and associated causes. This is particularly relevant for more recent years as death information is provisional due to reporting delay. Moreover, potential misclassification in causes of deaths may have occurred in 2020 during the COVID-19 pandemic. Cause of death information was based on the first-listed underlying cause of death. International Classification of Diseases, Tenth Revision (ICD-10) codes B20-B24, 098.7, or R75 were used to denote HIV/AIDS-related deaths that occurred in 2014-2023. The following ICD-10 codes were used to categorize non-HIV related deaths: Diseases of heart (I00-I09, I11, I13, I20-I51); Malignant neoplasms (C00-C97); Drug poisonings (overdose) unintentional (X40-X44); COVID-19 U07.1); Accidents (unintentional injuries) (V01-X59, Y85-Y86); Diabetes mellitus (E10-E14); Chronic liver disease and cirrhosis (K70, K73-K74); Chronic lower respiratory diseases (J40-J47); Intentional self-harm (suicide) (U03, X60-X84, Y87.0); All other causes (remaining non-missing ICD-10 codes) or Unknown causes (R99 or missing).

Social Determinants of Health (SDOH) indicators

Recognizing that disparities in SDOH can significantly impact health outcomes, it is also crucial to understand how these factors may contribute to disparities in HIV outcomes among individuals living with diagnosed HIV in Los Angeles County (LAC). For this reason, we linked HIV Surveillance data to census tract level SDOH data sourced from the U.S. Census Bureau's American Community Survey (ACS) 2019-2023 5-year estimates to obtain SDOH indicator values for each person aged ≥18 years who was diagnosed with HIV, AIDS, died in 2023 as well as PLWDH at year-end 2024 in LAC. The SDOH indicator variables were categorized using empirically derived quartiles using data from all census tracts in LAC for which SDOH were determined.

The following five key SDOH indicators are presented in this report:

1. **Federal poverty status**: Percentage of adult residents (≥18 years) living below the federal poverty level.
2. **Education level**: Percentage of adult residents (≥18 years) without a high school diploma.
3. **Median household income**: Median household income in the past 12 months (in 2023 inflation-adjusted dollars).
4. **Health insurance coverage**: Percentage of adult residents (>18 years) without health insurance coverage.
5. **Gini index**: The Gini index of income inequality measures the dispersion of the household income distribution. It ranges from 0 (perfect equality, where all households have an equal share of income) to 1 (perfect inequality, where one household has all the income, and the rest have none). The Gini index is based on the difference between the Lorenz curve (the observed cumulative income distribution) and the straight line denoting a perfectly equal income distribution.

Data Tables

Table A1.a. Counts, percentages, and rates of HIV and stage 3 (AIDS) diagnoses, and deaths among persons aged ≥ 13 years living with diagnosed HIV by sex, age group, race/ethnicity, and transmission category, LAC 2023-2024[1]

	Male[2] (sex listed at birth)												Female[2] (sex listed at birth)												Total											
	2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[3]			2023 Deaths[4]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[3]			2023 Deaths[4]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[3]			2023 Deaths[4]		
	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt
Age group (yrs.)																																				
13-19	41	(3)	9	<5	(-)	-	64	(<1)	14	<5	(-)	-	6	(3)	1	<5	(-)	-	25	(<1)	6	<5	(-)	-	47	(3)	5	<5	(-)	-	89	(<1)	10	<5	(-)	-
20-29	456	(33)	65	103	(18)	15	2,685	(6)	382	21	(3)	3	51	(22)	7	10	(10)	1	310	(5)	45	5	(5)	1	507	(31)	37	113	(17)	8	2,995	(6)	216	26	(4)	2
30-39	477	(34)	62	186	(33)	24	9,614	(21)	1,254	99	(16)	13	63	(27)	8	31	(31)	4	894	(15)	117	14	(13)	2	540	(33)	35	217	(33)	14	10,508	(20)	687	113	(16)	7
40-49	262	(19)	41	128	(23)	20	9,399	(20)	1,465	78	(12)	12	55	(24)	8	23	(23)	3	1,343	(22)	201	12	(12)	2	317	(19)	24	151	(23)	12	10,742	(21)	821	90	(12)	7
50-59	113	(8)	18	86	(15)	14	11,277	(24)	1,826	157	(25)	25	37	(16)	6	17	(17)	3	1,607	(27)	245	22	(21)	3	150	(9)	12	103	(15)	8	12,884	(25)	1,012	179	(25)	14
≥60	52	(4)	5	58	(10)	6	13,020	(28)	1,345	270	(43)	28	22	(9)	2	19	(19)	2	1,874	(31)	158	50	(48)	4	74	(5)	3	77	(12)	4	14,894	(29)	692	320	(44)	15
Race/ethnicity[5]																																				
American Indian/Alaskan Native[6]	6	(<1)	21	<5	(-)	-	298	(1)	1,067	6	(1)	21	<5	(-)	-	<5	(-)	-	52	(1)	171	<5	(-)	-	10	(1)	17	<5	(-)	-	350	(1)	599	10	(1)	17
Asian	68	(5)	11	25	(4)	4	1,892	(4)	311	9	(1)	1	8	(3)	1	<5	(-)	-	200	(3)	28	<5	(-)	-	76	(5)	6	28	(4)	2	2,092	(4)	158	10	(1)	1
Black	239	(17)	78	85	(15)	28	7,916	(17)	2,583	143	(23)	47	56	(24)	16	20	(20)	6	1,773	(29)	512	31	(30)	9	295	(18)	45	105	(16)	16	9,689	(19)	1,483	174	(24)	27
Latinx	846	(60)	43	352	(62)	18	22,943	(50)	1,157	262	(42)	13	121	(52)	6	52	(52)	3	2,922	(48)	141	40	(38)	2	967	(59)	24	404	(61)	10	25,865	(50)	638	302	(41)	7
Native Hawaiian/Pacific Islander	<5	(-)	-	<5	(-)	-	72	(<1)	791	<5	(-)	-	<5	(-)	-	<5	(-)	-	7	(<1)	72	<5	(-)	-	5	(<1)	27	<5	(-)	-	79	(<1)	421	<5	(-)	-
White	216	(15)	20	75	(13)	7	10,936	(24)	989	157	(25)	14	40	(17)	4	19	(19)	2	799	(13)	73	15	(14)	1	256	(16)	12	94	(14)	4	11,735	(23)	534	172	(24)	8
Multi-race	18	(1)	17	23	(4)	22	1,934	(4)	1,872	46	(7)	45	<5	(-)	-	<5	(-)	-	289	(5)	252	13	(13)	11	21	(1)	10	27	(4)	12	2,223	(4)	1,020	59	(8)	27
Transmission category[7]																																				
Male-to-male sexual contact (MMSC)	1,193	(85)	-	464	(82)	-	39,655	(86)	-	477	(76)	-	-	(-)	-	-	(-)	-	-	(-)	-	-	(-)	-	1,193	(73)	-	464	(70)	-	39,655	(76)	-	477	(65)	-
Injection drug use (IDU)	64	(5)	-	30	(5)	-	1,544	(3)	-	45	(7)	-	73	(31)	-	41	(41)	-	1,366	(23)	-	36	(35)	-	137	(8)	-	71	(11)	-	2,910	(6)	-	81	(11)	-
MMSC/IDU	55	(4)	-	37	(7)	-	2,594	(6)	-	66	(11)	-	-	(-)	-	-	(-)	-	-	(-)	-	-	(-)	-	55	(3)	-	37	(6)	-	2,594	(5)	-	66	(9)	-
Transgender persons with sexual contact (TGSC)	61	(4)	-	17	(3)	-	1,213	3	-	14	(2)	-	<5	(-)	-	<5	(-)	-	38	(1)	-	<5	(-)	-	65	(4)	-	17	(3)	-	1251	(2)	-	14	(2)	-
Heterosexual contact[8]	26	(2)	-	17	(3)	-	844	(2)	-	19	(3)	-	155	(66)	-	54	(54)	-	4,445	(73)	-	65	(63)	-	181	(11)	-	71	(11)	-	5,289	(10)	-	84	(12)	-
Hemophilia/transfusion	<5	(-)	-	<5	(-)	-	54	(<1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	39	(1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	93	(<1)	-	<5	(-)	-
Perinatal exposure	<5	(-)	-	<5	(-)	-	98	(<1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	143	(2)	-	<5	(-)	-	<5	(-)	-	5	(1)	-	241	(<1)	-	<5	(-)	-
Other risk[9]	<5	(-)	-	<5	(-)	-	58	(<1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	22	(<1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	80	(<1)	-	<5	(-)	-
Total[5,10]	1,401	[86]	34	565	[85]	14	46,059	[88]	1,111	625	[86]	15	234	[14]	5	100	[15]	2	6,053	[12]	138	104	[14]	2	1,635	[100]	19	665	[100]	8	52,112	[100]	611	729	[100]	9

1 Data are provisional due to reporting delay. Rates per 100,000 based on July 1, 2023 population estimates prepared by Hedderson Demographic Services for LAC ISD, released March 2024. Rates based on fewer than 12 observations may not be reliable (see Technical Notes).
2 Male and female categories are based on sex listed at birth.
3 Persons living with diagnosed HIV (PLWDH) are based on most recent known address at the end of 2024 in LAC.
4 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.
5 Persons with unknown race/ethnicity are not shown but are included in the total.
6 Includes all non-Latinx persons who have been reported with American Indian/Alaskan Native race, regardless of whether any other race or ethnicity information is reported; rates are based on 2023 adjusted population estimates prepared by LAC DPH OHAE, Vital Records and Demography Unit (see Technical Notes).
7 Persons without an identified transmission category are assigned one using multiple imputation (MI) methods (see Technical Notes). Rates for transmission category are not calculated because of the lack of denominator data. Due to rounding, the sum may not add up to the total.
8 Includes cisgender persons who have ever had heterosexual contact with a person known to have, or with certain risk factors, for HIV (e.g., a person who injects drugs).
9 Other risk includes transmission categories not reported/identified.
10 Percent of total cases that are male and female (based on sex listed at birth) is shown in this row.

Table A1.b. Counts, percentages, and rates of HIV and stage 3 (AIDS) diagnoses, and deaths among persons aged ≥ 13 years living with diagnosed HIV **who received care within the past 10 years** by sex, age group, race/ethnicity, and transmission category, LAC 2023-2024[1]

	Male[2] (sex listed at birth)												Female[2] (sex listed at birth)												Total											
	2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[3]			2023 Deaths[4]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[3]			2023 Deaths[4]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[3]			2023 Deaths[4]		
	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt
Age group (yrs.)																																				
13-19	41	(3)	9	<5	(-)	-	64	(<1)	14	<5	(-)	-	6	(3)	1	<5	(-)	-	25	(<1)	6	<5	(-)	-	47	(3)	5	<5	(-)	-	89	(<1)	10	<5	(-)	-
20-29	456	(33)	65	103	(18)	15	2,680	(7)	382	21	(3)	3	51	(22)	7	10	(10)	1	306	(6)	45	5	(5)	1	507	(31)	37	113	(17)	8	2,986	(7)	216	26	(4)	2
30-39	477	(34)	62	186	(33)	24	9,251	(23)	1,207	98	(16)	13	63	(27)	8	31	(31)	4	793	(15)	104	13	(13)	2	540	(33)	35	217	(33)	14	10,044	(22)	657	111	(16)	7
40-49	262	(19)	41	128	(23)	20	8,344	(21)	1,300	76	(13)	12	55	(24)	8	23	(23)	3	1,125	(22)	169	11	(11)	2	317	(19)	24	151	(23)	12	9,469	(21)	724	87	(12)	7
50-59	113	(8)	18	86	(15)	14	9,517	(24)	1,541	153	(25)	25	37	(16)	6	17	(17)	3	1,343	(26)	205	22	(22)	3	150	(9)	12	103	(15)	8	10,860	(24)	853	175	(25)	14
≥60	52	(4)	5	58	(10)	6	10,515	(26)	1,086	259	(43)	27	22	(9)	2	19	(19)	2	1,547	(30)	131	49	(49)	4	74	(5)	3	77	(12)	4	12,062	(27)	560	308	(44)	14
Race/ethnicity[5]																																				
American Indian/Alaskan Native[6]	6	(<1)	21	<5	(-)	-	279	(1)	999	6	(1)	21	<5	(-)	-	<5	(-)	-	49	(1)	161	<5	(-)	-	10	(1)	17	<5	(-)	-	328	(1)	561	10	(1)	17
Asian	68	(5)	11	25	(4)	4	1,717	(4)	282	9	(1)	1	8	(3)	1	<5	(-)	-	166	(3)	23	<5	(-)	-	76	(5)	6	28	(4)	2	1,883	(4)	142	10	(1)	1
Black	239	(17)	78	85	(15)	28	6,970	(17)	2,274	135	(22)	44	56	(24)	16	20	(20)	6	1,548	(30)	447	30	(30)	9	295	(18)	45	105	(16)	16	8,518	(19)	1,304	165	(23)	25
Latinx	846	(60)	43	352	(62)	18	19,565	(48)	987	257	(42)	13	121	(52)	6	52	(52)	3	2,407	(47)	116	39	(39)	2	967	(59)	24	404	(61)	10	21,972	(48)	542	296	(42)	7
Native Hawaiian/Pacific Islander	<5	(-)	-	<5	(-)	-	67	(<1)	736	<5	(-)	-	<5	(-)	-	<5	(-)	-	5	(<1)	52	<5	(-)	-	5	(<1)	27	<5	(-)	-	72	(<1)	383	<5	(-)	-
White	216	(15)	20	75	(13)	7	9,807	(24)	887	154	(25)	14	40	(17)	4	19	(19)	2	668	(13)	61	14	(14)	1	256	(16)	12	94	(14)	4	10,475	(23)	476	168	(24)	8
Multi-race	18	(1)	17	23	(4)	22	1,904	(5)	1843	44	(7)	43	<5	(-)	-	<5	(-)	-	285	(6)	249	13	(13)	11	21	(1)	10	27	(4)	12	2,189	(5)	1004	57	(8)	26
Transmission category[7,8]																																				
Male-to-male sexual contact (MMSC)	1,193	(85)	-	464	(82)	-	34,952	(87)	-	463	(76)	-	-	(-)	-	-	(-)	-	-	(-)	-	-	(-)	-	1,193	(73)	-	464	(70)	-	34,952	(77)	-	463	(65)	-
Injection drug use (IDU)	64	(5)	-	30	(5)	-	1,187	(3)	-	43	(7)	-	73	(31)	-	41	(41)	-	1,165	(23)	-	35	(35)	-	137	(8)	-	71	(11)	-	2,352	(5)	-	78	(11)	-
MMSC/IDU	55	(4)	-	37	(7)	-	2,262	(6)	-	65	(11)	-	-	(-)	-	-	(-)	-	-	(-)	-	-	(-)	-	55	(3)	-	37	(6)	-	2,262	(5)	-	65	(9)	-
Transgender persons with sexual contact (TGSC)	61	(4)	-	17	(3)	-	1,121	3	-	14	(2)	-	<5	(-)	-	<5	(-)	-	34	(1)	-	<5	(-)	-	65	(4)	-	17	(3)	-	1154	(3)	-	14	(2)	-
Heterosexual contact[9]	26	(2)	-	17	(3)	-	661	(2)	-	18	(3)	-	155	(66)	-	54	(54)	-	3,754	(73)	-	63	(62)	-	181	(11)	-	71	(11)	-	4,415	(10)	-	81	(11)	-
Hemophilia/transfusion	<5	(-)	-	<5	(-)	-	38	(<1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	28	(1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	66	(<1)	-	<5	(-)	-
Perinatal exposure	<5	(-)	-	<5	(-)	-	97	(<1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	137	(3)	-	<5	(-)	-	<5	(-)	-	5	(1)	-	234	(1)	-	<5	(-)	-
Other risk[10]	<5	(-)	-	<5	(-)	-	54	(<1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	21	(<1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	75	(<1)	-	<5	(-)	-
Total[5,11]	1,401	[86]	34	565	[85]	14	40,371	[89]	974	607	[86]	15	234	[14]	5	100	[15]	2	5,139	[11]	117	101	[14]	2	1,635	[100]	19	665	[100]	8	45,510	[100]	534	708	[100]	8

1 Data are provisional due to reporting delay. Rates per 100,000 based on July 1, 2023 population estimates prepared by Hedderson Demographic Services for LAC ISD, released March 2024. Rates based on fewer than 12 observations may not be reliable (see Technical Notes). Excludes persons who have not had a care indicator lab (viral load, CD4+ T-cell, or genotype test) within the past 10 years, or if no care indicator labs were reported at all, were diagnosed over 10 years ago.
2 Male and female categories are based on sex listed at birth.
3 Persons living with diagnosed HIV (PLWDH) are based on most recent known address at the end of 2024 in LAC.
4 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.
5 Persons with unknown race/ethnicity are not shown but are included in the total.
6 Includes all non-Latinx persons who have been reported with American Indian/Alaskan Native race, regardless of whether any other race or ethnicity information is reported; rates are based on 2023 adjusted population estimates prepared by LAC DPH OHAE, Vital Records and Demography Unit (see Technical Notes).
7 Persons without an identified transmission category are assigned one using multiple imputation (MI) methods (see Technical Notes). Rates for transmission category are not calculated because of the lack of denominator data. Due to rounding, the sum may not add up to the total.
8 Includes cisgender persons who have ever had heterosexual contact with a person known to have, or with certain risk factors, for HIV (e.g., a person who injects drugs).
9 Other risk includes transmission categories not reported/identified.
10 Percent of total cases that are male and female (based on sex listed at birth) is shown in this row.

Table A2.a. Counts, percentages, and rates of HIV and stage 3 (AIDS) diagnoses, and deaths among persons aged ≥ 13 years living with diagnosed HIV by sex, Service Planning Area (SPA), and Health District (HD), LAC 2023-2024[1]

SPA/HD[3]	Male[2] (sex listed at birth)												Female[2] (sex listed at birth)												Total											
	2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[4]			2023 Deaths[5]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[4]			2023 Deaths[5]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[4]			2023 Deaths[5]		
	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt
Antelope Valley [1]	33	(2)	20	16	(3)	9	901	(2)	535	24	(4)	14	11	(5)	6	<5	(-)	-	295	(5)	167	6	(6)	3	44	(3)	13	20	(3)	6	1,196	(2)	347	30	(4)	9
Antelope Valley	33	(2)	20	16	(3)	9	901	(2)	535	24	(4)	14	11	(5)	6	<5	(-)	-	295	(5)	167	6	(6)	3	44	(3)	13	20	(3)	6	1,196	(2)	347	30	(4)	9
San Fernando [2]	215	(15)	24	80	(14)	9	6,909	(15)	761	85	(14)	9	55	(24)	6	23	(23)	2	973	(16)	102	10	(10)	1	270	(17)	14	103	(15)	6	7,882	(15)	423	95	(13)	5
East Valley	59	(4)	32	20	(4)	11	2,127	(5)	1165	21	(3)	12	17	(7)	9	6	(6)	3	224	(4)	119	5	(5)	3	76	(5)	21	26	(4)	7	2,351	(5)	635	26	(4)	7
Glendale	23	(2)	16	6	(1)	4	826	(2)	584	11	(2)	8	<5	(-)	-	<5	(-)	-	82	(1)	52	<5	(-)	-	26	(2)	9	8	(1)	3	908	(2)	305	11	(2)	4
San Fernando	41	(3)	19	16	(3)	7	904	(2)	412	14	(2)	6	7	(3)	3	5	(5)	2	164	(3)	73	<5	(-)	-	48	(3)	11	21	(3)	5	1,068	(2)	240	17	(2)	4
West Valley	92	(7)	25	38	(7)	10	3,052	(7)	838	39	(6)	11	28	(12)	7	10	(10)	3	503	(8)	131	<5	(-)	-	120	(7)	16	48	(7)	6	3,555	(7)	474	41	(6)	5
San Gabriel [3]	136	(10)	19	52	(9)	7	3,737	(8)	511	52	(8)	7	20	(9)	3	<5	(-)	-	537	(9)	68	8	(8)	1	156	(10)	10	55	(8)	4	4,274	(8)	281	60	(8)	4
Alhambra	24	(2)	17	11	(2)	8	601	(1)	427	10	(2)	7	<5	(-)	-	<5	(-)	-	84	(1)	54	<5	(-)	-	26	(2)	9	12	(2)	4	685	(1)	231	11	(2)	4
El Monte	36	(3)	21	15	(3)	9	947	(2)	540	8	(1)	5	6	(3)	3	<5	(-)	-	133	(2)	73	<5	(-)	-	42	(3)	12	16	(2)	4	1,080	(2)	302	11	(2)	3
Foothill	21	(1)	16	10	(2)	8	593	(1)	460	6	(1)	5	5	(2)	4	<5	(-)	-	81	(1)	57	<5	(-)	-	26	(2)	10	10	(2)	4	674	(1)	249	7	(1)	3
Pasadena	17	(1)	29	<5	(-)	-	529	(1)	894	9	(1)	15	<5	(-)	-	<5	(-)	-	60	(1)	93	<5	(-)	-	18	(1)	15	<5	(-)	-	589	(1)	477	9	(1)	7
Pomona	38	(3)	17	13	(2)	6	1,067	(2)	469	19	(3)	8	6	(3)	2	<5	(-)	-	179	(3)	73	<5	(-)	-	44	(3)	9	13	(2)	3	1,246	(2)	264	22	(3)	5
Metro [4]	348	(25)	70	141	(25)	28	16,211	(35)	3,249	182	(29)	36	38	(16)	8	16	(16)	3	1,086	(18)	222	28	(27)	6	386	(24)	39	157	(24)	16	17,297	(33)	1,752	210	(29)	21
Central	125	(9)	76	54	(10)	33	5,882	(13)	3,555	71	(11)	43	17	(7)	11	9	(9)	6	558	(9)	367	18	(17)	12	142	(9)	45	63	(9)	20	6,440	(12)	2,028	89	(12)	28
Hollywood-Wilshire	170	(12)	79	65	(12)	30	8,646	(19)	4,030	84	(13)	39	17	(7)	8	5	(5)	2	361	(6)	170	8	(8)	4	187	(11)	44	70	(11)	16	9,007	(17)	2,112	92	(13)	22
Northeast	53	(4)	45	22	(4)	19	1,683	(4)	1,415	27	(4)	23	<5	(-)	-	<5	(-)	-	167	(3)	134	<5	(-)	-	57	(3)	23	24	(4)	10	1,850	(4)	761	29	(4)	12
West [5]	51	(4)	18	16	(3)	6	2,165	(5)	777	26	(4)	9	9	(4)	3	<5	(-)	-	234	(4)	77	<5	(-)	-	60	(4)	10	18	(3)	3	2,399	(5)	412	29	(4)	5
West	51	(4)	18	16	(3)	6	2,165	(5)	777	26	(4)	9	9	(4)	3	<5	(-)	-	234	(4)	77	<5	(-)	-	60	(4)	10	18	(3)	3	2,399	(5)	412	29	(4)	5
South [6]	224	(16)	56	83	(15)	21	5,695	(12)	1,432	87	(14)	22	43	(18)	10	21	(21)	5	1,260	(21)	293	23	(22)	5	267	(16)	32	104	(16)	13	6,955	(13)	841	110	(15)	13
Compton	42	(3)	39	15	(3)	14	935	(2)	867	16	(3)	15	5	(2)	4	<5	(-)	-	176	(3)	151	<5	(-)	-	47	(3)	21	18	(3)	8	1,111	(2)	495	19	(3)	8
South	41	(3)	57	15	(3)	21	1,063	(2)	1,480	19	(3)	26	7	(3)	9	5	(5)	6	273	(5)	351	6	(6)	8	48	(3)	32	20	(3)	13	1,336	(3)	893	25	(3)	17
Southeast	54	(4)	82	24	(4)	36	977	(2)	1,475	16	(3)	24	5	(2)	8	<5	(-)	-	190	(3)	287	<5	(-)	-	59	(4)	45	28	(4)	21	1,167	(2)	880	18	(2)	14
Southwest	87	(6)	57	29	(5)	19	2,720	(6)	1,793	36	(6)	24	26	(11)	15	9	(9)	5	621	(10)	368	12	(12)	7	113	(7)	35	38	(6)	12	3,341	(6)	1042	48	(7)	15
East [7]	169	(12)	32	58	(10)	11	3,555	(8)	676	57	(9)	11	20	(9)	4	10	(10)	2	524	(9)	94	10	(10)	2	189	(12)	17	68	(10)	6	4,079	(8)	376	67	(9)	6
Bellflower	32	(2)	22	5	(1)	3	806	(2)	549	9	(1)	6	<5	(-)	-	<5	(-)	-	120	(2)	76	5	(5)	3	35	(2)	12	5	(1)	2	926	(2)	304	14	(2)	5
East Los Angeles	33	(2)	41	17	(3)	21	704	(2)	883	14	(2)	18	8	(3)	9	<5	(-)	-	85	(1)	100	<5	(-)	-	41	(3)	25	21	(3)	13	789	(2)	480	15	(2)	9
San Antonio	76	(5)	46	27	(5)	16	1,366	(3)	822	19	(3)	11	5	(2)	3	<5	(-)	-	228	(4)	131	<5	(-)	-	81	(5)	24	30	(5)	9	1,594	(3)	468	21	(3)	6
Whittier	28	(2)	21	9	(2)	7	679	(1)	510	15	(2)	11	<5	(-)	-	<5	(-)	-	91	(2)	64	<5	(-)	-	32	(2)	12	12	(2)	4	770	(1)	279	17	(2)	6
South Bay [8]	195	(14)	31	84	(15)	13	6,457	(14)	1,016	94	(15)	15	32	(14)	5	15	(15)	2	1,073	(18)	157	15	(14)	2	227	(14)	17	99	(15)	8	7,530	(14)	572	109	(15)	8
Harbor	19	(1)	23	7	(1)	8	609	(1)	729	10	(2)	12	6	(3)	7	<5	(-)	-	106	(2)	120	<5	(-)	-	25	(2)	15	8	(1)	5	715	(1)	416	12	(2)	7
Inglewood	66	(5)	40	29	(5)	18	1,683	(4)	1021	26	(4)	16	12	(5)	7	7	(7)	4	370	(6)	204	6	(6)	3	78	(5)	23	36	(5)	10	2,053	(4)	593	32	(4)	9
Long Beach	86	(6)	44	42	(7)	22	3,396	(7)	1,743	48	(8)	25	8	(3)	4	6	(6)	3	457	(8)	221	6	(6)	3	94	(6)	23	48	(7)	12	3,853	(7)	960	54	(7)	13
Torrance	24	(2)	12	6	(1)	3	769	(2)	400	10	(2)	5	6	(3)	3	<5	(-)	-	140	(2)	68	<5	(-)	-	30	(2)	8	7	(1)	2	909	(2)	229	11	(2)	3
Total[6]	1,401	[86]	34	565	[85]	14	46,059	[88]	1,111	625	[86]	15	234	[14]	5	100	[15]	2	6,053	[12]	138	104	[14]	2	1,635	[100]	19	665	[100]	8	52,112	[100]	611	729	[100]	9

1 Data are provisional due to reporting delay. Rates per 100,000 based on July 1, 2023 population estimates prepared by Hedderson Demographic Services for LAC ISD, released March 2024. SPA and HD geographies integrated in by Population Health Assessment Team, Office of Health Assessment and Epidemiology (OHAE). Rates based on fewer than 12 observations may not be reliable (see Technical Notes).
2 Male and female categories are based on sex listed at birth.
3 Service Planning Area (SPA) and Health District (HD) are based on 2022 boundaries. Persons are assigned a SPA/HD using geocoded residence at diagnosis joined to census tracts, followed by 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.
4 Persons living with diagnosed HIV (PLWDH) are based on most recent known address at the end of 2024 in LAC.
5 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.
6 Percent of total cases that are male and female (based on sex listed at birth) is shown in this row. Persons not assigned to a SPA/HD are not shown but are included in the total.

Table A2.b. Counts, percentages, and rates of HIV and stage 3 (AIDS) diagnoses, and deaths among persons aged ≥ 13 years living with diagnosed HIV who received care within the past 10 years by sex, Service Planning Area (SPA), and Health District (HD), LAC 2023-2024[1]

SPA/HD[3]	Male[2] (sex listed at birth)												Female[2] (sex listed at birth)												Total											
	2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[4]			2023 Deaths[5]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[4]			2023 Deaths[5]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[4]			2023 Deaths[5]		
	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt
Antelope Valley [1]	33	(2)	20	16	(3)	9	826	(2)	490	24	(4)	14	11	(5)	6	<5	(-)	-	278	(5)	158	6	(6)	3	44	(3)	13	20	(3)	6	1,104	(2)	320	30	(4)	9
Antelope Valley	33	(2)	20	16	(3)	9	826	(2)	490	24	(4)	14	11	(5)	6	<5	(-)	-	278	(5)	158	6	(6)	3	44	(3)	13	20	(3)	6	1,104	(2)	320	30	(4)	9
San Fernando [2]	215	(15)	24	80	(14)	9	6,264	(16)	690	84	(14)	9	55	(24)	6	23	(23)	2	850	(17)	89	10	(10)	1	270	(17)	14	103	(15)	6	7,114	(16)	382	94	(13)	5
East Valley	59	(4)	32	20	(4)	11	1,937	(5)	1061	20	(3)	11	17	(7)	9	6	(6)	3	192	(4)	102	5	(5)	3	76	(5)	21	26	(4)	7	2,129	(5)	575	25	(4)	7
Glendale	23	(2)	16	6	(1)	4	748	(2)	529	11	(2)	8	<5	(-)	-	<5	(-)	-	69	(1)	44	<5	(-)	-	26	(2)	9	8	(1)	3	817	(2)	274	11	(2)	4
San Fernando	41	(3)	19	16	(3)	7	833	(2)	379	14	(2)	6	7	(3)	3	5	(5)	2	153	(3)	68	<5	(-)	-	48	(3)	11	21	(3)	5	986	(2)	222	17	(2)	4
West Valley	92	(7)	25	38	(7)	10	2,746	(7)	754	39	(6)	11	28	(12)	7	10	(10)	3	436	(8)	113	<5	(-)	-	120	(7)	16	48	(7)	6	3,182	(7)	424	41	(6)	5
San Gabriel [3]	136	(10)	19	52	(9)	7	3,414	(8)	467	51	(8)	7	20	(9)	3	<5	(-)	-	469	(9)	59	8	(8)	1	156	(10)	10	55	(8)	4	3,883	(9)	255	59	(8)	4
Alhambra	24	(2)	17	11	(2)	8	552	(1)	393	10	(2)	7	<5	(-)	-	<5	(-)	-	74	(1)	48	<5	(-)	-	26	(2)	9	12	(2)	4	626	(1)	211	11	(2)	4
El Monte	36	(3)	21	15	(3)	9	849	(2)	484	8	(1)	5	6	(3)	3	<5	(-)	-	115	(2)	63	<5	(-)	-	42	(3)	12	16	(2)	4	964	(2)	269	11	(2)	3
Foothill	21	(1)	16	10	(2)	8	559	(1)	434	5	(1)	4	5	(2)	4	<5	(-)	-	70	(1)	49	<5	(-)	-	26	(2)	10	10	(2)	4	629	(1)	232	6	(1)	2
Pasadena	17	(1)	29	<5	(-)	-	482	(1)	815	9	(1)	15	<5	(-)	-	<5	(-)	-	52	(1)	81	<5	(-)	-	18	(1)	15	<5	(-)	-	534	(1)	432	9	(1)	7
Pomona	38	(3)	17	13	(2)	6	972	(2)	427	19	(3)	8	6	(3)	2	<5	(-)	-	158	(3)	64	<5	(-)	-	44	(3)	9	13	(2)	3	1,130	(2)	239	22	(3)	5
Metro [4]	348	(25)	70	141	(25)	28	13,662	(34)	2,738	179	(29)	36	38	(16)	8	16	(16)	3	841	(16)	172	26	(26)	5	386	(24)	39	157	(24)	16	14,503	(32)	1,469	205	(29)	21
Central	125	(9)	76	54	(10)	33	4,606	(11)	2,784	70	(12)	42	17	(7)	11	9	(9)	6	417	(8)	274	18	(18)	12	142	(9)	45	63	(9)	20	5,023	(11)	1,582	88	(12)	28
Hollywood-Wilshire	170	(12)	79	65	(12)	30	7,653	(19)	3,567	83	(14)	39	17	(7)	8	5	(5)	2	289	(6)	136	6	(6)	3	187	(11)	44	70	(11)	16	7,942	(17)	1,862	89	(13)	21
Northeast	53	(4)	45	22	(4)	19	1,403	(3)	1,180	26	(4)	22	<5	(-)	-	<5	(-)	-	135	(3)	109	<5	(-)	-	57	(3)	23	24	(4)	10	1,538	(3)	632	28	(4)	12
West [5]	51	(4)	18	16	(3)	6	1,908	(5)	685	26	(4)	9	9	(4)	3	<5	(-)	-	199	(4)	65	<5	(-)	-	60	(4)	10	18	(3)	3	2,107	(5)	362	29	(4)	5
West	51	(4)	18	16	(3)	6	1,908	(5)	685	26	(4)	9	9	(4)	3	<5	(-)	-	199	(4)	65	<5	(-)	-	60	(4)	10	18	(3)	3	2,107	(5)	362	29	(4)	5
South [6]	224	(16)	56	83	(15)	21	5,099	(13)	1,282	83	(14)	21	43	(18)	10	21	(21)	5	1,076	(21)	250	22	(22)	5	267	(16)	32	104	(16)	13	6,175	(14)	746	105	(15)	13
Compton	42	(3)	39	15	(3)	14	844	(2)	783	15	(2)	14	5	(2)	4	<5	(-)	-	150	(3)	129	<5	(-)	-	47	(3)	21	18	(3)	8	994	(2)	443	18	(3)	8
South	41	(3)	57	15	(3)	21	933	(2)	1,299	18	(3)	25	7	(3)	9	5	(5)	6	229	(4)	294	5	(5)	6	48	(3)	32	20	(3)	13	1,162	(3)	776	23	(3)	15
Southeast	54	(4)	82	24	(4)	36	850	(2)	1,283	14	(2)	21	5	(2)	8	<5	(-)	-	162	(3)	244	<5	(-)	-	59	(4)	45	28	(4)	21	1,012	(2)	764	16	(2)	12
Southwest	87	(6)	57	29	(5)	19	2,472	(6)	1,629	36	(6)	24	26	(11)	15	9	(9)	5	535	(10)	317	12	(12)	7	113	(7)	35	38	(6)	12	3,007	(7)	938	48	(7)	15
East [7]	169	(12)	32	58	(10)	11	3,184	(8)	605	57	(9)	11	20	(9)	4	10	(10)	2	446	(9)	80	10	(10)	2	189	(12)	17	68	(10)	6	3,630	(8)	334	67	(9)	6
Bellflower	32	(2)	22	5	(1)	3	746	(2)	508	9	(1)	6	<5	(-)	-	<5	(-)	-	109	(2)	69	5	(5)	3	35	(2)	12	5	(1)	2	855	(2)	281	14	(2)	5
East Los Angeles	33	(2)	41	17	(3)	21	611	(2)	766	14	(2)	18	8	(3)	9	<5	(-)	-	67	(1)	79	<5	(-)	-	41	(3)	25	21	(3)	13	678	(1)	412	15	(2)	9
San Antonio	76	(5)	46	27	(5)	16	1,202	(3)	723	19	(3)	11	5	(2)	3	<5	(-)	-	190	(4)	109	<5	(-)	-	81	(5)	24	30	(5)	9	1,392	(3)	409	21	(3)	6
Whittier	28	(2)	21	9	(2)	7	625	(2)	470	15	(2)	11	<5	(-)	-	<5	(-)	-	80	(2)	56	<5	(-)	-	32	(2)	12	12	(2)	4	705	(2)	255	17	(2)	6
South Bay [8]	195	(14)	31	84	(15)	13	5,707	(14)	898	86	(14)	14	32	(14)	5	15	(15)	2	918	(18)	135	15	(15)	2	227	(14)	17	99	(15)	8	6,625	(15)	503	101	(14)	8
Harbor	19	(1)	23	7	(1)	8	499	(1)	597	10	(2)	12	6	(3)	7	<5	(-)	-	95	(2)	108	<5	(-)	-	25	(2)	15	8	(1)	5	594	(1)	346	12	(2)	7
Inglewood	66	(5)	40	29	(5)	18	1,532	(4)	929	23	(4)	14	12	(5)	7	7	(7)	4	325	(6)	179	6	(6)	3	78	(5)	23	36	(5)	10	1,857	(4)	536	29	(4)	8
Long Beach	86	(6)	44	42	(7)	22	2,983	(7)	1,531	43	(7)	22	8	(3)	4	6	(6)	3	379	(7)	183	6	(6)	3	94	(6)	23	48	(7)	12	3,362	(7)	837	49	(7)	12
Torrance	24	(2)	12	6	(1)	3	693	(2)	360	10	(2)	5	6	(3)	3	<5	(-)	-	119	(2)	58	<5	(-)	-	30	(2)	8	7	(1)	2	812	(2)	204	11	(2)	3
Total[6]	1,401	[86]	34	565	[85]	14	40,371	[89]	974	607	[86]	15	234	[14]	5	100	[15]	2	5,139	[11]	117	101	[14]	2	1,635	[100]	19	665	[100]	8	45,510	[100]	534	708	[100]	8

1 Data are provisional due to reporting delay. Rates per 100,000 based on July 1, 2023 population estimates prepared by Hedderson Demographic Services for LAC ISD, released March 2024. SPA and HD geographies integrated in by Population Health Assessment Team, Office of Health Assessment and Epidemiology (OHAE). Rates based on fewer than 12 observations may not be reliable (see Technical Notes). Excludes persons who have not had a care indicator lab (viral load, CD4+ T-cell, or genotype test) within the past 10 years, or if no care indicator labs were reported at all, were diagnosed over 10 years ago.

2 Male and female categories are based on sex listed at birth.

3 Service Planning Area (SPA) and Health District (HD) are based on 2022 boundaries. Persons are assigned a SPA/HD using geocoded residence at diagnosis joined to census tracts, followed by 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.

4 Persons living with diagnosed HIV (PLWDH) are based on most recent known address at the end of 2024 in LAC.

5 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.

6 Percent of total cases that are male and female (based on sex listed at birth) is shown in this row. Persons not assigned to a SPA/HD are not shown but are included in the total.

Table A3. HIV diagnoses counts, percentages, and rates[1] by gender, age group, race/ethnicity, and transmission category among persons aged ≥ 13 years diagnosed with HIV, LAC 2014-2023

	Year of Diagnosis																											
	2014			2015			2016			2017			2018			2019			2020			2021			2022			2023[2]		
	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt
Gender																														
Male	1,843	(88)	45	1,779	(87)	43	1,699	(87)	40	1,598	(87)	38	1,537	(86)	36	1,392	(84)	33	1,234	(84)	30	1,339	(85)	32	1,363	(83)	33	1,333	(82)	32
Female	218	(10)	5	197	(10)	5	200	(10)	5	184	(10)	4	193	(11)	4	187	(11)	4	155	(11)	4	169	(11)	4	204	(12)	5	229	(14)	5
Transgender person[3]	39	(2)	-	69	(3)	-	59	(3)	-	60	(3)	-	48	(3)	-	71	(4)	-	77	(5)	-	69	(4)	-	82	(5)	-	73	(4)	-
Age group (yrs.)																														
13-19	69	(3)	7	80	(4)	8	66	(3)	7	57	(3)	6	71	(4)	8	61	(4)	7	39	(3)	4	55	(3)	6	42	(3)	5	47	(3)	5
20-29	788	(38)	51	780	(38)	51	767	(39)	50	722	(39)	47	682	(38)	45	585	(35)	39	537	(37)	35	496	(31)	34	557	(34)	39	507	(31)	37
30-39	591	(28)	41	537	(26)	37	551	(28)	37	514	(28)	34	521	(29)	35	506	(31)	34	434	(30)	29	539	(34)	36	531	(32)	35	540	(33)	35
40-49	380	(18)	27	363	(18)	26	323	(16)	23	290	(16)	20	266	(15)	19	250	(15)	18	251	(17)	19	236	(15)	18	260	(16)	20	317	(19)	24
50-59	205	(10)	16	219	(11)	16	196	(10)	15	182	(10)	13	152	(9)	11	184	(11)	13	145	(10)	11	176	(11)	14	174	(11)	14	150	(9)	12
≥60	67	(3)	4	66	(3)	4	55	(3)	3	77	(4)	4	86	(5)	4	64	(4)	3	60	(4)	3	75	(5)	4	85	(5)	4	74	(5)	3
Race/ethnicity[4]																														
American Indian/Alaskan Native[5]	18	(1)	29	13	(1)	24	14	(1)	26	22	(1)	42	13	(1)	22	<5	(-)	-	9	(1)	15	11	(1)	18	5	(<1)	8	10	(1)	17
Asian	123	(6)	10	117	(6)	9	95	(5)	8	115	(6)	9	91	(5)	7	86	(5)	7	60	(4)	4	71	(5)	5	61	(4)	5	76	(5)	6
Black	364	(17)	51	412	(20)	58	418	(21)	59	352	(19)	49	362	(20)	50	317	(19)	44	284	(19)	42	343	(22)	52	318	(19)	49	295	(18)	45
Latinx	1,085	(52)	28	973	(48)	25	992	(51)	25	907	(49)	23	910	(51)	23	841	(51)	21	795	(54)	20	865	(55)	22	974	(59)	25	967	(59)	24
Native Hawaiian/Pacific Islander	<5	(-)	-	<5	(-)	-	<5	(-)	-	5	(<1)	25	6	(<1)	29	<5	(-)	-	<5	(-)	-	<5	(-)	-	8	(<1)	45	5	(<1)	27
White	416	(20)	17	432	(21)	18	331	(17)	13	355	(19)	14	312	(18)	13	320	(19)	13	258	(18)	11	235	(15)	10	237	(14)	10	256	(16)	12
Multi-race	92	(4)	81	92	(4)	76	104	(5)	84	84	(5)	66	83	(5)	64	69	(4)	50	55	(4)	27	38	(2)	19	35	(2)	18	21	(1)	10
Transmission category[3,6]																														
Male-to-male sexual contact (MMSC)	1,705	(81)	-	1,659	(81)	-	1,569	(80)	-	1,475	(80)	-	1,402	(79)	-	1,251	(76)	-	1,104	(75)	-	1,192	(76)	-	1,198	(73)	-	1,193	(73)	-
Injection drug use (IDU)	95	(5)	-	105	(5)	-	105	(5)	-	118	(6)	-	107	(6)	-	110	(7)	-	101	(7)	-	126	(8)	-	133	(8)	-	137	(8)	-
MMSC/IDU	75	(4)	-	60	(3)	-	67	(3)	-	63	(3)	-	67	(4)	-	69	(4)	-	61	(4)	-	57	(4)	-	69	(4)	-	55	(3)	-
Transgender persons with sexual contact (TGSC)	38	(2)	-	61	(3)	-	54	(3)	-	55	(3)	-	41	(2)	-	66	(4)	-	67	(5)	-	63	(4)	-	69	(4)	-	65	(4)	-
Heterosexual contact[7]	187	(9)	-	159	(8)	-	162	(8)	-	129	(7)	-	159	(9)	-	146	(9)	-	128	(9)	-	135	(9)	-	175	(11)	-	181	(11)	-
Hemophilia/transfusion	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-
Perinatal exposure	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-
Other risk[8]	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	8	(<1)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-
Total[4]	2,100	[100]	25	2,045	[100]	24	1,958	[100]	23	1,842	[100]	21	1,778	[100]	20	1,650	[100]	19	1,466	[100]	17	1,577	[100]	18	1,649	[100]	19	1,635	[100]	19

1 Rates per 100,000 based on population estimates 2014-2023 prepared by Hedderson Demographic Services for LAC ISD. Rates based on fewer than 12 observations may not be reliable (see Technical Notes).
2 Data are provisional due to reporting delay.
3 Rates for transgender persons and transmission category are not calculated because of the lack of denominator data.
4 Rates by race/ethnicity are based on 2014-2023 adjusted population estimates produced by LAC DPH OHAE, Vital Records and Demography Unit (see Technical Notes); persons with unknown race/ethnicity are not shown but are included in the total.
5 American Indian/Alaskan Native race includes all non-Latinx persons who have been reported with American Indian/Alaskan Native race, regardless of whether any other race or ethnicity information is reported.
6 Persons without an identified transmission category are assigned one using multiple imputation (MI) methods (see Technical Notes). Due to rounding, the sum may not add up to the total.
7 Includes cisgender persons who have ever had heterosexual contact with a person known to have, or with certain risk factors, for HIV (e.g., a person who injects drugs).
8 Other risk includes transmission categories not reported or not identified.

Table A4. HIV diagnoses counts, percentages, and rates[1] by Service Planning Area (SPA)/Health District (HD) of residence among persons aged ≥ 13 years diagnosed with HIV, LAC 2014-2023

SPA/HD[2]	Year of Diagnosis																							
	2014			2015			2016			2017			2018			2019			2020			2021			2022			2023[3]		
	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt
Antelope Valley [1]	45	(2)	14	31	(2)	10	43	(2)	13	37	(2)	12	44	(2)	13	38	(2)	12	53	(4)	16	47	(3)	14	56	(3)	16	44	(3)	13
Antelope Valley	45	(2)	14	31	(2)	10	43	(2)	13	37	(2)	12	44	(2)	13	38	(2)	12	53	(4)	16	47	(3)	14	56	(3)	16	44	(3)	13
San Fernando [2]	306	(15)	17	310	(15)	16	311	(16)	16	270	(15)	14	303	(17)	16	284	(17)	15	226	(15)	12	242	(15)	13	246	(15)	13	270	(17)	14
East Valley	85	(4)	23	92	(4)	24	91	(5)	23	81	(4)	21	101	(6)	26	77	(5)	20	58	(4)	15	81	(5)	22	73	(4)	20	76	(5)	21
Glendale	32	(2)	11	38	(2)	12	27	(1)	9	23	(1)	8	30	(2)	10	39	(2)	12	40	(3)	13	21	(1)	7	22	(1)	7	26	(2)	9
San Fernando	41	(2)	10	33	(2)	8	52	(3)	12	42	(2)	9	41	(2)	9	32	(2)	7	27	(2)	6	36	(2)	8	43	(3)	10	48	(3)	11
West Valley	148	(7)	20	147	(7)	20	141	(7)	19	124	(7)	16	131	(7)	17	136	(8)	17	101	(7)	13	104	(7)	14	108	(7)	14	120	(7)	16
San Gabriel [3]	196	(9)	13	178	(9)	12	182	(9)	12	204	(11)	13	164	(9)	11	162	(10)	10	171	(12)	11	164	(10)	11	159	(10)	11	156	(10)	10
Alhambra	34	(2)	11	31	(2)	10	30	(2)	10	37	(2)	12	24	(1)	8	20	(1)	6	14	(1)	5	26	(2)	9	27	(2)	9	26	(2)	9
El Monte	55	(3)	15	48	(2)	13	57	(3)	16	50	(3)	14	46	(3)	12	39	(2)	10	57	(4)	16	43	(3)	12	52	(3)	15	42	(3)	12
Foothill	38	(2)	15	29	(1)	11	23	(1)	9	34	(2)	13	25	(1)	9	23	(1)	8	16	(1)	6	26	(2)	10	13	(1)	5	26	(2)	10
Pasadena	25	(1)	21	27	(1)	22	18	(1)	15	20	(1)	16	19	(1)	15	15	(1)	12	16	(1)	13	14	(1)	11	10	(1)	8	18	(1)	15
Pomona	44	(2)	10	43	(2)	9	54	(3)	12	63	(3)	13	50	(3)	11	65	(4)	14	68	(5)	14	55	(3)	12	57	(3)	12	44	(3)	9
Metro [4]	678	(32)	69	603	(29)	61	533	(27)	53	526	(29)	52	455	(26)	45	417	(25)	41	355	(24)	36	346	(22)	35	430	(26)	44	386	(24)	39
Central	231	(11)	78	220	(11)	74	219	(11)	72	185	(10)	60	204	(11)	67	173	(10)	55	129	(9)	41	140	(9)	45	174	(11)	56	142	(9)	45
Hollywood-Wilshire	372	(18)	86	328	(16)	75	266	(14)	60	283	(15)	63	203	(11)	45	206	(12)	46	172	(12)	40	162	(10)	38	205	(12)	49	187	(11)	44
Northeast	75	(4)	29	55	(3)	21	48	(2)	18	58	(3)	22	48	(3)	18	38	(2)	14	54	(4)	22	44	(3)	18	51	(3)	21	57	(3)	23
West [5]	109	(5)	19	101	(5)	17	66	(3)	11	66	(4)	11	71	(4)	12	87	(5)	15	53	(4)	9	59	(4)	10	46	(3)	8	60	(4)	10
West	109	(5)	19	101	(5)	17	66	(3)	11	66	(4)	11	71	(4)	12	87	(5)	15	53	(4)	9	59	(4)	10	46	(3)	8	60	(4)	10
South [6]	261	(12)	32	296	(14)	36	310	(16)	37	293	(16)	34	278	(16)	33	230	(14)	27	201	(14)	24	268	(17)	32	280	(17)	34	267	(16)	32
Compton	55	(3)	25	48	(2)	21	62	(3)	27	60	(3)	26	61	(3)	27	48	(3)	21	42	(3)	19	56	(4)	25	47	(3)	21	47	(3)	21
South	55	(3)	37	58	(3)	39	70	(4)	45	54	(3)	35	66	(4)	43	49	(3)	32	37	(3)	24	58	(4)	38	65	(4)	43	48	(3)	32
Southeast	46	(2)	35	42	(2)	31	47	(2)	33	46	(2)	33	48	(3)	35	40	(2)	29	43	(3)	33	44	(3)	33	59	(4)	45	59	(4)	45
Southwest	105	(5)	33	148	(7)	47	131	(7)	40	133	(7)	40	103	(6)	31	93	(6)	28	79	(5)	24	110	(7)	34	109	(7)	35	113	(7)	35
East [7]	188	(9)	18	181	(9)	17	190	(10)	18	174	(9)	16	172	(10)	16	153	(9)	14	152	(10)	14	190	(12)	18	160	(10)	15	189	(12)	17
Bellflower	46	(2)	15	49	(2)	16	48	(2)	16	41	(2)	14	37	(2)	12	45	(3)	15	28	(2)	9	41	(3)	13	46	(3)	15	35	(2)	12
East Los Angeles	28	(1)	17	29	(1)	17	35	(2)	21	30	(2)	18	28	(2)	17	21	(1)	13	32	(2)	20	39	(2)	24	27	(2)	17	41	(3)	25
San Antonio	69	(3)	20	69	(3)	20	70	(4)	20	69	(4)	20	67	(4)	19	60	(4)	17	57	(4)	17	78	(5)	23	55	(3)	16	81	(5)	24
Whittier	45	(2)	17	34	(2)	12	37	(2)	14	34	(2)	12	40	(2)	14	27	(2)	10	35	(2)	13	32	(2)	12	32	(2)	12	32	(2)	12
South Bay [8]	291	(14)	23	302	(15)	23	285	(15)	22	241	(13)	18	246	(14)	19	242	(15)	18	202	(14)	15	215	(14)	16	219	(13)	17	227	(14)	17
Harbor	34	(2)	20	21	(1)	12	25	(1)	14	17	(1)	10	28	(2)	16	23	(1)	13	13	(1)	8	15	(1)	9	20	(1)	12	25	(2)	15
Inglewood	87	(4)	26	96	(5)	28	93	(5)	27	77	(4)	22	81	(5)	23	83	(5)	24	69	(5)	20	73	(5)	21	86	(5)	25	78	(5)	23
Long Beach	131	(6)	34	137	(7)	35	127	(6)	32	113	(6)	28	100	(6)	25	102	(6)	25	91	(6)	23	89	(6)	22	80	(5)	20	94	(6)	23
Torrance	39	(2)	10	48	(2)	12	40	(2)	10	34	(2)	9	37	(2)	9	34	(2)	8	29	(2)	7	38	(2)	10	33	(2)	8	30	(2)	8
Total[4]	2,100	[100]	25	2,045	[100]	24	1,958	[100]	23	1,842	[100]	21	1,778	[100]	20	1,650	[100]	19	1,466	[100]	17	1,577	[100]	18	1,649	[100]	19	1,635	[100]	19

1 Rates are per 100,000 and based on population estimates 2014-2023 prepared by Hedderson Demographic Services for LAC ISD. SPA and HD geographies integrated in by Population Health Assessment Team, Office of Health Assessment and Epidemiology (OHAE). Rates based on fewer than 12 observations may not be reliable (see Technical Notes).
2 Service Planning Areas (SPA) and Health Districts (HD) are based on 2012 boundaries for diagnoses 2014-2019 and 2022 boundaries for diagnoses 2020-2023. Persons are assigned a SPA/HD using geocoded residence at diagnosis joined to census tracts, followed by 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.
3 Data are provisional due to reporting delay.
4 Persons not assigned to a SPA/HD are not shown but are included in the total.

Table A5.a. HIV care continuum indicators among persons aged ≥ 13 years living with diagnosed HIV by gender, age group, race/ethnicity, and transmission category, LAC 2023-2024[1]

	HIV diagnoses 2023	Linked to care 1 month[2,3]		PLWDH as of 2024[4]	Engaged in care 2024[2,5]		Retained in care 2024[2,5]		No. of persons with ≥ 1 VL test in 2024	Viral Suppression[2] (VL < 200)		
										Virally suppressed	Among PLWDH[5]	Among persons with ≥ 1 VL test[6]
	N	N	%	N	N	%	N	%	N	N	%	%
Gender												
Male	1,333	1,051	79	43,691	31,904	73	23,631	54	30,840	28,816	66	93
Female	229	186	81	5,816	4,104	71	3,108	53	4,042	3,708	64	92
Transgender person	73	61	84	1,397	1,078	77	845	60	1,065	931	67	87
Age group (yrs.)[7]												
13-19	47	41	87	108	94	87	67	62	94	87	81	93
20-29	507	405	80	3,328	2,659	80	1,814	55	2,623	2,344	70	89
30-39	540	436	81	10,408	7,825	75	5,447	52	7,666	6,913	66	90
40-49	317	244	77	10,525	7,507	71	5,457	52	7,313	6,726	64	92
50-59	150	113	75	13,200	9,479	72	7,245	55	9,174	8,628	65	94
≥ 60	74	59	80	13,335	9,522	71	7,554	57	9,077	8,757	66	96
Race/ethnicity[8]												
American Indian/Alaskan Native[9]	10	7	70	345	281	81	207	60	273	238	69	87
Asian	76	60	79	2,043	1,493	73	1,124	55	1,459	1,424	70	98
Black	295	223	76	9,475	6,677	70	4,659	49	6,524	5,813	61	89
Latinx	967	792	82	25,146	17,914	71	13,788	55	17,592	16,385	65	93
Native Hawaiian/Pacific Islander	5	<5	-	77	55	71	42	55	54	53	69	98
White	256	193	75	11,549	8,755	76	6,418	56	8,214	7,870	68	96
Multi-race	21	16	76	2,209	1,879	85	1,331	60	1,801	1,646	75	91
Transmission category[10]												
Male-to-male sexual contact (MMSC)	1,193	948	79	38,782	28,618	74	21,213	55	27,649	25,969	67	94
Injection drug use (IDU)	137	99	72	2,805	1,771	63	1,303	46	1,726	1,518	54	88
MMSC/IDU	55	43	78	2,541	1,865	73	1,380	54	1,806	1,589	63	88
Transgender persons with sexual contact (TGSC)	65	55	85	1,216	927	76	732	60	915	810	67	89
Heterosexual contact	181	151	83	5,160	3,599	70	2,747	53	3,554	3,307	64	93
Hemophilia/transfusion	<5	<5	-	93	61	66	42	45	59	58	62	98
Perinatal exposure	<5	<5	-	239	200	84	139	58	195	165	69	85
Other risk	<5	<5	-	69	45	65	28	41	42	39	57	93
Total[8]	1,635	1,298	79	50,904	37,086	73	27,584	54	35,947	33,455	66	93

1 Data are provisional due to reporting delay.
2 Persons are considered linked to care if there was at least one viral load, CD4+ T-cell, or genotype test within 1 month of an HIV diagnosis; persons are considered engaged in care if there was at least one viral load, CD4+ T-cell, or genotype test in 2024; persons are considered retained in care if there were ≥ 2 viral load, CD4+ T-cell, or genotype tests in 2024, at least 3 months apart; persons are considered virally suppressed when their last VL test in 2024 was < 200 copies/mL.
3 Denominator for linkage to care includes persons who were reported with a new HIV diagnosis in 2023; does not include estimated persons unaware of HIV infection.
4 Persons living with diagnosed HIV include those diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence.
5 Denominator for engagement and retention in care and overall viral load suppression in 2024 includes persons diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence.
6 Denominator includes persons diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence, who had at least one documented VL test in 2024.
7 Age group for new diagnoses was based on age at the time of initial HIV diagnosis, whereas age group for persons living with diagnosed HIV was based on age at the beginning of 2024.
8 Persons with unknown race/ethnicity are not shown but are included in the total.
9 Includes all non-Latinx persons who have been reported with American Indian/Alaskan Native race, regardless of whether any other race or ethnicity information is reported.
10 Persons without an identified transmission category are assigned one using multiple imputation (MI) methods (see Technical Notes). Due to rounding, the sum may not add up to the total; Heterosexual contact includes cisgender persons who have ever had heterosexual contact with a person known to have, or with certain risk factors, for HIV (e.g., a person who injects drugs); Other risk includes transmission categories not reported or not identified.

Table A5.b. HIV care continuum indicators among persons aged ≥ 13 years living with diagnosed HIV **who received care within the past 10 years** by gender, age group, race/ethnicity, and transmission category, LAC 2023-2024[1]

	HIV diagnoses 2023	Linked to care 1 month[2,3]		PLWDH as of 2024[4]	Engaged in care 2024[2,5]		Retained in care 2024[2,5]		No. of persons with ≥ 1 VL test in 2024	Viral Suppression[2] (VL < 200)		
										Virally suppressed	Among PLWDH[5]	Among persons with ≥ 1 VL test[6]
	N	N	%	N	N	%	N	%	N	N	%	%
Gender												
Male	1,333	1,051	79	38,103	31,904	84	23,631	62	30,840	28,816	76	93
Female	229	186	81	4,907	4,104	84	3,108	63	4,042	3,708	76	92
Transgender person	73	61	84	1,292	1,078	83	845	65	1,065	931	72	87
Age group (yrs.)[7]												
13-19	47	41	87	108	94	87	67	62	94	87	81	93
20-29	507	405	80	3,310	2,659	80	1,814	55	2,623	2,344	71	89
30-39	540	436	81	9,882	7,825	79	5,447	55	7,666	6,913	70	90
40-49	317	244	77	9,168	7,507	82	5,457	60	7,313	6,726	73	92
50-59	150	113	75	11,070	9,479	86	7,245	65	9,174	8,628	78	94
≥ 60	74	59	80	10,764	9,522	88	7,554	70	9,077	8,757	81	96
Race/ethnicity[8]												
American Indian/Alaskan Native[9]	10	7	70	323	281	87	207	64	273	238	74	87
Asian	76	60	79	1,834	1,493	81	1,124	61	1,459	1,424	78	98
Black	295	223	76	8,304	6,677	80	4,659	56	6,524	5,813	70	89
Latinx	967	792	82	21,253	17,914	84	13,788	65	17,592	16,385	77	93
Native Hawaiian/Pacific Islander	5	<5	-	70	55	79	42	60	54	53	76	98
White	256	193	75	10,289	8,755	85	6,418	62	8,214	7,870	76	96
Multi-race	21	16	76	2,175	1,879	86	1,331	61	1,801	1,646	76	91
Transmission category[10]												
Male-to-male sexual contact (MMSC)	1,193	948	79	34,079	28,618	84	21,213	62	27,649	25,969	76	94
Injection drug use (IDU)	137	99	72	2,247	1,771	79	1,303	58	1,726	1,518	68	88
MMSC/IDU	55	43	78	2,209	1,865	84	1,380	62	1,806	1,589	72	88
Transgender persons with sexual contact (TGSC)	65	55	85	1,119	927	83	732	65	915	810	72	89
Heterosexual contact	181	151	83	4,286	3,599	84	2,747	64	3,554	3,307	77	93
Hemophilia/transfusion	<5	<5	-	66	61	92	42	64	59	58	88	98
Perinatal exposure	<5	<5	-	232	200	86	139	60	195	165	71	85
Other risk	<5	<5	-	64	45	70	28	44	42	39	61	93
Total[8]	1,635	1,298	79	44,302	37,086	84	27,584	62	35,947	33,455	76	93

1 Data are provisional due to reporting delay. Excludes persons who have not had a care indicator lab (viral load, CD4+ T-cell, or genotype test) within the past 10 years, or if no care indicator labs were reported at all, were diagnosed over 10 years ago.
2 Persons are considered linked to care if there was at least one viral load, CD4+ T-cell, or genotype test within 1 month of an HIV diagnosis; persons are considered engaged in care if there was at least one viral load, CD4+ T-cell, or genotype test in 2024; persons are considered retained in care if there were ≥ 2 viral load, CD4+ T-cell, or genotype tests in 2024, at least 3 months apart; persons are considered virally suppressed when their last VL test in 2024 was < 200 copies/mL.
3 Denominator for linkage to care includes persons who were reported with a new HIV diagnosis in 2023; does not include estimated persons unaware of HIV infection.
4 Persons living with diagnosed HIV include those diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence.
5 Denominator for engagement and retention in care and overall viral load suppression in 2024 includes persons diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence.
6 Denominator includes persons diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence, who had at least one documented VL test in 2024.
7 Age group for new diagnoses was based on age at the time of initial HIV diagnosis, whereas age group for persons living with diagnosed HIV was based on age at the beginning of 2024.
8 Persons with unknown race/ethnicity are not shown but are included in the total.
9 Includes all non-Latinx persons who have been reported with American Indian/Alaskan Native race, regardless of whether any other race or ethnicity information is reported.
10 Persons without an identified transmission category are assigned one using multiple imputation (MI) methods (see Technical Notes). Due to rounding, the sum may not add up to the total; Heterosexual contact includes cisgender persons who have ever had heterosexual contact with a person known to have, or with certain risk factors, for HIV (e.g., a person who injects drugs); Other risk includes transmission categories not reported or not identified

Table A6.a. HIV care continuum indicators among persons aged ≥ 13 years living with diagnosed HIV by Service Planning Area (SPA) and Heath District (HD) of residence, LAC 2023-2024[1]

SPA/HD[2]	HIV diagnoses 2023	Linked to care 1 month[3,4]		PLWDH as of 2024[5]	Engaged in care 2024[3,6]		Retained in care 2024[3,6]		No. of persons with ≥ 1 VL test in 2024	Viral Suppression[3] (VL < 200)		
										Virally suppressed	Among PLWDH[6]	Among persons with ≥ 1 VL test[7]
	N	N	%	N	N	%	N	%	N	N	%	%
Antelope Valley [1]	44	30	68	1,162	899	77	633	54	885	818	70	92
Antelope Valley	44	30	68	1,162	899	77	633	54	885	818	70	92
San Fernando [2]	270	229	85	7,680	5,903	77	4,350	57	5,750	5,443	71	95
East Valley	76	66	87	2,298	1,772	77	1,328	58	1,719	1,623	71	94
Glendale	26	20	77	891	700	79	502	56	680	649	73	95
San Fernando	48	42	88	1,039	824	79	598	58	813	768	74	94
West Valley	120	101	84	3,452	2,607	76	1,922	56	2,538	2,403	70	95
San Gabriel [3]	156	117	75	4,165	3,126	75	2,303	55	3,059	2,894	69	95
Alhambra	26	19	73	667	492	74	348	52	483	462	69	96
El Monte	42	33	79	1,042	761	73	600	58	751	712	68	95
Foothill	26	20	77	660	526	80	387	59	512	482	73	94
Pasadena	18	9	50	579	451	78	332	57	441	414	72	94
Pomona	44	36	82	1,217	896	74	636	52	872	824	68	94
Metro [4]	386	307	80	16,997	11,878	70	8,838	52	11,327	10,542	62	93
Central	142	110	77	6,317	3,954	63	2,937	46	3,810	3,418	54	90
Hollywood-Wilshire	187	152	81	8,873	6,652	75	4,896	55	6,277	5,947	67	95
Northeast	57	45	79	1,807	1,272	70	1,005	56	1,240	1,177	65	95
West [5]	60	50	83	2,349	1,698	72	1,210	52	1,607	1,514	64	94
West	60	50	83	2,349	1,698	72	1,210	52	1,607	1,514	64	94
South [6]	267	217	81	6,775	4,964	73	3,756	55	4,867	4,398	65	90
Compton	47	39	83	1,082	811	75	635	59	797	738	68	93
South	48	41	85	1,295	909	70	703	54	900	788	61	88
Southeast	59	46	78	1,137	808	71	624	55	796	706	62	89
Southwest	113	91	81	3,261	2,436	75	1,794	55	2,374	2,166	66	91
East [7]	189	145	77	3,948	2,967	75	2,277	58	2,921	2,743	69	94
Bellflower	35	26	74	888	676	76	507	57	664	621	70	94
East Los Angeles	41	34	83	772	567	73	448	58	558	524	68	94
San Antonio	81	65	80	1,540	1,142	74	882	57	1,126	1,056	69	94
Whittier	32	20	63	748	582	78	440	59	573	542	72	95
South Bay [8]	227	179	79	7,371	5,522	75	4,144	56	5,419	5,045	68	93
Harbor	25	18	72	702	504	72	374	53	493	451	64	91
Inglewood	78	61	78	1,997	1,517	76	1,086	54	1,480	1,352	68	91
Long Beach	94	76	81	3,788	2,851	75	2,199	58	2,815	2,652	70	94
Torrance	30	24	80	884	650	74	485	55	631	590	67	94
Total[8]	1,635	1,298	79	50,904	37,086	73	27,584	54	35,947	33,455	66	93

1 Data are provisional due to reporting delay.
2 Service Planning Area (SPA) and Health District (HD) are based on 2022 boundaries (see Technical Notes).
3 Persons are considered linked to care if there was at least one viral load, CD4+ T-cell, or genotype test within 1 month of an HIV diagnosis; persons are considered engaged in care if there were ≥ 1 viral load, CD4+ T-cell, or genotype tests in 2024; persons are considered retained in care if there were ≥ 2 viral load, CD4+ T-cell, or genotype tests in 2024, at least 3 months apart; persons are considered virally suppressed when the last VL test in 2024 was < 200 copies/mL.
4 Denominator for linkage to care includes persons who were reported with a new HIV diagnosis in 2023; does not include estimated persons unaware of HIV infection.
5 Persons living with diagnosed HIV include those diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence.
6 Denominator for engagement and retention in care and overall viral load suppression in 2024 includes persons diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence.
7 Denominator includes persons diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence, who had at least one documented VL test in 2024.
8 Persons not assigned to a SPA/HD are not shown but are included in the total.

Table A6.b. HIV care continuum indicators among persons aged ≥ 13 years living with diagnosed HIV **who received care within the past 10 years** by Service Planning Area (SPA) and Heath District (HD) of residence, LAC 2023-2024[1]

SPA/HD[2]	HIV diagnoses 2023	Linked to care 1 month[3,4]		PLWDH as of 2024[5]	Engaged in care 2024[3,6]		Retained in care 2024[3,6]		No. of persons with ≥ 1 VL test in 2024	Viral Suppression[3] (VL < 200)		
										Virally suppressed	Among PLWDH[6]	Among persons with ≥ 1 VL test[7]
	N	N	%	N	N	%	N	%	N	N	%	%
Antelope Valley [1]	44	30	68	1,070	899	84	633	59	885	818	76	92
Antelope Valley	44	30	68	1,070	899	84	633	59	885	818	76	92
San Fernando [2]	270	229	85	6,912	5,903	85	4,350	63	5,750	5,443	79	95
East Valley	76	66	87	2,076	1,772	85	1,328	64	1,719	1,623	78	94
Glendale	26	20	77	800	700	88	502	63	680	649	81	95
San Fernando	48	42	88	957	824	86	598	62	813	768	80	94
West Valley	120	101	84	3,079	2,607	85	1,922	62	2,538	2,403	78	95
San Gabriel [3]	156	117	75	3,774	3,126	83	2,303	61	3,059	2,894	77	95
Alhambra	26	19	73	608	492	81	348	57	483	462	76	96
El Monte	42	33	79	926	761	82	600	65	751	712	77	95
Foothill	26	20	77	615	526	86	387	63	512	482	78	94
Pasadena	18	9	50	524	451	86	332	63	441	414	79	94
Pomona	44	36	82	1,101	896	81	636	58	872	824	75	94
Metro [4]	386	307	80	14,203	11,878	84	8,838	62	11,327	10,542	74	93
Central	142	110	77	4,900	3,954	81	2,937	60	3,810	3,418	70	90
Hollywood-Wilshire	187	152	81	7,808	6,652	85	4,896	63	6,277	5,947	76	95
Northeast	57	45	79	1,495	1,272	85	1,005	67	1,240	1,177	79	95
West [5]	60	50	83	2,057	1,698	83	1,210	59	1,607	1,514	74	94
West	60	50	83	2,057	1,698	83	1,210	59	1,607	1,514	74	94
South [6]	267	217	81	5,995	4,964	83	3,756	63	4,867	4,398	73	90
Compton	47	39	83	965	811	84	635	66	797	738	76	93
South	48	41	85	1,121	909	81	703	63	900	788	70	88
Southeast	59	46	78	982	808	82	624	64	796	706	72	89
Southwest	113	91	81	2,927	2,436	83	1,794	61	2,374	2,166	74	91
East [7]	189	145	77	3,499	2,967	85	2,277	65	2,921	2,743	78	94
Bellflower	35	26	74	817	676	83	507	62	664	621	76	94
East Los Angeles	41	34	83	661	567	86	448	68	558	524	79	94
San Antonio	81	65	80	1,338	1,142	85	882	66	1,126	1,056	79	94
Whittier	32	20	63	683	582	85	440	64	573	542	79	95
South Bay [8]	227	179	79	6,466	5,522	85	4,144	64	5,419	5,045	78	93
Harbor	25	18	72	581	504	87	374	64	493	451	78	91
Inglewood	78	61	78	1,801	1,517	84	1,086	60	1,480	1,352	75	91
Long Beach	94	76	81	3,297	2,851	86	2,199	67	2,815	2,652	80	94
Torrance	30	24	80	787	650	83	485	62	631	590	75	94
Total[8]	1,635	1,298	79	44,302	37,086	84	27,584	62	35,947	33,455	76	93

1 Data are provisional due to reporting delay. Excludes persons who have not had a care indicator lab (viral load, CD4+ T-cell, or genotype test) within the past 10 years, or if no care indicator labs were reported at all, were diagnosed over 10 years ago.
2 Service Planning Area (SPA) and Health District (HD) are based on 2022 boundaries (see Technical Notes).
3 Persons are considered linked to care if there was at least one viral load, CD4+ T-cell, or genotype test within 1 month of an HIV diagnosis; persons are considered engaged in care if there were ≥ 1 viral load, CD4+ T-cell, or genotype tests in 2024; persons are considered retained in care if there were ≥ 2 viral load, CD4+ T-cell, or genotype tests in 2024, at least 3 months apart; persons are considered virally suppressed when the last VL test in 2024 was < 200 copies/mL.
4 Denominator for linkage to care includes persons who were reported with a new HIV diagnosis in 2023; does not include estimated persons unaware of HIV infection.
5 Persons living with diagnosed HIV include those diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence.
6 Denominator for engagement and retention in care and overall viral load suppression in 2024 includes persons diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence.
7 Denominator includes persons diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence, who had at least one documented VL test in 2024.
8 Persons not assigned to a SPA/HD are not shown but are included in the total.

Table A7. Counts, percentages, and rates for underlying causes of death among PWDH aged ≥13 years by demographic and transmission category LAC 2022-2023[1,2,3]

	HIV/AIDS			Diseases of the heart			Malignant neoplasms			Drug overdoses (unintentional)			COVID-19			Other/Unknown			Total		
	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt
Gender																					
Male	318	(82)	340	180	(87)	192	141	(82)	151	168	(86)	180	39	(81)	42	433	(85)	463	1,279	(84)	1,368
Female	59	(15)	486	24	(12)	198	31	(18)	255	23	(12)	190	7	(15)	58	65	(13)	536	209	(14)	1,722
Transgender person	10	(3)	344	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	13	(3)	447	34	(2)	1,169
Age (yrs.)																					
Median age	55			61			63			45			56			58			57		
Age group																					
13-19	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-
20-29	18	(5)	226	<5	(-)	-	<5	(-)	-	11	(6)	138	<5	(-)	-	22	(4)	277	56	(4)	704
30-39	54	(14)	244	11	(5)	50	10	(6)	45	56	(29)	253	<5	(-)	-	64	(13)	289	198	(13)	895
40-49	67	(17)	301	14	(7)	63	9	(5)	40	45	(23)	202	9	(19)	40	70	(14)	315	214	(14)	962
50-59	107	(28)	362	68	(33)	230	37	(21)	125	52	(27)	176	17	(35)	58	119	(23)	403	400	(26)	1,355
≥60	141	(36)	533	114	(55)	431	117	(68)	442	31	(16)	117	15	(31)	57	235	(46)	888	653	(43)	2,468
Race/ethnicity																					
American Indian/Alaskan Native	5	(1)	671	<5	(-)	-	<5	(-)	-	6	(3)	805	<5	(-)	-	5	(1)	671	19	(1)	2,550
Asian	6	(2)	145	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	15	(3)	361	31	(2)	747
Black	83	(21)	402	62	(30)	300	39	(23)	189	51	(26)	247	13	(27)	63	121	(24)	586	369	(24)	1,787
Latinx	191	(49)	368	71	(34)	137	61	(35)	117	75	(38)	144	25	(52)	48	195	(38)	375	618	(41)	1,190
White	78	(20)	303	56	(27)	217	56	(32)	217	45	(23)	175	6	(13)	23	135	(26)	524	376	(25)	1,459
Other	24	(6)	464	15	(7)	290	13	(8)	251	14	(7)	271	<5	(-)	-	39	(8)	754	108	(7)	2,087
Transmission category																					
Male-to-male sexual contact (MMSC)	259	(67)	313	141	(68)	170	116	(67)	140	116	(59)	140	34	(71)	41	322	(63)	389	987	(65)	1,192
Injection drug use (IDU)	44	(11)	734	19	(9)	317	16	(9)	267	32	(16)	534	5	(10)	83	54	(11)	901	169	(11)	2,819
MMSC/IDU	27	(7)	475	22	(11)	387	11	(6)	194	29	(15)	511	<5	(-)	-	61	(12)	1,074	153	(10)	2,694
Transgender persons with sexual contact (TGSC)	8	(2)	318	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	13	(3)	517	30	(2)	1,193
Heterosexual contact	45	(12)	418	22	(11)	204	27	(16)	251	14	(7)	130	5	(10)	46	56	(11)	520	170	(11)	1,579
Hemophilia/transfusion	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	5	(<1)	2,525
Perinatal exposure	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	8	(1)	1,581
Other	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-	<5	(-)	-
Experienced homelessness																					
Yes	80	(21)	720	36	(17)	324	23	(13)	207	101	(52)	909	12	(25)	108	112	(22)	1,008	364	(24)	3,275
No	307	(79)	315	172	(83)	177	150	(87)	154	94	(48)	96	36	(75)	37	399	(78)	409	1,158	(76)	1,188
Virally suppressed (VL <200 mL)																					
Yes	155	(49)	237	120	(63)	184	118	(76)	181	73	(43)	112	18	(51)	28	265	(58)	405	749	(57)	1,146
No	164	(51)	430	72	(38)	189	37	(24)	97	97	(57)	254	17	(49)	45	188	(42)	493	575	(43)	1,506
Total	387	(25)	356	208	(14)	192	173	(11)	159	195	(13)	180	48	(3)	44	511	(34)	471	1,522	(100)	1,402

1 Includes persons with diagnosed HIV who died in 2022-2023 and whose residence at death was in LAC or whose most recent known address before death was in LAC, when residence at death is missing. Rates per 100,000 are based on persons living in LAC with diagnosed HIV (PLWDH) at the beginning of 2022 or diagnosed in 2022 plus PLWDH at the beginning of 2023 or diagnosed in 2023, based on the most recent known address at that time. *

2 Cause of death information was based on the first-listed underlying cause of death. International Classification of Diseases (ICD)-10 codes were used to classify the underlying causes of death into six categories: (1) HIV/AIDS (B20-B24, O98.7, R75); (2) Diseases of the heart (I00-I09, I11, I13, I20-I51); (3) Malignant neoplasms (C00-C97); (4) Drug poisonings (overdose) Unintentional (X40-X44); (5) COVID-19 (U07.1); (6) All other causes (remaining non-missing ICD-10 codes) or Unknown causes (R99 or missing).

3 Age is based on age at death for the numerator and for age on January 1 of the year of death for the denominator. 'Other' race/ethnicity includes Native Hawaiian/Pacific Islander and persons of multiple race/ethnicities; persons without an identified transmission category are assigned one using multiple imputation (MI) methods (see Technical Notes); 'Other' transmission category includes transmission categories not reported or not identified. Persons experiencing homelessness (PEH) includes persons who have ever experienced homelessness, if reported. Viral suppression (< 200 copies/mL) is based on a person's last viral load within the year prior to their year of death; the denominator is based on persons living at year-end prior to their year of death (2021 or 2022) and diagnosed the year before (2020 or 2021) with or without a viral load test.

* PWDH denominator was based on methodology from CDC: Bosh KA, Johnson AS, Hernandez AL, Prejean J, Taylor J, Wingard R, Valleroy LA, Hall HI. Vital Signs: Deaths Among Persons with Diagnosed HIV Infection, United States, 2010-2018. MMWR Morb Mortal Wkly Rep. 2020 Nov 20;69(46):1717-1724. DOI: http://dx.doi.org/10.15585/mmwr.mm6946a1.

Table A8. Counts, percentages, and rates of HIV and stage 3 (AIDS) diagnoses, and deaths among persons aged ≥ 18 years living with diagnosed HIV by select social determinants of health (SDOH), LAC 2023-2024[1]

	Male[2] (sex listed at birth)										Female[2] (sex listed at birth)										Total									
	2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[3]			2023 Deaths[4]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[3]			2023 Deaths[4]			2023 HIV Diagnoses			2023 AIDS Diagnoses			PLWDH as of 2024[3]			2023 Deaths[4]		
	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt	N	(%)	Rt
Below FPL (%)																																				
< 7	168	(12)	18	54	(10)	6	5,226	(11)	572	67	(11)	7	12	(5)	1	<5	(-)	-	600	(10)	61	7	(7)	1	180	(11)	9	58	(9)	3	5,826	(11)	306	74	(10)	4
7-10	249	(18)	25	106	(19)	11	8,662	(19)	887	125	(20)	13	37	(16)	4	11	(11)	1	1,029	(17)	98	17	(16)	2	286	(18)	14	117	(18)	6	9,691	(19)	479	142	(19)	7
11-16	387	(28)	37	143	(25)	14	13,189	(29)	1,261	166	(27)	16	62	(26)	6	27	(27)	2	1,579	(26)	141	34	(33)	3	449	(28)	21	170	(26)	8	14,768	(28)	683	200	(27)	9
≥17	511	(37)	58	204	(36)	23	14,221	(31)	1,617	228	(36)	26	109	(47)	12	50	(50)	5	2,193	(36)	238	43	(41)	5	620	(38)	34	254	(38)	14	16414	(32)	911	271	(37)	15
Not determined	75	(5)	-	58	(10)	-	4,739	(10)	-	39	(6)	-	14	(6)	-	8	(8)	-	641	(11)	-	<5	(-)	-	89	(5)	-	66	(10)	-	5,380	(10)	-	42	(6)	-
Less than high school (%)																																				
< 6	176	(13)	20	70	(12)	8	9,337	(20)	1,040	96	(15)	11	22	(9)	2	6	(6)	1	603	(10)	62	9	(9)	1	198	(12)	11	76	(11)	4	9,940	(19)	532	105	(14)	6
6-15	285	(21)	28	102	(18)	10	9,802	(21)	952	127	(20)	12	38	(16)	3	16	(16)	1	1,102	(18)	98	18	(17)	2	323	(20)	15	118	(18)	5	10,904	(21)	507	145	(20)	7
16-28	368	(26)	37	140	(25)	14	10,851	(24)	1,096	187	(30)	19	74	(32)	7	36	(36)	3	1,690	(28)	160	36	(35)	3	442	(27)	22	176	(26)	9	12,541	(24)	612	223	(31)	11
≥29	486	(35)	53	195	(35)	21	11,358	(25)	1,245	176	(28)	19	86	(37)	9	34	(34)	4	2,008	(33)	215	38	(37)	4	572	(35)	31	229	(34)	12	13,366	(26)	724	214	(29)	12
Not determined	75	(5)	-	58	(10)	-	4,689	(10)	-	39	(6)	-	14	(6)	-	8	(8)	-	639	(11)	-	<5	(-)	-	89	(5)	-	66	(10)	-	5328	(10)	-	42	(6)	-
Median household income ($)																																				
≥112,000	158	(11)	16	55	(10)	6	6,800	(15)	706	82	(13)	9	21	(9)	2	5	(5)	1	653	(11)	63	9	(9)	1	179	(11)	9	60	(9)	3	7453	(14)	373	91	(12)	5
87,000-111,999	279	(20)	28	96	(17)	10	9,876	(21)	994	127	(20)	13	37	(16)	3	15	(15)	1	994	(16)	93	13	(13)	1	316	(19)	15	111	(17)	5	10,870	(21)	527	140	(19)	7
65,000-86,999	392	(28)	40	154	(27)	16	10,568	(23)	1,077	141	(23)	14	61	(26)	6	19	(19)	2	1,518	(25)	144	24	(23)	2	453	(28)	22	173	(26)	9	12,086	(23)	595	165	(23)	8
<65,000	476	(34)	55	197	(35)	23	13,875	(30)	1,600	231	(37)	27	100	(43)	11	52	(52)	6	2,219	(37)	243	55	(53)	6	576	(35)	32	249	(37)	14	16,094	(31)	904	286	(39)	16
Not determined	85	(6)	-	63	(11)	-	4,918	(11)	-	44	(7)	-	15	(6)	-	9	(9)	-	658	(11)	-	<5	(-)	-	100	(6)	-	72	(11)	-	5,576	(11)	-	47	(6)	-
Without health insurance (%)																																				
< 4	142	(10)	17	51	(9)	6	5,713	(12)	701	67	(11)	8	15	(6)	2	5	(5)	1	534	(9)	60	<5	(-)	-	157	(10)	9	56	(8)	3	6,247	(12)	366	71	(10)	4
4-7	276	(20)	27	103	(18)	10	11,388	(25)	1,126	152	(24)	15	41	(18)	4	21	(21)	2	1,193	(20)	109	22	(21)	2	317	(20)	15	124	(19)	6	12,581	(24)	598	174	(24)	8
8-14	394	(28)	37	141	(25)	13	11,736	(25)	1,101	163	(26)	15	64	(27)	6	26	(26)	2	1,591	(26)	140	30	(29)	3	458	(28)	21	167	(25)	8	13,327	(26)	604	193	(26)	9
≥15	503	(36)	54	212	(38)	23	12,462	(27)	1,342	204	(33)	22	100	(43)	10	40	(40)	4	2,084	(34)	216	45	(43)	5	603	(37)	32	252	(38)	13	14546	(28)	768	249	(34)	13
Not determined	75	(5)	-	58	(10)	-	4,738	(10)	-	39	(6)	-	14	(6)	-	8	(8)	-	640	(11)	-	<5	(-)	-	89	(5)	-	66	(10)	-	5,378	(10)	-	42	(6)	-
Gini Index																																				
<0.39	299	(22)	30	115	(20)	12	8,084	(18)	812	126	(20)	13	59	(25)	6	21	(21)	2	1,242	(21)	118	21	(20)	2	358	(22)	17	136	(20)	7	9,326	(18)	455	147	(20)	7
0.39-0.42	363	(26)	37	139	(25)	14	9,091	(20)	926	114	(18)	12	49	(21)	5	26	(26)	2	1,442	(24)	137	23	(22)	2	412	(25)	20	165	(25)	8	10,533	(20)	518	137	(19)	7
0.43-0.46	308	(22)	35	105	(19)	12	9,913	(22)	1,112	162	(26)	18	63	(27)	7	25	(25)	3	1,298	(21)	136	27	(26)	3	371	(23)	20	130	(20)	7	11,211	(22)	606	189	(26)	10
≥0.47	345	(25)	36	148	(26)	16	14,200	(31)	1,502	184	(29)	19	49	(21)	5	20	(20)	2	1,416	(23)	140	30	(29)	3	394	(24)	20	168	(25)	9	15616	(30)	798	214	(29)	11
Not determined	75	(5)	-	58	(10)	-	4,749	(10)	-	39	(6)	-	14	(6)	-	8	(8)	-	644	(11)	-	<5	(-)	-	89	(5)	-	66	(10)	-	5,393	(10)	-	42	(6)	-
Total[5]	1,390	[86]	36	565	[85]	15	46,037	[88]	1,202	625	[86]	16	234	[14]	6	100	[15]	2	6,042	[12]	148	104	[14]	3	1,624	[100]	21	665	[100]	8	52,079	[100]	658	729	[100]	9

1 Data are provisional due to reporting delay. Rates per 100,000 based on July 1, 2023 population estimates prepared by Hedderson Demographic Services for LAC ISD, released March 2024. Rates based on fewer than 12 observations may not be reliable. Social determinants of health (SDOH) are based on census tract level ACS estimates for 2019-2023 and joined to addresses geocoded to the census tract level and 2023 population estimates. Quartiles are determined based on LAC census tracts. "Not determined" includes persons who were residing in census tracts for which a SDOH measure was not determined or persons for whom a census tract is not available (see Technical Notes).
2 Male and female categories are based on sex listed at birth.
3 Persons living with HIV are based on most recent known address at the end of 2024 in LAC.
4 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.
5 Percent of total cases that are male and female (based on sex listed at birth) is shown in this row.

Table A9. HIV care continuum indicators among persons aged ≥ 18 years living with diagnosed HIV by select social determinants of health (SDOH), LAC 2023-2024[1]

	HIV diagnoses 2023	Linked to care 1 month[2,3]		PLWDH as of 2024[4]	Engaged in care 2024[2,5]		Retained in care 2024[2,5]		No. of persons with ≥ 1 VL test in 2024	Viral Suppression[2] (VL < 200)		
										Virally suppressed	Among PLWDH[5]	Among persons with ≥ 1 VL test[6]
	N	N	%	N	N	%	N	%	N	N	%	%
Below FPL (%)												
< 7	180	147	82	5,704	4,576	80	3,355	59	4,390	4,186	73	95
7-10	286	224	78	9,484	7,541	80	5,622	59	7,267	6,872	72	95
11-16	449	364	81	14,467	10,841	75	8,130	56	10,515	9,917	69	94
≥17	620	484	78	15,981	12,227	77	9,163	57	11,964	10,924	68	91
Not determined	89	69	78	5,230	1,865	36	1,288	25	1,775	1,522	29	86
Less than high school (%)												
< 6	198	150	76	9,784	7,888	81	5,745	59	7,433	7,122	73	96
6-15	323	260	80	10,687	8,566	80	6,299	59	8,309	7,877	74	95
16-28	442	348	79	12,224	9,550	78	7,131	58	9,341	8,624	71	92
≥29	572	461	81	12,992	9,196	71	7,107	55	9,068	8,288	64	91
Not determined	89	69	78	5,179	1,850	36	1,276	25	1,760	1,510	29	86
Median household income ($)												
≥112,000	179	145	81	7,324	5,274	72	3,804	52	4,999	4,776	65	96
87,000-111,999	316	248	78	10,655	8,504	80	6,275	59	8,187	7,811	73	95
65,000-86,999	453	355	78	11,805	9,308	79	7,054	60	9,078	8,481	72	93
<65,000	576	462	80	15,665	11,962	76	9,034	58	11,739	10,712	68	91
Not determined	100	78	78	5,417	2,002	37	1,391	26	1,908	1,641	30	86
Without health insurance (%)												
< 4	157	118	75	6,144	4,956	81	3,551	58	4,716	4,529	74	96
4-7	317	243	77	12,340	9,234	75	6,856	56	8,890	8,384	68	94
8-14	458	377	82	13,017	10,247	79	7,678	59	9,957	9,331	72	94
≥15	603	481	80	14,137	10,749	76	8,186	58	10,574	9,656	68	91
Not determined	89	69	78	5,228	1,864	36	1,287	25	1,774	1,521	29	86
Gini Index												
<0.39	358	282	79	9,085	6,535	72	4,898	54	6,416	6,016	66	94
0.39-0.42	412	341	83	10,266	8,000	78	6,051	59	7,821	7,284	71	93
0.43-0.46	371	294	79	10,947	8,551	78	6,354	58	8,264	7,728	71	94
≥0.47	394	302	77	15,326	12,092	79	8,962	58	11,628	10,864	71	93
Not determined	89	69	78	5,242	1,872	36	1,293	25	1,782	1,529	29	86
Total	1,624	1,288	79	50,866	37,050	73	27,558	54	35,911	33,421	66	93

1 Data are provisional due to reporting delay. Social determinants of health (SDOH) are based on census tract level ACS estimates for 2019-2023 and joined to addresses geocoded to the census tract level. Quartiles are determined based on LAC census tracts. "Not determined" includes persons who were residing in census tracts for which a SDOH measure was not determined or persons for whom a census tract is not available (see Technical Notes).

2 Persons are considered linked to care if there was at least one viral load, CD4+ T-cell, or genotype test within 1 month of an HIV diagnosis; persons are considered engaged in care if there was at least one viral load, CD4+ T-cell, or genotype test in 2024; persons are considered retained in care if there were ≥ 2 viral load, CD4+ T-cell, or genotype tests in 2024, at least 3 months apart; persons are considered virally suppressed when their last VL test in 2024 was < 200 copies/mL.

3 Denominator for linkage to care includes persons who were reported with a new HIV diagnosis in 2023; does not include estimated persons unaware of HIV infection.

4 Persons living with diagnosed HIV include those diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence.

5 Denominator for engagement and retention in care and overall viral load suppression in 2024 includes persons diagnosed through 2023 and living in LAC at year-end 2024 based on most recent residence.

6 Denominator includes persons diagnosed with an HIV through 2023 and living in LAC at year-end 2024, based on most recent residence, who had at least one documented VL test in 2024.

COUNTY OF LOS ANGELES
Public Health
Division of HIV and STD Programs