Annual HIV/STD Update to the Los Angeles County Commission on HIV

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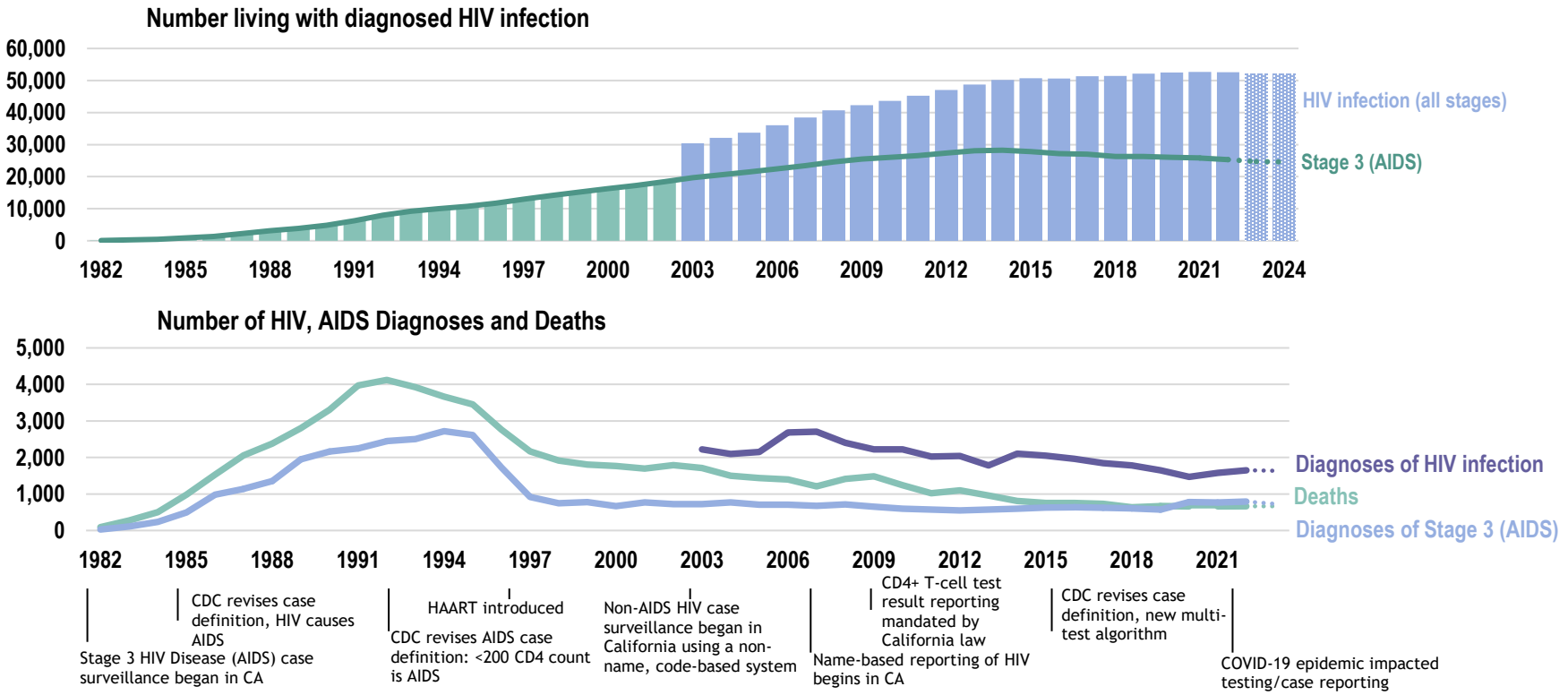
November 13, 2025

1. HIV, STD, and Mpox Morbidity Trends
2. Federal Budget and Policy Updates
3. Workforce and Program Impacts
4. Priority Setting
5. Questions and Answers

HIV, STD, and Mpox Morbidity Trends

HIV Diagnoses, AIDS Diagnoses, Persons Living with AIDS and Non-AIDS HIV, and Deaths among Persons Living with Diagnosed HIV, Los Angeles County 1982-2024[1,2,3]

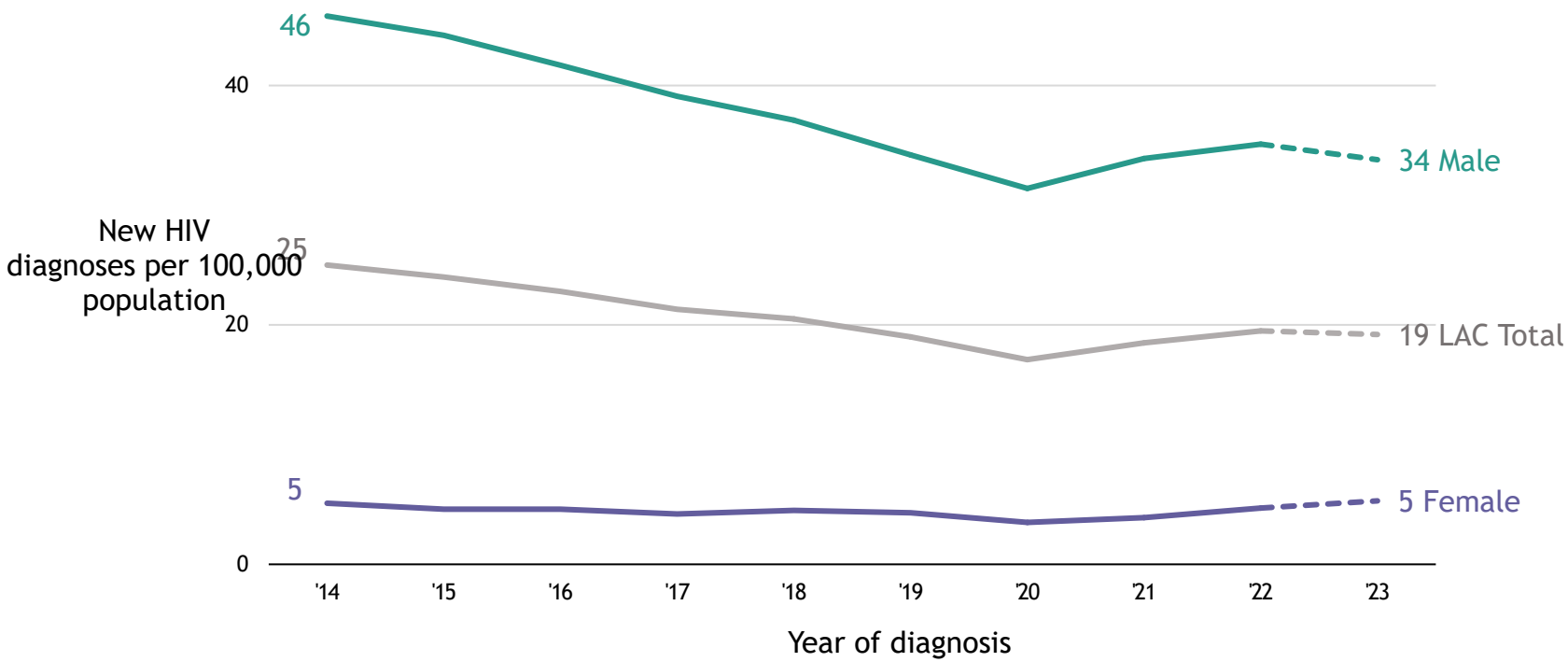


History of the HIV epidemic: In LAC, AIDS reporting began in 1982 and the annual number of cases peaked in 1992 with more than 4,000 cases reported that year. In 1994, deaths reached an all-time high followed by a significant decline that coincided with the introduction of highly active antiretroviral 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.

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

Source: HIV Surveillance data as of December 2024

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

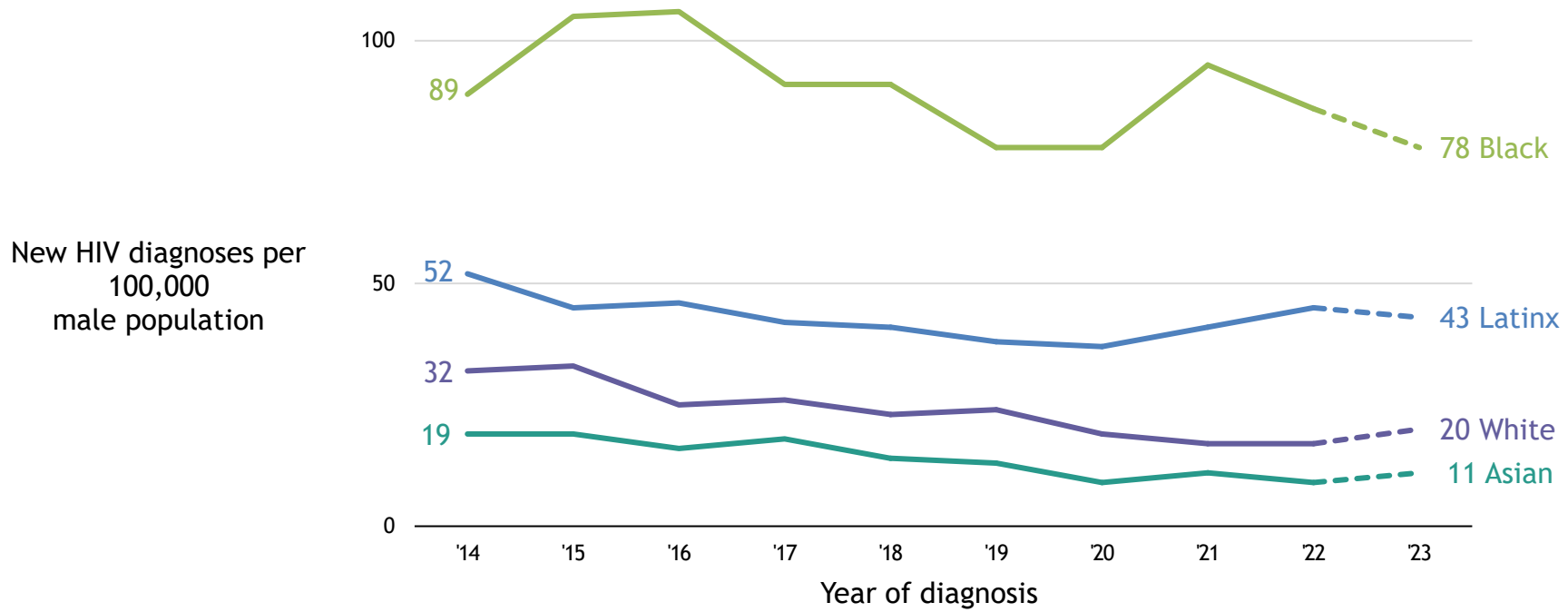


HIV diagnosis rates remain substantially higher among males compared with females. Over the past decade, HIV diagnosis rates among males have declined, while rates among females have remained stable.

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

Source: HIV Surveillance data as of December 2024

HIV diagnoses rates among males[1] aged ≥ 13 years by race/ethnicity,[2] LAC 2014-2023[3,4]

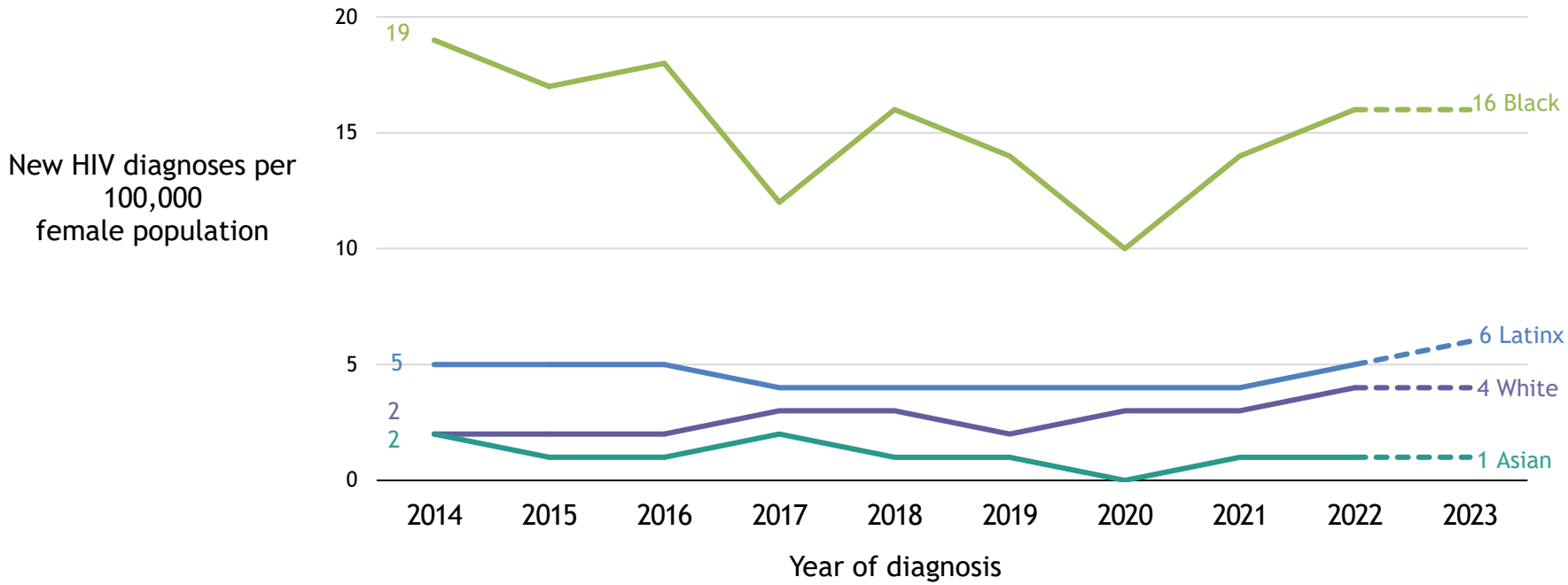


Over the past decade, HIV diagnoses rates have declined among LAC males across all race/ethnicity groups. However, stark disparities persist, with Black males experiencing significantly higher rates than other race/ethnicity groups.

[1] Based on sex at birth.
[2] Native Hawaiian and Pacific Islanders (NHPI) and American Indians and Alaska Natives (AIAN) were not included in the analysis due to small numbers, while persons of multiple race/ethnicities were not included due to lack of denominator data to calculate rates. In 2023, NHPI, AIAN, and multi-racial persons represented 0.3%, 0.4%, and 1.3% of males newly diagnosed with HIV, respectively.
[3] Due to reporting delay, 2023 HIV diagnosis data are provisional as indicated by the dashed line.
[4] The decline in HIV diagnoses rates observed in 2020, a year in which the COVID-19 pandemic may have depressed HIV testing and reporting, seems to have been followed by a rebound in diagnoses in 2021 and 2022.

Source: HIV Surveillance data as of December 2024

HIV diagnoses rates among females[1] aged ≥ 13 years by race/ethnicity,[2] LAC 2014-2023[3,4]



Over the past decade, HIV diagnosis rates have remained relatively low and stable among Latinx, White, and Asian women 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.

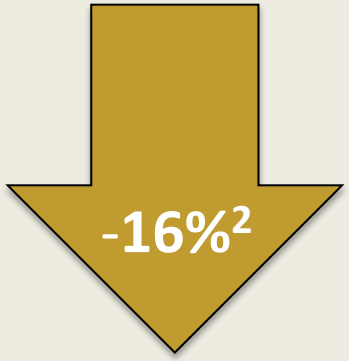
[1] Based on sex at birth.
[2] Native Hawaiian and Pacific Islanders (NHPI) and American Indians and Alaska Natives (AIAN) were not included in the analysis due to small numbers, while persons of multiple race/ethnicities were not included due to lack of denominator data to calculate rates. In 2023,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

Source: HIV Surveillance data as of December 2024

LAC saw a 15% case reduction in 3 reported STIs from 2023–24, matching or surpassing national trends[1]

Chlamydia

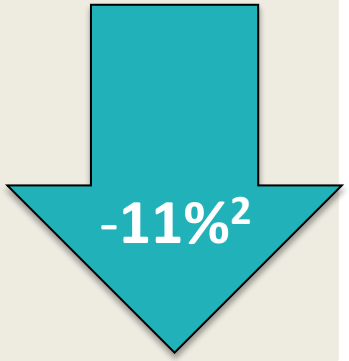
- Reductions since peak in 2019
- National: -8%



Gonorrhea

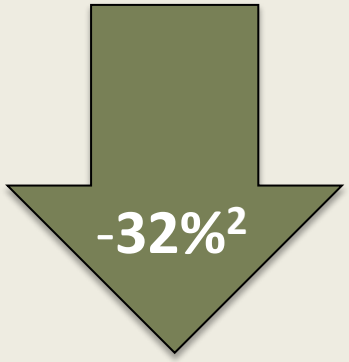
- Reductions since peak in 2021*
- National: -10%

Third year in a row



Early Syphilis[3]

- Reductions since 2021
  - Primary/secondary: -34%
- National
  - Primary/ secondary: -22%



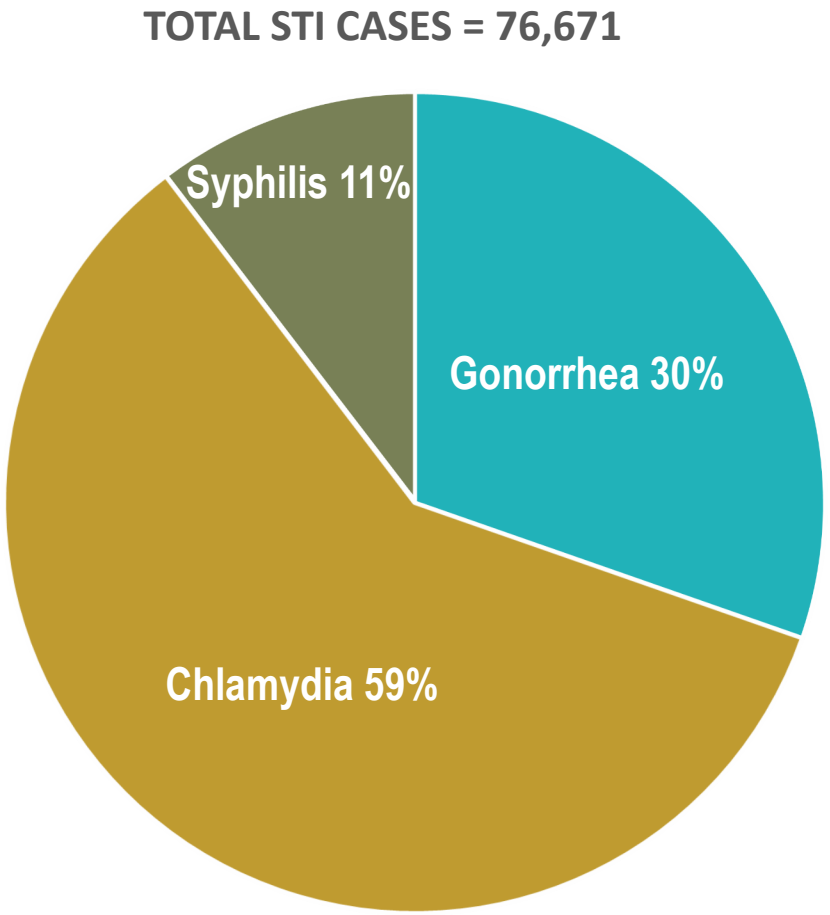
Congenital syphilis

- Reductions since 2022: -19%
- *Cases still >3x than a decade ago*
- National: increase

1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena. Preliminary 2024 data.
2. Reductions in number of cases from 2023 to 2024.
3. Early syphilis includes all cases staged as primary, secondary or early non-primary, non-secondary (early latent).

Source: LAC DPH Division of HIV and STD Programs

Preliminary Reported Sexually Transmitted Infections, Los Angeles County, 2024[1]



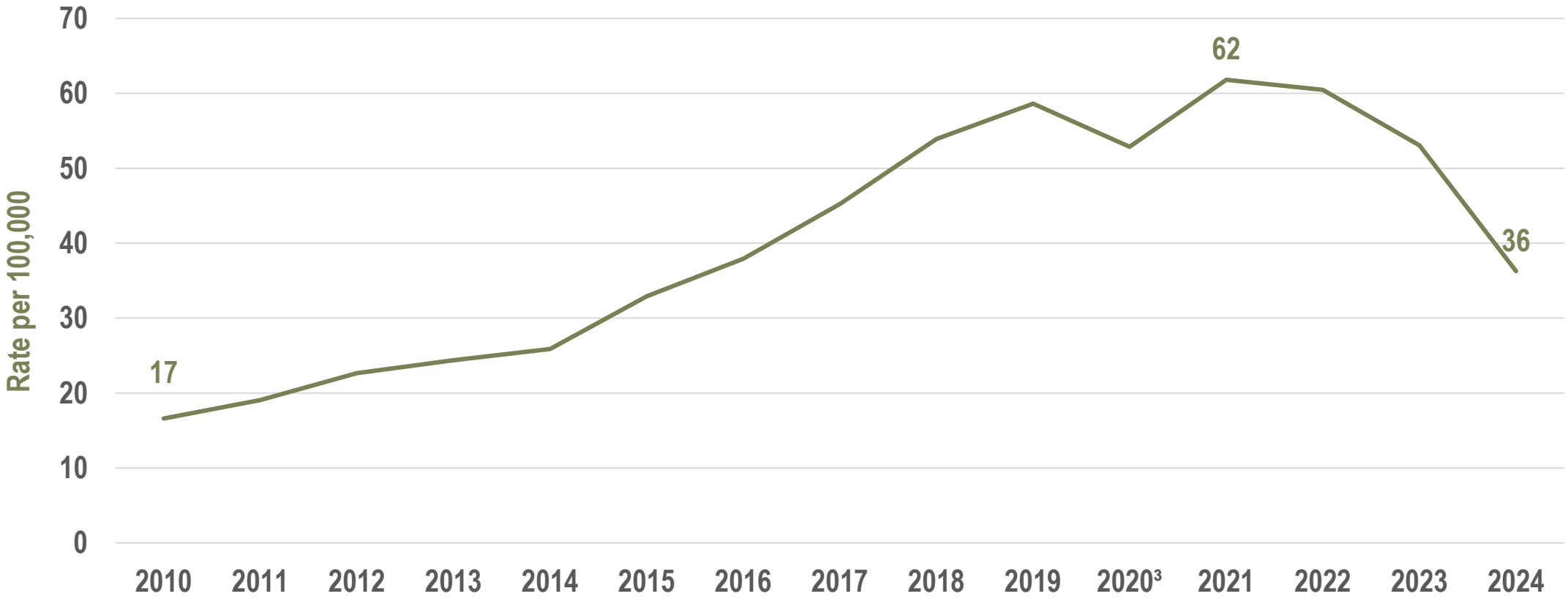
Although syphilis represents only 11% of STIs in LAC, the health consequences of untreated syphilis can be more severe than untreated chlamydia and gonorrhea.

Source: LAC DPH Division of HIV and STD Programs

1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.

The early syphilis rate has been decreasing since its peak in 2021.

Preliminary Early Syphilis[1] Rates, Los Angeles County, 2010-2024[2]

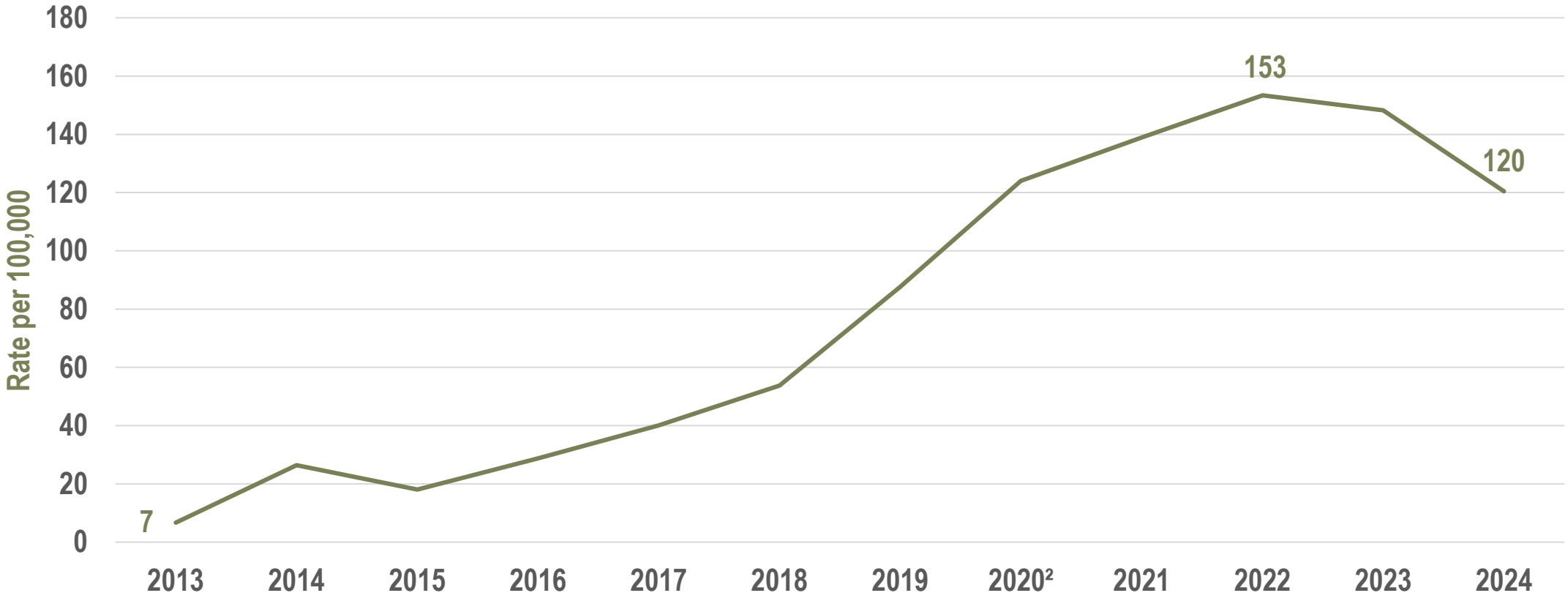


1. Early syphilis includes all cases staged as primary, secondary or early non-primary non-secondary (early latent).
2. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
3. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

Source: LAC DPH Division of HIV and STD Programs

The congenital syphilis rate has been decreasing since its peak in 2022.

Preliminary Congenital Syphilis Rates, Los Angeles County, 2013-2024[1]

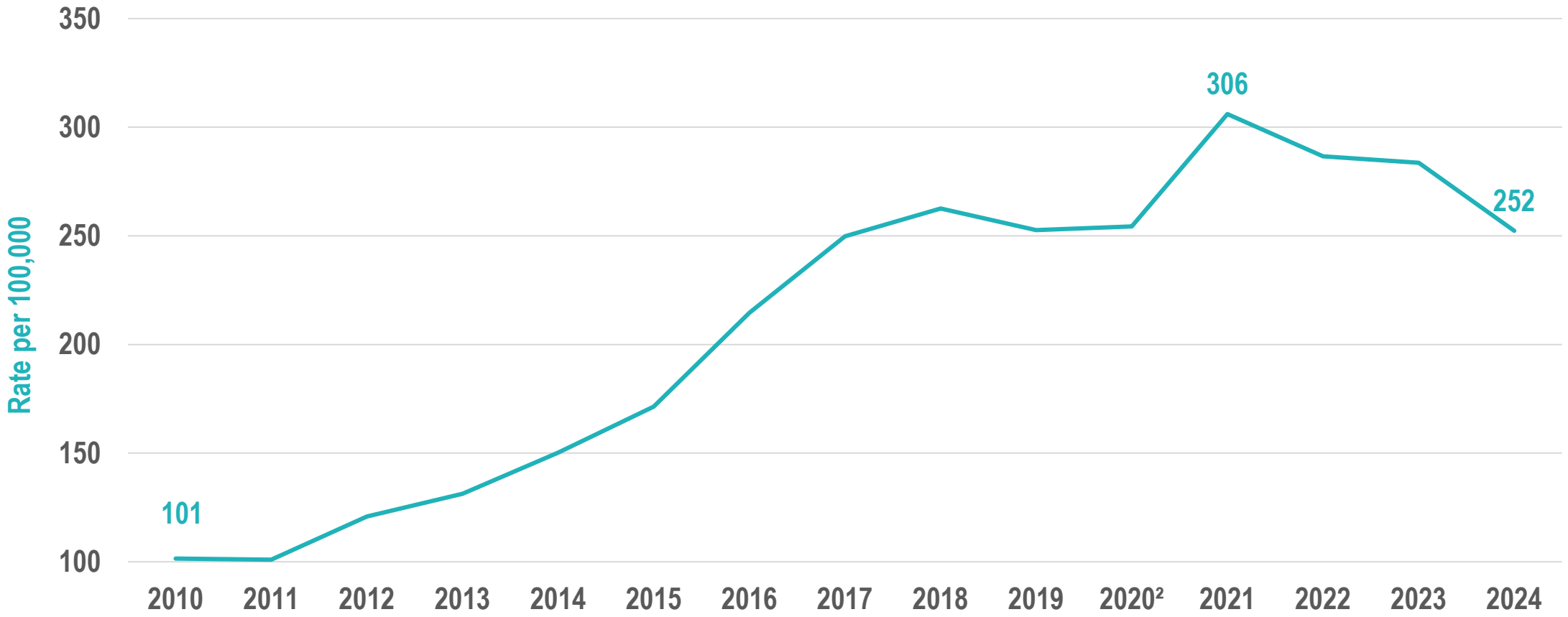


1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
2. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

Source: LAC DPH Division of HIV and STD Programs

The gonorrhea rate has been decreasing since its peak in 2021.

Preliminary Gonorrhea Rates, Los Angeles County, 2010-2024[2]

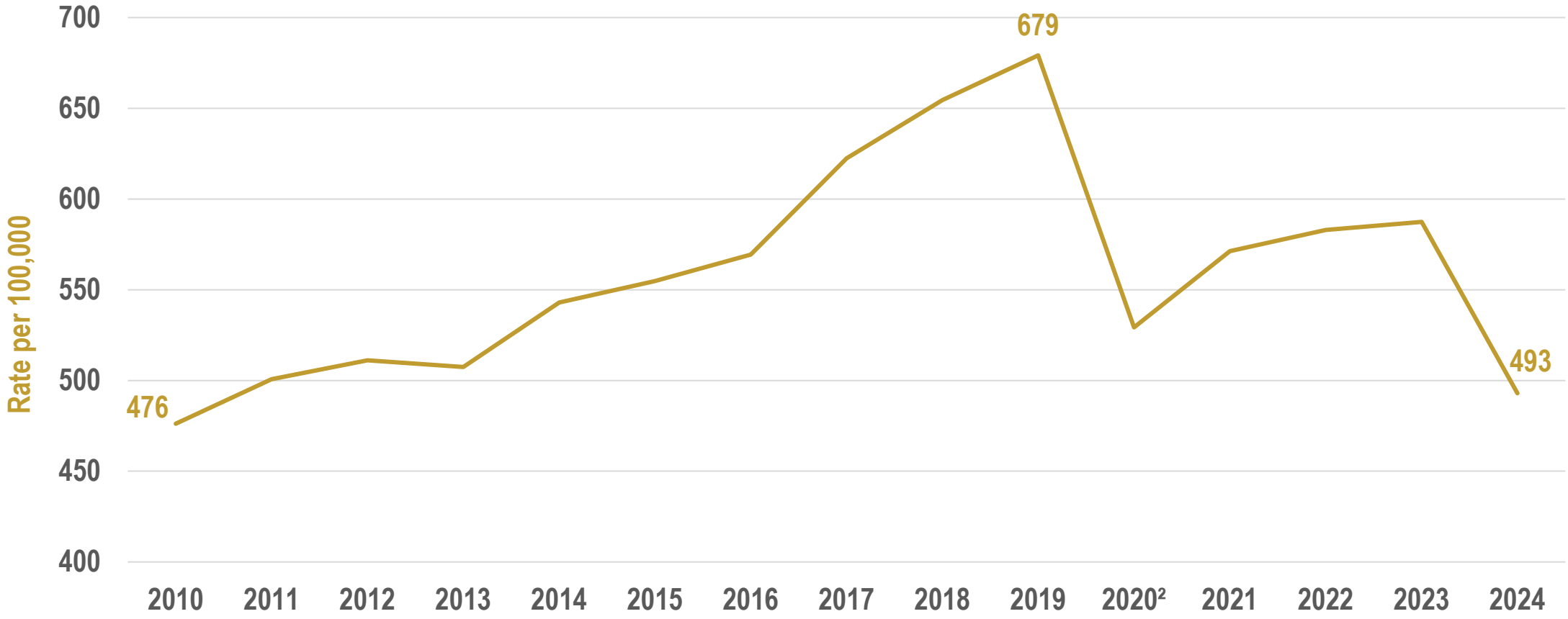


1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
2. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

Source: LAC DPH Division of HIV and STD Programs

The chlamydia rate has been decreasing since its peak in 2019.

Preliminary Chlamydia Rates, Los Angeles County, 2010-2024[2]

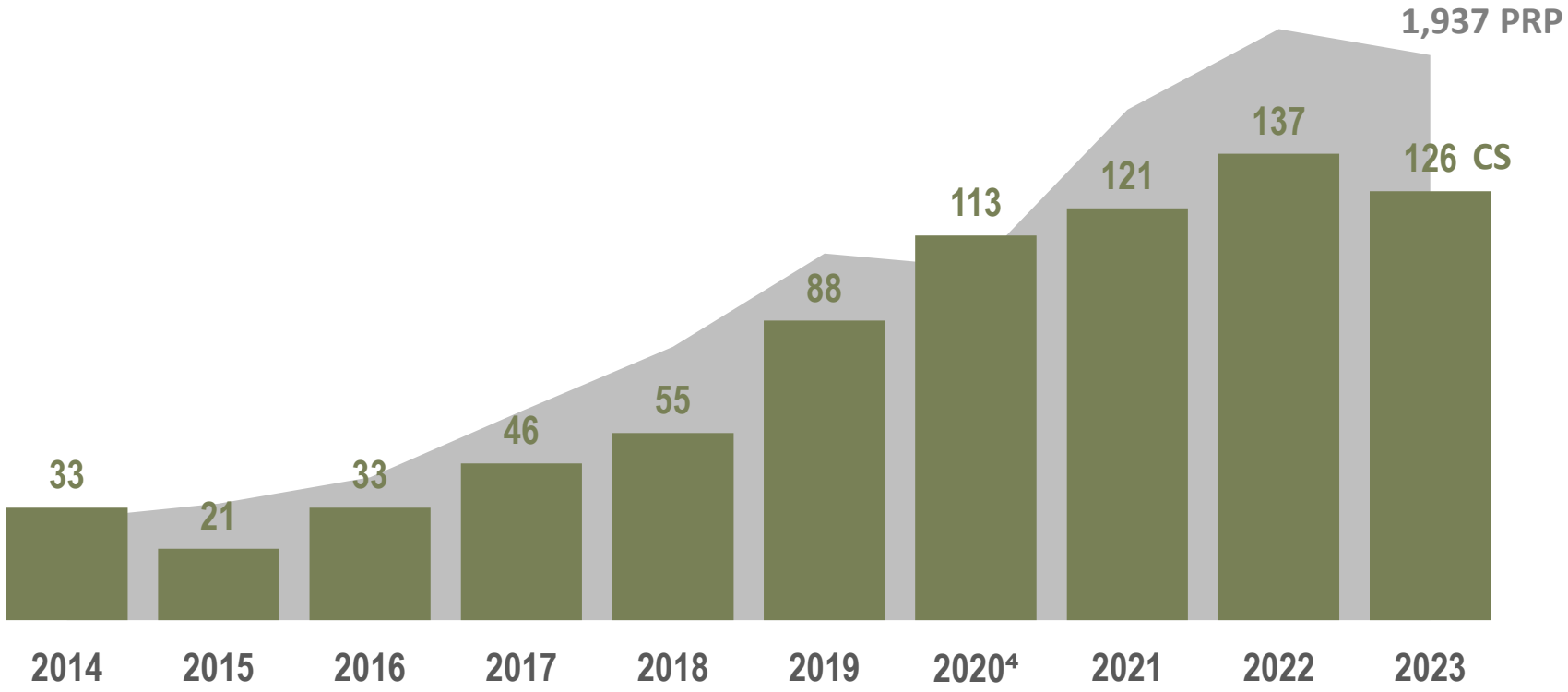


1. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
2. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

Source: LAC DPH Division of HIV and STD Programs

Syphilis among Persons of Reproductive Potential (PRP) and infants with congenital syphilis have increased substantially since 2014.

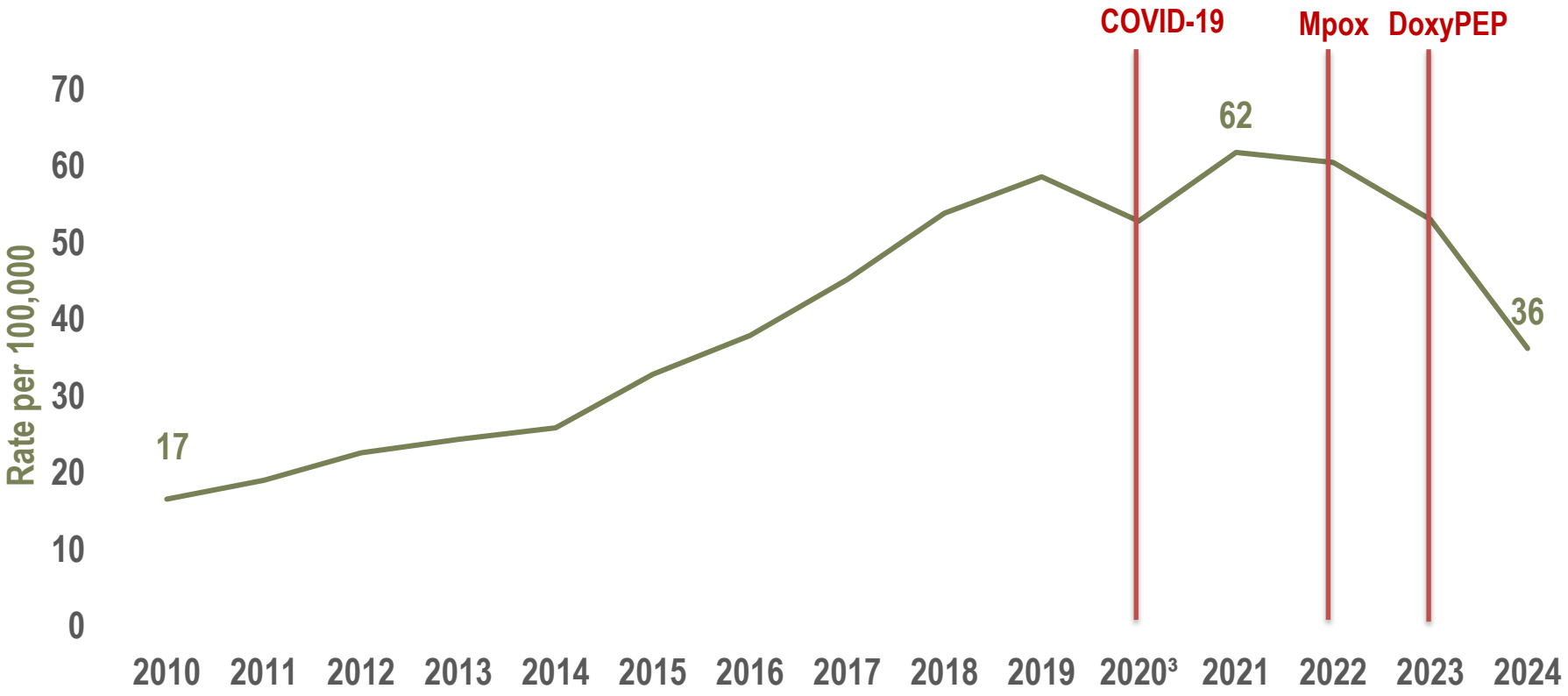
Provisional Number of PRP and Infants with Congenital Syphilis[1,2] Los Angeles County, 2014-2023[3]



1. Syphilis among females of childbearing age (ages 15-44) including all cases staged as primary, secondary, early non-primary non-secondary (previously early latent) and unknown duration/late (previously late latent). 2. Congenital syphilis includes syphilitic stillbirths and neonatal deaths. 3. Data as of September 27, 2024 and excludes cities of Long Beach and Pasadena. Data are preliminary and subject to further change. 4. Note that the number of reported STIs in 2020 decreased as a result of decreased STD screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order. Data sources: LAC DPH Division of HIV and STD Programs

The early syphilis rate has been decreasing since its peak in 2021.

Preliminary Early Syphilis[1] Rates, Los Angeles County, 2010-2024[2]



- DoxyPEP uptake & DoxyPEPLA
- ED/UCC screening & community-based testing
- Syphilis Outbreak Strategy: Clinical Field Team, Specialized Investigation Team, incentives & housing
- Benzathine penicillin delivery
- Provider education & training

1. Early syphilis includes all cases staged as primary, secondary or early non-primary non-secondary (early latent).
2. Data as of September 22, 2025 and excludes data from the cities of Long Beach and Pasadena.
3. Note that the number of reported STIs for 2020 decreased as a result of decreased STI screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

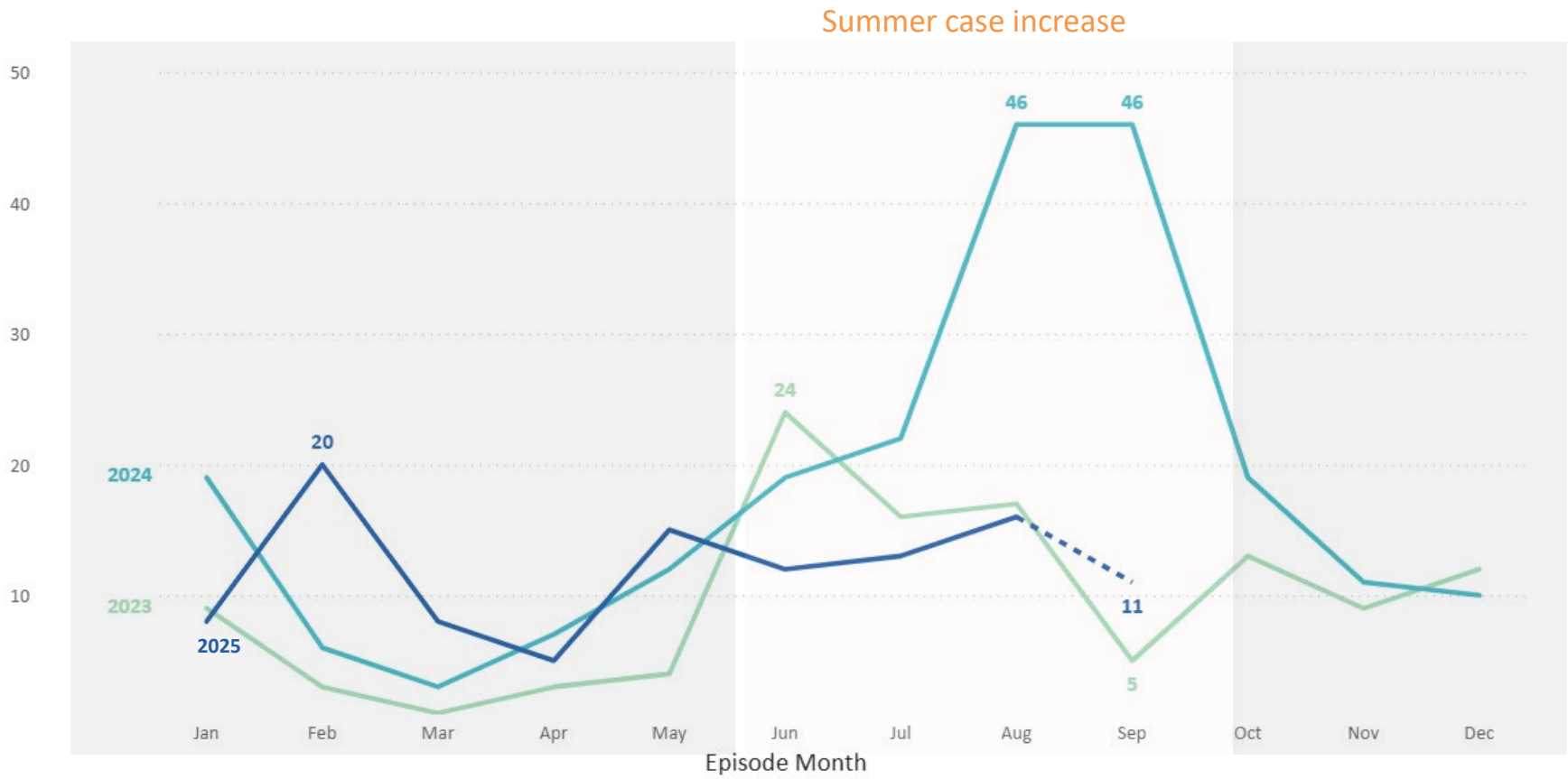
Source: LAC DPH Division of HIV and STD Programs

Mpox Epidemiology

- Global outbreak of mpox since 2022 has been Mpox Clade II
- Regional clusters, waxing and waning across the US and LAC since then
- Increasing 2-dose vaccination coverage and counseling re: other prevention strategies are best ways to prevent cases
- Deaths still being reported nationally, none in LAC since 2022

Mpox cases generally peak during summer months. We did not see a summer 2025 peak.

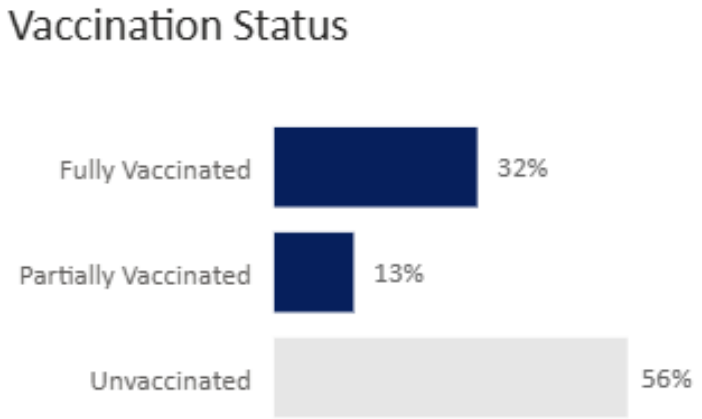
Monthly mpox cases by episode year

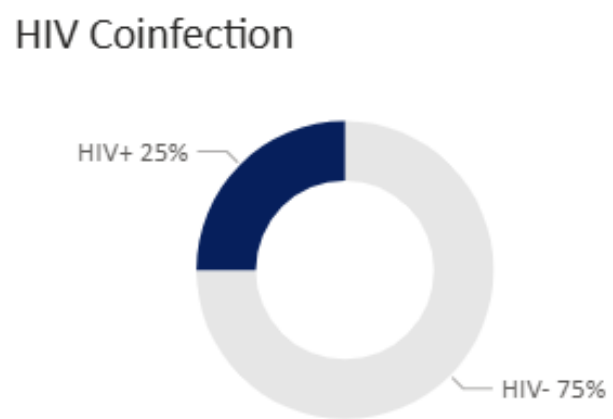


*Episode date: earliest existing value of: date of onset, date of diagnosis, date of death, date received, specimen collection date.
Recent dates may be incomplete due to lags in data reporting.

Over a recent 6 month period, most LAC mpox cases did not require hospitalization. Forty-five percent were partially or fully vaccinated and 25% were coinfected with HIV.

Clinical features of mpox cases with episode dates* from 4/1/25 – 9/30/2025 (N=72)

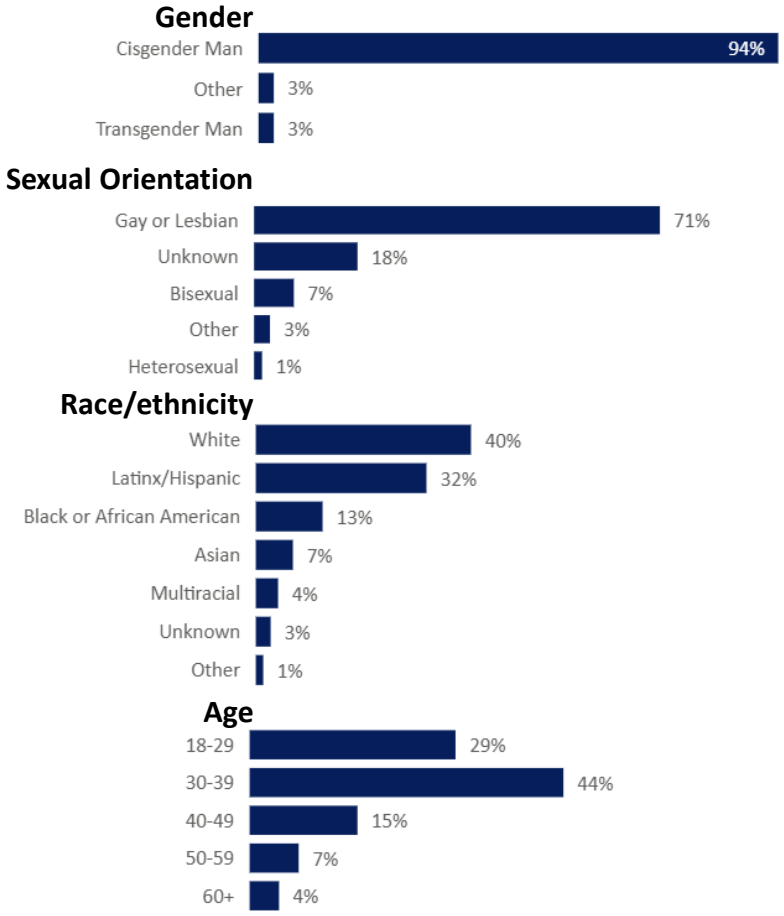


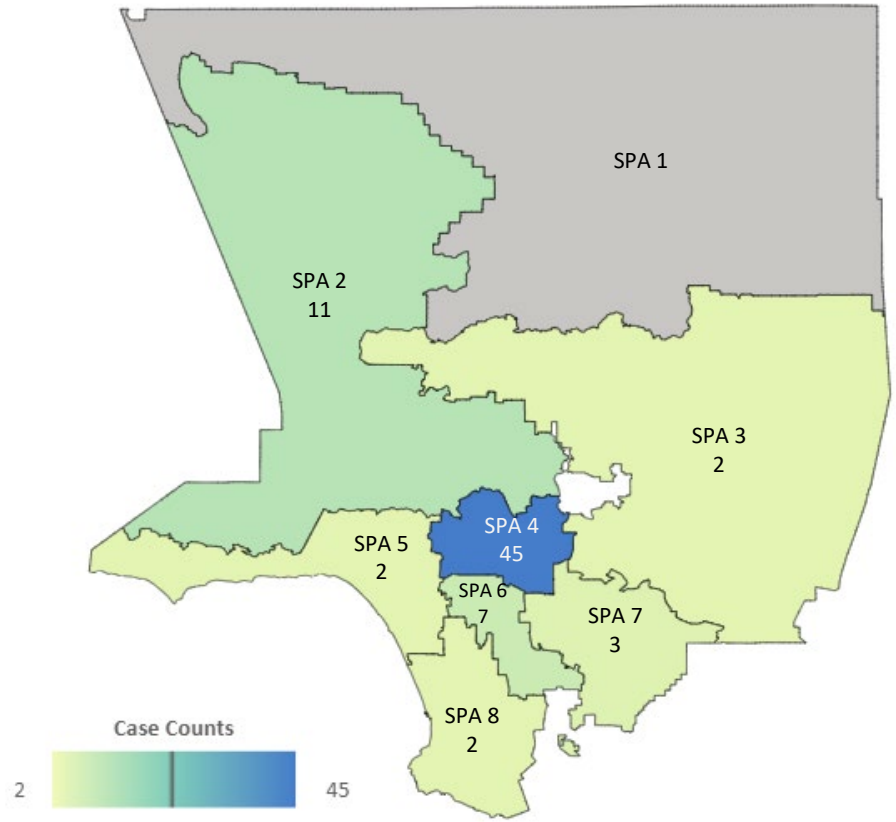


2 Hospitalizations**

***Episode date:** earliest existing value of: date of onset, date of diagnosis, date of death, date received, specimen collection date. ** Among two hospitalized cases, one person was HIV+, one was HIV-. Both were unvaccinated. Recent dates may be incomplete due to lags in data reporting.

Demographics of LAC mpox cases with episode dates* from 4/1/25 – 9/30/2025 (N=72)





***Episode date:** earliest existing value of: date of onset, date of diagnosis, date of death, date received, specimen collection date.
Recent dates may be incomplete due to lags in data reporting.

Clade I Mpox Cases without Associated Travel Reported in southern California, October 2025

- As of October 21, 2025:
  - **Three confirmed Clade I mpox cases without associated travel reported in LA County**
  - These are the first Clade I mpox cases in the nation without travel to another country where Clade I has been known to be circulating

- Similarities:
  - Men who have sex with men
  - Report no international travel, no sexual contact, and no contact with one another in 21 days prior to symptom onset
  - **3 hospitalized (1 ICU); 2 immuno-compromised**
  - All isolating at home

- Public health investigation, including contact tracing and symptom monitoring is ongoing

About Clade I Mpox

- Community transmission of Clade I mpox within California is now occurring among gay, bisexual, and other men who have sex with men and their social networks.
- Overall risk of Clade I mpox to the general population in California and the US remains low.
- At this time, Clade I mpox has not been shown to be more transmissible than Clade II. Transmission studies are ongoing.
- Clade I and II mpox can both transmit through sexual or intimate contact (e.g., massage, cuddling), shared living spaces or personal items.
- Clade I mpox may be severe. Risk of severe mpox disease and hospitalization are highest for people with weakened immune systems.
- Jynneos vaccination is protective against both clade I and II; under-accessed resource.

Federal Budget and Policy Updates; Proposed Federal Cuts to the HIV and STD Portfolio; ADAP Rebate Fund and; Recent Executive Orders

Federal Budget and Policy Update

- **8 Senate Democrats voted for a Republican-backed continuing resolution that funds the federal government through January 2026**
  - **DOES NOT** include extension on ACA advanced premium tax credits.
  - Includes 3 appropriations bills (Military Spending/VA, Dept of Agriculture/FDA, Legislative Branch)

- **Budget proposals differ significantly between the Senate and the House**
  - Senate: Keeps funding flat or slightly reduced for CDC, HRSA, and SAMHSA, among other areas
  - House: Significant reductions to CDC budget and elimination of several HRSA funding areas
    - **Eliminates**: CDC HIV prevention funding (> $1B), EHE funding (HRSA+CDC), and HRSA Ryan White Program Parts C, D, and F funding

Looming Financial Threats

Direct Funding to DHSP - $31.7M

- CDC HIHPS (Program, Surveillance, EHE) - $19.7M
- CDC STD PCHD - $3.3M (potential 6% cut or ~$200,000)
- CDC NHBS - $620,000
- HRSA RWP MAI - $3.7M
- HRSA RWP EHE - $7.5M

Looming Financial Threats

Indirect, To DHSP Partners - $12.85M

- RWP Part C EIS and Cap Bldg Awards (HIV Specialty Clinics)
  - EIS: 14 clinics totaling $5,738,844
  - Cap Bldg: 3 clinics totaling $450,000

- RWP Part D (Agencies serving Women, Infants, Children, Youth)
  - USC, UCLA, AltaMed: $1,633,218

Looming Financial Threats

Indirect, To DHSP Partners (continued)

- RWP Part F Dental (Universities providing Oral Health Care)
  - USC, UCLA, Western Univ. of Health Services: $1,570,737

- Title X (Supports Sex & Repro Health/Fam Planning Services in CA)
  - Essential Access Health: $13,200,000 (~$3.5M LAC)
    - 679,454 family planning encounters
    - 227,362 GC tests
    - 113,537 syphilis tests
    - 173,328 HIV tests

ADAP Rebate Fund

- Need for More Spending Flexibility and Additional Triggers
- Three-year Contingency Planning?
- Fund Replenishment

Executive Orders

- Sex/Gender
- Environmental Justice
- DEI (for federal agencies and government contractors)
- Immigration
- Homelessness and Harm Reduction
- Oversight of Federal Grantmaking
- Pharmaceuticals
- Make America Healthy Again
  - Establishing *MAHA Commission, Make Our Children Healthy Again Strategy*

Recent Workforce and Program Impacts

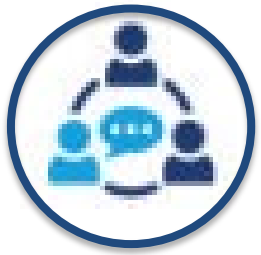
DHSP Key Actions (February 2025 and Ongoing)

76 DHSP Staff Layoffs or Reassignments to Other DPH Programs

- 38 Contractors
- 38 Permanent County Staff
- Additional Cost Containment Efforts

Aligned Contract Obligations with Projected FY 2025 Revenue

- Ryan White Program
- HIV Prevention Portfolio



Stakeholder, Provider, and Consumer Meetings

- Prevention, Housing, Oral Health, Food/Nutrition

Prioritization in an Era of Scarcity:

Perspectives from Dr. Matthew Golden

Possible Hierarchy of Priorities

Disease Control Activities in Order of Priority

1. Sustain (increase) HIV viral suppression among people with HIV
2. Prevention of congenital syphilis
   - Treatment and case-management of pregnant persons and pregnancy capable people
3. Maintain core HIV/STI surveillance
4. Sustain HIV linkage to care (integrated with surveillance)
5. Drug user health - Narcan and syringe distribution
6. Treating symptomatic STIs (particularly syphilis)
7. Promotion of HIV/STI control by healthcare system
8. High yield public health syphilis case-finding
9. Sustain high yield public health funded HIV case-finding
10. HIV PrEP

Possible Hierarchy of Priorities (continued)

Sustain the infrastructure to rebuild and strategize for longer term goals

- Sexual health clinics
- Low barrier HIV clinics - outreach to promote care?
- Surveillance
- Community collaboration - focus on healthcare organizations

Publicly Funded HIV Testing 2021

1,736,850
Total CDC-funded HIV tests conducted in 2021

18,244
had **a positive** HIV test result

8,149
were **newly diagnosed** with HIV (0.5% positivity)

78%
of those newly diagnosed with HIV were **linked to HIV medical care within 30 days**

	TESTS (% POSITIVITY)
Health care setting	**1,278,274 (0.4%)**
Community Health Centers	410,981 (0.3%)
STD Clinics	395,934 (0.5%)
Emergency Departments	198,641 (0.3%)
Correctional Clinics	54,535 (0.2%)
Other[a]	218,183 (0.4%)

	TESTS (% POSITIVITY)
Non-health care setting	**436,304 (0.7%)**
HIV Testing Sites	226,834 (0.8%)
Community Settings[b]	105,970 (0.5%)
Correctional Facilities, Non-health care	15,250 (0.4%)
Other[c]	88,250 (0.5%)

* Not shown: 16,743 tests were conducted in mobile settings, 3,990 self-tests were reported, and 1,539 tests were missing information on site type.

~22% of new HIV diagnoses were a result of federally funded HIV testing

https://www.cdc.gov/hiv/library/reports/testing/2021/index.html#Table4

HIV Testing

- What publicly funded activities identify new cases of HIV
  - King County - ~21% of diagnoses from publicly funded testing - 2/3 in a single SHC

- Cost per case detected
  - Hard to calculate – what costs do you include
    - CBOs - funded >1 activities – how much is for testing?
    - Sexual health clinic - How much of the funding is related to HIV testing?
      - Not just the cost of the test

King County Program	Approximate Cost per New HIV+ Detected
CBO #1	∞ (no cases identified)
CBO #2	~$23,000
SHC*	~$44,000
Primary care+	~$40,000

*Assumes 20% SHC budget is for HIV testing
+0.1% positivity, $40/test, no other costs included

- Does publicly funded testing reach a population that would otherwise not get tested?
- Are there things you are not doing to promote routine testing that is not directly funded by public health?
  - Promotion of testing in primary care

New HIV diagnoses at DHSP contracted sites

HIV & STI Testing Contracted Agencies	HIV Testing Volume	HIV Positivity	HIV New Positivity	HIV Surveillance Report: New HIV Diagnoses	% New Positivity HIV from Contracted Agencies
2022	69,881	908 (1.3%)	419 (0.6%)	1641	25.5%
2023	82,058	1321 (1.6%)	400 (0.5%)	1635 (pending CSO review)	24.5%
2024	90,401	1105 (1.2%)	314 (0.3%)		
2025 (Jan-Oct 2025 except June 2025)	51,774	493 (1.0%), preliminary	184 (0.4%), preliminary		

DHSP Funded Testing

- Contracted Agencies
- DHSP Direct Testing (DCS, CFT)
- Self-Testing/At Home Testing
- Emergency Departments
- Public Health Clinics

HIV/Syphilis Testing in Jails

- SCORE
  - Private jail for misdemeanor offenses
  - Syphilis testing using rapid tests
  - Performed by HIV/STI/HCV program DIS
- KCJ/MRJC
  - More serious criminal offenses
  - Testing using conventional tests (blood draws)
  - Performed by Jail staff (includes DRIS) – Newly added HIV/STI prgm staff (2025)
- Outreach testing
  - 35 ½ day testing events
- **Sexual Health Clinic**
  - **242 syphilis diagnoses in 2024 - 67 (28%) in MSW and cisgender women**

	SCORE Jan 2023-July 2024 **18 Months**	KCJ/MRJC Jan-June 2024 **6 months**	Outreach Testing
Bookings	19,869	7321	NA
Tested (excluding symptomatics)	1,243 (6%)	1127 (15%)	174
New Syphilis Diagnoses	**42 (4%)**	**45 (4%)** ~135 over 18m	**6 (3.4%)**
New HIV Diagnoses	4 (0.3)	2 (0.2%)	0

- >1600 cases syphilis/year - ~50% in cis-MSW/ciswomen

Should we Continue to Provide Partner Services at the Current Level or Prioritize Jail Testing?

Syphilis rapid test positivity at CRDF was 11.5% in 2024.

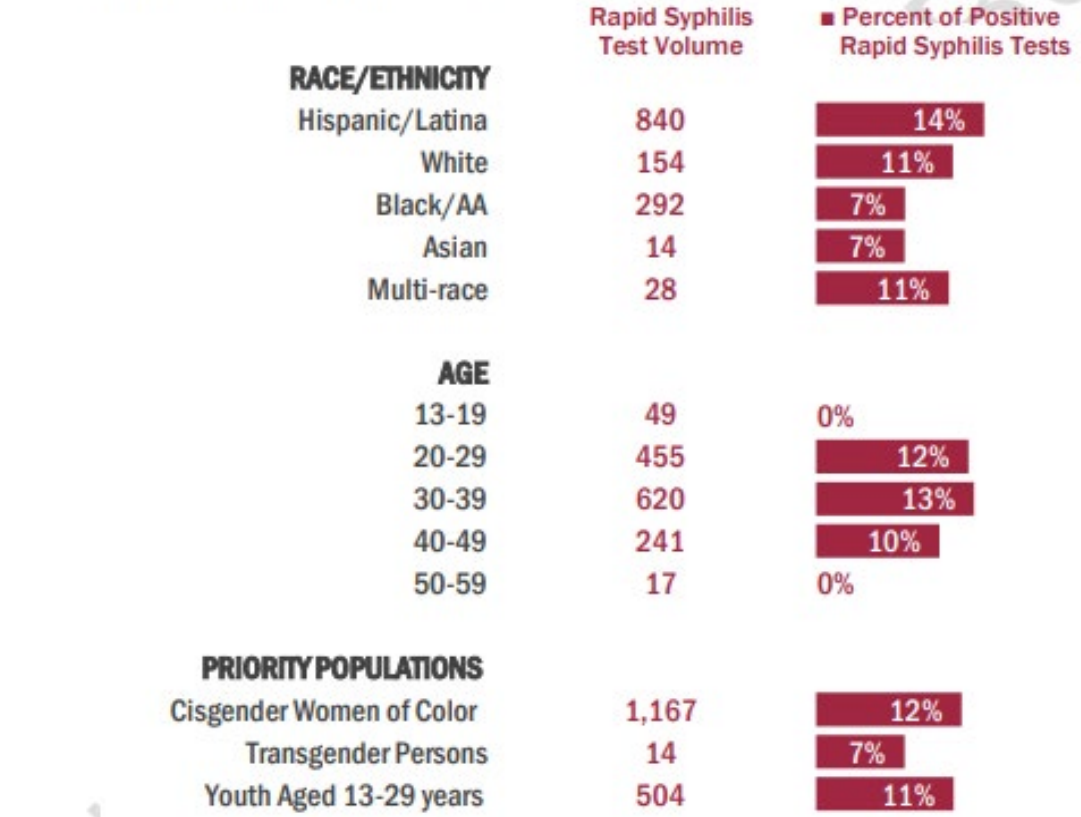
In 2024, **1382 women and transgender men** received rapid syphilis testing at Century Regional Detention Facility (CRDF).

- **Rapid Test Positivity: 159 (11.5%)**
  Confirmatory Lab Received: 79
  Confirmatory Lab Positivity: 54 (4%)

- **Treatment**
  54 confirmed syphilis positive clients*
  - 19 did not need treatment (serofast)
  - 33 of 35 new/untreated cases received treatment onsite
  - 2 released before treatment

  - **2 clients with only positive rapid test (no labs) received treatment**

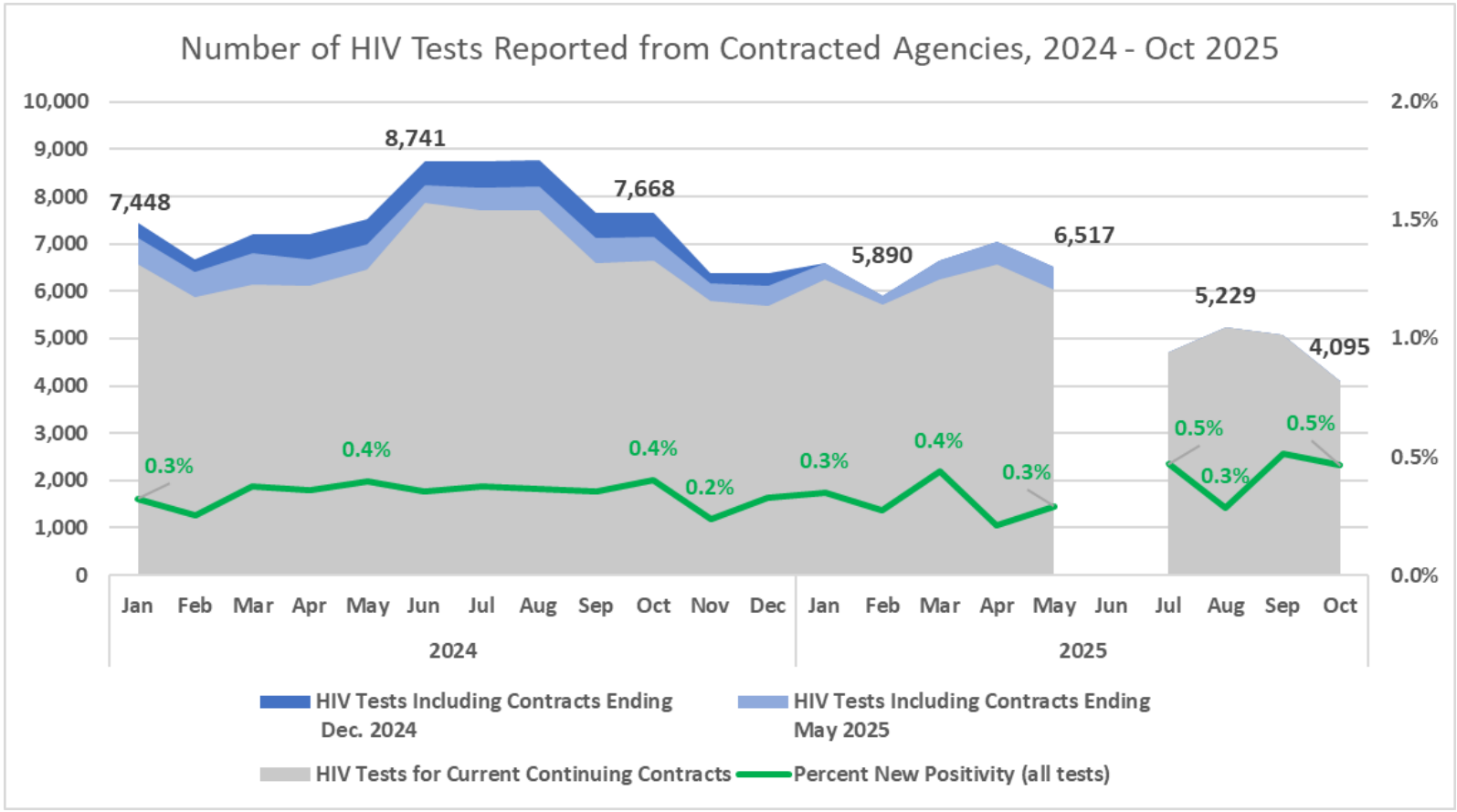
Figure 32. Percent of Positive Rapid Syphilis Tests[33] out of Tests with Results by Race/Ethnicity, Age, and Priority Population, Incarcerated Settings, 2024[34]



	Rapid Syphilis Test Volume	Percent of Positive Rapid Syphilis Tests
RACE/ETHNICITY		
Hispanic/Latina	840	14%
White	154	11%
Black/AA	292	7%
Asian	14	7%
Multi-race	28	11%
AGE		
13-19	49	0%
20-29	455	12%
30-39	620	13%
40-49	241	10%
50-59	17	0%
PRIORITY POPULATIONS		
Cisgender Women of Color	1,167	12%
Transgender Persons	14	7%
Youth Aged 13-29 years	504	11%

In 2025, agencies that had contracts had a decrease in HIV testing volume, with new HIV positivity has fluctuating between 0.3-0.5%

		HIV Tests Including Contracts Ending Dec. 2024	HIV Tests Including Contracts Ending May 2025	HIV Tests for Current Continuing Contracts	Percent New Positivity (all tests)
2024	Jan	7,448	7,114	6,569	0.3%
	Feb	6,660	6,411	5,875	0.3%
	Mar	7,204	6,796	6,147	0.4%
	Apr	7,202	6,660	6,109	0.4%
	May	7,528	6,985	6,467	0.4%
	Jun	8,741	8,238	7,857	0.4%
	Jul	8,745	8,192	7,696	0.4%
	Aug	8,774	8,205	7,709	0.4%
	Sep	7,651	7,113	6,592	0.4%
	Oct	7,668	7,152	6,639	0.4%
	Nov	6,375	6,159	5,802	0.2%
	Dec	6,382	6,111	5,692	0.3%
2025	Jan		6,583	6,241	0.3%
	Feb		5,890	5,707	0.3%
	Mar		6,643	6,255	0.4%
	Apr		7,044	6,563	0.2%
	May		6,517	6,040	0.3%
	Jun				
	Jul			4,693	0.5%
	Aug			5,229	0.3%
	Sep			5,080	0.5%
	Oct			4,095	0.5%



*Contract Performance/Cost-Analysis Available

Factors Influencing Prioritization

- **Stakeholders** – funders, elected officials, affected communities, people charged with implementing interventions
- **Scale & morbidity of the problem**
- **Effectiveness and scalability of the available interventions**
  - Cost per unit of outcome
- **Essential Role of Public Health**
  - Can someone other than Public Health provide the service?
- **Equity**
- **Influence on critical infrastructure** – Strategize for longer term goals
  - Are there things or capacity we might lose that will be particularly hard to rebuild?

Framing the Prioritization Process

1. What will make the biggest difference as we seek to advance the public's health?

2. Which core HIV/STD activities will be maintained, reduced, or terminated based on impact and cost?

3. What strategies will help leverage partnerships to sustain critical services?

Questions and Answers

Thank You!