

HIV/AIDS HEALTH DISPARITIES

CALIFORNIA'S HIV/AIDS EPIDEMIC

In 2017, an estimated **153,000** Californians were living with HIV

Almost 9 in 10 knew they had HIV

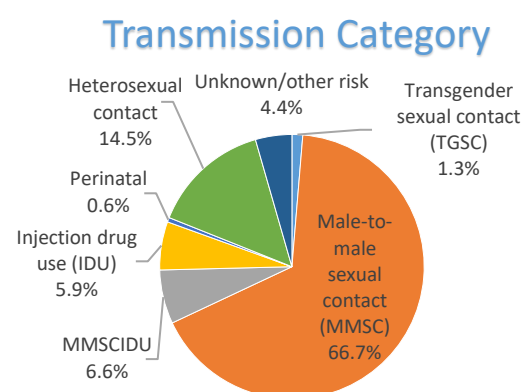
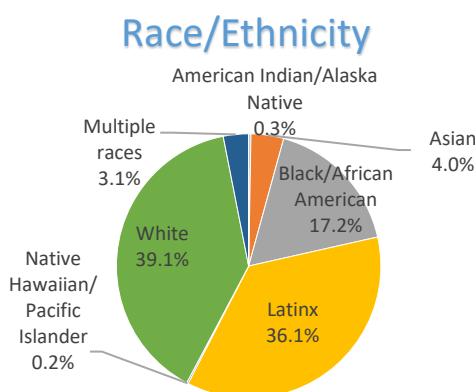
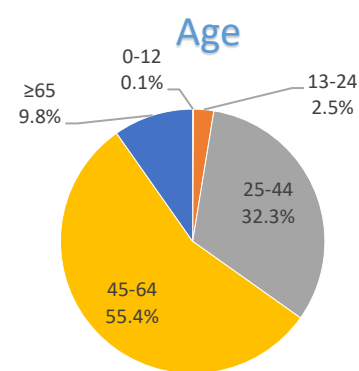
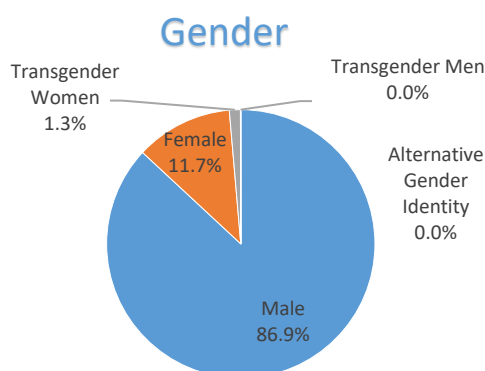


135,082 Californians were living with diagnosed HIV in 2017

MMSC, including MMSCIDU, accounted for 73% of all living HIV cases in 2017

People Living with Diagnosed HIV, 2017

N=135,082



Of the 4,791 HIV diagnoses in California in 2017:

Gender

- **87%** were among **cisgender men**

Age

- **57%** were among **25-44 years olds**

Race/Ethnicity

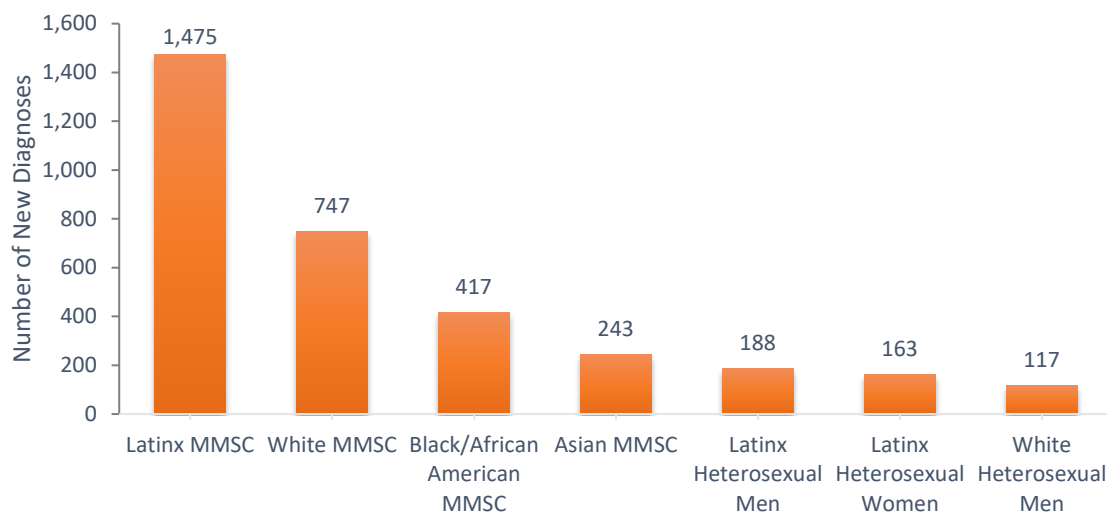
- **47%** were among **Latinx**

Transmission Category

- **66%** were attributed to **MMSC**, including MMSCIDU

New HIV Diagnoses, 2017

California Subpopulations with the Largest Numbers of New HIV Diagnoses by Race, Transmission Category, and Gender

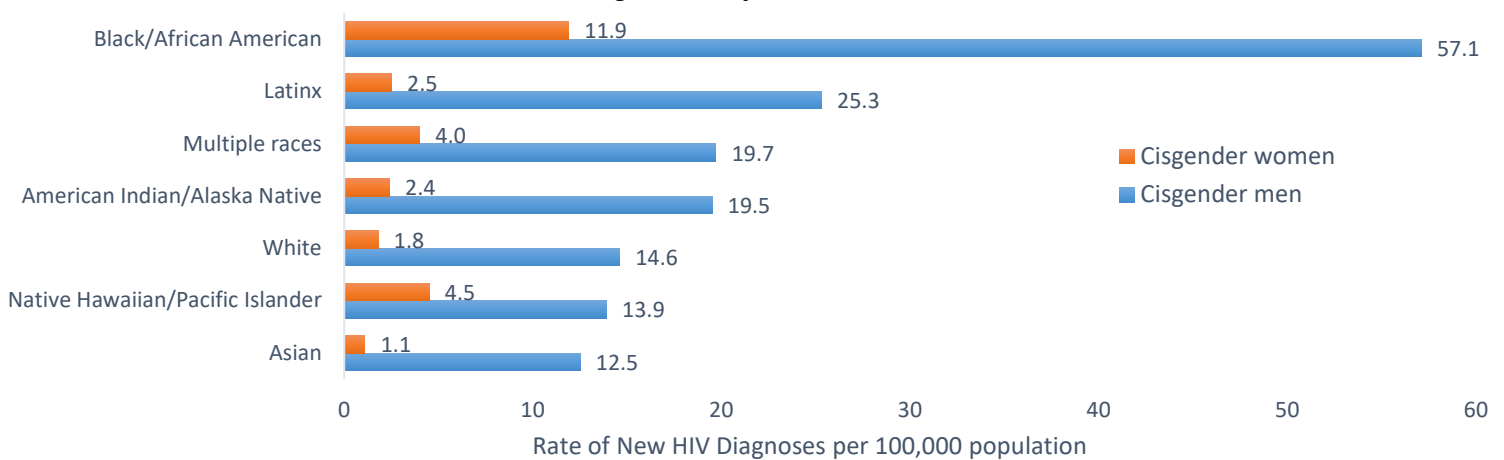


Latinxs made up almost half of all new HIV diagnoses in California in 2017. The subpopulations with the largest number of new diagnoses were Latinx MMSC (31 percent), followed by White MMSC (16 percent), and Black/African American MMSC (9 percent).

Rates of New HIV Diagnoses

Black African Americans are the most disproportionately affected by HIV with rates 3.9 times higher than Whites among men and 6.6 times higher among women. Latinxs are also disproportionately affected by HIV with rates of new HIV diagnoses 1.7 times higher than Whites among men and 1.4 times higher among women. Compared to women, men are disproportionately affected by HIV. Although rates for transgender people are not available due to unavailability of population denominators, evidence suggests that transgender people are disproportionately affected by HIV.

Rate of New HIV Diagnoses by Race and Gender, California 2017

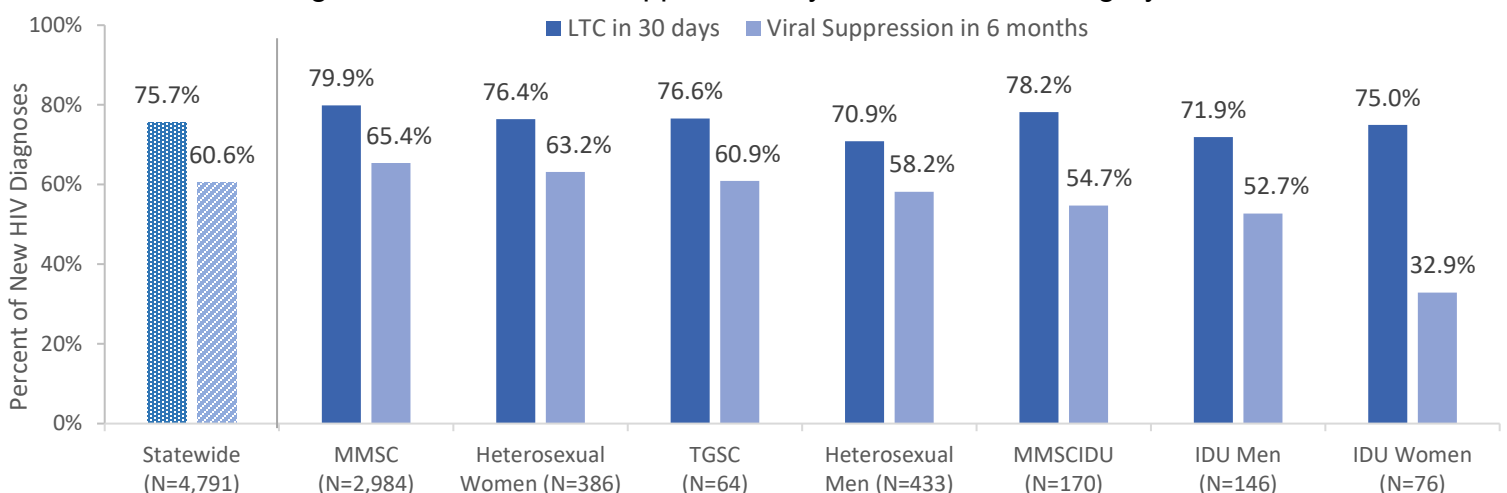


Transmission Categories

Health Outcomes by Transmission Category

California's Getting to Zero objectives include linking 85 percent of newly diagnosed persons into care within one month and increasing the percentage who achieve viral suppression within six months of HIV diagnosis to 75 percent by 2021. In 2017, linkage to care within one month of diagnosis was similar across transmission categories, but viral suppression varied widely. The lowest viral suppression was among people with transmission via IDU, especially women IDU, and the highest for MMSC.

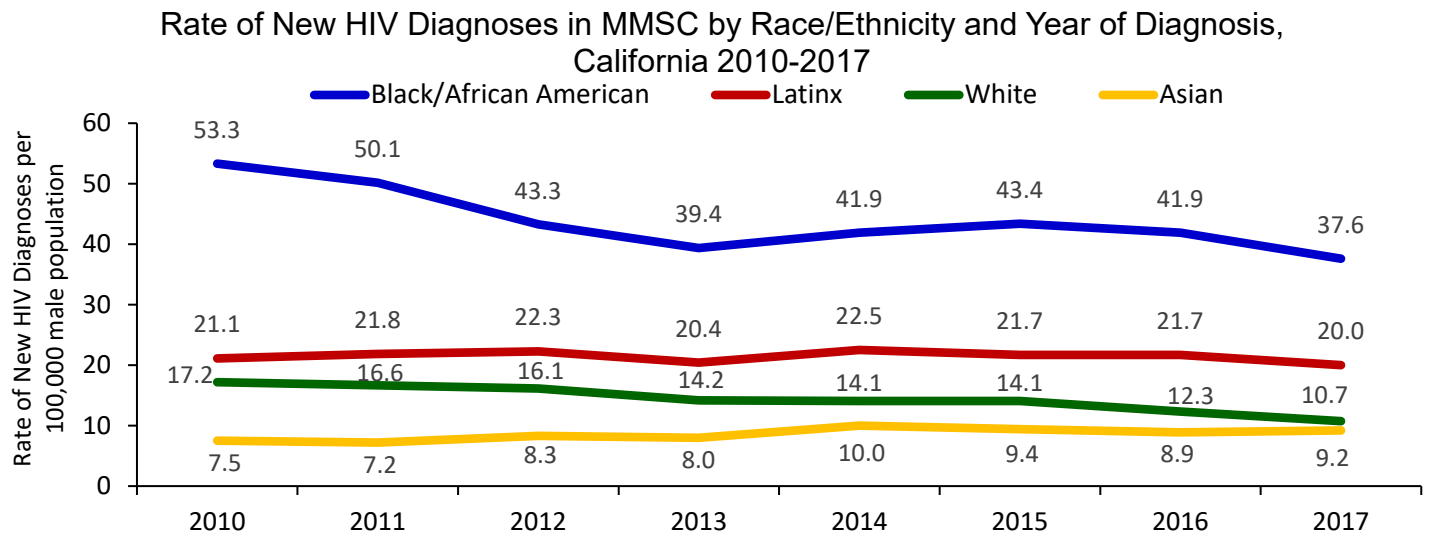
Linkage to Care and Viral Suppression by Transmission Category, California 2017



Male-to-Male Sexual Contact

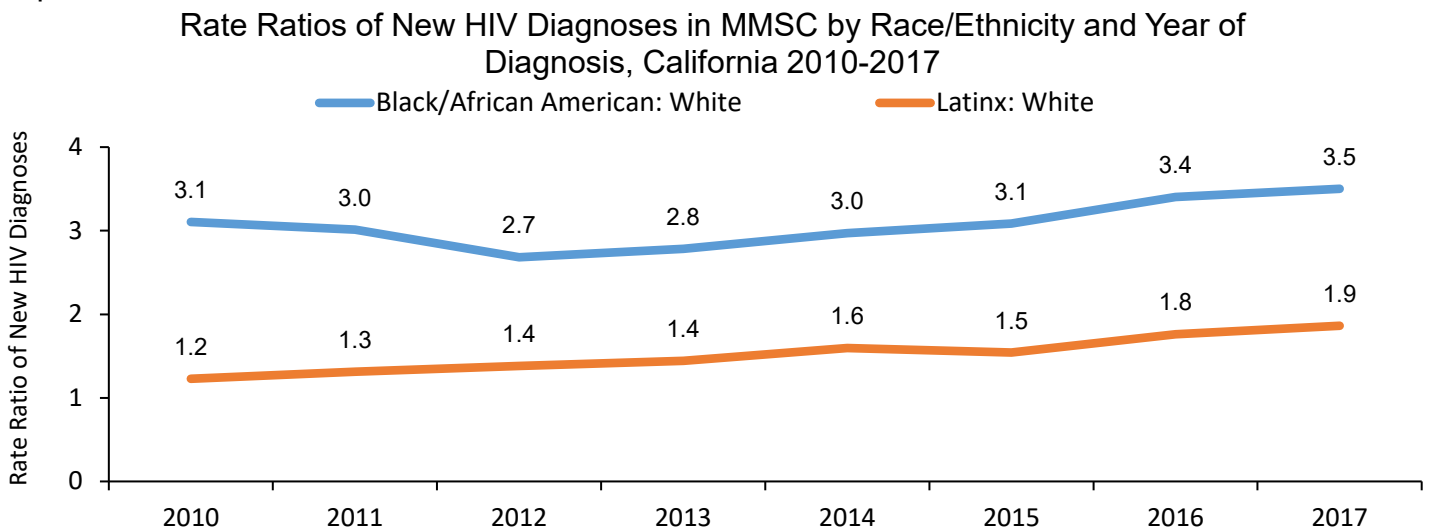
Rate Trends of New HIV Diagnoses by Race/Ethnicity for MMSC

From 2010 to 2017, the rates of new HIV diagnoses for MMSC of all race/ethnicities declined, except for Asians. Asian MMSC had a 23% increase from 7.5 new HIV diagnoses per 100,000 in 2010 to 9.2 in 2017. Black/African American MMSC had the highest rates of new HIV diagnoses among all race/ethnicity groups. Whites had the highest percent decrease of 38% from 17.2 new HIV diagnoses per 100,000 in 2010 to 10.7 in 2017.



Rate Ratios of New HIV Diagnoses by Race/Ethnicity for MMSC

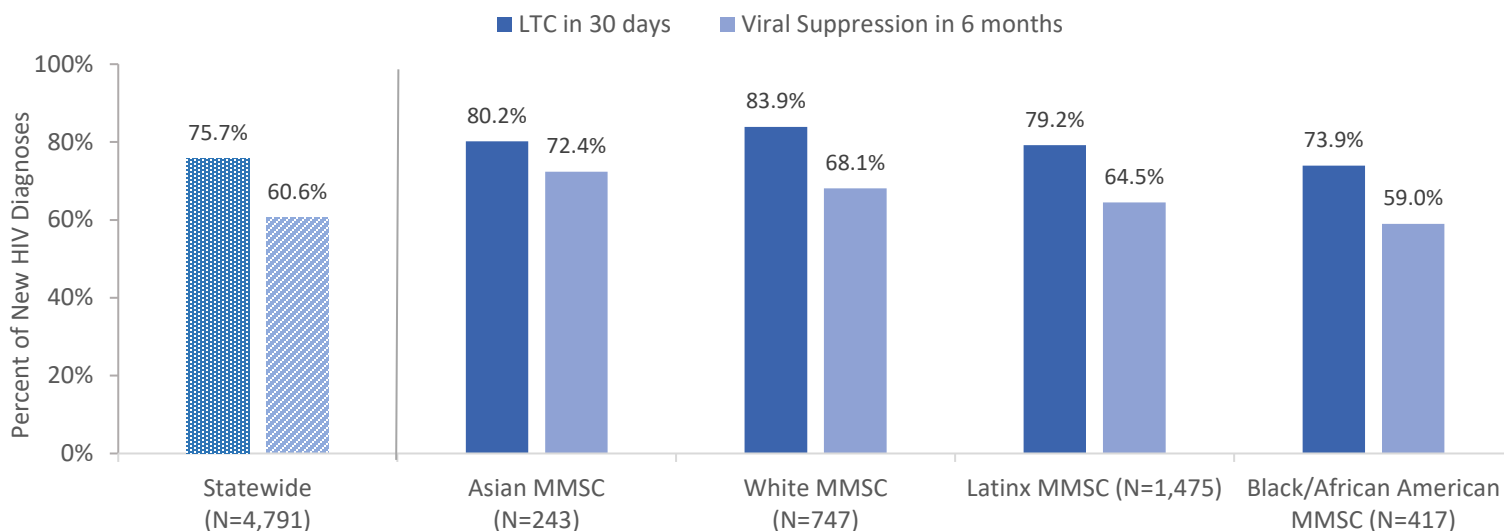
In 2017, the rate of new HIV diagnoses among Black/African American MMSC was 3.5 times higher than White MMSC; Latinx MMSC was 1.9 times higher than White MMSC. From 2010 to 2017, racial/ethnic disparities for MMSC have increased for Black/African-Americans and Latinxs compared to Whites. While new HIV diagnoses rates for both African-American and Latinx MMSC have decreased, the rates for White MMSC had greater declines, which contributed to the increasing disparities.



Health Outcomes for MMSC

Overall, health outcomes for MMSC are better than the statewide average, with all race/ethnicities above the statewide average except Black/African Americans. White and Asian MMSC have the highest health outcomes with viral suppression within six months of diagnosis at 68 and 72 percent, respectively.

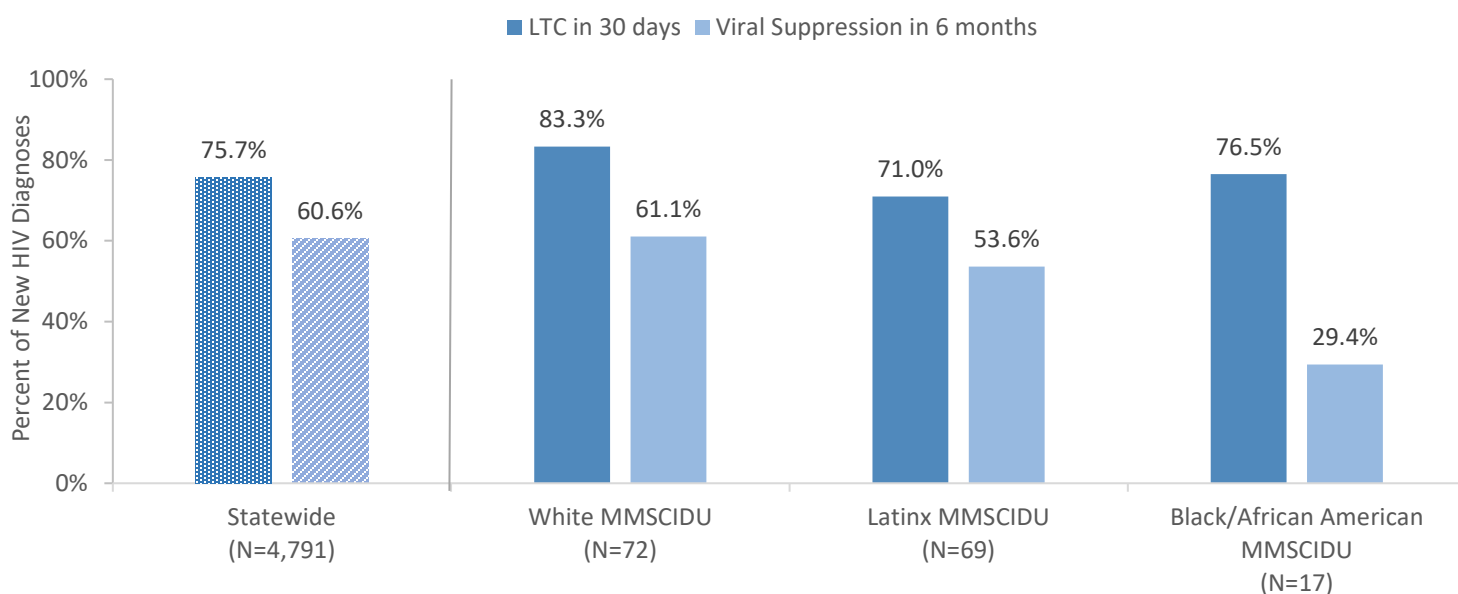
Linkage to Care and Viral Suppression for MMSC, California 2017



Health Outcomes for MMSCIDU

Viral suppression is lower for MMSCIDU compared to MMSC. The only group with viral suppression above the statewide average was White MMSCIDU. Black/African American MMSCIDU had the lowest viral suppression within six months of diagnosis at only 29.4 percent.

Linkage to Care and Viral Suppression for MMSCIDU, California 2017

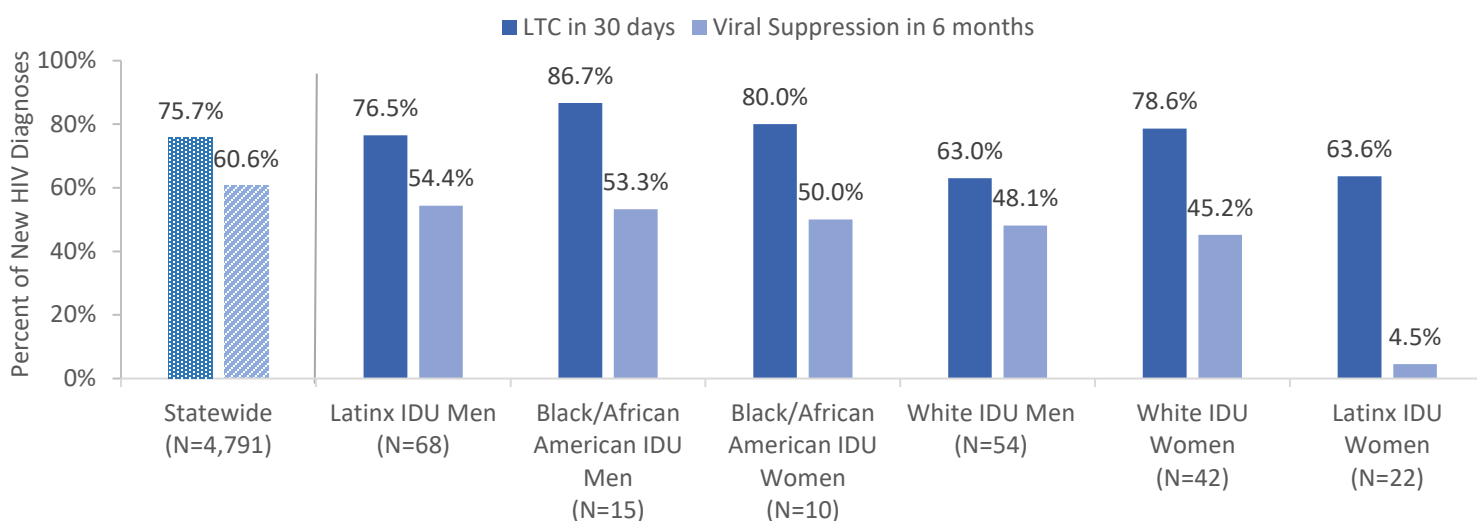


Injection Drug Use

Health Outcomes for IDU

Although linkage to care rates are in many cases above the statewide average of 75.7 percent, viral suppression for IDU is without exception lower for all race/ethnicities in this group. Viral suppression was especially low among Latinx women, and White women and men. Linkage to care within 30 days of diagnosis was also low among White men and Latinx women.

Linkage to Care and Viral Suppression for Injection Drug Use, California 2017

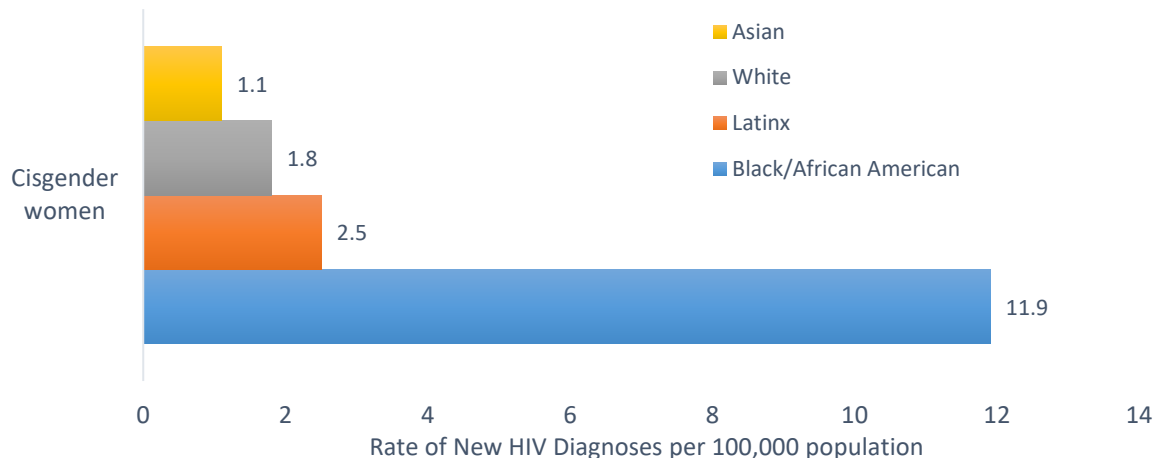


Gender Women

Rates of New HIV Diagnoses among Women by Race/Ethnicity

The pattern of disparity in new HIV diagnoses by race/ethnicity is similar in women, with Black/African Americans highly impacted and Latinxs also disproportionately affected compared to White women. Although rates of new HIV diagnoses for transgender women are not available, national estimates indicate 14.1 percent of transgender women are living with HIV with Black/African American and Latinx transgender women being particularly vulnerable.¹

Rate of New HIV Diagnoses in Women, California 2017



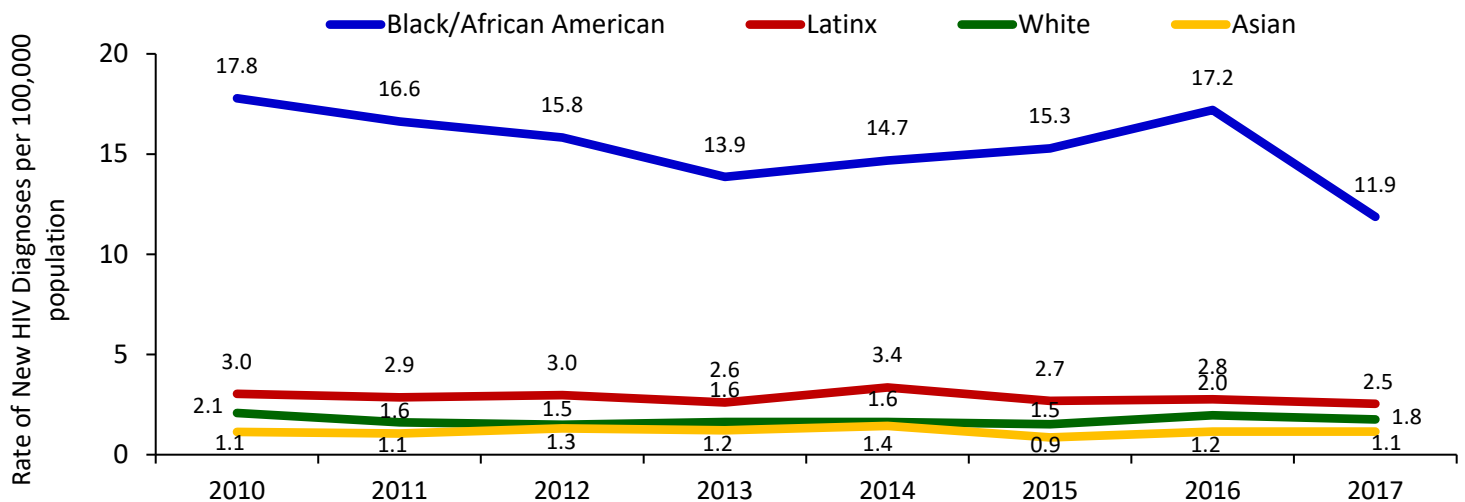
The rate among newly diagnosed **African American women** was **6.6** times that of White women

The rate among newly diagnosed **Latinx women** was **1.4** times that of White women

Rate Trends of New HIV Diagnoses by Race/Ethnicity among Women

Among cisgender women, the rate of new HIV diagnoses has declined or remained stable since 2010 across all race/ethnicity groups. Black/African American women have had the largest decrease, a 33 percent decrease from 17.8 new HIV diagnoses per 100,000 in 2010 to 11.9 in 2017. Yet, the disparity gap between Black/African Americans and Whites remains large and is higher for women than it is for men.

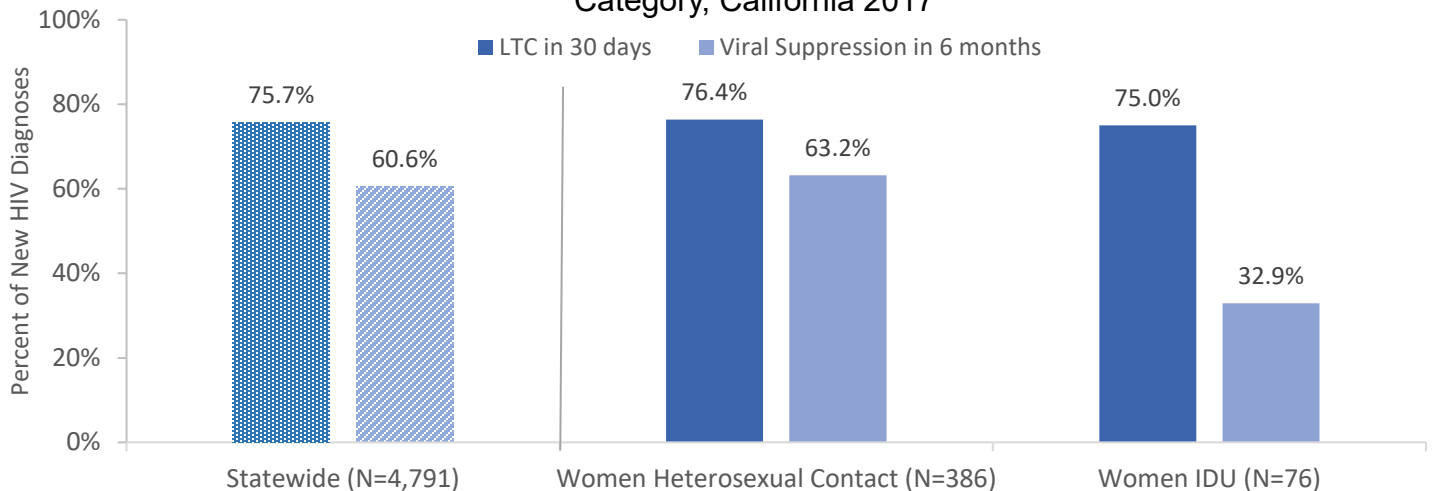
Rate of New HIV Diagnoses in Cisgender Women by Race/Ethnicity and Year of Diagnosis, California 2010-2017



Health Outcomes for Women by Transmission Category

Women whose transmission was attributed to heterosexual contact had significantly better viral suppression than those whose transmission was via IDU in spite of similar rates of linkage to care. Overall, health outcomes for heterosexual women are above the statewide average and higher than that of their male heterosexual counterparts.

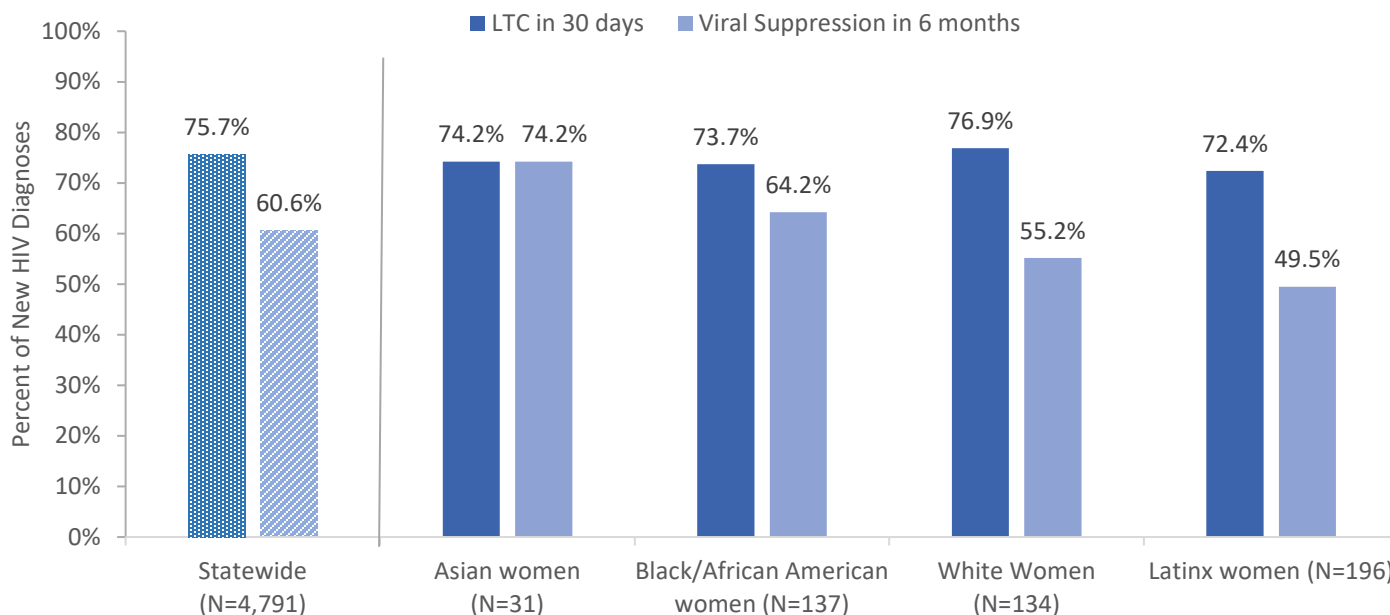
Linkage to Care and Viral Suppression among Women by Transmission Category, California 2017



Health Outcomes for Women by Race/Ethnicity

Linkage to care within one month of diagnosis was similar among Latinx, Black/African American, Asian, and White women, ranging from 72 to 77 percent. In contrast, viral suppression varied with Latinx and White women having the lowest viral suppression within six months of diagnosis at 49.5 and 55.2 percent respectively. Asian women achieved the highest viral suppression within six months of diagnosis at 74.2 percent.

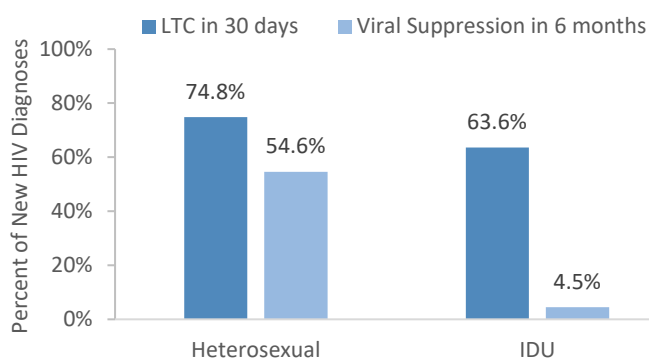
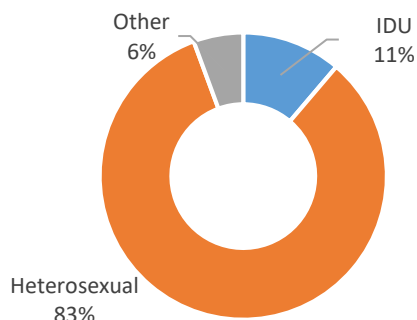
Linkage to Care and Viral Suppression among Women by Race/Ethnicity, California 2017



A higher percentage of transmission by IDU may be driving the lower viral suppression, especially among White women. In 2017, 31 percent of new HIV diagnoses among White women were attributed to IDU while only 7 percent were attributed to IDU among Black/African American women. Although only 11 percent of new diagnoses were attributed to IDU among Latinx women, health outcomes among this group were especially low with 63.6 percent linked to care within one month and only 4.5 percent virally suppressed within six months. Asian women achieved the highest viral suppression within six months of diagnosis and had zero transmissions attributed to IDU among new diagnoses. Among heterosexual women, Latinx and Black/African American women had the lowest viral suppression within six months of diagnosis at 54.6 percent and 66 percent, respectively.

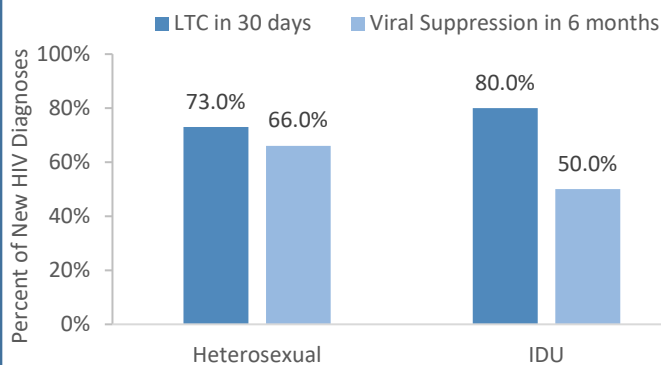
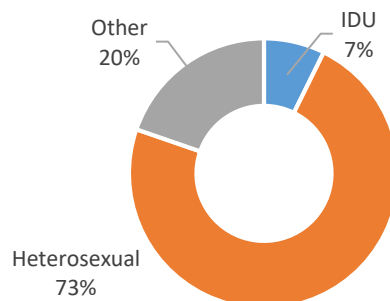
Latinx Women

N=196



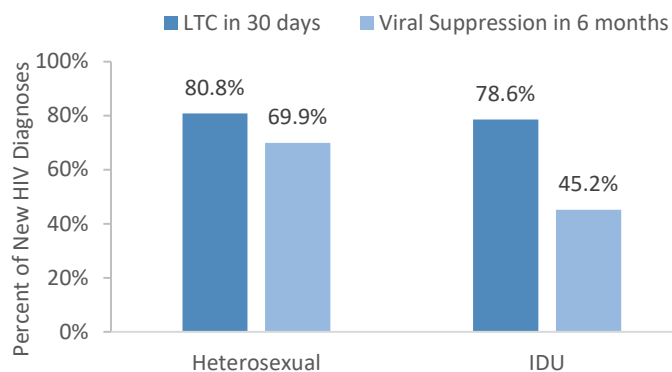
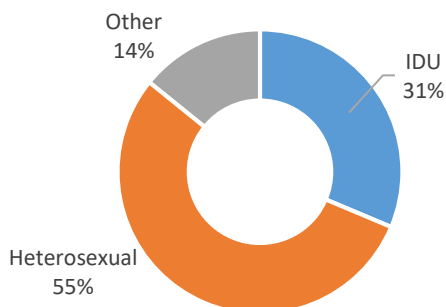
Black/African American Women

N=137



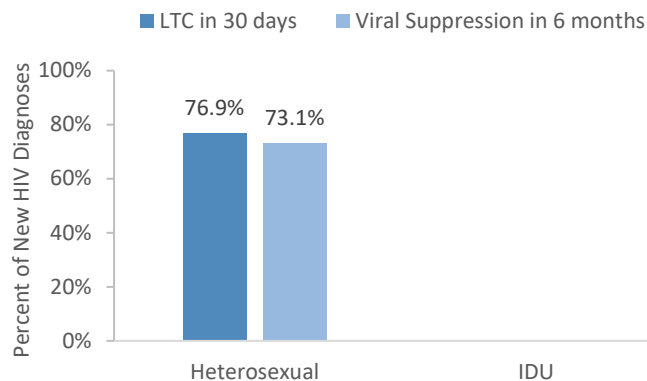
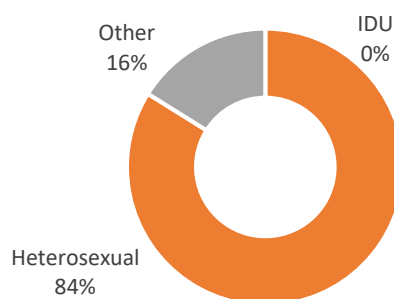
White Women

N=134



Asian Women

N=31

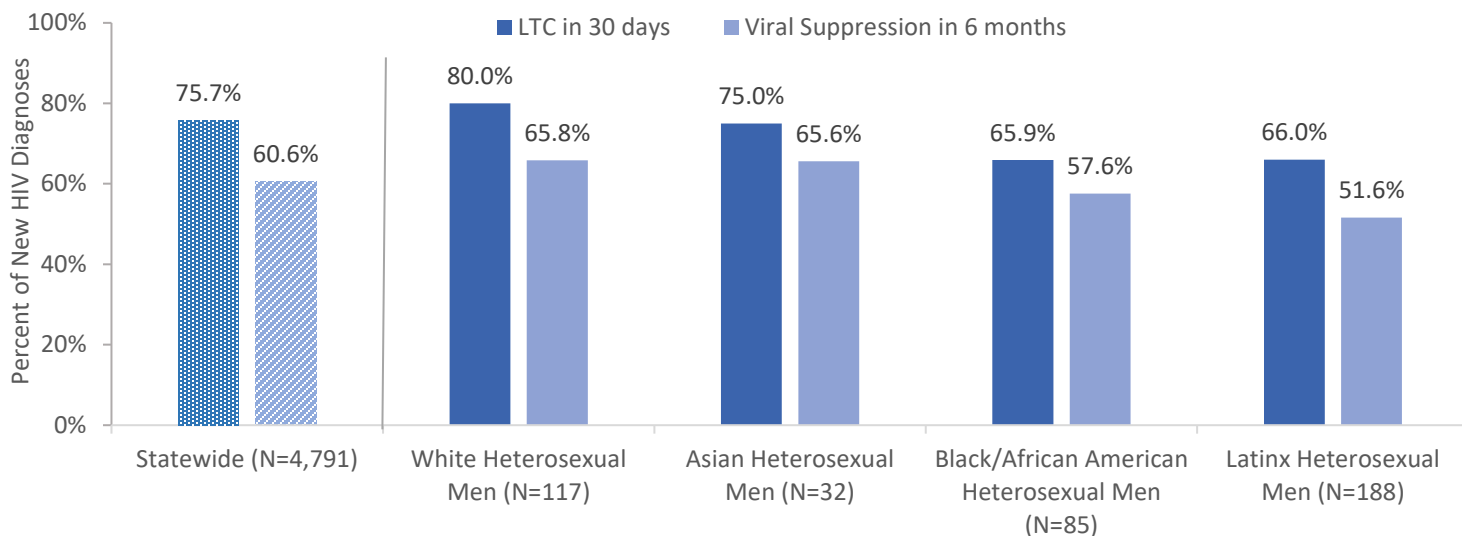


Men

Health Outcomes for Heterosexual Men

Compared to heterosexual women, health outcomes for heterosexual men are lower across all racial/ethnic groups. Latinx and Black/African American heterosexual men have low linkage to care in 30 days and low viral suppression within six months of diagnosis, while White heterosexual men have the highest health outcomes.

Linkage to Care and Viral Suppression among Heterosexual Men, California 2017

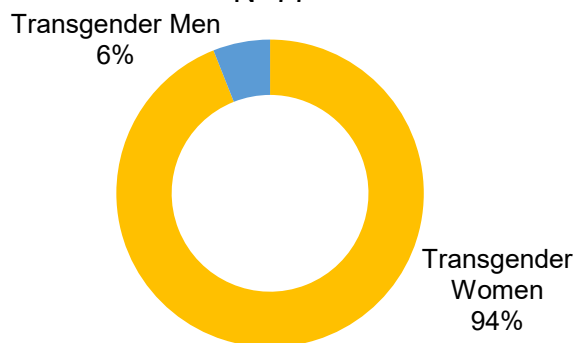


Transgender people

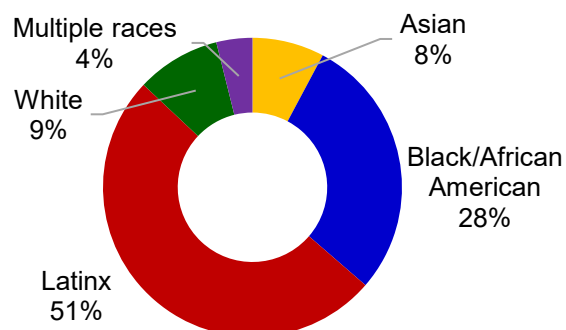
New HIV Diagnoses among Transgender People

In 2017, 94 percent of transgender people who received an HIV diagnosis were transgender women. Although rates among transgender people are not available, it is estimated that both transgender women and men are disproportionately affected by HIV. According to an analysis conducted by CDC scientists, HIV prevalence among transgender people in the US is estimated to be 9.2 percent overall, and higher among transgender women (14.1 percent) than transgender men (3.2 percent).¹

Percent of New HIV Diagnosis among Transgender in California, 2017
N=77



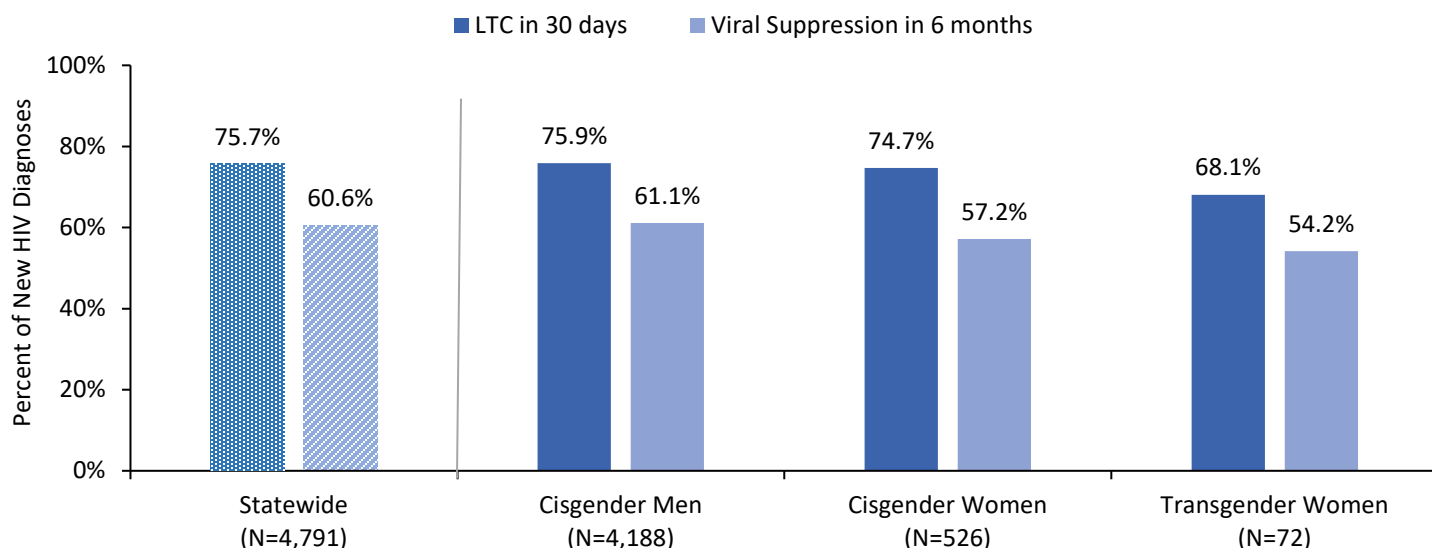
New HIV Diagnoses among Transgender in California by Race/Ethnicity, 2017



Health Outcomes for Transgender People

Compared to cisgender men and women, transgender women had the lowest linkage to care within one month of HIV diagnosis and achieved the lowest viral suppression within six months of HIV diagnosis. Data for transgender men not displayed to preserve confidentiality.

Linkage to Care and Viral Suppression by Gender, California 2017

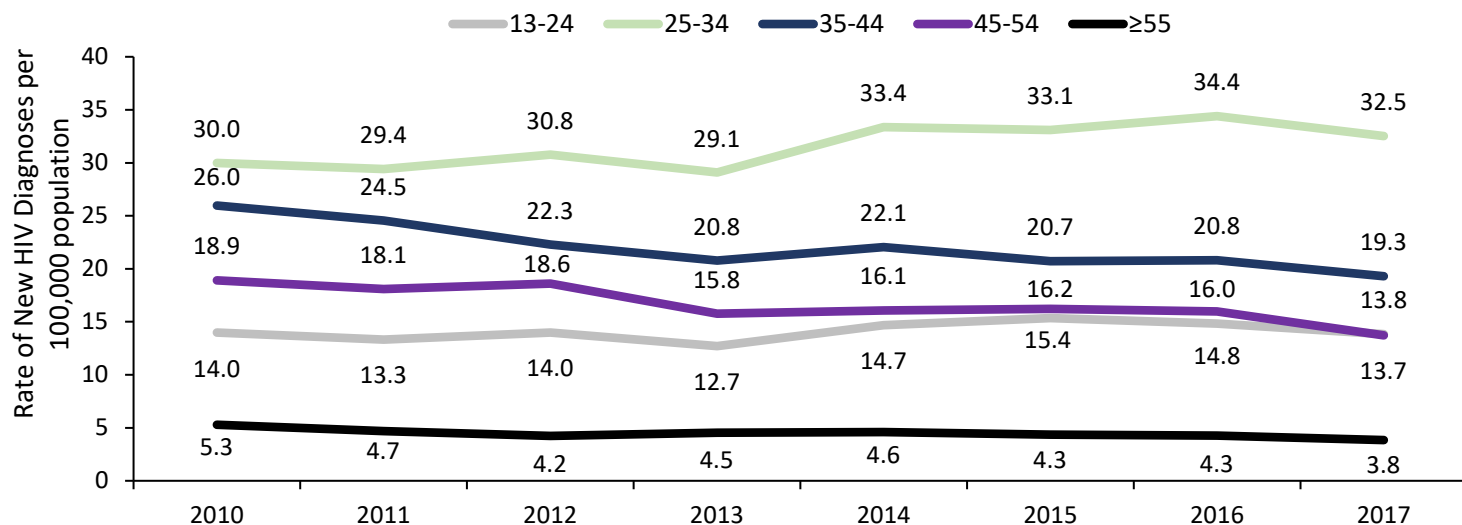


Age Group

Rate Trends of New HIV Diagnoses by Age Group

From 2010 to 2017, the rates of new HIV diagnoses among all age groups have declined, except for 25-34 year olds. The 25-34 age group has the highest rates of new HIV diagnoses and has increased by eight percent since 2010. The 55 and older age group has had the largest rate decrease, 28 percent since 2010.

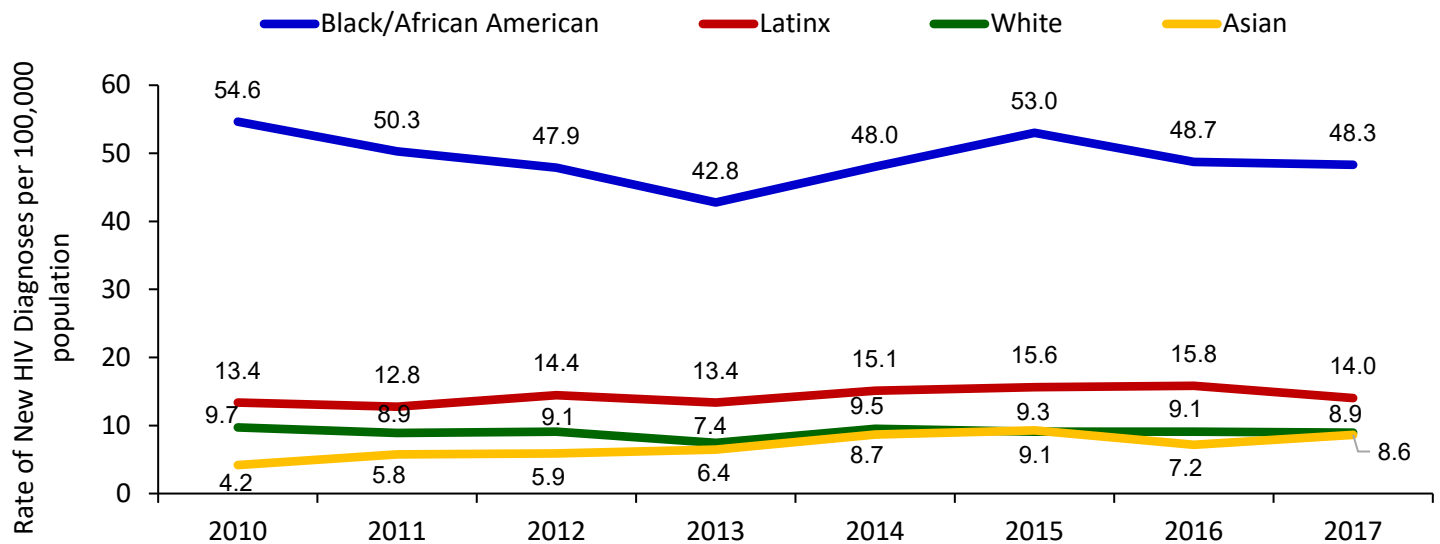
Rate of New HIV Diagnoses by Age and Year of Diagnosis, California 2010-2017



Rate Trends of New HIV Diagnoses by Race/Ethnicity among 13-24 year olds

Among 13-24 year olds, Black/African Americans have significantly higher rates of new HIV diagnoses than any other racial/ethnic group. Although the rate among newly diagnosed Black/African American 13-24 year olds has declined by almost 12 percent since 2010, the rate in 2017 was 5.4 times higher than White 13-24 year olds. The rate among 13-24 year old Asians has more than doubled since 2010 from 4.2 new HIV diagnoses per 100,000 in 2010 to 8.6 in 2017.

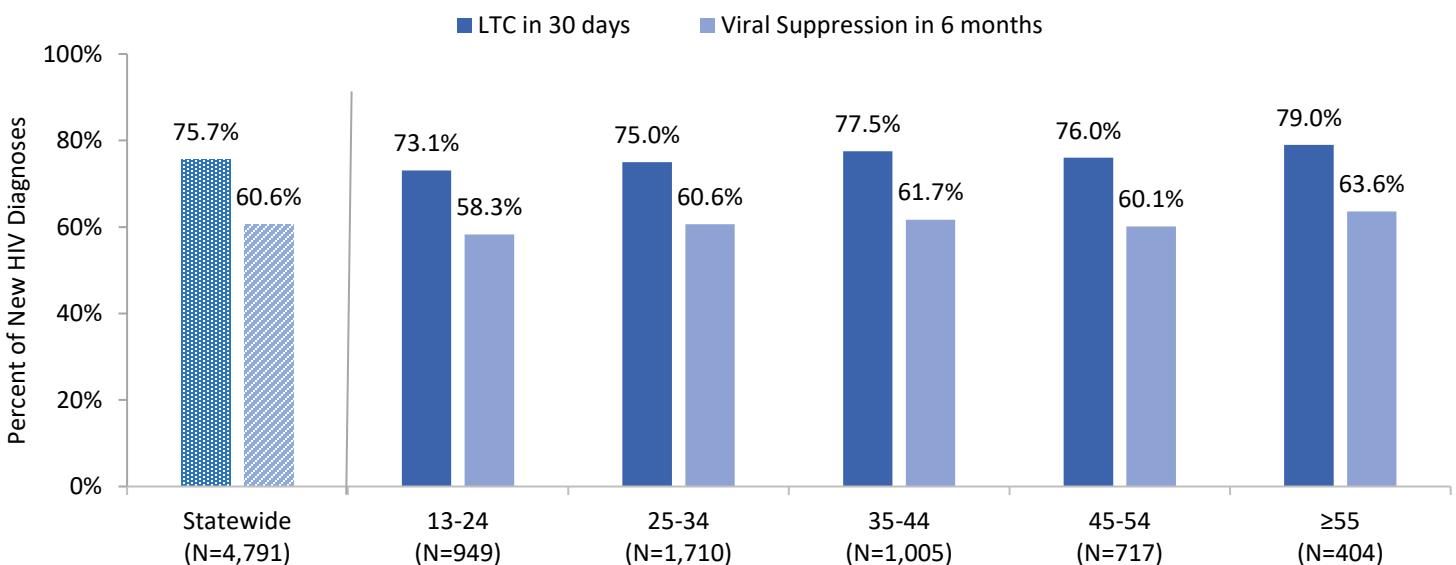
Rate of New HIV Diagnoses in 13-24 year olds by Race/Ethnicity and Year of Diagnosis, California 2010-2017



Health Outcomes by Age Group

Health outcomes were similar across age groups, with the 13-24 age group having slightly lower health outcomes than other groups.

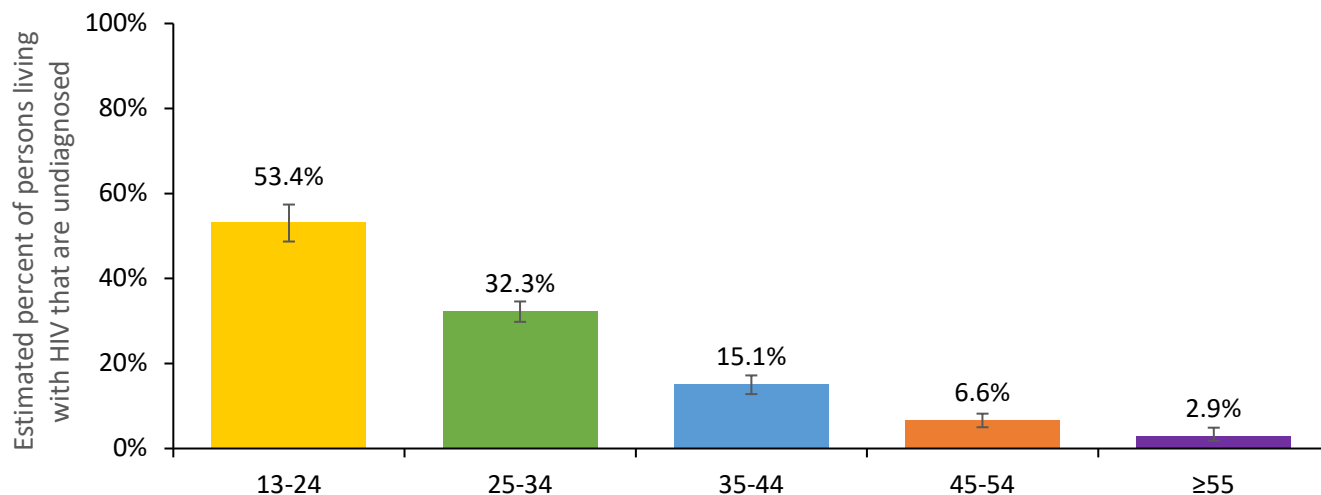
Linkage to Care and Viral Suppression by Age Group, California 2017



Undiagnosed HIV by Age Group

Statewide, an estimated 12 percent of people living with HIV in 2017 were unaware of their infection. Youth (aged 13-24) had the highest estimated percentage of individuals living with undiagnosed HIV of any age group. Among people aged 13-24 with HIV, an estimated 53 percent were unaware of their infection.

Estimated percent of persons living with HIV that are undiagnosed by age group in California, 2017



Implications

From 2010 through 2017, both the annual number and rate of new HIV diagnoses has declined in California. The number of new diagnoses declined by 10 percent from 5,321 in 2010 to 4,791 in 2017, while the rate of new diagnoses per 100,000 population declined by 15 percent, from 14.3 to 12.1 during the same time period. Although HIV has declined overall, disparities persist among racial/ethnic groups, gender, age, and transmission categories.

Among all racial/ethnic groups, Black/African Americans are the most disproportionately affected by HIV. In 2017, Black/African Americans made up approximately 6 percent of California's population, yet they accounted for 17 percent of California's HIV epidemic. Among women newly diagnosed with HIV, Black/African Americans accounted for 26 percent, and among transgender people they accounted for 28 percent. Rates among newly diagnosed Black/African American men are 3.9 times higher than White men, and among Black/African American women, 6.6 times higher than White women. Viral suppression among Black/African Americans is typically lower than other race/ethnicities regardless of gender, age, or transmission category.

Latinxs make up the largest racial/ethnic group among new HIV diagnoses, accounting for 47 percent of all new HIV diagnoses in 2017; however, they also make up the largest racial/ethnic group in California at almost 40 percent. Disparities among Latinxs include higher rates of HIV diagnoses and lower viral suppression, especially among heterosexual men and women, and IDU. Rates among newly diagnosed Latinx men are 1.7 times higher than White men, and among Latinx women 1.4 times higher than White women. In addition, disparities for MMSC have increased from 2010 to 2017 between Latinxs and Whites. In 2010, the rate of new diagnoses among Latinx MMSC was 1.2 times that of White MMSC; in 2017 it was 1.9 times that of Whites.

Transmission by MMSC makes up the majority of the HIV epidemic in California, accounting for 66 percent of new HIV diagnoses and 75 percent of all living HIV cases in 2017. Overall, health outcomes for MMSC are better than the statewide average and rates of new diagnoses among this group have declined by 14 percent since 2010. However, progress for MMSC has been uneven across race/ethnicities. While the rate of new diagnoses among White MMSC has declined by 38 percent since 2010, rates among other groups have declined at a slower pace resulting in increasing disparities.

The lowest rates of viral suppression by transmission category are for IDU followed by MMSCIDU. Regardless of gender or race/ethnicity, people who inject drugs have lower viral suppression than any other transmission group. Overall linkage to care among people who inject drugs is similar to the statewide average, which suggests that retention in care may be an issue. Continued support of syringe services programs and other support services are both important and necessary to improve viral suppression among people who inject drugs.

Cisgender women made up about 11 percent of new HIV diagnoses in 2017. Although the rate of new HIV diagnoses among women has declined since 2010, disparities across race/ethnicity and transmission categories remain. From 2010 to 2017, Black/African American women have had the largest rate decrease yet their rate is still 6.6 times that of White women. Viral suppression among women varies substantially depending on their transmission category. Women whose transmission was attributed to heterosexual contact had significantly better viral suppression than those whose transmission was via IDU.

Among transgender people diagnosed with HIV in 2017, 94 percent were transgender women and 6 percent were transgender men. Many transgender people face stigma, discrimination, and social rejection and as a result face additional barriers to accessing medical care. Health outcomes among newly diagnosed transgender women were the lowest among all gender groups, with only 54 percent achieving viral suppression within six months of diagnosis. Although rates for transgender people are unknown, national HIV prevalence among transgender people is estimated at 9.2 percent with transgender women among the groups most affected by HIV.¹

In 2017, an estimated 12 percent of people living with HIV in California were unaware of their infection. The highest percentage of undiagnosed HIV is estimated to be among younger groups, especially 13-24 year olds (53.4 percent) and 25-34 year olds (32.3 percent). Understanding disparities among the estimated undiagnosed population is important, to focus HIV testing and prevention initiatives.

The only way to achieve California's Getting to Zero objectives is by ensuring effective HIV prevention and treatment reaches all communities, especially those disproportionately affected by HIV. It is also important to consider all factors that contribute to health disparities, including structural and social factors such as racism, poverty, stigma, access to care, and education. Efforts should focus on closing disparities among the populations most impacted by HIV, especially Black/African Americans. Since Latinxs are quickly becoming the largest proportion of people living with HIV, it is important to offer education and services that are culturally and linguistically appropriate. Both individual-level and structural interventions are necessary to reduce HIV transmission and eliminate health inequities.

¹Jeffrey S. Becasen, Christa L. Denard, Mary M. Mullins, Darrel H. Higa, and Theresa Ann Sipe, 2019: Estimating the Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006–2017 American Journal of Public Health 109, e1_e8, <https://doi.org/10.2105/AJPH.2018.304727> Accessed 9/4/19

Technical Notes

The information presented in this fact sheet is based on HIV surveillance data reported to the OA through January 9, 2019, allowing for a minimum of 12 months reporting delay. For living HIV cases, persons are presumed to reside in California if the most recent available address is located in the state. For new diagnoses, persons are included if they were living in California at the time of diagnosis.

The term HIV infection is defined as any diagnosis of HIV infection that met the Centers for Disease Control and Prevention (CDC) surveillance case definition, regardless of the stage of disease (stage 0, 1, 2, 3 [AIDS], or unknown). Because persons test at differing times after becoming infected, the number of persons with newly diagnosed HIV infection is not necessarily representative of persons newly infected with HIV (HIV incidence).

Please use caution when interpreting data on trends for groups with fewer than 20 cases. Small fluctuations from year to year can lead to dramatic changes in rates, which may not be indicative of changes in the epidemiology of HIV in these populations.

Undiagnosed: The estimated percent of undiagnosed persons living with HIV infection in California was calculated using the CD4-based model generated by the CDC. For more information about the CD4-based methodology, please see [*Hall HI, Song R, Tang T, An Q, Prejean J, Dietz P, Hernandez AL, Green T, Harris N, McCray E, Mermin J HIV Trends in the United States: Diagnoses and Estimated Incidence, JMIR Public Health Surveill 2017;3\(1\):e8.*](#)

Age: For newly diagnosed persons, the age group is based on the date of diagnosis. For persons living with HIV, the age group is based on the age at the end of the specified calendar year.

Gender: Persons were classified as being transgender if a case report form affirming their transgender status was present in HIV surveillance data by January 9, 2019. Otherwise individuals were classified according to their sex-at-birth.

Race and ethnicity: Latinx persons can be of any race. Race/ethnicity data were collected using Asian/Native Hawaiian/Pacific Islander as a single category until 2003; therefore persons who were classified as Asian/Native Hawaiian/Pacific Islander prior to 2003 and for whom no subsequent race/ethnicity information is available are classified as Asian, because they cannot be disaggregated. Although California Government Code Section 8310.5 requires CDPH to tabulate information by expanded ethnicities for each major Asian and Pacific Islander group, the data shown here are not disaggregated into those groups in order to maintain the confidentiality of these persons.

Transmission category: Transmission category is the term for classifying cases based on a person's reported HIV risk factors. The classification results from selecting the single risk factor most likely to have been responsible for transmission, even if multiple risk factors were reported. The CDC hierarchy of risk factors, from most likely to lead to HIV transmission, to least likely, is as follows:

male-to-male sexual contact (MMSC) and injection drug use (IDU), MMSC alone, IDU alone, receipt of clotting factor blood product for treatment of hemophilia or other chronic coagulation disorder, and heterosexual contact.

Gay, bisexual, and other men who have sex with men are in the transmission category of MMSC. Transgender people who have sex with men are placed in the transmission category of transgender sexual contact, regardless of injection drug use. Persons who inject drugs are in the transmission category IDU. Persons whose transmission category is classified as heterosexual contact are cisgender persons who reported engaging in heterosexual intercourse with a person of the opposite sex-at-birth. The heterosexual categories exclude men who report ever having had sexual contact with both men and women— these persons are classified as MMSC. Perinatal includes persons who were exposed immediately before or during birth, or by breastfeeding. Cases of HIV infection reported without a risk factor listed in the hierarchy of transmission categories are classified as “unknown risk.” Other includes exposure to blood transfusion or blood products, receiving a transplant, and other unspecified risks.

Rates: Rates take into account population sizes and help describe disease in a particular group. Rates per 100,000 persons are based on population estimates from the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060 (Sacramento, California, January 2018). Accessed 1/9/19 <http://dof.ca.gov/Forecasting/Demographics/Projections/>

Rates for MMSC: Traditionally, disease rates take the form of “X number of cases per 100,000” of the population group specified. However, for some populations, such as MMSC, it can be difficult to accurately estimate population denominators. For that reason, the rates reported on this fact sheet represent the number of MMSC cases per 100,000 males within the specified race/ethnicity and/or age group.

In Care: Persons who had at least one CD4, viral load, or HIV-1 genotype test within 30 days after diagnosis were considered to be in care.

Viral Suppression: Persons whose most recent HIV viral load test result during the six months after diagnosis was ≤ 200 copies/ml were considered to be virally suppressed.