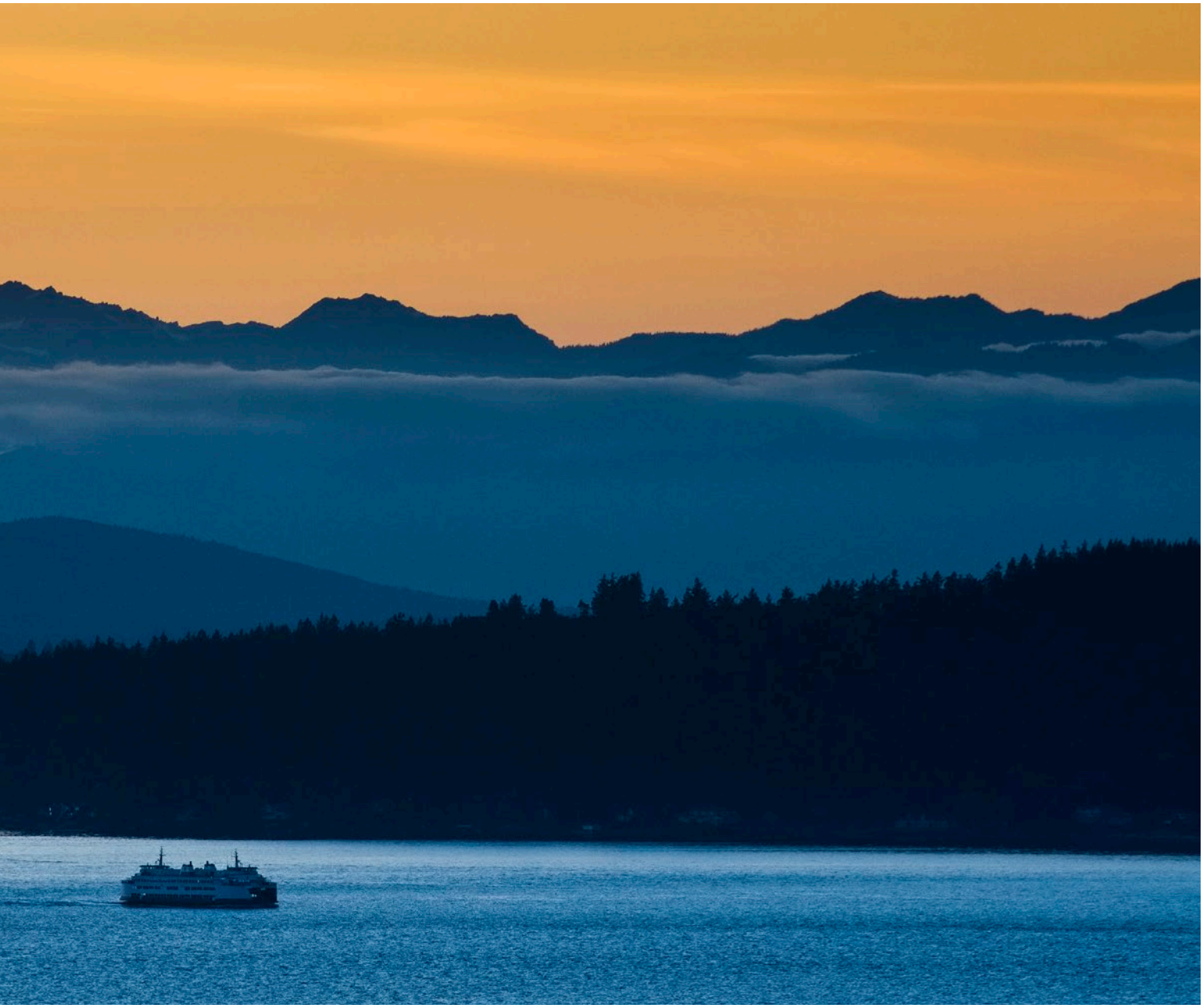
HIV

Epidemiology Report and Community Profile



King County and Washington State

2024

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HIV/AIDS Reporting Requirements

Detailed requirements for reporting of communicable diseases including HIV/AIDS are described in the Washington Administrative Code (WAC), section 246-101 (http://apps.leg.wa.gov/WAC/default.aspx?cite=246-101).

Washington health care providers are required to report all HIV infections, regardless of the date of the patient's initial diagnosis, to the health department. Providers are also required to report new diagnoses of AIDS in a person previously diagnosed with HIV infection. Local health department officials forward case reports to the Department of Health. Names are never sent to the federal government.

Laboratories are required to report evidence of HIV infection (i.e., positive HIV screening tests, p24 antigen detection, viral culture, and nucleic acid detection), all HIV viral load tests (detectable or not), and all CD4 counts in the setting of HIV infection. If the laboratory cannot distinguish tests, such as CD4 counts, done due to HIV versus other diseases (such as cancer), the CD4 counts should be reported and the health department will investigate. However, laboratory reporting does not relieve health care providers of their duty to report, as most of the critical information necessary for surveillance and follow-up is not available to laboratories.

For further information about HIV/AIDS reporting requirements, please call your local health department or the Washington State Department of Health at 888-367-5555. In King County, call 206-263-2000.

Alternate Formats & Questions

- HIV Epidemiology publications are online at: www.kingcounty.gov/hivepi
- Alternate formats provided upon request
- To be included on the mailing list or for address corrections, please call 206-263-2000
- For questions or comments about information included in the report, please contact Jen Balkus – jbalkus@kingcounty.gov

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Definitions and Abbreviations

Acute HIV Infection: The earliest stage of HIV during which many people experience a flu-like illness occurring 2 to 4 weeks of after infection.

Another Gender Identity: A category on the Washington state HIV case report form that includes people who report gender expressions that are not cisgender women, cisgender men, transgender women, and transgender men.

Acquired Immunodeficiency Syndrome (AIDS): A result of HIV infection whereby the immune system is damaged and can no longer effectively fight against opportunistic infections and cancers.

Assigned Male at Birth (AMAB): Refers to the sex that is assigned to an infant (male), most often based on the infant's anatomical and other biological characteristics.

Assigned Female at Birth (AFAB): Refers to the sex that is assigned to an infant (female), most often based on the infant's anatomical and other biological characteristics.

Antiretroviral Therapy (ART): A group of medications used to treat HIV.

American Indian and Alaskan Native (AI/AN): A racial/ethnic group. Individuals may also identify as First Nations or Indigenous.

CD4 Count: A measure of the number of CD4+ T cells in the bloodstream.

Centers for Disease Control and Prevention (CDC): The CDC is a federal disease prevention agency. The CDC both researches and analyzes public health issues, is responsible for working with state and local agencies to monitor health threats and implement measures to prevent outbreaks and for educating the public on health issues and maintaining medical statistics.

Cisgender: Describes a person whose gender identity aligns with their sex assigned at birth.

Epidemiology: The branch of public health science that deals with the incidence, determinants, distribution, and possible control of diseases and other factors relating to health.

Ending the HIV Epidemic (EHE): A federal initiative that aims to capitalize on scientific advances in HIV diagnosis, treatment, and prevention to accelerate national progress in controlling the HIV epidemic.

Gender: Gender refers to the characteristics of women, men, that are socially constructed.

Human Immunodeficiency Virus (HIV): The virus that causes AIDS.

HIV Viral Load: The amount of HIV viral RNA that is in the bloodstream.

Latinx: A racial/ethnic group. This is used as the gender inclusive term for people whose ethnicity is from Latin America, South America, and Spanish speaking Caribbean.

Homeless/Unstably Housed: Lacking a stable and safe place to live. This includes those who are both unsheltered and sheltered, as well as those living in temporary settings due to lack of adequate economic resources.

Incidence: The number or rate of new diagnoses over defined period of time.

Linkage to HIV Care: Having the first clinic visit or accessing medical care after an HIV diagnosis.

Men Who Have Sex with Men (MSM): An HIV transmission category. Unless otherwise specified, in this report MSM includes cisgender and transgender men who report sex with men.

Native Hawaiian or Pacific Islander (NH/PI): A racial/ethnic group. This group includes people who originate from Hawaii, Guam, Samoa, or Pacific Islands.

Out of Care (OOC): Someone diagnosed with HIV with no medical visit or laboratory results over the past year or more.

No identifiable Risk (NIR): An HIV transmission category where documentation is insufficient to assign a mode for transmission.

Pediatric: A transmission category used to describe transmission of HIV from a pregnant person to their infant during pregnancy, labor, delivery or breastfeeding; also known as vertical transmission.

Pre-exposure Prophylaxis (PrEP): Antiretroviral medication taken by individuals to prevent HIV infection.

People Who Inject Drugs (PWID): An HIV transmission category.

Surveillance: The continuous collection, analysis, and distribution of data regarding a health-related event.

Transgender Man: Person who identifies as a man and was assigned female sex at birth.

Transgender Woman: Person who identifies as a woman and was assigned male sex at birth.

Transmission Category: A system that classifies individuals by possible HIV transmission-related factors or mode(s) of infection, e.g. PWID, MSM/PWID, perinatal transmission, heterosexual sexual contact.

Viral Suppression: When a person living with HIV has less than 200 copies of HIV per milliliter of blood.

Executive Summary

Background

The HIV Epidemiology Report & Community Profile is a longstanding joint effort between Public Health – Seattle & King County (PHSKC) and the Washington State Department of Health (WA DOH). Our goal each year is to provide a detailed summary and evaluation of efforts related to HIV in King County and share data from across Washington state.

The report includes HIV surveillance data, information on populations most affected by HIV, and evaluations of various components of our program. We aim to answer these questions: What is the current scope of the HIV epidemic in King County and how does that compare to the overall epidemic in Washington state? Who is most impacted by the epidemic? and What is PHSKC and our community doing about HIV, and what progress has been made to prevent HIV and ensure the successful treatment of people living with HIV?

In 2019, the U.S. Department of Health and Human Services released its Ending the HIV Epidemic (EHE) plan, which supports jurisdictions most impacted by HIV, including King County. The primary objective of EHE is to reduce the number of new HIV infections by 75% by 2025 and by 90% by 2030. This report, which includes data through the end of 2023, focuses on each of the four EHE pillars: 1) Diagnose, 2) Treat, 3) Prevent, and 4) Respond. Our King County HIV Goals and Metrics Dashboard reflects national and local goals for 2025 that are aligned with the EHE pillars. We set goals that we believe are ambitious and aligned with the county's broader goals related to health equity. Each pillar-focused chapter includes data documenting progress toward meeting EHE goals and descriptions of pillar-related activities in support of these goals.

Over the past decade, King County and Washington state have met numerous goals related to HIV prevention, care, and treatment. To our knowledge, King County was the first urban jurisdiction in the U.S. to meet UNAIDS 90-90-90 goals (90% of people living with HIV are diagnosed, 90% of diagnosed persons are on HIV treatment, and 90% of treated persons are virally suppressed). King County successfully increased pre-exposure prophylaxis (PrEP) use, the proportions of people with HIV who know their HIV status and who are virally suppressed continue to be much higher than national estimates, deaths from HIV-related causes has plummeted, and in 2023 the number of men who have sex with men newly diagnosed with HIV infection was the lowest of any year since the start of the HIV epidemic.

However, there has been little change in the percentage of people who are virally suppressed, progress towards eliminating HIV-related racial disparities has stagnated, and overdose deaths among PLWH has risen dramatically since 2017. Notably, the overall rate of new diagnoses has remained stable, reflecting a rise in new diagnoses among women concurrent with a decline in diagnoses among MSM. Overall, King County has made remarkable progress in the fight against HIV, but it now confronts an epidemic that is increasingly concentrated among marginalized populations characterized by high rates of poverty, substance use, and homelessness. Below we summarize key findings for each EHE pillar.

EHE Pillar 1: Diagnose

In 2023, there were 168 new HIV diagnoses resulting in an annual rate of 7.2 per 100,000 people. This represents a slight decline in the diagnosis rate in 2019 (7.9 per 100,000 people). Thirty-two percent of new diagnoses occurred among Seattle residents, 39% among residents of south King County (39%), and 18% of new diagnoses occurred among people who were homeless or unstably housed. The majority of new HIV diagnoses (56%) were among men who have sex men (MSM), including MSM who also inject drugs (people who inject drugs; PWID). Of note, 2023 had the lowest number of new diagnoses among MSM since the start of the HIV epidemic in the 1980s.

Twelve percent of new diagnoses occurred in persons thought to have acquired the infection through heterosexual sexual contact, and 4% occurred in PWID (including MSM who inject drugs). In 2023, 36 women were newly diagnosed with HIV, the largest number of diagnoses in cisgender women since 2018. This represents a 60% increase in the rate of new diagnosis between 2022 and 2023.

The HIV epidemic continues to disproportionately impact racial and ethnic minority groups. In 2023, 16% of new HIV diagnoses occurred in U.S.-born Black residents; only 5% of King County residents identify as Black and were born in the U.S.. The proportion of new HIV diagnoses among Latinx people was also disproportionately high (23% of new diagnoses versus 11% of the population in King County). Among both Black and Latinx populations, new HIV diagnoses disproportionately affect people born outside of the U.S. In King County, 97% of residents with HIV are aware of their status, which surpasses the national and local goals of 95%.

EHE Pillar 2: Treat

People living with HIV (PLWH) on sustained antiretroviral therapy improve their own health outcomes and, if virally suppressed, cannot sexually transmit HIV to their partners. Over the past decade, King County has made tremendous progress toward meeting and exceeding previous goals related to HIV treatment and viral suppression. EHE aims for >95% of PLWH to be linked to care within 1 month of their diagnosis and >95% of PLWH to be virally suppressed. In 2023, 85% of King County residents newly diagnosed with HIV were linked to care within one month and 85% of all persons with diagnosed HIV infection were virally suppressed. While this estimate is substantially higher than CDC's 2022 national estimate of 66% viral suppression (the most recent year for which data are available), it is unchanged from 2017.

Differences in viral suppression by race and ethnicity have also remained generally the same over the past five years. Viral suppression was lowest among PLWH who reported injection drug use (69%). People who are out of care or not virally suppressed often face complex barriers to care. PHSKC has various ongoing efforts to re-engage people in HIV care and treatment, including several low-barrier clinics and a mobile team to reach people outside of the clinical setting.

EHE Pillar 3: Prevent

The EHE initiative promotes two highly effective HIV prevention strategies: PrEP and syringe services programs (SSPs). King County's PrEP implementation guidelines recommend PrEP use among MSM and transgender people who have sex with men based on specific criteria that identify people at elevated risk for HIV acquisition. Approximately 67% of MSM who meet King County's PrEP priority criteria are currently taking PrEP. PrEP use has steadily increased over the past decade, making excellent progress towards PHSKC's goal of 70%. Data on PrEP use among transgender populations are limited, but we estimate that 42-66% of transgender people who met PrEP priority criteria are taking PrEP. Among PWID, PrEP use among is very low (≤1%). PHSKC supports several ongoing efforts to promote PrEP use, such as running a large PrEP program at the PHSKC Sexual Health Clinic, and promoting increased PrEP provision through diverse community healthcare organizations, including an EHE-funded low-barrier clinic in north Seattle. Most King County residents who are on PrEP receive it from primary care medical providers.

SSPs provide PWID with sterile syringes to reduce the risk of blood-borne infections (HIV and hepatitis C), as well as overdose prevention services, safer smoking supplies, wound care, and linkages to treatment for substance use disorder and hepatitis C. The PHSKC SSP's sites distributed over 1.5 million syringes in 2023, nearly a 71% drop from 2020. Across all SSPs in King County, nearly 2.5 million syringes were distributed. The steep decline in the number of syringes distributed is due to changes in local drug use patterns, primarily the increase in smoking fentanyl. This has also led to an unprecedented increase in the number of fatal overdoses, including record numbers of overdose deaths among people living with HIV. To encourage engagement in harm reduction services and overdose prevention among people who are not injecting drugs, the PHSKC SSP expanded its safer smoking supplies program in 2023.

EHE Pillar 4: Respond

Pillar 4 of EHE promotes novel methods of identifying groups of people with HIV (clusters) who may be linked to one another in sexual or drug using network where there is recent and rapid growth of HIV diagnoses. This identification is followed by a rapid response to provide prevention and treatment resources to individuals linked to the cluster. King County response efforts blend traditional epidemiologic and partner services investigations with molecular HIV analysis that uses viral genetic sequencing techniques. When clusters are identified, PHSKC can employ focused interventions to expand HIV testing, HIV prevention, and linkage to HIV care for people living with HIV.

To date, PHSKC has received HIV genetic sequences from 76% of people newly diagnosed with HIV. In 2023, molecular HIV analyses identified 14 clusters with recent and rapid growth that had at least one member residing in King County at the time of their diagnosis. PHSKC has connected people identified through cluster investigations to HIV care and referred PLWH to receive housing support, case management, food and meal resources, dental care, legal assistance, and maternal health services. No new HIV diagnoses were identified through cluster-related HIV testing or outreach.

Conclusion

This HIV Epidemiology Report and Community Profile reports data primarily collected four years into the EHE Initiative. While our community faced a myriad of challenges as a result of the COVID-19 pandemic, there have been some more recent successes — such increased PrEP use among priority populations, decreased new infections among MSM, a very high proportion of people with HIV knowing their diagnosis, and levels of viral suppression that substantially exceed national estimates. However, overall rates of new HIV diagnoses and viral suppression have remained relatively unchanged, with the epidemic disproportionately impacting racial and ethnic minorities and increasingly concentrated among people affected by poverty, substance use, and unstable housing.

To meet the EHE goals, PHSKC aims to fundamentally change how HIV prevention and HIV care services are delivered in King County to better meet the needs of people for whom HIV prevention and care services have not historically been accessible, acceptable, or effective. EHE funding supports an array of expanded services to diagnose, treat, prevent, and respond to the HIV epidemic, including two new low-barrier HIV prevention and care clinics that opened in south King County in 2023. We remain optimistic that the immense progress that our community has collectively made toward reducing HIV incidence and improving the lives and well-being of people living with HIV will continue.

King County HIV Goals and Evaluation Metrics: 2023 Dashboard

	2025 Goals[1]		King County Data, 2019, 2023		Status
	National	King County	2019	2023	
DIAGNOSE					
New HIV diagnoses, rate	↓75%	↓75%	7.9/100,000	7.2/100,000 (↓9%)	↑
Disparities in new HIV diagnoses by race/ethnicity[2] (rate per 100,000 pop.)	--	<5% difference between groups and overall rate	AI/AN....10.2 Asian....2.2 FB Black....44.4 U.S.-born Black...18.3 Latinx....17.5 NH/PI....15.8 White....6.2	AI/AN....17.9 Asian....2.4 FB Black....69.0 U.S.-born Black..23.7 Latinx....14.3 NH/PI....9.3 White....4.1	–
Know HIV status[3]	>95%	≥95%	94%	97%	✓
Late HIV diagnosis[4]	--	<10%	17%	25%	↓
TREAT					
Linked to care in 1 month[5]	≥95%	≥95%	90%	83%	↓
In HIV care[6,7]	--	≥95%	89%	93%	↑
Viral suppression[6,8]	≥95%	≥95%	85%	85%	–
Disparities in viral suppression by race/ethnicity[2,6,8]		<5% difference between groups and overall rate	AI/AN....80% Asian....89% FB Black....86% U.S.-born Black....77% Latinx....85% NH/PI....82% White....87%	AI/AN....80% Asian....88% FB Black....86% U.S.-born Black...79% Latinx....86% NH/PI....82% White....85%	↑
Viral suppression within 4 months of diagnosis[5]	--	≥90%	69%	70%	↑
Homelessness among PLWH[6,9]	--	<5%	11%	10%	↑
Disparities in homelessness by race/ethnicity[2,6,9]		<5% difference between groups and overall rate	--[12]	AI/AN....19% Asian....6% Black....13% Latinx....12% NH/PI....11% White....10%	
PREVENT					
PrEP use, MSM who meet PrEP priority criteria[10]	--	≥70%	47%	67%	↑
Disparities in PrEP use among MSM who meet PrEP priority criteria by race/ethnicity[2,10,12]		<5% difference between groups and overall rate	AI/AN....47% Asian....63% Black....55% Latinx....64% NH/PI....66% White....62%	AI/AN....50% Asian....70% Black....56% Latinx....68% NH/PI....60% White....68%	↑
Syringe coverage[11]	--	≥365/PWID	283/PWID	319/PWID	↑

Abbreviations: AI/AN = American Indian/Alaska Native; FB = foreign-born; MSM = men who have sex with men; NH/PI = Native Hawaiian or Pacific Islander; PrEP = pre-exposure prophylaxis for HIV; PLWH = people living with HIV; PWID = people who inject drugs; U.S. = United States.

✓ GOAL MET ↑ MOVING TOWARD THE GOAL – NO CHANGE FROM BASELINE ↓ MOVING AWAY FROM GOAL ✗ GOAL NOT MET[14]

Technical Notes to Dashboard

[1] All 2025 goals use 2019 as the baseline.

[2] The goal for disparity-related indicators is for no difference between each racial/ethnic group and the estimate for the entire population for each indicator. This is defined as having all racial/ethnicity-specific estimates within 5% of the overall estimate. For new HIV diagnoses, racial categories are mutually exclusive in order to calculate population-level rates. For all other metrics, racial categories are not mutually exclusive and individuals reporting multiple racial and ethnic identities are represented in each group.

[3] Percent of people living with HIV who know their HIV status. Based on an estimation method developed by the University of Washington.

[4] Percent of people diagnosed with HIV in 2022 who were diagnosed with AIDS within 1 year of HIV diagnosis. Excludes people who had an HIV-negative test within 2 years of their diagnosis.

[5] Among people with a new HIV diagnosis.

[6] Among people who have been diagnosed with HIV.

[7] Defined as one or more HIV care visits in a calendar year.

[8] See Technical Note 6 for details on calculating viral suppression.

[9] We define people as living homeless if they report being homeless or unstably housed. People who report being institutionalized (e.g., in jail) are not classified as living homeless. See Technical Note 5 for more details.

[10] In King County, MSM who are a priority population for PrEP are defined in analyses as HIV-negative MSM who report any of the following in the past year: ≥10 sex partners, methamphetamine use, diagnosis of gonorrhea or syphilis, or condomless receptive anal intercourse. The annual estimate of PrEP use among these MSM is an average across multiple contemporaneous surveys.

[11] Defined as the number of syringes provided by SSPs per PWID per year. There is no national goal, but the WHO has a benchmark of 300 syringes per PWID per year by 2030.

[12] These goals were first monitored in 2022, thus baseline estimates are from 2022 not 2019.

[13] "No change from baseline" is defined as a 0% or 1%-point difference between 2019 and 2023.

[14] Prior to 2025, all goals that have not been met will be assessed each year as "no change from baseline", "moving toward the goal", or "moving away from the goal."

1. Key HIV Data in King County



TABLE 1-1

People Living with HIV by Residence Status, King County, WA, 2023

	CURRENT KING COUNTY RESIDENTS						OUT-MIGRANTS (Diagnosed in King County, but now presumed living elsewhere)	
	Total		At Time of Diagnosis: King County Resident		At Time of Diagnosis: Out of Area Resident			
	N	%	N	%	N	%	N	%
TOTAL[A]	7,402		4,000		3,402		3,268	
GENDER[B]								
Cisgender Men	6,244	84%	3,413	85%	2,831	83%	2,928	90%
Cisgender Women	1,032	14%	527	13%	505	15%	309	9%
Transgender Men	9	<1%	5	<1%	4	<1%	3	<1%
Transgender Women	104	1%	49	1%	55	2%	28	1%
Another Gender Identity	13	<1%	6	<1%	7	<1%	0	0%
CURRENT AGE (years)								
< 13	6	<1%	0	0%	6	<1%	0	0%
13-24	125	2%	60	2%	65	2%	10	<1%
25-34	1,019	14%	475	12%	544	16%	189	6%
35-44	1,609	22%	731	18%	878	26%	484	15%
45-54	1,701	23%	860	22%	841	25%	800	24%
55+	2,942	40%	1,874	47%	1,068	31%	1,785	55%
RACE/ETHNICITY[C, D]								
American Indian/Alaska Native	273	4%	177	4%	96	3%	127	4%
Asian	633	9%	336	8%	297	9%	186	6%
Black	2,074	28%	946	24%	1,128	33%	610	19%
- U.S.-Born	1,198	16%	554	14%	644	19%	379	12%
- Foreign-Born	876	12%	392	10%	484	14%	231	7%
Latinx or Hispanic *(all races)*	1,312	18%	627	16%	685	20%	475	15%
- U.S.-Born	602	8%	270	7%	332	10%	244	7%
- Foreign-Born	710	10%	357	9%	353	10%	231	7%
Native Hawaiian or Pacific Islander	118	2%	67	2%	51	1%	31	1%
White	4,841	65%	2,748	69%	2,093	62%	2,463	75%
Multiracial	511	7%	278	7%	233	7%	234	7%
TRANSMISSION CATEGORY[E]								
Cisgender Men								
MSM	4,791	65%	2,633	66%	2,158	63%	2,250	69%
PWID	153	2%	89	2%	64	2%	81	2%
MSM and PWID	614	8%	303	8%	311	9%	347	11%
Heterosexual Sexual Contact	196	3%	116	3%	80	2%	75	2%
Perinatal	24	<1%	5	<1%	19	1%	7	<1%
Transfusion/Transplant	12	<1%	10	<1%	2	<1%	4	<1%
No Identified Risk	454	6%	257	6%	197	6%	164	5%
Cisgender Women								
PWID	93	1%	67	2%	26	1%	44	1%
Heterosexual Sexual Contact	637	9%	374	9%	263	8%	217	7%
Perinatal	46	1%	13	<1%	33	1%	9	<1%
Transfusion/Transplant	9	<1%	8	<1%	1	<1%	3	<1%
No Identified Risk	247	3%	65	2%	182	5%	36	1%
Transgender Men								
All Transmission Types	9	<1%	5	<1%	4	<1%	3	<1%
Transgender Women								
Male Sex Partner	81	1%	38	1%	43	1%	19	1%
PWID	1	<1%	0	0%	1	<1%	0	0%
Male Sex Partner and PWID	20	<1%	10	<1%	10	<1%	9	<1%
No Identified Risk	2	<1%	1	<1%	1	<1%	0	0%
Another Gender Identity								
All Transmission Types	13	<1%	6	<1%	7	<1%	0	0%

A Based on HIV/AIDS surveillance data reported to the Washington State Department of Health as of June 30, 2024.

B We assume that people are cisgender in the absence of known transgender or another gender identity.

C Race/ethnicity categories are not mutually exclusive. Those reporting multiple racial/ethnic identities are represented in each group, therefore percentages will sum >100%.

D Individuals are assumed born in the U.S. when birth country is unknown; people born in U.S. territories are counted as Foreign Born.

E Transmission categories are not presented for transgender men and another gender identity due to small numbers.

TABLE 1-2 (Part 1 of 2)

New Diagnoses of HIV Infection, King County, WA, 2018-2023

	New HIV Diagnoses										Late HIV Diagnoses
	2018	2019	2020	2021	2022	2023	2022-2023		2022-2023	2023	2018-23*
	N	N	N	N	N	N	N	%	Rate	Rate	%
TOTAL[A]	214	178	161	161	181	168	349	100%	7.50		21%
GENDER[B]											
Cisgender Men	168	145	138	132	152	130	282	81%	12.4	11.2	19%
Cisgender Women	46	29	18	22	23	36	59	17%	2.6	3.2	31%
Transgender Men	0	0	0	1	0	1	1	<1%	N/A	N/A	0%
Transgender Women	0	3	4	6	5	1	6	2%	N/A	N/A	5%
Another Gender Identity	0	1	1	0	1	0	1	<1%	N/A	N/A	0%
AGE AT DIAGNOSIS (years)											
< 13	0	0	0	0	0	0	0	0%			
13-24	26	25	27	17	28	18	46	13%	7.1	5.5	8%
25-34	80	70	57	74	64	69	133	38%	16.4	16.9	13%
35-44	50	39	36	37	49	39	88	25%	11.8	10.3	26%
45-54	30	28	23	18	26	22	48	14%	8.0	7.3	35%
55+	28	16	18	15	14	20	34	10%	2.9	3.3	36%
RACE/ETHNICITY[C, D]											
American Indian/ Alaska Native	1	1	1	2	2	2	4	1%	17.6	17.9	11%
Asian	10	9	17	9	18	12	30	9%	3.1	2.4	20%
Black	45	34	27	36	45	58	103	30%	33.3	37.1	30%
- U.S.-Born	20	19	15	21	25	26	51	15%	23.5	23.7	18%
- Foreign-Born	25	15	12	15	20	32	52	15%	56.2	69.0	43%
Latinx or Hispanic *(all races)*	39	41	20	35	45	38	83	24%	15.8	14.3	22%
- U.S.-Born	25	16	9	16	17	12	29	8%	8.4	6.8	28%
- Foreign-Born	14	25	11	19	28	26	54	15%	30.1	29.5	15%
Native Hawaiian or Pacific Islander	3	3	1	1	3	2	5	1%	11.8	9.3	23%
White	105	77	86	64	58	50	108	31%	4.4	4.1	16%
Multiracial	11	13	9	14	10	6	16	5%	5.0	3.7	16%

TABLE 1-2 (Part 2 of 2)

New Diagnoses of HIV Infection, King County, WA, 2018-2023

	New HIV Diagnoses										Late HIV Diagnoses
	2018	2019	2020	2021	2022	2023	2022-2023		2022-2023	2023	2018-23*
	N	N	N	N	N	N	N	%	Rate	Rate	%
TRANSMISSION CATEGORY											
Cisgender Men											
MSM	104	108	108	97	104	85	189	54%			16%
PWID	15	8	3	3	5	3	8	2%			30%
MSM and PWID	25	13	16	18	12	8	20	6%			11%
Heterosexual Sexual Contact	6	5	3	2	6	7	13	4%			45%
Pediatric	0	0	0	0	0	0	0	0%			
Transfusion/Hemophiliac	0	0	0	0	0	0	0	0%			
No Identified Risk	18	11	8	12	25	27	52	15%			35%
Cisgender Women											
Injecting Drug Use	15	9	1	5	1	4	5	1%			3%
Heterosexual Sexual Contact	24	15	10	12	18	13	31	9%			33%
Pediatric	1	0	0	0	0	0	0	0%			1%
Transfusion/Hemophiliac	0	0	0	0	0	0	0	0%			
No Identified Risk	6	5	7	5	4	19	23	7%			48%
Transgender Men											
All Transmission Types	0	0	0	1	0	1	1	<1%			0%
Transgender Women											
All Transmission Types	0	3	4	6	5	1	6	2%			5%
Another Gender Identity											
All Transmission Types	0	1	1	0	1	0	1	<1%			0%

A Late HIV diagnoses based on new HIV cases diagnosed between 2018 and 2023; late diagnoses are defined as those with AIDS (a CD4 count of <200/microliter and/or opportunistic infection diagnosis) within one year of initial HIV diagnosis and no evidence of a negative HIV test in the two years preceding

B We assume that people are cisgender in the absence of known transgender identity.

C Race/ethnicity includes Latinx/Hispanic persons of any race and non-Latinx/Hispanic individuals with single races or whom are multiracial. These categories differ from categories used elsewhere in this report to match census data for rate calculations.

D When country of birth is unknown, we assume individuals were born in the United States. Additionally, people born in U.S. Territories were counted as foreign born.

E Transmission categories are not presented for transgender men and another gender identity due to small numbers.

TABLE 1-3

AIDS Diagnoses and Cumulative Deaths, King County, WA, 1982-2023

	Recent AIDS Cases 2022-2023			AIDS Cases Living in King Co. 2023			Cumulative AIDS Cases 1982-2023		Cumulative Deaths 1982-2023[B]	
	N	%	Rate	N	%	Prevalence	N	%	N	%
TOTAL[A]	215	100%	4.6	3,417	100%	145.5	9,577	100%	5,953	100%
GENDER[C]										
Cisgender Men	158	73%	6.8	2,893	85%	245.4	8,684	91%	5,560	93%
Cisgender Women	53	25%	2.3	479	14%	41.0	839	9%	375	6%
Transgender Men	0	0%		1	<1%		1	<1%	1	<1%
Transgender Women	3	1%		41	1%		52	1%	17	<1%
Another Gender Identity	1	<1%		3	<1%		1	<1%	0	0%
AGE (years)	Age at Diagnosis			Current Age			Age at Diagnosis		Age at Death	
< 13	0	0%	0.0	0	0%	0.0	14	<1%	7	<1%
13-24	15	7%	2.3	18	1%	5.5	329	3%	42	1%
25-34	60	28%	7.3	216	6%	52.6	3,211	34%	1,183	20%
35-44	64	30%	8.5	543	16%	142.6	3,700	39%	2,140	36%
45-54	47	22%	7.9	810	24%	268.7	1,689	18%	1,386	23%
55+	29	13%	2.5	1,830	54%	305.7	634	7%	1,195	20%
RACE/ETHNICITY[D]										
American Indian/Alaska Native	2	1%	8.7	24	1%	210.0	96	1%	74	1%
Asian	10	5%	1.0	162	5%	32.6	229	2%	79	1%
Black	57	27%	18.3	731	21%	461.8	1,376	14%	659	11%
Latinx or Hispanic *(all races)*	57	27%	10.9	597	17%	224.1	1,016	11%	375	6%
Native Hawaiian or Pacific Islander	3	1%	7.0	15	<1%	69.1	27	<1%	13	<1%
White	77	36%	3.1	1,627	48%	132.1	6,333	66%	4,550	76%
Multiracial	9	4%	2.8	261	8%	161.8	500	5%	203	3%
TRANSMISSION CATEGORY[E]										
Cisgender Men										
MSM	97	45%		2,091	61%		6,491	68%	4,203	71%
PWID	13	6%		100	3%		393	4%	296	5%
MSM and PWID	18	8%		323	9%		1,032	11%	705	12%
Heterosexual Sexual Contact	6	3%		127	4%		211	2%	72	1%
Perinatal	1	<1%		10	<1%		11	<1%	6	<1%
Transfusion/Transplant	0	0%		10	<1%		66	1%	55	1%
No Identified Risk	23	11%		232	7%		480	5%	223	4%
Cisgender Women										
PWID	4	2%		50	1%		177	2%	149	3%
Heterosexual Sexual Contact	34	16%		327	10%		528	6%	179	3%
Perinatal	3	1%		13	<1%		17	<1%	4	<1%
Transfusion/Transplant	0	0%		7	<1%		23	<1%	18	<1%
No Identified Risk	12	6%		82	2%		94	1%	25	<1%
Transgender Men										
All Transmission Types	0	0%		1	<1%		1	<1%	1	<1%
Transgender Women										
All Transmission Types	3	1%		41	1%		52	1%	17	<1%
Another Gender Identity										
All Transmission Types	1	<1%		3	<1%		1	<1%	0	0%

Abbreviations: MSM = men who have sex with men; PWID = people who inject drugs.

A Based on HIV/AIDS surveillance data reported to the Washington State Department of Health as of June 30, 2024. Rates and prevalence are per 100,000 residents

B Includes 456 cases with an HIV-only diagnosis and 5,497 AIDS cases. 3,958/5,953 (66%) deaths had HIV listed as an underlying condition.

C It is assumed that people are cisgender in the absence of reporting transgender or another gender identity.

D Race/ethnicity includes Latinx/Hispanic persons of any race and non-Latinx/Hispanic indivduals with single races or whom are multiracial. These categories differ from categories used elsewhere in this report to match census data fore rate calculations.

E Transmission categories are not presented for transgender men and another gender identity due to small numbers.

TABLE 1-4

People Living with HIV by Gender Identity, Race/Ethnicity, and Transmission Category, King County, WA, 2023

	American Indian/ Alaska Native		Asian		Black		Latinx		Native Hawaiian/ Pacific Islander		White	
	N	%	N	%	N	%	N	%	N	%	N	%
CISGENDER MEN												
MSM	174	77%	424	76%	862	62%	953	82%	79	80%	3,587	81%
PWID	5	2%	9	2%	53	4%	17	1%	2	2%	99	2%
MSM and PWID	37	16%	38	7%	106	8%	87	8%	11	11%	524	12%
Heterosexual Sexual Contact	2	1%	14	3%	125	9%	30	3%	2	2%	63	1%
- U.S.-Born	1	<1%	1	<1%	35	3%	2	<1%	1	1%	32	1%
- Foreign-Born	1	<1%	13	2%	90	6%	28	2%	1	1%	31	1%
Perinatal	1	<1%	1	<1%	18	1%	2	<1%	0	0%	5	<1%
Transfusion/Transplant	0	0%	0	0%	2	<1%	2	<1%	0	0%	10	<1%
No Identified Risk	6	3%	73	13%	222	16%	66	6%	5	5%	164	4%
Total Cisgender Men	**225**	**100%**	**559**	**100%**	**1,388**	**100%**	**1,157**	**100%**	**99**	**100%**	**4,452**	**100%**
CISGENDER WOMEN												
PWID	16	46%	3	5%	22	3%	6	5%	1	11%	64	20%
Heterosexual Sexual Contact	15	43%	44	76%	388	60%	83	74%	7	78%	203	64%
- U.S.-Born	11	31%	10	17%	99	15%	24	21%	4	44%	141	44%
- Foreign-Born	4	11%	34	59%	289	44%	59	53%	3	33%	62	19%
Perinatal	0	0%	1	2%	36	6%	2	2%	0	0%	11	3%
Transfusion/Transplant	0	0%	1	2%	6	1%	0	0%	0	0%	3	1%
No Identified Risk	4	11%	9	16%	198	30%	21	19%	1	11%	38	12%
Total Cisgender Women	**35**	**100%**	**58**	**100%**	**650**	**100%**	**112**	**100%**	**9**	**100%**	**319**	**100%**
GENDER DIVERSE PEOPLE												
All Transmission Types	13	100%	16	100%	36	100%	43	100%	10	100%	70	100%

Abbreviations: MSM = men who have sex with men; PWID = people who inject drugs.

Based on HIV/AIDS surveillance data reported to the Washington State Department of Health as of June 30, 2024.

It is assumed that people are cisgender in the absence of reporting transgender or another gender identity. Gender Diverse People includes people that identify as transgender women, transgender men, or additional gender identity, and have been combined due to small population size.

Race/ethnicity categories are not mutually exclusive. Individuals reporting multiple racial and ethnic identities are represented in each group.

When country of birth is unknown, we assume individuals were born in the United States. Additionally, people born in U.S. Territories we counted as Foreign Born.

TABLE 1-5

People Living with HIV by Gender Identity, WHO Birth Region, and Transmission Category, King County, WA, 2023

	United States		African Region		Region of the Americas		South-East Asian Region		European Region		Eastern Mediteranean Region		Western Pacific Region	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
CISGENDER MEN														
MSM	3,677	80%	51	18%	522	82%	31	52%	85	70%	19	44%	206	78%
PWID	132	3%	2	1%	5	1%	1	2%	3	2%	1	2%	4	2%
MSM and PWID	560	12%	0	0%	22	3%	5	8%	9	7%	0	0%	6	2%
Heterosexual Sexual Contact	60	1%	81	29%	26	4%	4	7%	8	7%	8	19%	5	2%
Perinatal	11	<1%	12	4%	0	0%	0	0%	0	0%	0	0%	1	<1%
Transfusion/Transplant	12	<1%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
No Identified Risk	141	3%	136	48%	60	9%	19	32%	16	13%	15	35%	43	16%
Total Cisgender Men	**4,593**	**100%**	**282**	**100%**	**635**	**100%**	**60**	**100%**	**121**	**100%**	**43**	**100%**	**265**	**100%**
CISGENDER WOMEN														
PWID	84	22%	1	<1%	1	1%	1	5%	2	10%	0	0%	0	0%
Heterosexual Sexual Contact	239	64%	266	57%	68	82%	12	63%	11	52%	10	59%	21	81%
Perinatal	12	3%	29	6%	0	0%	0	0%	2	10%	2	12%	1	4%
Transfusion/Transplant	6	2%	2	<1%	0	0%	0	0%	0	0%	0	0%	1	4%
No Identified Risk	34	9%	169	36%	14	17%	6	32%	6	29%	5	29%	3	12%
Total Cisgender Women	**375**	**100%**	**467**	**100%**	**83**	**100%**	**19**	**100%**	**21**	**100%**	**17**	**100%**	**26**	**100%**
GENDER DIVERSE PEOPLE														
All Transmission Types	91	100%	0	0%	25	100%	0	0%	0	0%	0	0%	9	100%

Abbreviations: MSM = men who have sex with men; PWID = people who inject drugs.

Based on HIV/AIDS surveillance data reported to the Washington State Department of Health as of June 30, 2024.

Table excludes 270 individuals whose country of birth is Unknown.

It is assumed that people are cisgender in the absence of reporting transgender or another gender identity.

Gender Diverse People includes people that identify as transgender women, transgender men, or additional gender identity, and have been combined due to small population size.

TABLE 1-6

New HIV Diagnoses Among Men Who Have Sex With Men (MSM), King County, WA, 2022-2023

	MSM		All King County Residents		MSM Living with HIV Presumed Living in King County at the End of 2023	
	N	%	N	%	N	%
TOTAL	210		349		5,413	
AGE AT HIV DIAGNOSIS (years)	Age at Diagnosis		Age at Diagnosis		Age at End of 2023	
< 13	0	0%	0	0%	0	0%
13-24	33	16%	46	13%	64	1%
25-34	92	44%	133	38%	800	15%
35-44	44	21%	88	25%	1,207	22%
45-54	28	13%	48	14%	1,149	21%
55+	13	6%	34	10%	2,193	41%
RACE/ETHNICITY[A]						
American Indian/Alaska Native	6	3%	9	3%	211	4%
Asian	25	12%	39	11%	463	9%
Black	43	20%	118	34%	970	18%
Latinx or Hispanic *(all races)*	62	30%	83	24%	1,042	19%
Native Hawaiian or Pacific Islander	6	3%	9	3%	90	2%
White	118	56%	161	46%	4,117	76%
Multiracial	9	4%	261	8%	500	5%
INJECTION DRUG USE						
Yes	20	10%	35	10%	616	11%
No	56	27%	115	33%	2,127	39%
Unknown	134	64%	199	57%	2,670	49%
COUNTRY OF BIRTH						
United States	137	65%	196	56%	4,244	78%
Outside of the United States	65	31%	140	40%	957	18%
Unknown	8	4%	13	4%	212	4%

Based on HIV/AIDS surveillance data reported to the Washington State Department of Health as of June 30, 2023. Men who have sex with men includes cisgender and transgender men who have sex with men.

A Racial and ethnic groups in this table include multiracial individuals; individuals appear more than once and percentages will sum >100%.

TABLE 1-7

New HIV Diagnoses Among Transgender and Gender Diverse People, King County, WA, 2018-2023

	Transgender and Gender Diverse People[A]		All King County Residents		Transgender and Gender Diverse People Living with HIV in King County at the End of 2023	
	N	%	N	%	N	%
TOTAL	24		1,063		126	
GENDER IDENTITY[A]						
Transgender Men	2	8%	2	<1%	9	7%
Transgender Women	19	79%	19	2%	104	83%
Another Gender Identity	3	13%	3	<1%	13	10%
AGE AT HIV DIAGNOSIS (years)	Age at Diagnosis		Age at Diagnosis		Age at End of 2023	
< 13	0	0%	0	0%	0	0%
13-24	8	33%	141	13%	5	4%
25-34	12	50%	414	39%	48	38%
35-44	4	17%	250	24%	35	28%
45-54	0	0%	147	14%	21	17%
55+	0	0%	111	10%	17	13%
RACE/ETHNICITY[B]						
American Indian/Alaska Native	1	4%	34	3%	12	11%
Asian	6	25%	98	9%	16	14%
Black	5	21%	298	28%	34	30%
Latinx or Hispanic *(all races)*	6	25%	218	21%	41	36%
Native Hawaiian or Pacific Islander	4	17%	27	3%	10	9%
White	10	42%	632	59%	59	52%
INJECTION DRUG USE						
Yes	3	13%	167	16%	26	21%
No	6	25%	327	31%	37	29%
Unknown	15	63%	569	54%	63	50%

Based on HIV/AIDS surveillance data reported to the Washington State Department of Health as of June 30, 2023.

A Identification of people that descibe themselves as transgender relies on review of information in medical records and/or self-disclosure during partner services interviews. Gender identity has been collected on the HIV/AIDS case report in Washington since late 2004. Data presented here are a potential undercount.

B Racial and ethnic groups in this table include multiracial individuals; individuals appear more than once and percentages will sum >100%.

TABLE 1-8 Cisgender Women Newly Diagnosed with HIV by Year and Nativity, King County, WA, 2019-2023[A]

	2019				2020				2021				2022				2023				Total 2019-2023			
	U.S.-Born		Foreign-Born		U.S.-Born		Foreign-Born		U.S.-Born		Foreign-Born		U.S.-Born		Foreign-Born		U.S.-Born		Foreign-Born		U.S.-Born		Foreign-Born	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
TOTAL	20	69%	9	31%	8	44%	10	56%	9	41%	13	59%	8	35%	15	65%	16	44%	20	56%	61	48%	67	52%
AGE (years)																								
<24	3	15%	1	11%	1	13%	0	0%	1	11%	1	8%	2	25%	1	7%	3	19%	2	10%	10	16%	5	7.5%
25-34	4	20%	0	0%	3	38%	3	30%	4	44%	5	38%	2	25%	4	27%	3	19%	6	30%	16	26%	18	27%
35-44	5	25%	3	33%	2	25%	4	40%	1	11%	2	15%	3	38%	5	33%	4	25%	5	25%	15	25%	19	28%
45-54	5	25%	3	33%	1	13%	1	10%	1	11%	3	23%	0	0%	2	13%	3	19%	3	15%	10	16%	12	18%
55+	3	15%	2	22%	1	13%	2	20%	2	22%	2	15%	1	13%	3	20%	3	19%	4	20%	10	16%	13	19%
RACE/ETHNICITY[B]																								
American Indian/Alaska Native	0	0%	1	11%	1	13%	0	0%	1	11%	0	0%	0	0%	0	0%	2	13%	0	0%	4	7%	1	1%
Asian	0	0%	1	11%	0	0%	2	20%	0	0%	0	0%	1	13%	2	13%	0	0%	0	0%	1	2%	5	7%
Black	4	20%	7	78%	2	25%	8	80%	5	56%	9	69%	3	38%	12	80%	3	19%	19	95%	17	28%	55	82%
Latinx or Hispanic *(all races)*	3	15%	0	0%	0	0%	0	0%	0	0%	4	31%	0	0%	1	7%	2	13%	1	5%	5	8%	6	9%
Native Hawaiian or Pacific Islander	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	6%	0	0%	1	2%	0	0%
Multiple racial identities	2	10%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	2	13%	0	0%	4	7%	0	0%
White	11	55%	0	0%	5	63%	0	0%	3	33%	0	0%	4	50%	0	0%	6	38%	0	0%	29	48%	0	0%
TRANSMISSION CATEGORY[C]																								
Heterosexual Sexual Contact	11	55%	4	44%	5	63%	5	50%	5	56%	7	54%	6	75%	12	80%	6	38%	7	35%	33	54%	35	52%
PWID	8	40%	1	11%	1	13%	0	0%	4	44%	1	8%	1	13%	0	0%	4	25%	0	0%	18	44%	2	6%
No Identified Risk	1	5%	4	44%	2	25%	5	50%	0	0%	5	38%	1	13%	3	20%	6	38%	13	65%	10	16%	30	45%
ADDITIONAL FACTORS																								
Methamphetamine use	7	35%	0	0%	0	0%	0	0%	3	33%	0	0%	2	25%	0	0%	4	25%	0	0%	16	43%	0	0%
Unhoused or Homeless at Diagnosis	8	40%	1	11%	1	13%	1	10%	5	56%	1	8%	2	25%	2	13%	5	31%	3	15%	21	34%	8	12%

A We assume that people are cisgender in the absence of known transgender or another gender identity.

B Race/ethnicity includes Latinx/Hispanic persons of any race and non-Latinx/Hispanic individuals with single races or whom are multiracial. These categories differ from categories used elsewhere in this report to match census data for rate calculations.

C There were no new diagnoses as a result of perinatal transmission or transfusion/transplant during this period.

Overview of HIV
in King County



2. Overview of HIV in King County

KEY POINTS

In 2023, an estimated 7,402 people were living with HIV and 168 people were newly diagnosed with HIV in King County (rate = 7.2 per 100,000). The rate of new HIV diagnoses in 2023 decreased by 9% compared to 2019.

Living with HIV

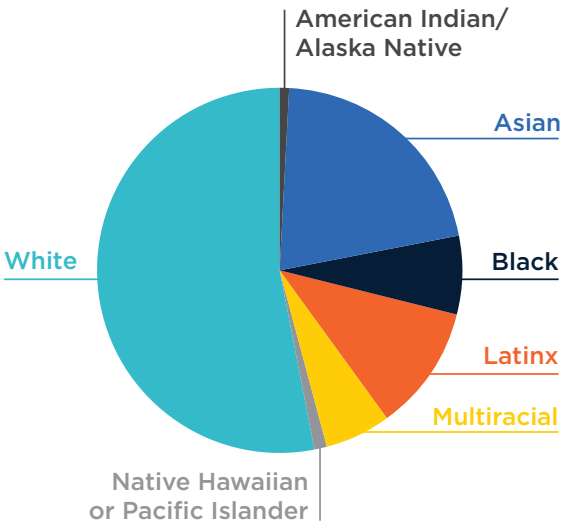
Newly Diagnosed

- Men who have sex with men (MSM) continue to comprise the majority of new HIV diagnoses; however, the new diagnosis rate has steadily declined over the past decade. In 2023, we observed the lowest number of new diagnoses in MSM since the start of the epidemic.
- HIV incidence in King County is characterized by profound and persistent racial and ethnic disparities, with the highest rates of new infections observed among Black, American Indian/Alaska Native, and Latinx people, respectively.
- The proportion of new HIV diagnoses among residents of south King County has been increasing since 2021. Overall, approximately 18% of people newly diagnosed with HIV in King County were homeless or unstably housed.
- The age-adjusted mortality rate among people living with HIV in King County has generally been declining since 2012, as has the proportion of deaths attributable to HIV. However, the proportion of deaths attributable to overdose started increasing in 2017 and increased nearly six-fold between 2017 and 2021.

Overview of the Population Residing in King County

King County is located on the traditional land of the Coast Salish people, whose communities have lived here for generations. The county currently has a population of about 2.3 million and is the most populous county in Washington state. Based on 2020 census data, it is estimated that 1% of King County residents identify as American Indian or Alaska Native, 21% as Asian, 7% as Black or African American (Black is used going forward), 11% as Hispanic or Latino/Latina/Latinx (Latinx is used going forward), 6% as Multiracial, 1% as Native Hawaiian or Pacific Islander, and 53% as White. These estimates are based on U.S. census data, which uses mutually exclusive classifications for racial identity. Approximately 25% of King County residents were born outside of the United States, including 31% of Black, 35% of Latinx, and 67% of Asian residents. In 2023, 14% of the King County population was under 13 years of age, and 25% was 55 years of age or older. The population sizes for relevant demographics characteristics among King County residents and additional details regarding population estimates and rate calculations are provided in the Technical Notes.

FIGURE 2-1 Race/Ethnicity, King County, WA, 2020



HIV Prevalence

Across Washington state, 49% of people living with HIV (PLWH) reside in King County (Table 9-1). As of December 31, 2023, PHSKC estimated there were 7,402 PLWH with a King County address. This estimate has been stable for many years and includes 3,402 (46%) PLWH who were originally diagnosed outside of King County. Details on the approach to calculating HIV prevalence in King County are presented in Technical Note 1. The numbers of PLWH in King County by gender, age, race and ethnicity, and HIV transmission category are presented in Table 1-1. Overall, 74% of all PLWH are classified in the MSM transmission category (including MSM who inject drugs), 12% as presumed heterosexual sexual contact, and 3% as non-MSM PWID.

HIV prevalence in King County is characterized by profound racial and ethnic disparities and regional variation. A disproportionate number of American Indian/Alaska Native, Black and Latinx residents are living with HIV.

For example, 28% of PLWH in King County are Black, including 16% of PLWH who identify as Black and were born in the U.S., which is higher than the 5% of the overall King County population that is Black and born in the U.S. These disparities reflect the impact of both social and structural determinants of health, such as poverty, and systemic racism. The impact of these intersecting determinants of health is exemplified by disparities in homelessness or housing instability by race/ethnicity among PLWH, with 19%, 13%, and 12% American Indian/Alaska Native, Black, and Latinx PLWH reporting homelessness compared to 10% homelessness among all PLWH in King County. In addition, the population of PLWH in King County includes residents who have immigrated from regions of the world where the prevalence of HIV is higher than King County (Table 1-5). Furthermore, the number of PLWH varies across regions within King County, with the majority of PLWH (62%) living in Seattle (Table 2-1).

TABLE 2-1

Key Metrics of Incident HIV Diagnoses (2019-2023) and Prevalence (2023) by King County Cities

	New Diagnoses (2019-2023) N	New Diagnoses N	Diagnosis Rate (2023) per 100K	People Living With HIV (PLWH) N	Population Size[A] N	Population Living in Poverty[A] %
CITY						
Seattle	459	80	10.3	4,576	780,482	10.1
Kent	61	15	10.9	387	137,865	10.5
Federal Way	56	15	14.9	342	100,988	11.8
Renton	43	8	7.4	316	108,007	7.9
Auburn	33	11	12.7	249	86,692	8.0
Bellevue	24	3	1.9	188	156,674	7.2
Burien	18	2	3.8	159	52,437	11.4
Tukwilla	20	2	9.2	153	21,846	13.3
Seatac	19	5	15.3	132	32,869	11.3
Shoreline	26	9	9.6	116	94,262	6.6
Kirkland	20	3	4.7	113	63,417	8.2
Des Moines	15	6	18.2	111	33,064	11.8
Redmond	9	1	1.2	95	82,981	5.9
Sammamish	6	0	0.0	24	67,307	4.1
Other Cities or Unincorporated	40	8	2.7	441	528,909	
Total	**849**	**168**	**8.0**	**7,402**	**2,347,800**	

Data for PLWH by city in King County that had a population size above 50,000 or more than 100 PLWH in 2023.

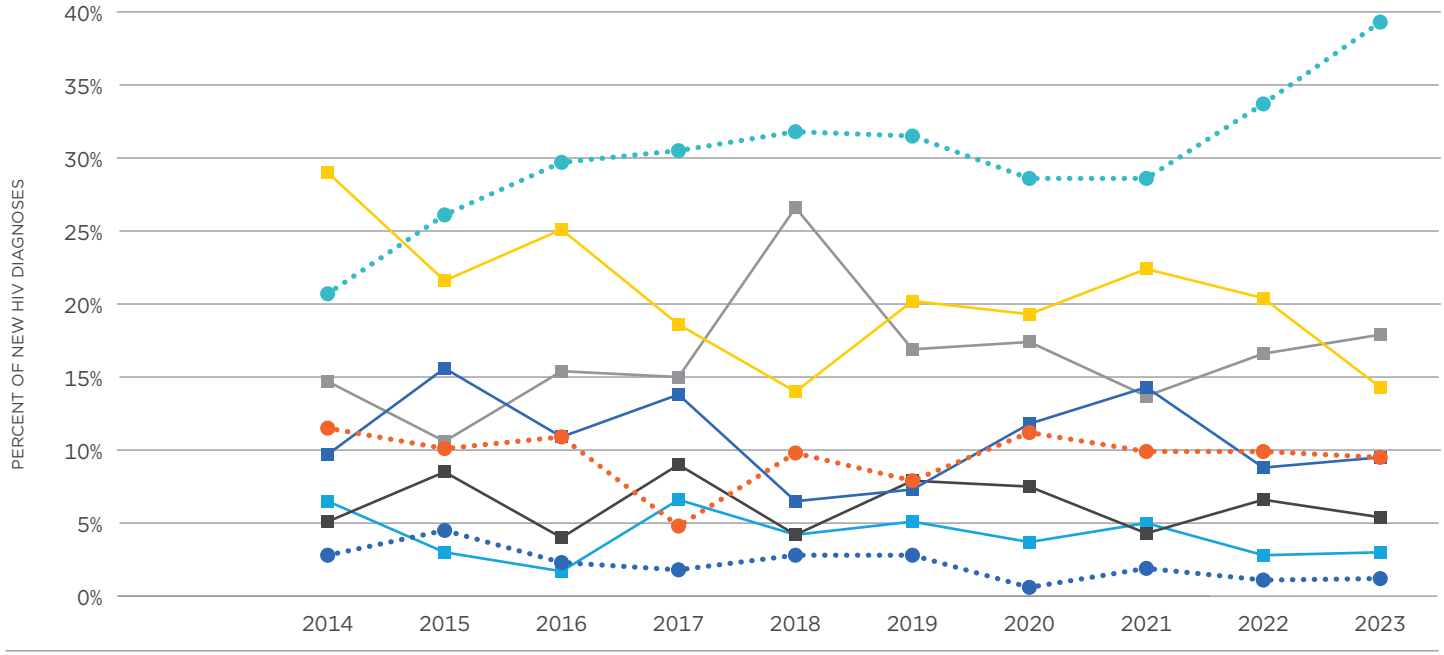
[A] Population estimates and percent of population living in poverty from the U.S. Census data

New HIV Diagnoses

Following a small decline in new HIV diagnoses in 2020-2021 associated with the COVID-19 pandemic, the overall rate of new diagnoses in 2022 was similar to 2019, prior to the COVID-19 pandemic. In 2023, there were 168 new HIV diagnoses resulting in an annual rate of 7.2 per 100,000, which is 8% lower than 2022. The majority of new HIV diagnoses were among cisgender men (77%), followed by cisgender women (21%), transgender women (<1%) and transgender men (<1%) (Table 1-2). Of note, the rate of new HIV diagnoses among cis women increased in 2023, described in more detail below.

Individuals with a Seattle residence comprised 32% of new HIV diagnoses, followed by south King County (39%) and individuals who were homeless or unstably housed (18%) (Figure 2-2). Trends in HIV diagnosis rates among people who were homeless or unstably housed are described in more detail below. Accounting for population size, the rate of new HIV diagnoses varied across King County and was highest in urban areas, like Seattle, and other areas with a higher proportion of individuals experiencing poverty (Table 2-1). Details on the approach to calculating new HIV diagnoses and population rates in King County are presented in Technical Note 2.

FIGURE 2-2 Trends in Residence Among People Newly Diagnosed with HIV, King County, WA, 2014-2023



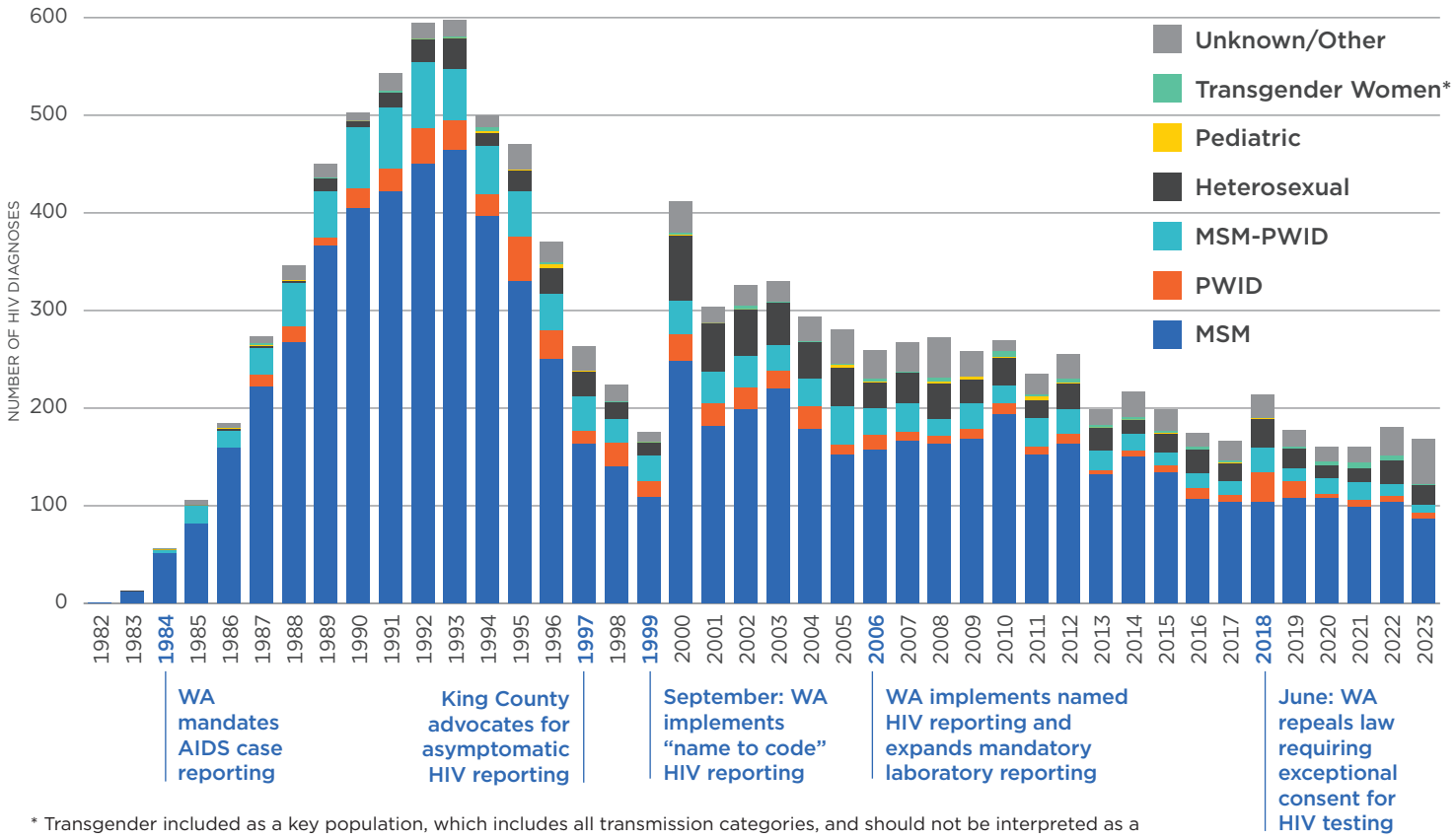
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
KC East	12%	10%	11%	5%	10%	8%	11%	10%	10%	10%
KC North	3%	5%	2%	2%	3%	3%	1%	2%	1%	1%
KC South	21%	26%	30%	31%	32%	32%	29%	29%	34%	39%
Seattle Central	29%	22%	25%	19%	14%	20%	19%	22%	20%	14%
Seattle North	10%	16%	11%	14%	7%	7%	12%	14%	9%	10%
Seattle South	5.%	9%	4%	9%	4%	8%	8%	4%	7%	5%
Seattle West	7%	3%	2%	7%	4%	5%	4%	5%	3%	3%
Homeless or Unstably Housed	15%	11%	15%	15%	27%	17%	17%	14%	17%	18%

TRENDS BY TRANSMISSION CATEGORY:

The number of new HIV diagnoses in 2023 by transmission category among King County residents is presented in Table 1-2. MSM who did not report injection drug use accounted for 51% of new HIV diagnoses, a percentage that has been generally consistent over the past decade (Figure 2-3).

Heterosexual sexual contact was indicated among 12% of newly diagnosed residents (Table 1-2), followed by PWID (9%, including MSM). Among 240 pregnant people living with HIV who had a live birth over the past decade in a King County facility, there were no cases of perinatal transmission.

FIGURE 2-3 HIV Diagnoses by Year and HIV Transmission Category or Key Population, King County, WA, 1982-2023



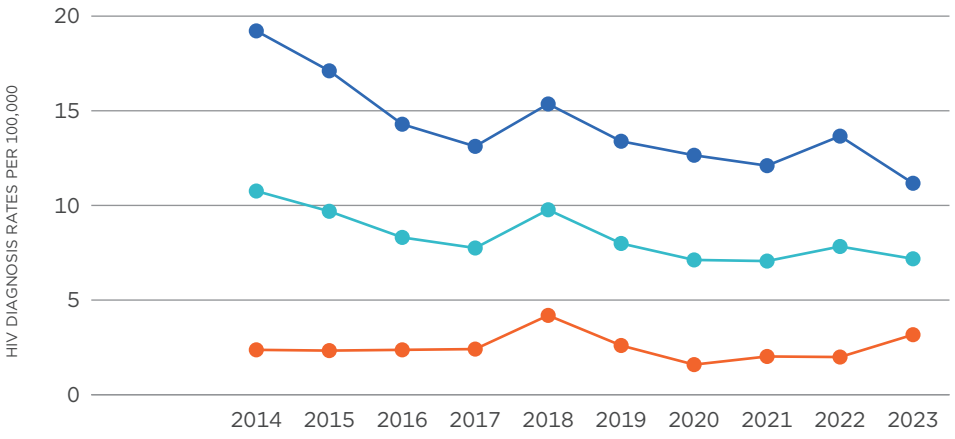
* Transgender included as a key population, which includes all transmission categories, and should not be interpreted as a transmission category.

TRENDS IN HIV DIAGNOSIS RATES BY SEX ASSIGNED AT BIRTH AND NATIVITY:

The HIV diagnosis rate among people assigned male sex at birth (males) declined over the past 10 years (Figure 2-4). Among U.S.-born males, the HIV diagnosis rate declined between 2022 and 2023. While the HIV diagnosis rate among foreign-born males increased in 2022 compared to 2021, the 2023 rate declined slightly and is similar to the rate observed in 2019 (Figure 2-5). COVID-19 healthcare disruptions resulted in reduced HIV testing in 2020 and 2021, which may have contributed to fewer new HIV diagnoses reported (Chapter 3). However, HIV testing at publicly supported facilities has reached or exceeded pre-COVID levels, thus this decrease is likely to reflect a true decrease in new diagnoses.

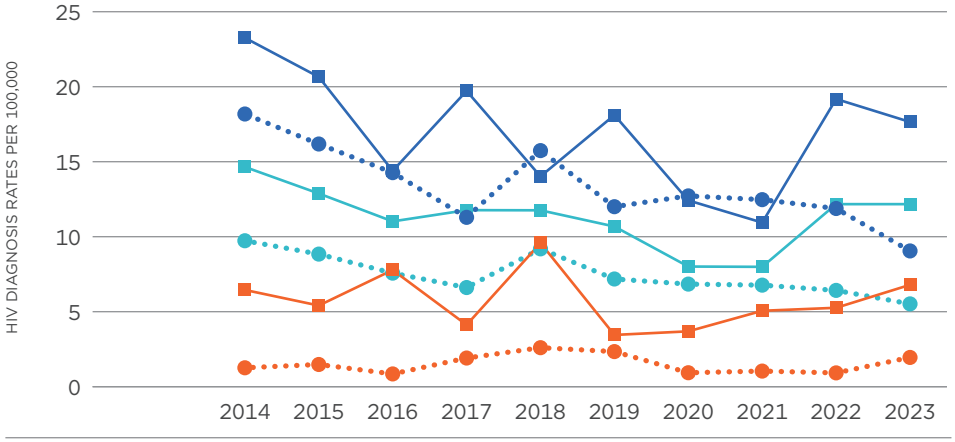
With the exception of a 2018 outbreak of HIV among heterosexual individuals, many of whom reported substance use and were living homeless, the HIV diagnoses rate among people assigned female at birth (females) has been stable over the last decade. However, in 2023, 36 cisgender women were newly diagnosed with HIV, the largest number of diagnoses in cisgender women since 2018 (Table 1-8). This represents a 60% increase in the rate of new diagnosis between 2022 and 2023 and reflects an increase in diagnoses among both foreign-born and U.S.-born females (Figure 2-4). The trends are identical when restricted to cisgender women. In 2023, 53% of cisgender women newly diagnosed with HIV reported no identified risk for HIV exposure, followed by heterosexual sexual contact with a person at risk for or living with HIV (36%).

FIGURE 2-4 HIV Diagnoses Rates by Year and Sex Assigned at Birth, King County, WA, 2014-2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Female	2.4	2.3	2.4	2.4	4.2	2.6	1.6	2.0	2.0	3.2
Male	19.2	17.1	14.3	13.1	15.4	13.4	12.7	12.1	13.7	11.2
Total	10.8	9.7	8.3	7.8	9.8	7.9	7.1	7.1	7.9	7.2

FIGURE 2-5 HIV Diagnosis Rates by Year, Sex Assigned at Birth, and Nativity, King County, WA, 2014-2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Female U.S.B	1.3	1.5	0.9	1.9	2.6	2.3	0.9	1.0	0.9	2.0
Female FB	6.5	5.4	7.8	4.1	9.6	3.5	3.7	5.0	5.3	6.8
Male U.S.B	18.2	16.2	14.3	11.3	15.7	12.0	12.7	12.5	11.9	9.1
Male FB	23.3	20.7	14.4	19.7	14.0	18.1	12.4	10.9	19.2	17.7
Total FB	14.7	12.9	11.0	11.8	11.8	10.7	8.0	8.0	12.2	12.2
Total U.S.B	9.7	8.8	7.6	6.6	9.2	7.2	6.8	6.8	6.4	5.5

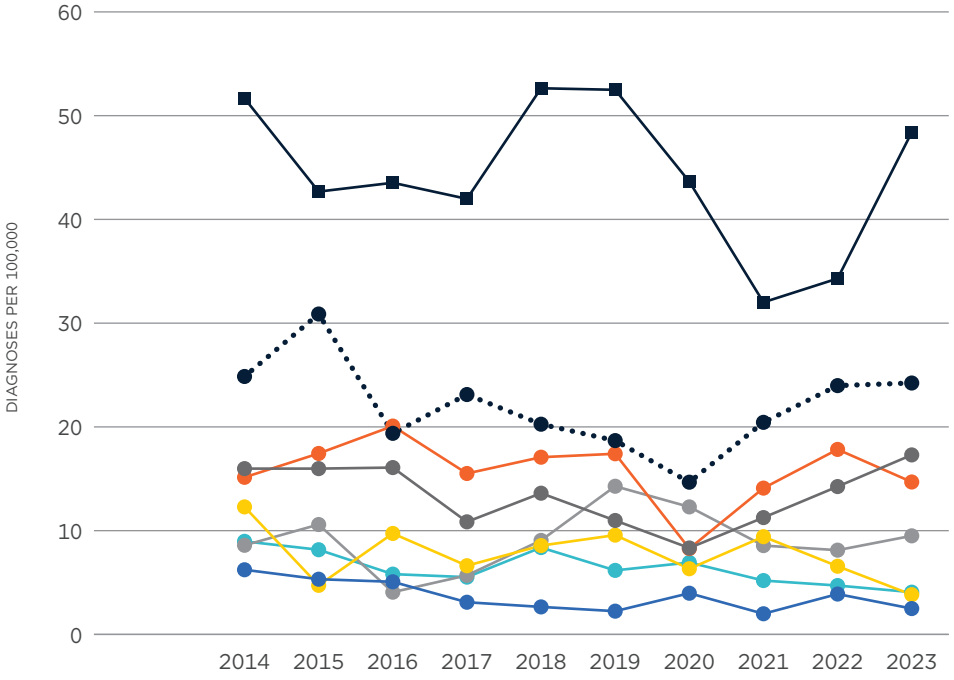
AI/AN = American Indian/Alaska Native; FB = Foreign-born; U.S.B = U.S.-born; NH/PI = Native Hawaiian or Pacific Islander.

TRENDS IN HIV DIAGNOSIS BY RACE, ETHNICITY AND NATIVITY:

Similar to trends observed with HIV prevalence, HIV incidence in King County is also characterized by profound racial and ethnic disparities, with the highest rates of new diagnoses observed among Black, Latinx and American Indian/Alaska Native people, respectively (Table 1-2). While the overall rate of new diagnosis has decreased over the past decade, rates have either plateaued or increased among Black U.S.-born, Latinx, and American Indian/Alaska Native people (Figure 2-6). In 2023, the rate for U.S.-born Black individuals was similar to 2022, decreased for Latinx people, and increased for American Indian/Alaska Native people.

PHSKC also summarizes new HIV diagnoses by country of birth as individuals who immigrated to the U.S. and who are living with HIV may not be aware of their status prior to relocating; therefore, a new diagnosis in King County may and may not represent recent local transmission. Over the past decade, the new HIV diagnosis rate was highest among Black foreign-born populations, with little change over this period.

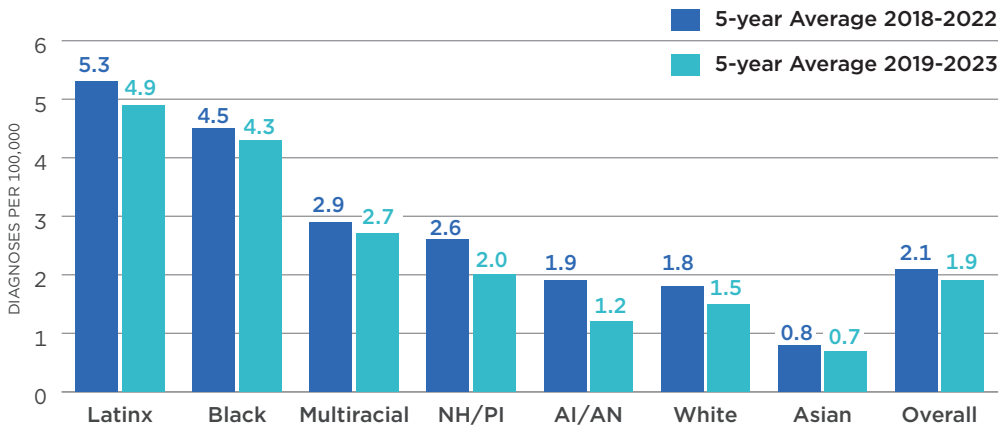
FIGURE 2-6 Rate of HIV Diagnoses per 100,000 by Year and Race/Ethnicity, King County, WA, 2014-2023*



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
AI/AN*	16.0	16.0	16.1	10.9	13.6	11.0	8.3	11.3	14.3	17.3
Asian	6.2	5.3	5.1	3.1	2.7	2.2	4.0	2.0	3.9	2.5
U.S.B*	25.0	30.9	19.4	23.1	20.4	18.7	14.7	20.4	24.0	24.2
FBB*	51.7	42.7	43.5	42.0	52.6	52.5	43.6	32.0	34.3	48.4
Latinx	15.1	17.4	20.9	15.5	17.1	17.4	8.3	14.1	17.8	14.7
Multi-racial	12.3	4.7	9.7	6.6	8.6	9.6	6.3	9.4	6.6	3.8
NH/PI*	8.6	10.6	4.1	5.7	9.1	14.3	12.3	8.6	8.1	9.5
White	9.0	8.2	5.8	5.5	8.4	6.2	6.9	5.2	4.7	4.1

* Designates 3 year averages; FBB=Foreign born Black; U.S.BB=U.S. born Black; AI/AN = American Indian/Alaska Native; PI=Pacific Islander/Native.

FIGURE 2-7 New HIV Diagnoses per 100,000 by 5-year Averages and Race/Ethnicity, King County, WA



AI/AN = American Indian or Alaska Native; NH/PI = Native Hawaiian or Pacific Islander.

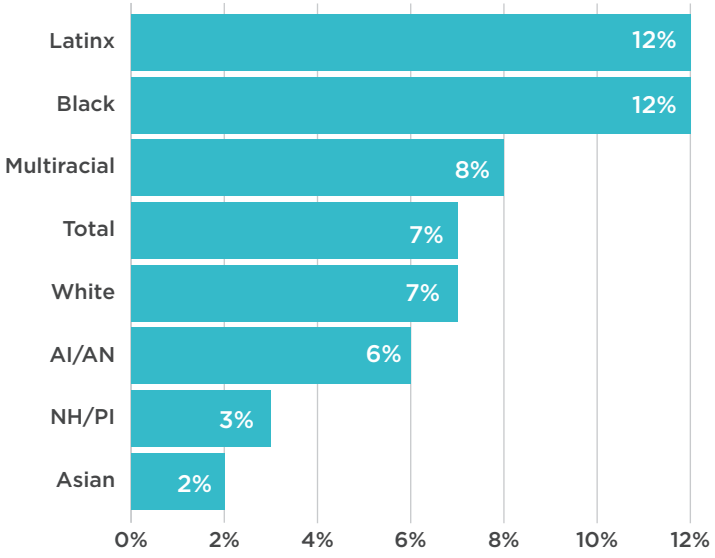
Key Populations

HIV DIAGNOSIS AMONG MSM BY RACE/ETHNICITY:

Data on demographic characteristics of MSM, including cisgender and transgender MSM, with recent HIV diagnoses are presented in Table 1-6. Because MSM are the population with the largest proportion of HIV diagnoses in King County, we compared diagnosis rates over the past 5 years among MSM by race/ethnicity (see Technical Note 3 for details on our approach for calculating the size of the MSM population in King County). Compared to the 5-year average from 2018-2022, the average rate of new HIV infections among MSM decreased in 2019-2023 (2.1 per 1,000 versus 1.9 per 1,000). MSM who identified as Latinx, Black, Multiracial, Native Hawaiian or Pacific Islander, or American Indian/Alaska Native had the highest rates of new HIV diagnoses over the past 5 years compared to the overall population of MSM (Figure 2-7). The trend differs somewhat when examining HIV prevalence by race/ethnicity, where HIV prevalence is highest among Latinx, Black, and Multiracial MSM, respectively (Figure 2-8).

FIGURE 2-8

HIV Prevalence Among Men Who Have Sex with Men by Race/Ethnicity, King County, WA, 2023



AI/AN = American Indian or Alaska Native; NH/PI = Native Hawaiian or Pacific Islander.

HIV DIAGNOSES AMONG TRANSGENDER PEOPLE AND PEOPLE WHO REPORT ANOTHER GENDER IDENTITY:

PHSKC and Washington state updated HIV surveillance data collection to allow individuals to report another gender identity if they do not identify as a cisgender or transgender man or woman. In 2023, PHSKC included data in our HIV Epidemiology Report for people who report another gender identity for the first time.

Among transgender people and people who reported another gender identity, there was one transgender woman diagnosed with HIV in 2023, one transgender man, and no individuals who reported another gender identity (Table 1-2). Because transgender and gender diverse people represent a smaller proportion of the overall population, data on select factors among newly diagnosed transgender and gender diverse people diagnosed with HIV in the past five years are presented in aggregate (Table 1-7).

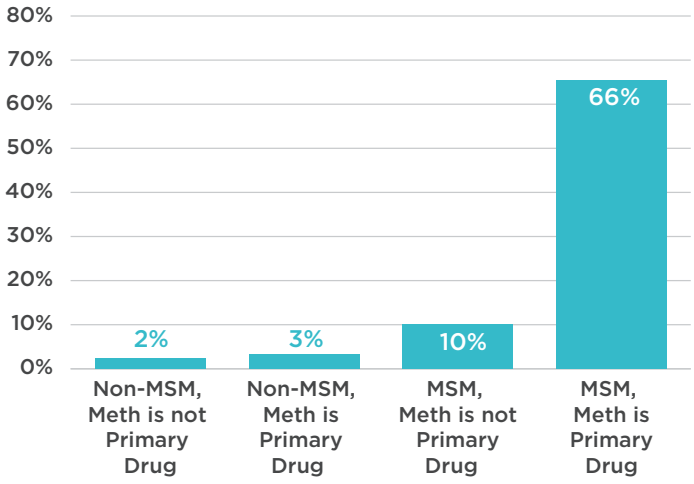
A higher proportion of newly diagnosed transgender and gender diverse people identified as Asian, Latinx, or Native Hawaiian or Pacific Islander compared to all newly diagnosed people in King County during the same period. In addition, newly diagnosed transgender and gender diverse people were younger than the overall population of people diagnosed with HIV in King County with 83% being under 35 years of age. The U.S. Census does not provide a population size estimate for the number of King County residents who are transgender or gender diverse, and reliable alternative estimates are currently not available, therefore, rates of new diagnoses among transgender people or people who report another gender were not calculated.

DRUG USE AND DISPARITIES IN HIV PREVALENCE AMONG PWID:

Local epidemiological data show significant changes in how people use drugs, with shifts away from injection to smoking. Using a revised estimate of the size of the population that injects drugs (see Technical Note 4 for details), the rate of new HIV diagnosis for PWID was 1.0 per 1,000. Based on data from routine HIV surveillance, including the 2022 National HIV Behavioral Surveillance (NHBS) PWID survey, we estimate that MSM-PWID who primarily inject methamphetamine have an HIV prevalence of approximately 60%. In the 2022 NHBS-PWID survey, MSM who primarily inject methamphetamine were approximately 25 times as likely to be living with HIV relative to non-MSM PWID, and seven times as likely to be living with HIV relative to MSM-PWID who primarily inject drugs other than methamphetamine (Figure 2-9).

FIGURE 2-9

HIV Prevalence Among PWID, Seattle Area National HIV Behavioral Surveillance, 2022

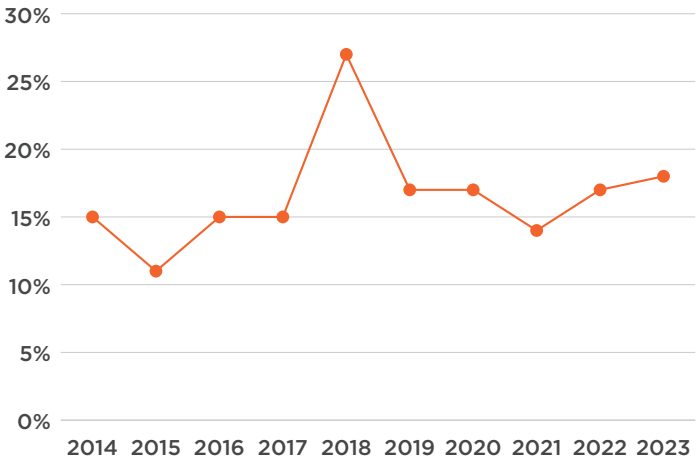


HIV DIAGNOSES AMONG PEOPLE WHO REPORT HOMELESSNESS AND UNSTABLE HOUSING:

The percent of individuals newly diagnosed with HIV reporting homelessness and unstable housing has fluctuated over the past decade (Figure 2-10), ranging from 11% to 18%. This range excludes an increase in 2018 attributable to the HIV outbreak among PWID, a large proportion of whom were also homeless. In 2022, 15% of newly diagnosed individuals were homeless or unstably housed. Reports of being homeless at the time of HIV diagnosis varied across race and ethnicity, with 33% of AI/AN individuals newly diagnosed with HIV reporting homelessness, followed by 21% of white individuals, and 20% of Black individual. Homelessness and housing instability threaten the ability of PLWH to engage in consistent HIV care, which is often needed to achieve viral suppression. The chapter documenting progress towards EHE pillar 2 of this report provides detailed information related to engagement in HIV care and viral suppression among PLWH who experience homelessness or housing instability.

FIGURE 2-10

Prevalence of Homelessness Among People Newly Diagnosed with HIV, King County, WA, 2023



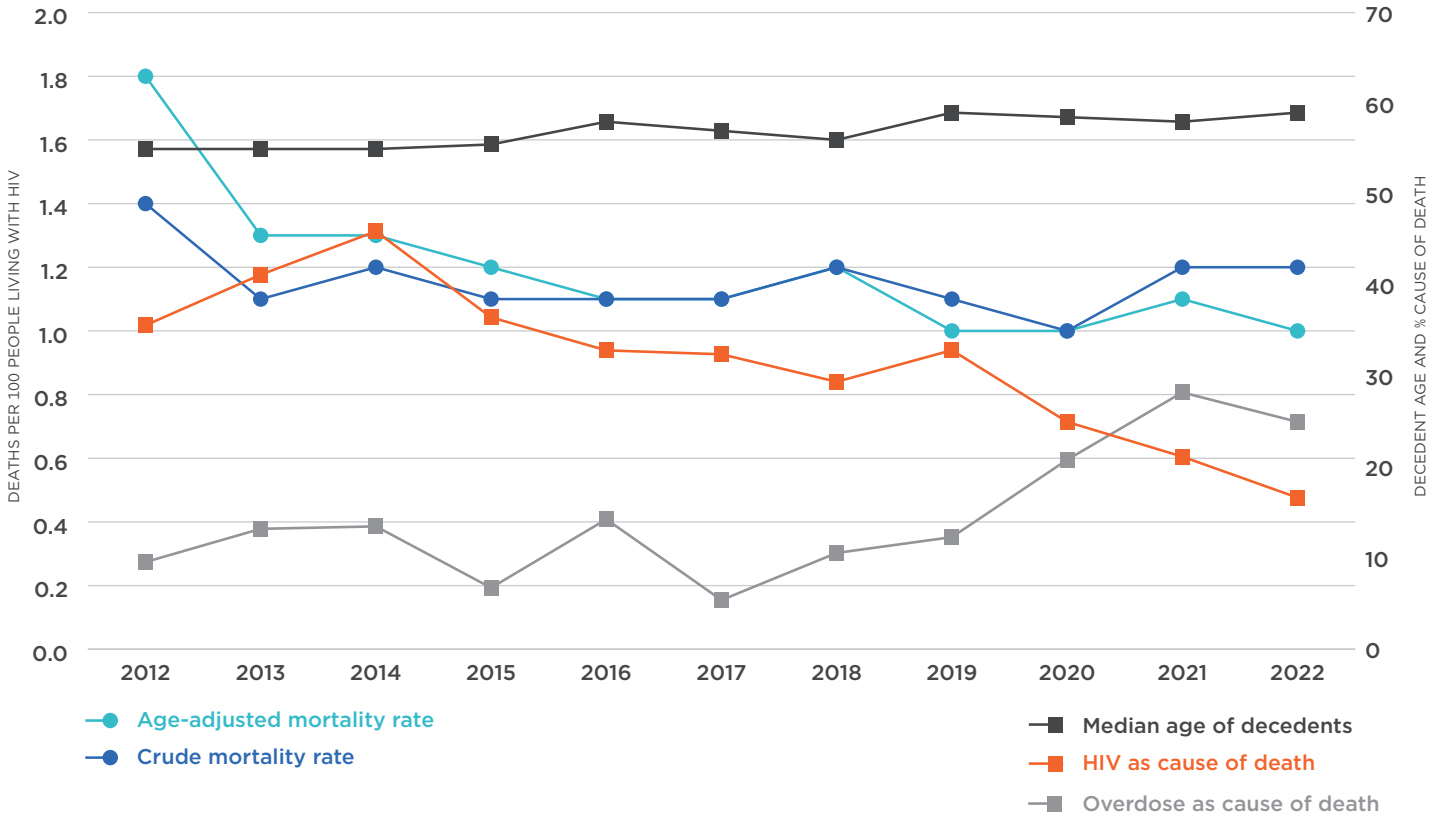
Mortality

Due to lags in mortality data reporting, this report includes all-cause mortality rates among PLWH between 2012 through 2022. Although the age-adjusted mortality rate has been relatively stable over the past five years, there has been a marked shift in the causes of death among PLWH (Figure 2-11).

The proportion of deaths caused by HIV declined steadily between 2013 to 2022, with only 17% of deaths in PLWH in 2022 attributable to an HIV-related cause. More recently, the percentage of deaths caused by overdose increased from 12% in 2019 to 28% in 2021 and 25% in 2022, becoming the leading cause of death among PLWH in King County. PHSKC is working with community partners to better address the needs of PLWH who use drug and prevent overdose.

FIGURE 2-11

Mortality Rates Among People Diagnosed with HIV, King County, WA, 2012–2022



3. Ending the HIV Epidemic Initiative in King County

EHE Strategies and Support

In February 2019, the U.S. federal government announced Ending the HIV Epidemic: A Plan for America (EHE) to decrease new HIV infections in the U.S. by 75% by 2025, and 90% by 2030.[1] The EHE initiative seeks to capitalize on scientific advances in HIV diagnosis, treatment, and prevention to accelerate national progress in controlling the 43-year-old HIV epidemic. King County is one of 57 geographic areas funded through the first phase of EHE.

This section reviews the King County EHE Plan and the implementation status of the EHE initiative in King County through 2023 (the fourth year of implementation), referencing data presented in detail in subsequent chapters that focus on progress within each EHE pillar. EHE supports implementation of activities that link to four "pillars" prioritized by federal funders: 1) Diagnose, 2) Treat, 3) Prevent, and 4) Respond (Table 3-1).

TABLE 3-1 EHE Pillars

Diagnose	Ensure that people with HIV are diagnosed as soon as possible following infection
Treat	Treat people with HIV immediately after they are diagnosed, and ensure that all people with HIV are effectively treated, achieving sustained viral suppression
Prevent	Prevent new HIV infections using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSP)
Respond	Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them

The King County EHE Plan

In 2019, Public Health – Seattle & King County (PHSKC) convened a diverse group of stakeholders including representatives from government, community, healthcare, and social service organizations to develop the King County EHE plan, which would guide EHE funding and resource allocation from 2020-2025.

Through this plan, PHSKC and its collaborators sought to identify populations whose needs were not met through prior HIV prevention and care efforts with the goal of developing strategies that more effectively met the needs of the entire population.

Four Primary Principles of King County's EHE Plan

King County's EHE plan aims to fundamentally change how HIV prevention and HIV care services are delivered in King County to better meet the needs of persons for whom HIV prevention and care services have not historically been accessible, acceptable, or effective. The following four primary principles guide implementation of EHE in King County:

1. HIV care and prevention services need to be more geographically dispersed. Prior to EHE, HIV prevention and care services were concentrated in the Seattle city center, with inadequate prevention and treatment capacity in north Seattle and south King County. Historically, this aligned with where many men who have sex with men (MSM) resided in the county, with nearly half of all new HIV diagnoses in 2012 occurring among persons living in central Seattle (Figure 2-2).

However, since 2018, the largest proportion of new HIV diagnoses — approximately one-third — have occurred among persons living in south King County, with this proportion rising each year. A large outbreak of HIV among persons living in north Seattle in 2018 further highlighted the need to expand the availability of prevention and care services outside of central Seattle.[2] As such, EHE is working to meet the needs of a more dispersed population by expanding clinical HIV and prevention infrastructure to north Seattle and south King County.

2. HIV care and prevention services need to better address the needs of the most marginalized persons with HIV, particularly persons who are unhoused and/or who use drugs. As HIV transmission in King County has declined, the epidemic has become increasingly concentrated among persons who are unhoused and who use substances. Among King County residents living with HIV in 2023, we estimate that 10% are unhoused or unstably housed, 25% of whom were not receiving HIV care or were not virally suppressed (Table 5-3).

King County's inter-related epidemics of homelessness and substance use coupled with the area's success in preventing and treating HIV in more advantaged populations necessitates a shift in the public health and clinical approach to HIV to one that addresses HIV as part of a larger syndemic. EHE is creating the infrastructure needed to better serve the most disadvantaged populations with HIV and at elevated risk for HIV.

3. Prevention and treatment efforts need to focus on eliminating racial/ethnic disparities in HIV care and prevention. As noted in subsequent chapters for King County HIV epidemiology and Pillar 2, the HIV epidemic in King County disproportionately affects racial and ethnic minorities. Black foreign-born individuals have the highest rate of new HIV diagnoses in King County (Figure 2-6), while the rate of new HIV diagnoses among Black, Latinx, and Multiracial MSM continues to be higher than the rate observed in MSM overall (Figure 2-7).

Among people diagnosed with HIV, Black MSM had the lowest rate of viral suppression compared to all other MSM racial and ethnic groups (Table 5-2). A key focus of the EHE Plan in King County is reducing and ultimately eliminating racial and ethnic disparities in HIV care and prevention. This effort includes new funding to support community-based organizations to reach and serve their respective populations outside traditional healthcare settings, such as culturally specific stigma reduction events and providing outreach testing.

4. HIV testing and prevention needs to be better integrated into the wider healthcare system. Success in preventing and treating HIV using biomedical interventions (e.g., testing, PrEP, antiretroviral treatment) depends on the existence and success of the HIV clinical infrastructure. King County has a significant specialized clinical infrastructure related to HIV and other sexually transmitted infections that plays a central role in HIV prevention, including the PHSKC Sexual Health Clinic, Seattle's LGBTQ+ Center, Madison Clinic, Max Clinic, and numerous private medical practices.

EHE supported the creation of three low-barrier clinics (Engage Health Federal Way and Kent, and Aurora Clinic) and is promoting new or expanded walk-in sexual health services through community health centers and public health clinics throughout the county. King County's EHE effort also seeks to promote HIV testing and PrEP throughout the healthcare system through a county-wide EHE Health Care Collaborative.

Current Status of King County EHE Activities and Outcomes

At the end of 2023, the fourth year of implementing EHE, PHSKC had launched all activities prioritized in the EHE Plan. For detailed information on all King County EHE activities, see Table 3-2 or the EHE website: www.kingcounty/EHE.

King County's progress towards achieving population level goals for EHE are available throughout this report. These goals are intended to be ambitious but achievable, with both long term and interim measures of success.

UPDATES ON KEY COMPONENTS OF KING COUNTY'S EHE PLAN

Differentiated models of care

Differentiated care is a client-centered approach to the provision of healthcare that seeks to meet patients' needs by adjusting the frequency and content of care, who provides care, and where it is provided.[3] It acknowledges that the same system of care cannot work for everyone and that the healthcare system needs to adapt to meet patients' needs. Expanding King County's system of differentiated prevention and care is a centerpiece of the local EHE initiative. Prior to EHE, the county had three low-barrier clinics: MAX Clinic, MOD Clinic, and SHE Clinic, all of which provided walk-in care and sought to serve persons living unhoused or unstably housed with complex social or behavioral barriers to successful HIV treatment.

EHE has enabled King County to expand its system of low-barrier care through the following activities:

- Increased capacity at the MAX and MOD Clinics, both of which are located on the Harborview Medical Center campus in central Seattle.
- Establishment of the Aurora Clinic and expansion of the SHE Clinic, both of which are low- barrier clinics co-located with Aurora Commons, a community-based organization trusted by people living unhoused in north Seattle, many of whom exchange sex.
- Establishment of two new low-barrier clinics in south King County: Engage Health-Federal Way (opened December 2022) and Engage Health-Kent (opened August 2023), both of which are co-located in Archdiocese Housing Authority (AHA) engagement centers.

From March 2023-Februray 2024, King County's north Seattle and south King County low-barrier clinics (Aurora Clinic, SHE Clinic, Engage Health-Federal Way, and Engage Health - Kent) served 899 clients, 53 of whom were living with HIV. At central Seattle clinics, 307 clients with HIV were served at MOD and 283 clients with HIV at Max Clinic, including 133 (47%) clients who received services during EHE-funded expanded hours.

HIV mobile outreach and linkage to care

In addition to the expansion of brick-and-mortar low-barrier services, EHE supported the development of a HIV mobile outreach team (HIV MOT). The HIV MOT aims to reach PLWH who are virally unsuppressed, not engaged in care, and facing complex barriers to care such as behavioral health disorders, housing instability, or justice system involvement. The HIV MOT was piloted with a small team that included a PHSKC Disease Research and Intervention Specialist (DRIS) and Peer Services Specialist employed by Peer Washington who identify clients through referrals from low-barrier clinics, public health, and other community organizations. The HIV MOT connects with individuals where they are and provides peer coaching and support in meeting their personal goals, with an ultimate objective of relinking people to HIV care and treatment. Services through the HIV MOT began in March 2023. As of October 2024, 198 individuals were referred to the HIV MOT and determined to be candidates; 149 were successfully contacted, 118 of whom were willing to engage. Among those 118 PLWH, 61% started or re-started ART, and 43% achieved viral suppression. Building on these successes, the HIV MOT developed a plan to expand in 2024-2025, bringing on a registered nurse and medical assistant to add tailored medical services (i.e., wound care, vaccines, blood draws) in the field, and work towards implementing long-acting injectable antiretroviral treatment (LAI ART) in the field.

Community-based services to support EHE priority populations

King County's EHE program supports community-based organizations to provide several HIV related services (see Table 3-2 for details). Following a request for proposals, EHE funded seven community-based organizations in 2023. The organizations and services provided were specifically designed to expand access to prevention and care services for Black and Latinx people living or staying in south King County. Four projects were funded to provide targeted HIV outreach and testing: POCAAN, Seattle's LGBTQ+ Center, Center for MultiCultural Health, and the Harambee! Project (YMCA and UW collaboration).

The four projects performed a total of 1,001 HIV tests, 15 of which were positive (3 newly diagnosed with HIV), and 50 individuals initiated PrEP. The PHSKC EHE team continues to collaborate with state, county, and city officials to expand resources for priority populations, including allocating new HOPWA housing vouchers for low-barrier clinic patients in Seattle and south King County.

Promotion of systemic healthcare change

Widespread expansion and improvement in services and available care for diverse populations, particularly LGBTQ+ populations, is needed to end the HIV epidemic. Guided by Bree Collaborative recommendations,[4] in 2020 PHSKC initiated an EHE Health Care Organizations (HCO) Collaborative. The HCO Collaborative aims to work across King County health systems to define and implement systemic changes to increase sexual orientation and gender identity data collection, HIV testing, PrEP use, and culturally affirming and responsive HIV care services among LGBTQ+ populations. Collaborative members provide medical care to approximately 1.1 million adults in King County (see Table 3-3) and work together to make changes to their electronic health record systems that allow patients to voluntarily identify their gender, sexual orientation, and behaviors related to HIV vulnerability; develop staff training; increase access to PrEP; and promote HIV/STI/hepatitis C testing according to local and national guidelines. The EHE HCO Collaborative is an engaged and dynamic group that has adapted over time to address diverse public health concerns, such as mpox, syphilis, hepatitis C, and overdose response. Similarly, the EHE Emergency Department (ED) Collaborative seeks to bring together EDs from across the county with the goal of increasing HIV/HCV/syphilis screening in EDs and urgent care settings. See Table 3-2 for more detail.

Future of EHE activities

Phase one of EHE ends in 2025. As of October 2024, PHSKC has been awarded CDC funds to continue the work through 2030 and has applied for funds from HRSA for phase two. We will continue working with community members and agency partners to build on the work done to date to end the HIV epidemic in King County.

TABLE 3-2 (Part 1 of 3)

Core Elements of the King County EHE Plan and Progress to Date

Strategy	Objective	EHE Activities
Diagnose	Increase routine testing in clinical settings	• Foster systemic changes at health care organizations to improve risk identification, testing, and care • Promote universal or risk-based HIV testing through the EHE Emergency Department Collaborative (See Table 3-3 for list of participating organizations) • Incorporate syndemic (HCV, STIs, mpox) testing into collaborative work • Promote and provide HIV testing through new low-barrier clinic sites
	Increase HIV testing in non-clinical settings (e.g., street outreach, jails)	• Provide HIV, HCV, and syphilis testing through the South County Correctional Entity (SCORE) • Support community-based organizations' outreach and provision of HIV testing for populations at higher risk for HIV
	Increase partner notification services	• Expand capacity for partner services at PHSKC
	Conduct public awareness and mobilization campaigns focusing on Black and Latinx populations	• 12-week digital media social marketing campaign to raise awareness of the four central EHE strategies • Campaigns to promote low-barrier services, PrEP, and HIV testing for new low-barrier clinics • Contracted with community-based organizations to develop promotional campaigns focusing on PrEP awareness and uptake • Campaign to promote HIV testing across King County emergency departments • Completed pharmacy-based PrEP promotional campaign • Developed Easier Access campaign to promote HIV services in King County — widespread campaign and Pride month promotion • Began information gathering for campaign aimed at reaching Black and Latinx MSM who are out-of-care

TABLE 3-2 (Part 2 of 3)

Core elements of the King County EHE Plan and Progress to Date

Treat	Expand access to low-barrier HIV care by reducing structural barriers to care and collocating mental health, substance use, and psychosocial support services — with a focus on north Seattle and south King County	• Expanded services initiated in MAX Clinic and MOD Clinic on the HMC campus • Opened Aurora Clinic in north Seattle in late 2021, expanded SHE Clinic in 2022 • Opened Engage Health – Federal Way in late 2022, and Engage Health – Kent in mid-2023 • Initiated Hygiene Center services for north low-barrier clinic patients • Walk-in sexual health services and tele-PrEP in PHSKC Sexual and Reproductive Health Clinics and Community Health Centers • Supported development of walk-in sexual health clinic day at SeaMar in Auburn • Conducted a needs assessment of remaining gaps in south King County for people living unstably housed with HIV
	Build a HIV mobile outreach team to link/re-link PLWH back into HIV care	• Successfully developed and piloted HIV mobile outreach team (HIV MOT) to reach PLWH who are virally unsuppressed and out-of-care • Developed a plan to expand the team to provide tailored medical care and LAI-ART
	Enhance linkage to care for persons with newly diagnosed HIV infection	• Expanded PHSKC staffing for engaging with persons with early indication of falling out of care • Targeted outreach and linkage to individuals identified through HIV testing in emergency department settings • Supported UW Emergency Department outreach and linkage to HIV Care for folks who test positive in ED or inpatient
	Expand real-time data to care to re-engage persons who are not virally suppressed — focus on emergency rooms, inpatient hospitals, jails, pharmacies	• Identification of out of care persons using Collective Medical
	Enhanced retention in care efforts	• Pre-housing case management services for people with HIV and housing case management for people living with HIV, or those who would benefit most from HIV prevention • Expanded cross-systems collaboration engaging partners in housing, mental health, and substance use systems to improve access and service delivery to people living with HIV, or those who would benefit most from HIV prevention

TABLE 3-2 (Part 3 of 3)

Core elements of the King County EHE Plan and Progress to Date

Prevent	Expand PrEP access – with a focus on north and south King County and healthcare system-level interventions	• PrEP promotion through the EHE Health Care Collaborative • PrEP provision through new and expanded low-barrier clinic sites, Madison Clinic, and Community Health Centers throughout King County • Expanded PrEP services in the PHSKC Sexual Health Clinic • Expanded PrEP and HIV services in PHSKC Sexual and Reproductive Health Clinics in south Seattle and south King County PrEP promotional campaigns • Expended PrEP services at low-barrier clinics in north Seattle and south King County • Expanded PrEP services through community health centers • Linkage to PrEP through Emergency Department Collaborative
	Develop new PrEP navigation and retention models	• CBO partners link communities at high risk for HIV to PrEP and provide PrEP navigation • Community health centers provide more robust PrEP navigation across the county
	Expand condom access – focus on north and south King County	• Condom distribution project — 1,146,210 condoms distributed in King County in 2023 • Continued expansion to additional zip codes with high incidence of HIV
	Expand SSP – focus on north Seattle and south King County	• South County Outreach and Referral Exchange (SCORE) SSP expansion • Expanded morning hours at downtown SSP
	Expand availability and accessibility of medications for opiate use disorder	• Increased availability of medication for opioid use through low-barrier clinics in north Seattle & south King County • Education through both collaboratives on overdose response and available OUD treatment services
	Improve delivery of comprehensive health services to LGBTQ+ persons by medical providers	• EHE Health Care Organizations Collaborative providing support and guidance to create widespread improvements in care to LGBTQ+ populations • Support improvement projects among participants
Respond	Identify and investigate HIV outbreaks using molecular laboratory and other data	• Implemented a Cluster Detection and Response (CDR) system • Expanded staff capacity to conduct outreach to cluster members, test them for HIV, and link them to PrEP or HIV care
	Provide outreach to persons identified through outbreak investigations – focus on virally unsuppressed persons	
	Community engagement	• CDR focus groups and one on one interviews completed to inform implementation of CDR • Educational video developed • Needs assessment among PLWH in south King County living unstably housed

TABLE 3-3

EHE Collaborative members

Health Care Collaborative Organizations (HCOs)	Non-Provider Participating Organizations:	Emergency Department (ED) Collaborative
CHI Franciscan	Mountain West AIDS Education and Training Center	CHI Franciscan St Anne Hospital
Country Doctor & Carolyn Downs Community Clinics	Bree Collaborative (Foundation for Health Care Quality)	Kaiser Permanente Urgent Care
HealthPoint	Washington Department of Health	Multicare – Auburn
International Community Health Services		Overlake Hospital
Kaiser Permanente Washington		Swedish Ballard
NeighborCare Health		Swedish Issaquah
PHSKC Sexual and Reproductive Health Program		Swedish Redmond
UW Harborview Medical Center		UW Harborview Medical Center
UW Northwest Hospital		UW Northwest Hospital
UW Montlake		UW Medical Center Montlake
Seattle Indian Health Board		Virginia Mason Franciscan Health
Sea Mar Community Health Center		
Swedish Medical Center		
VA Puget Sound Health Care System		

4. Ending the HIV Epidemic Pillar 1: Diagnose

KEY POINTS

- An estimated 97% of all people living with HIV in King County have been diagnosed with HIV.
- The number of publicly-funded HIV tests conducted has effectively returned to pre-COVID levels, with 18,908 publicly-funded HIV tests performed in 2023.
- Among people newly diagnosed with HIV, 13% reported never testing for HIV before testing positive.
- One-quarter (24%) of people with newly diagnosed HIV who did not have a negative HIV test within the past two years were diagnosed concurrently with AIDS, suggesting that they likely had longstanding infections.

Background

HIV testing is a cornerstone of HIV care and prevention. It plays a critical role in advancing both of Public Health – Seattle & King County's (PHSKC) primary objectives related to HIV: averting the morbidity and mortality associated with HIV and preventing HIV transmission. PHSKC and the Washington State Department of Health (WA DOH) promote widespread HIV testing as part of routine medical care and directly fund testing for people at higher risk for acquiring HIV. PHSKC monitors the success of HIV diagnosis and case-finding at the population level. Key indicators of the success of HIV testing efforts are presented in Table 4-1. PHSKC/WA State HIV Testing Guidelines are shown in Table 4-2.

TABLE 4-1 King County Progress Towards HIV Diagnosis Goals

Goals and Evaluation Metrics	2019	2023	2025 Goal
New HIV diagnoses, rate	7.9/100,000	7.2/100,000 (↓9%)	↓75%
Disparities in new HIV diagnoses by race/ ethnicity (per 100,000)	AI/AN: ..... 11.0 Asian: ..... 2.2 U.S.-Born Black: ..... 18.7 Foreign-Born Black:..... 52.5 Latinx: ..... 17.4 NH/PI: ..... 14.3 White: 6.2	AI/AN: ..... 17.3 Asian: ..... 2.5 U.S.-Born Black: ..... 24.2 Foreign-Born Black:... 48.4 Latinx: ..... 14.7 NH/PI: ..... 9.5 White: 4.1	<5% difference between groups and overall rate
Know HIV status	94%	97%	>95%
Late HIV diagnosis	17%	25%[A]	<10%

2019 is the first year for the EHE initiative. AI/AN = American Indian or Alaska Native; NH/PI = Native Hawaiian or Pacific Islander.

Note: The goal for disparity-related indicators is for no difference between each racial/ethnic group and the estimate for the entire population for each indicator. This is defined as having all racial/ethnicity-specific estimates within 5% of the overall estimate. Detailed definitions for metrics can be found in the Technical Notes to the Dashboard.

[A]Late HIV diagnosis calculated among those diagnosed in 2022 since there has not yet, as of this writing, been a full year for AIDS to develop among those diagnosed in 2023.

TABLE 4-2 PHSKC & WA DOH HIV Testing Guidelines

All WA State Residents	• Test at least once between the ages of 13 and 64 • Test concurrent with any diagnosis of gonorrhea or syphilis • During pregnancy, test in the first trimester and test again the 3rd trimester in the setting of methamphetamine use, opioid use, exchange sex, or housing instability/ homelessness
Men who Have Sex with Men & Transgender People who Have Sex with Men	Indications for testing every 3 months (any of below reported in the last 12 months): • Diagnosis of a bacterial STI in the prior year (e.g., syphilis, gonorrhea, chlamydia) • Use of methamphetamine or poppers (amyl nitrate) • >10 sex partners in the prior year (anal or oral) • Condomless anal intercourse with an HIV+ partner or partner of unknown HIV status • Ongoing use of HIV pre-exposure prophylaxis (PrEP) MSM and transgender people who have sex with men who do not report any of the above should test annually[A]
People who Inject Drugs	• Annual testing • Every 3 months for PWID who exchange sex for money or drugs or who are pregnant

Note: People should also be tested for syphilis and for gonorrhea and chlamydia at all exposed anatomical sites.

[A]People who have not had sex in the prior year or who are in long-term mutually monogamous relationships do not require annual HIV/ STI testing.

HIV Testing Among Select King County Populations

Estimating the Proportion of People Living with HIV who are Undiagnosed

Based on HIV testing history data, PHSKC uses a tool developed by University of Washington (UW) researchers to estimate the proportion of all people with HIV who are unaware of their status (i.e., the undiagnosed fraction).[5]

In 2023, the overall estimated undiagnosed fraction for HIV in King County was 3%. Among men who have sex with men (MSM), the estimated undiagnosed fraction was 2%.

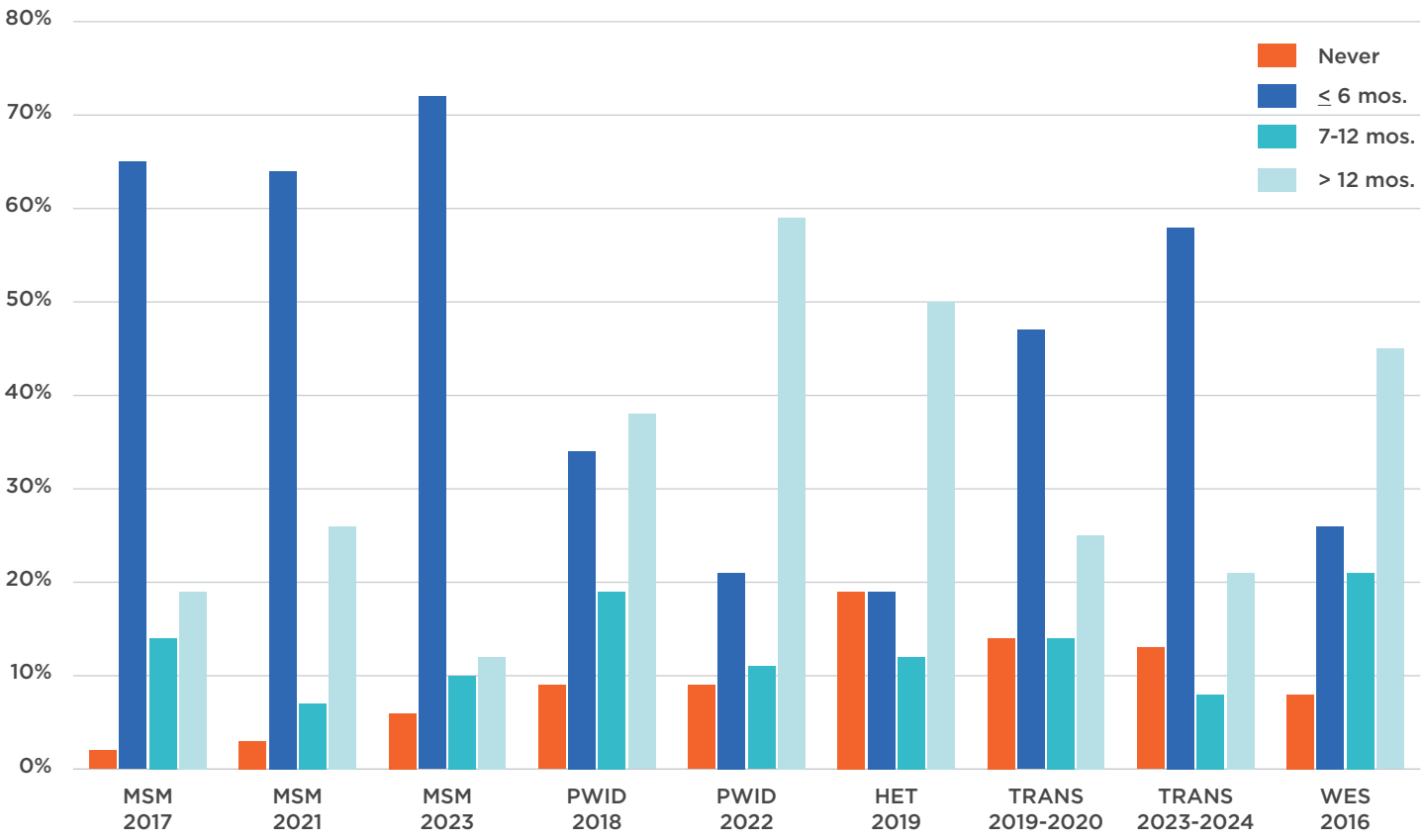
HIV Testing History in Populations at Higher Risk for HIV

HIV testing histories were collected during nine NHBS surveys between 2016 and 2024, which sampled MSM (thrice), PWID (twice), transgender women (twice), heterosexually-active people at higher risk for HIV, and women who exchange sex (WES) (Figure 4-1).

Of these five populations, MSM and transgender women were the most likely to have had an HIV test in the past 6 months (64-65% and 47-58%, respectively). Compared to MSM, PWID, and transgender women, heterosexually-active people at higher risk for HIV had the lowest HIV prevalence (Table 1-1) and were the most likely to report never having had an HIV test (19%).

FIGURE 4-1

HIV testing history among men who have sex with men (MSM), people who inject drugs (PWID), heterosexually-active people at higher risk for HIV (HET), transgender women (TRANS), and women who exchange sex for drugs or money (WES), Seattle-area National HIV Behavioral Surveillance System, 2016-2024



HIV Testing History in People with Newly Diagnosed HIV

In King County, because new HIV diagnoses are most prevalent among MSM, we report in detail on HIV testing history in that population. Between 2014 and 2020, an average of 9% (range: 5% to 12%) of MSM reported never testing for HIV prior to their initial HIV diagnosis (Figure 4-2). This proportion increased in 2021 and 2022 (14% and 15%, respectively), then decreased again in 2023, with 10% of newly diagnosed MSM reporting never having tested for HIV prior to their HIV diagnosis in 2023.

Among MSM diagnosed with HIV in 2023, 61% had tested in the past two years and 43% had tested HIV-negative in the past year. Of note, a lower proportion of Latinx MSM newly diagnosed with HIV reported testing in the prior year compared to all MSM (32% versus 41%, respectively, Table 4-3).

FIGURE 4-2

HIV Testing History Among Men Who Have Sex with Men Newly Diagnosed with HIV, King County, WA 2013-2023

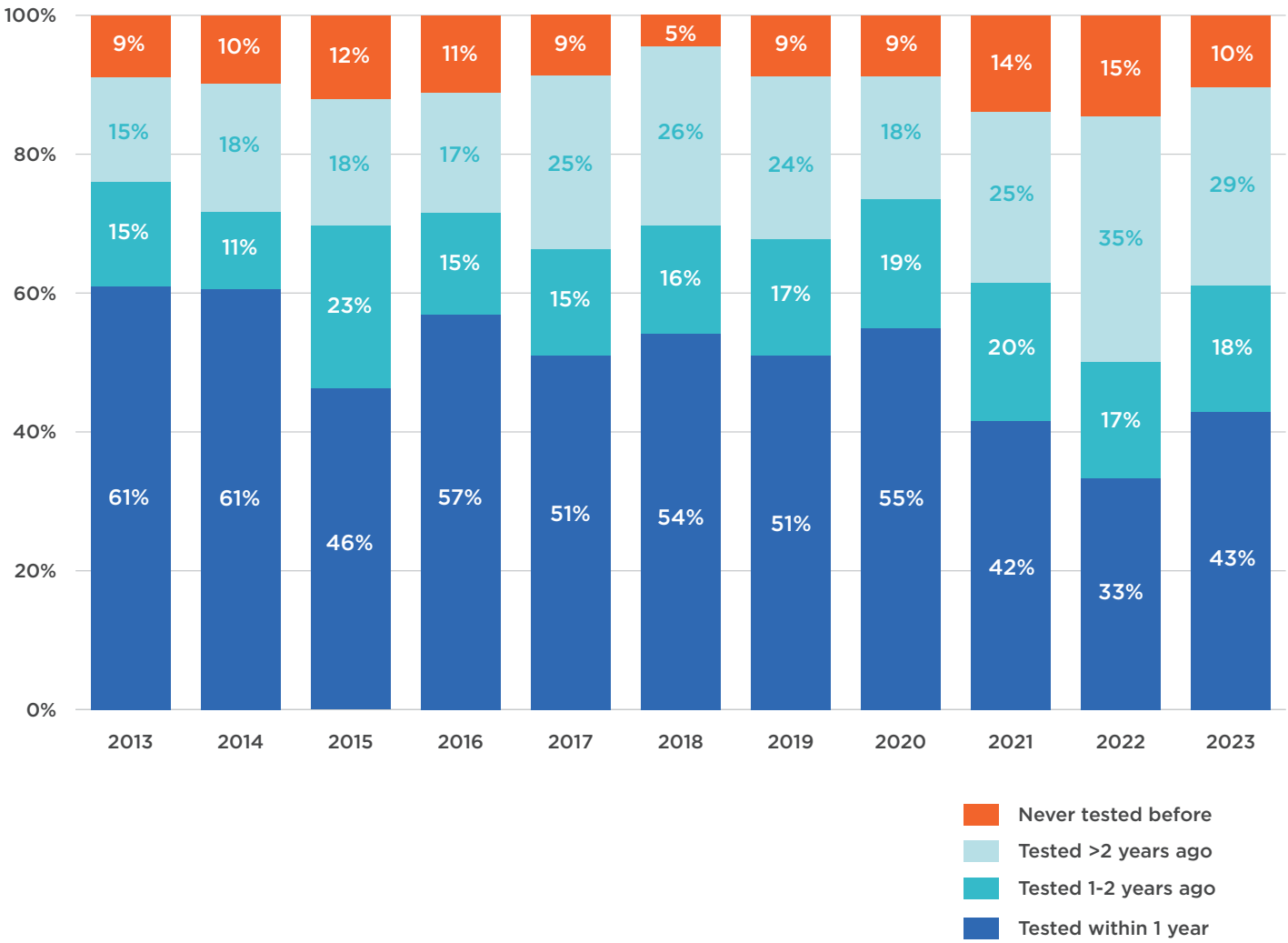


TABLE 4-3

Key HIV Testing Metrics Among Individuals Newly Diagnosed with HIV, King County, WA, 2023

		N	Percent Never Previously HIV Tested[A]	Median Inter-test Interval (IQR)[A]	Percent HIV Tested in the Prior Year[A]	Percent HIV Tested in the Prior 2 Years[A]	Percent with Concurrent HIV & AIDS Diagnoses[B]
TOTAL[A]		168	13%	22 (8, 52)	31%	46%	24%
AGE AT DIAGNOSIS (years)							
	13-24	18	17%	10 (7, 13)	55%	82%	22%
	25-34	69	8%	20 (7, 49)	38%	52%	29%
	35-44	39	4%	26 (8, 60)	32%	43%	23%
	45-54	22	25%	44 (9, 90)	20%	73%	23%
	55+	20	36%	26 (22, 57)	29%	64%	15%
GENDER							
	Cisgender Men	130	11%	16 (7, 44)	39%	55%	25%
	Cisgender Women	36	23%	57 (39, 90)	9%	77%	22%
	Transgender People[C]	39	19%	8 (4, 32)	50%	56%	10%
TRANSMISSION CATEGORY							
	MSM	86	11%	13 (7, 37)	41%	60%	27%
	– Black MSM[D]	23	5%	12 (4, 50)	47%	63%	22%
	– Latinx MSM[D]	25	20%	21 (6, 23)	32%	63%	40%
	– White MSM[D]	42	13%	16 (7, 44)	37%	55%	24%
	– Another race MSM[D]	14	<1%	18 (7, 63)	45%	55%	21%
	PWID[E]						
	– Non-MSM	7	<1%	47 (13, 57)	14%	29%	29%
	– MSM	8	<1%	9 (3, 26)	57%	71%	0%
	Heterosexual Sexual Contact[F]	20	20%	33 (24, 71)	13%	20%	30%
	– U.S.-born	8	29%	73 (68, 104)	14%	71%	25%
	– Foreign-born	12	13%	30 (22, 34)	13%	25%	33%
	Unknown Transmission Risk[G]	46	28%	56 (40, 66)	6%	11%	22%

Abbreviations: MSM = men who have sex with men; PWID = people who inject drugs.

[A] Among those with a known HIV test history.

[B] Proportion of people diagnosed with AIDS within 30 days following HIV diagnosis.

[C] Due to small numbers in 2023, the time interval was expanded to 2014–2023 for transgender people; most of the 39 transgender people diagnosed in the 10-year period were transgender women (80%). Since data on "Another Gender Identity" was only recently collected, numbers are too small to summarize.

[D] Race and Latinx ethnicity categories are not mutually exclusive. Due to small numbers, people who identify as American Indian/Alaska Native, Asian, or Native Hawaiian or Pacific Islander are included in the "Another race" category.

[E] Given the differences in non-MSM and MSM PWID, no aggregate estimate is presented.

[F] Heterosexual sexual contact includes all people recently diagnosed with HIV without known report of injection drug use or, if the person is a man, sex with a male-identified partner.

[G] Unknown/other transmission risk includes those with no identified risk.

Among people who tested for HIV prior to their initial diagnosis, the HIV inter-test interval (ITI) is the time between a person's last HIV-negative test and first HIV-positive test. A lower ITI among people with newly diagnosed HIV suggests a shorter period between initial infection and diagnosis. PHSKC's goal is to promote widespread and frequent testing in populations at elevated risk for HIV, thereby shortening the ITI. Between 2014 and 2020, the median ITI in MSM newly diagnosed with HIV was relatively stable and ranged from 7 to 11 months (Figure 4-3).

The median ITI increased to 13 months and 17 months in 2021 and 2022, respectively, then dropped back to 13 months in 2023. This suggests that HIV screening patterns that were interrupted due to the COVID-19 pandemic may be returning to pre-pandemic levels.

HIV testing histories for people in other transmission categories differ from MSM. Overall, people in the heterosexual sexual contact transmission category were more likely to report no prior HIV testing (Table 4-3). People in this risk category also had a lower proportion testing in the prior year compared to MSM.

FIGURE 4-3 Median and Interquartile Range (IQR) of Inter-test Intervals (Months Between Last Negative and First Positive Test) of MSM Newly Diagnosed with HIV, King County, WA, 2014-2023

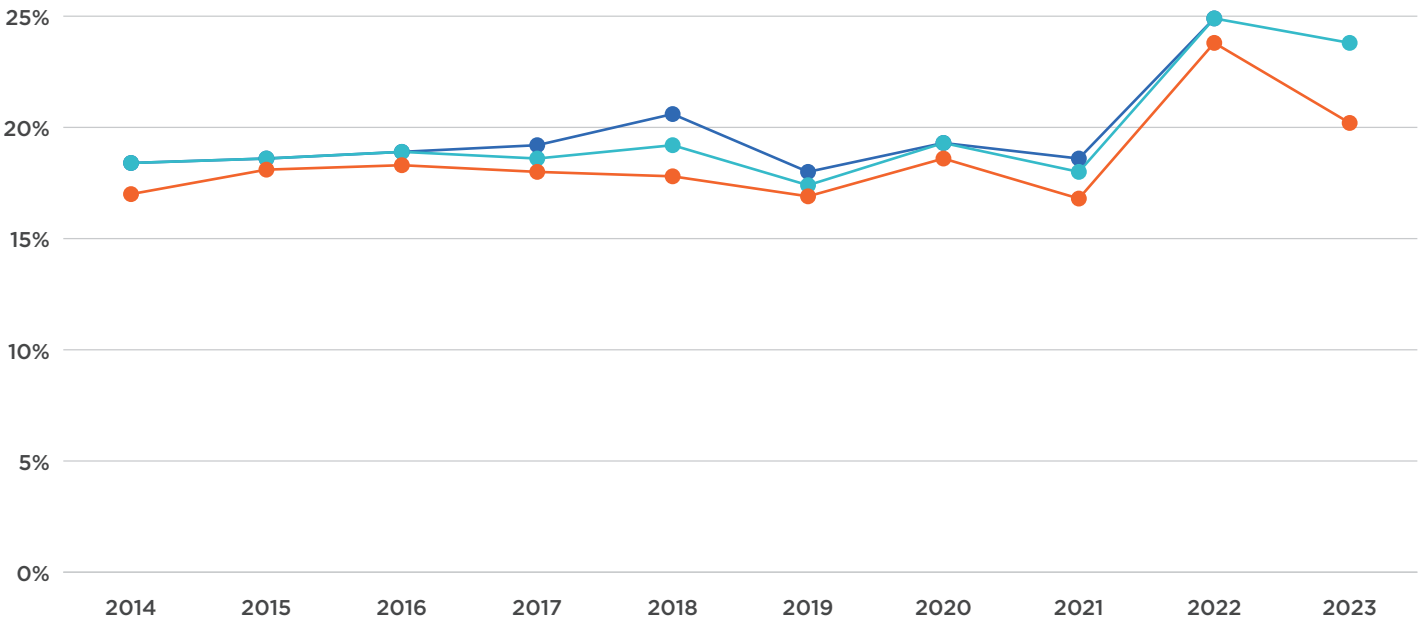


HIV Testing History and AIDS at Time of HIV Diagnosis

As shown in Figure 4-4, the percentages of people with newly diagnosed HIV who were diagnosed with AIDS at the same time or within 12 months of their HIV diagnosis remained relatively stable over most of the past decade, ranging from 17% to 21% between 2014 and 2021. In 2022, the proportions of people with AIDS diagnosed at the same time or within 12 months of their HIV diagnosis increased to 24% and 25%, respectively. In 2023, the proportion of people diagnosed with AIDS at the same time as their HIV diagnosis declined to 20%, but the proportion diagnosed with AIDS within six months remained higher at 24%.

Among people in the heterosexual sexual contact transmission category, a higher proportion of foreign-born individuals had a concurrent HIV and AIDS diagnosis than U.S.-born individuals (33% versus 25%; Table 4-3). Importantly, the proportion of foreign-born individuals decreased substantially since 2022, when 69% were concurrently diagnosed with HIV and AIDS. Public health and health care system should continue to provide accessible HIV testing services to identify HIV earlier in the course of infection (i.e., before progression to AIDS).

FIGURE 4-4 Late HIV Diagnoses Defined by AIDS Diagnosis Concurrent, within Six Months, or within One Year of HIV Diagnosis, King County, WA, 2014-2023[A,B]



[A] Excludes people who reported having a negative HIV test within 24 months of HIV diagnosis.

[B] "AIDS within 1 year of HIV" excludes 2023 as there has not yet been a full year for AIDS to develop.

Place of HIV Diagnosis and Reason for HIV Testing

Figure 4-5 presents information on the facilities where people were initially diagnosed with HIV in King County between 2019 and 2023. In 2023, over 40% of all newly diagnosed cases of HIV were tested in outpatient clinics or community health centers, and almost a quarter of all diagnoses were a consequence of medical provider-initiated HIV testing. PHSKC works with large healthcare organizations to promote routine HIV testing in primary care through the King County Health Care Organizations Collaborative. Organizations participating in the collaborative provide care to approximately half of all adults in King County. Among adults receiving care though collaborating organizations between January 2021 and December 2023, 39% had ever tested for HIV within those organizations, an increase from 33% from 2020-2021. Together, these data demonstrate the central role of testing in primary care as a means for ensuring the timely diagnosis of HIV infection in King County.

Table 4-4 presents data on reasons for HIV testing at the time of HIV diagnosis in 2019 and 2023. Among people diagnosed with HIV in 2023 for whom PHSKC had data on reason for testing, most sought testing themselves (24%) or a medical provider initiated the testing (23%).

FIGURE 4-5 HIV Diagnosis Facilities, King County, WA, 2019-2023

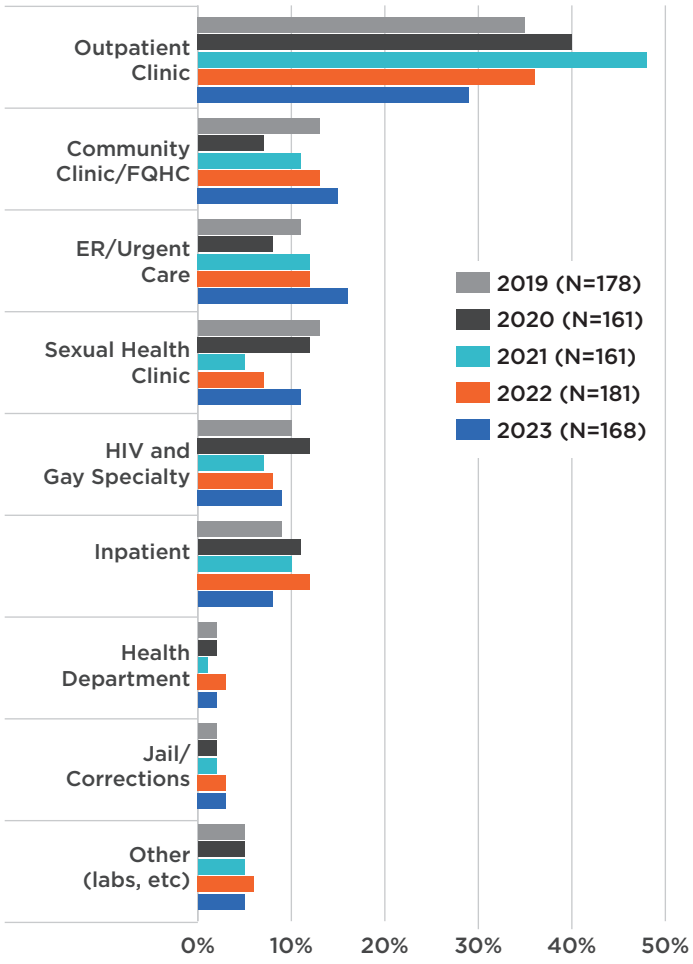


TABLE 4-4

Reason for HIV Testing Among People Diagnosed with HIV*

	2019		2023	
	N	%	N	%
Patient initiated regular or risk-based testing, including plasma and blood donations	38	32%	22	24%
Medical provider-initiated testing[A]	17	15%	21	23%
HIV partner notification[B]	26	22%	12	13%
Symptoms of HIV/AIDS	7	6%	10	11%
PrEP screening	8	7%	10	11%
Symptoms of acute HIV infection	6	5%	10	11%
Symptoms of sexually transmitted infection (STI) or STI partner notification	12	10%	5	5%
Prenatal testing	2	2%	1	1%
Administrative testing (refugee screening, insurance)	1	1%	1	1%

* Data from King County Partner Services interviews; 2019 = 117/183 (64%) and 2023 = 92/168 (56%) of persons with newly diagnosed HIV infection completed a Partner Services interview.

[A] Routine testing or testing occurring in the absence of symptoms attributable to HIV.

[B] Partner notification includes both partners notified by Public Health – Seattle & King County staff and people who tested after a partner notified them that they had tested positive for HIV or an STI.

Public Health Interventions that Support this Pillar

WA DOH and PHSKC fund HIV testing primarily for populations with a higher prevalence of HIV. Publicly funded testing occurs at PHSKC's Sexual Health Clinic and other public health clinics, community-based organizations, and in King County jails. Figure 4-6 shows trends in the number of HIV tests performed using public health funds between 2014 and 2023, overall and for MSM. The COVID-19 pandemic resulted in reduced testing in 2020, but as of 2023 the total volume of publicly-funded testing is on par with testing prior to the pandemic (2019).

HIV test positivity is the percentage of tests that are positive among all tests performed. The proportion of people who tested positive for HIV among those tested at publicly-funded sites is presented in Figure 4-7. Between 2014 and 2019, HIV test positivity among tests performed among MSM through publicly-funded testing declined from 0.8% to 0.5%, a 38% reduction. In 2020, test positivity among MSM increased, likely because routine HIV testing — including testing among persons on PrEP — declined with the COVID-19 pandemic and a larger percentage of tests were done among persons with symptoms of STI. HIV test positivity declined again in 2021 and has remained relatively stable over the past two years.

FIGURE 4-6
Publicly-Funded HIV Tests Overall and Among Men Who Have Sex With Men (MSM), King County, WA, 2014-2023

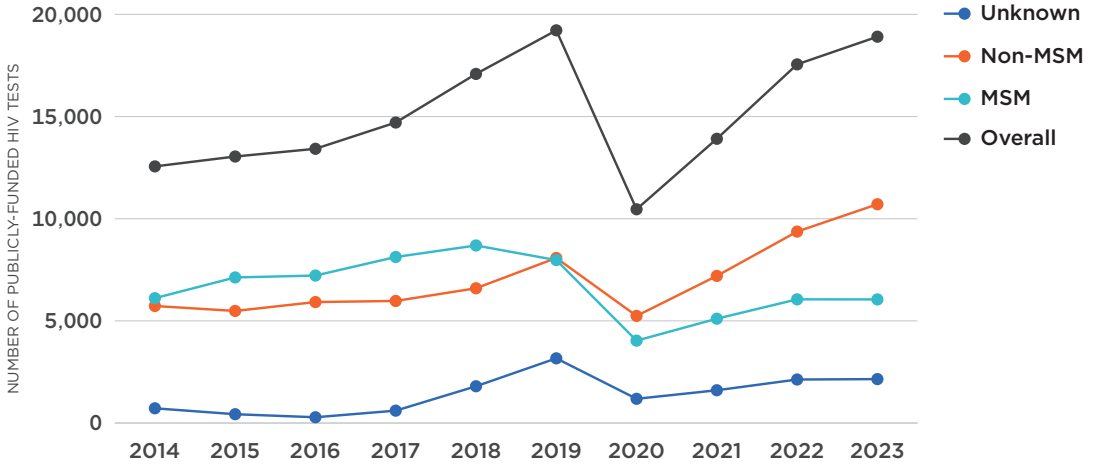
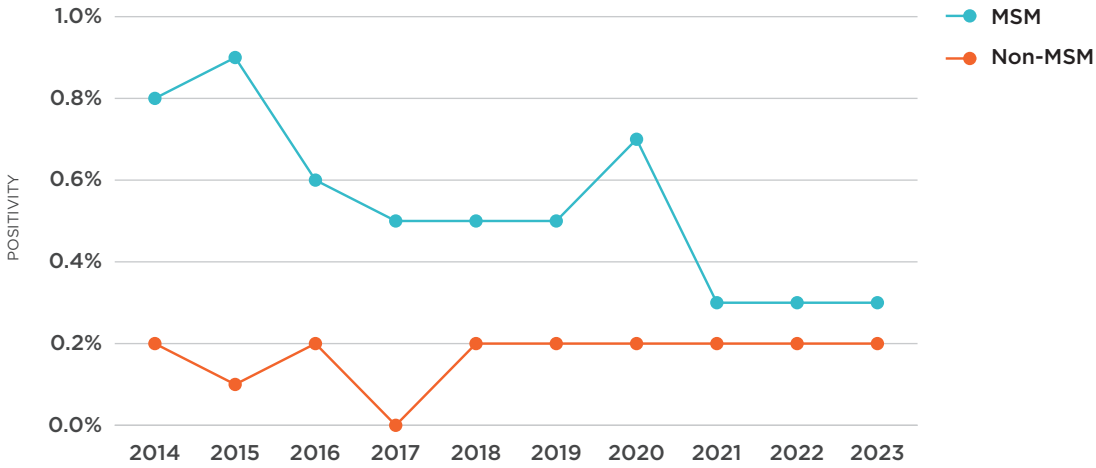


FIGURE 4-7
HIV Positivity Rate for Men Who Have Sex With Men (MSM) and Non-MSM at Publicly-Funded Testing Sites, King County, WA, 2014-2023



Summary

HIV testing in King County has been extremely successful, reflecting the combined efforts of medical providers, community-based organizations, communities affected by HIV, WA DOH, and PHSKC. As of 2023, an estimated 97% of all people living with HIV had been diagnosed with HIV. Among MSM diagnosed with HIV in 2023, 61% had tested HIV-negative in the prior two years and only 10% reported never having tested for HIV previously. Data from 2023 demonstrate that HIV testing patterns continue to shift back to resemble what PHSKC observed prior to the COVID-19 pandemic, with MSM testing somewhat more frequently and the number of publicly funded tests comparable to 2019. Despite King County's substantial success in promoting HIV testing, one in five newly diagnosed individuals in the heterosexual sexual contact transmission category never had an HIV test before, and about a third were diagnosed concurrently with HIV and AIDS. These data highlight the need for expanded testing in these populations.

5. Ending the HIV Epidemic Pillar 2: Treat

KEY POINTS

- Among people newly diagnosed with HIV in 2023, 85% linked to care within 1 month and 70% were virally suppressed within 4 months of diagnosis.
- Among all people with diagnosed HIV in King County, 85% were virally suppressed at the end of 2023. This level of viral suppression is higher than that reported in most other U.S. cities but is unchanged since 2019. Racial disparities in viral suppression persist, as the percent of individuals who were virally suppressed was lowest among Black people living with HIV (PLWH) who were born in the U.S. (79%) and American Indian/Alaska Native PLWH (80%).
- The lowest levels of viral suppression occurred among persons who inject drugs (69%) and those who reported meth use (73%).

Background

The primary goal of the EHE initiative is to reduce new HIV diagnoses by 75% by 2025 and by 90% by 2030. A key aspect of achieving the EHE goals is ensuring that all PLWH in King County have access to medical care, achieve viral suppression as soon as possible after diagnosis, and remain virally suppressed over time. Achieving and sustaining viral suppression benefits an individual's health and prevents HIV transmission. King County has four specific goals related to HIV care and treatment (e.g., the HIV care continuum) which are presented in Table 5-1 and discussed in detail below.

TABLE 5-1 King County Progress Towards HIV Treatment Goals

Goals and Evaluation Metrics	2019	2023	2025 Goal
Linked to care in 1 month	90%	85%	>95%
In HIV Care	89%	93%	>95%
Viral Suppression	85%	85%	>95%
Disparities in Viral Suppression by Race/Ethnicity	AI/AN: 80% Asian: 89% FB Black: 86% U.S.B Black: 77% Latinx: 85% NH/PI: 82% White: 87%	AI/AN: 80% Asian: 88% FB Black:86% U.S.B Black: 79% Latinx: 86% NH/PI: 82% White: 85%	<5% Difference Between Groups and Overall Rate
Viral suppression within 4 months of diagnosis	69%	70%	>90%

2019 is the first year for the EHE initiative. AI/AN = American Indian/Alaska Native; FB = Foreign-born; U.S.B = U.S.-born; NH/PI = Native Hawaiian or Pacific Islander. Note: The goal for disparity-related indicators is for no difference between each racial/ethnic group and the estimate for the entire population for each indicator. This is defined as having all racial/ethnicity-specific estimates within 5% of the overall estimate. Detailed definitions for metrics can be found in the Technical Notes to the Dashboard on page 11.

HIV Care Continuum & Linkage to Care

The HIV care continuum for King County in 2023 is presented in Figure 5-1. Of an estimated 7,663 PLWH, an estimated 97% have been diagnosed and know their HIV status. Among those diagnosed with HIV, 93% had one or more care visits in 2023, and 85% were virally suppressed. After a person is newly diagnosed with HIV, public health, medical providers, other clinical staff, and community partners work to ensure that each person has access to HIV medical care as soon as possible.

Figure 5-2 shows data on linkage to care within 1 month from 2019 to 2023. In 2023, 83% of newly diagnosed individuals were linked to care within one month of diagnosis. This is lower than both the 2025 goal (95%) and the 2019 measure (88%) and may reflect the fact that new HIV diagnoses in King County are increasingly concentrated in populations facing complex barriers to care (e.g., homelessness, substance use, poverty).

FIGURE 5-1
HIV Care Continuum, King County, WA, 2023

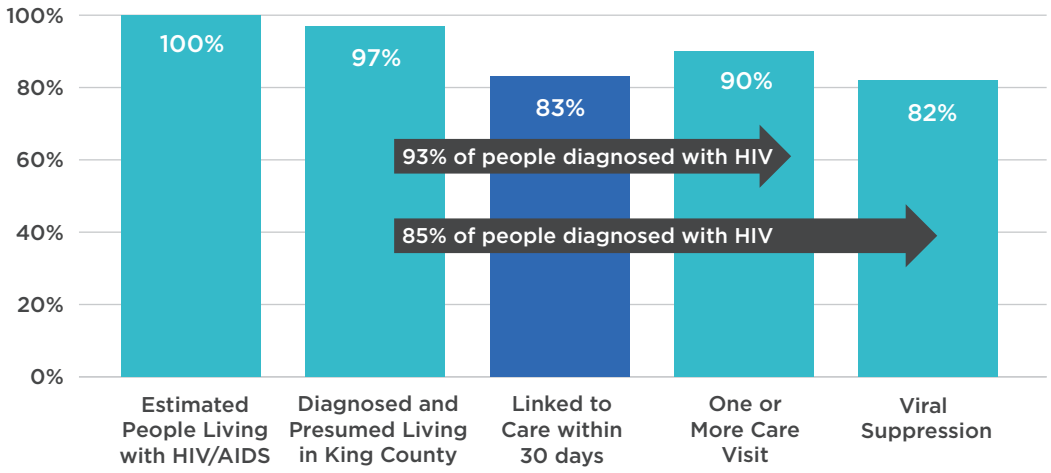
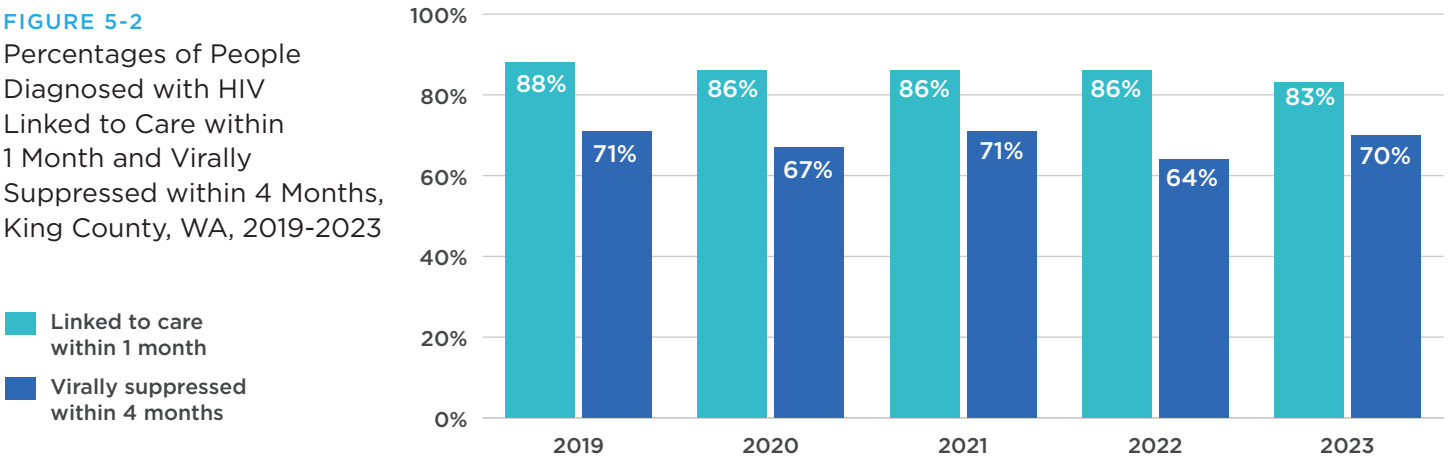


FIGURE 5-2
Percentages of People Diagnosed with HIV Linked to Care within 1 Month and Virally Suppressed within 4 Months, King County, WA, 2019-2023



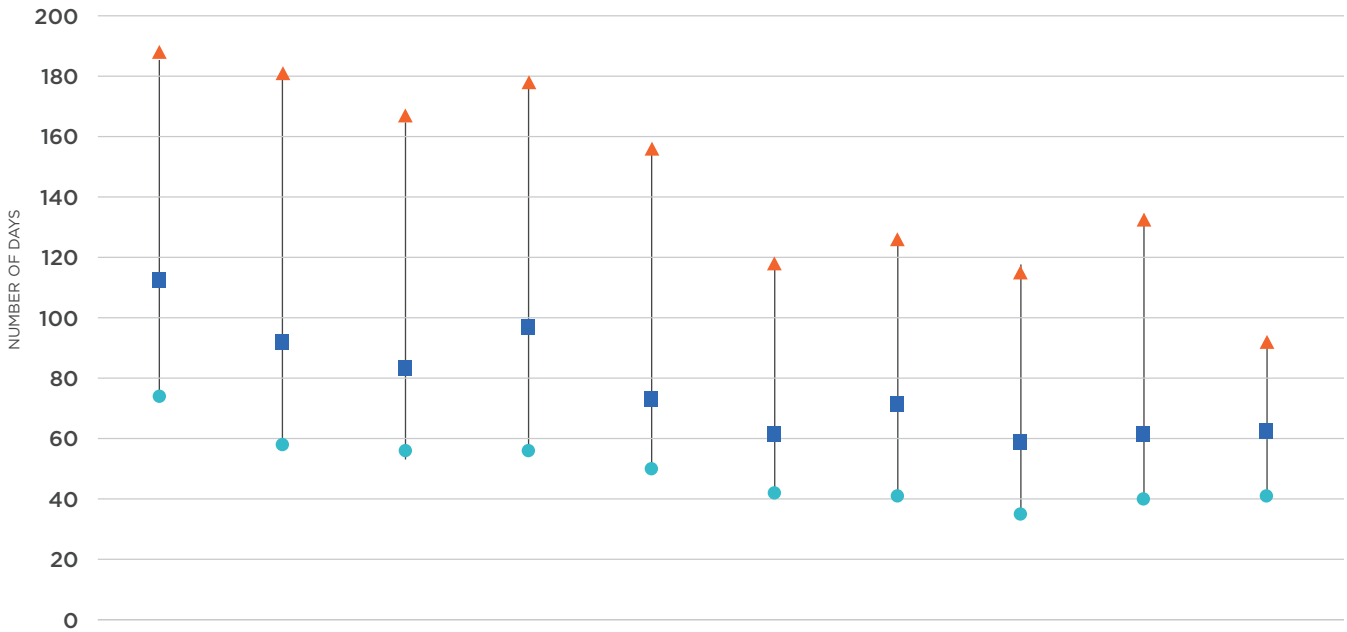
Viral Suppression

Viral Suppression After a New HIV Diagnosis

A key step in successful linkage to HIV treatment is the initiation of antiretroviral medication, ideally as soon as possible. The rapidity with which people newly diagnosed with HIV achieve viral suppression reflects the combined functioning of public health and clinical infrastructure in King County as well as the efficacy of modern HIV treatment regimens. In 2023, 70% of people with newly diagnosed HIV had documented viral suppression within 4 months after diagnosis. This percentage is substantially lower than the King County 2025 goal (↓95%) and has remained essentially stable since 2019 (Figure 5-2) even as linkage to care at one month as somewhat declined.

However, other metrics point to ongoing improvement in viral suppression after diagnosis. In 2023, the median time to viral suppression after diagnosis was 63 days [interquartile range (IQR): 41 to 92 days]. The median time to viral suppression after an HIV diagnosis decreased substantially from 2013 to 2020. and has remained stable since 2021. The interquartile range has also narrowed, and was the most narrow in 2023, meaning that overall more people were achieving viral suppression in a shorter period of time (Figure 5-3).

FIGURE 5-3 Median Time to Viral Suppression in Days (Interquartile Range, IQR) Following an HIV Diagnosis, King County, WA, 2014-2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Lower IQR	74	58	56	56	50	42	41	35	40	41
Median	112.5	92	83.5	97	73	61.5	71.5	59	61.5	62.5
Upper IQR	188	181	167	178	156	118	126	115	132.5	92

Viral Suppression and Receipt of HIV Care

Of all PLWH in King County, 92% had at least one visit with a medical provider in 2023 and 85% were virally suppressed (<200 copies/mL) at the end of 2023. Table 5-2 summarizes viral suppression and care among PLWH in King County by gender, age, race/ethnicity, nativity, HIV transmission risk category, and other factors. The following populations had viral suppression rates below 80%: U.S.-born Black people, PWID, MSM-PWID, people who use methamphetamine, and people who were homeless or unstably housed.

Racial/Ethnic Disparities in Viral Suppression and Receipt of Care

The proportion of PLWH who were virally suppressed was lowest among Black PLWH who were born in the U.S. (79%) and highest among Asian individuals (88%) (Table 5-2). There was a similar pattern in the proportion of PLWH who received any care in 2023 (range: 67%-100%); however, a lower proportion PLWH who identified as AI/AN were engaged in care (67%). The persistent disparity in engagement in care and viral suppression shows that we need ongoing concerted efforts to ensure that systems of HIV care counteract and mitigate the impact of social and structural factors that drive the observed racial disparities.

TABLE 5-2 (Part 1 of 2) HIV Care Metrics, Including Linkage to Care, Being in Medical Care, and Viral Suppression for Selected Groups Living with Diagnosed HIV, King County, WA, 2023

			Percent of People in King County in 2023 with New HIV Diagnoses who:		Percent of People with Diagnosed HIV in King County in 2023 who:
	People Diagnosed with HIV, N	New diagnoses,[A] N	Linked to care within one month of diagnosis	Had one or more care visits	Had suppressed recent viral load in 2023 (<200 copies)
TOTAL	**7,402**	**168**	**85%**	**92%**	**85%**
GENDER					
Cisgender Men	6,244	130	87%	95%	85%
Cisgender Women	1,032	36	67%	81%	82%
Gender Diverse People[B]	126	2	100%	100%	83%
AGE (years)	**Age at Year End**	**Age at Diagnosis**			
<25	131	18	83%	94%	82%
25-34	1,019	69	87%	97%	79%
35-44	1,609	39	85%	87%	81%
45-54	1,701	22	68%	86%	85%
55+	2,942	20	80%	90%	88%
RACE/ETHNICITY[C,D]					
American Indian/Alaska Native	273	6	33%	67%	80%
Asian	633	14	86%	93%	88%
Black	2,074	66	82%	92%	82%
- U.S.-born[E]	1,198	30	83%	97%	79%
- Foreign-born[E]	876	36	81%	89%	86%
Latinx *(all races)*	1,312	38	95%	95%	86%
- U.S.-born[E]	602	12	100%	100%	84%
- Foreign-born[E]	710	26	92%	92%	87%
Native Hawaiian or Pacific Islander	118	3	100%	100%	82%
White	4,841	72	81%	94%	85%

TABLE 5-2 (Part 2 of 2) HIV Care Metrics, Including Linkage to Care, Being in Medical Care, and Viral Suppression for Selected Groups Living with Diagnosed HIV, King County, WA, 2023

			Percent of People in King County in 2023 with New HIV Diagnoses who:		Percent of People with Diagnosed HIV in King County in 2023 who:
	People Diagnosed with HIV, N	New diagnoses, N	Linked to care within one month of diagnosis	Had one or more care visits	Had suppressed recent viral load in 2023 (<200 copies)
TOTAL	**7,402**	**168**	**85%**	**92%**	**85%**
TRANSMISSION CATEGORY[E]					
MSM	4,797	86	88%	99%	87%
PWID	246	7	57%	71%	69%
MSM - PWID	616	8	88%	100%	78%
Heterosexual Sexual Contact	833	20	85%	85%	84%
Other transmission risks	910	47	74%	85%	82%
OTHER FACTORS					
Foreign-born	2,075	71	82%	89%	87%
Methamphetamine use[F]	457	28	79%	89%	73%
Homeless or Unstably housed	757	30	87%	90%	75%
RACE/ETHNICITY AMONG MSM (NOT INCLUDING PWID-MSM) [A,C]					
American Indian/Alaskan Native	174	3	67%	100%	89%
Asian	425	10	90%	100%	91%
Black	864	23	87%	100%	80%
Latinx	953	25	100%	100%	88%
Native Hawaiian or Pacific Islander	79	2	100%	100%	87%
White	3,591	42	83%	98%	88%

Abbreviations: VL = viral load; MSM = men who have sex with men; PWID = people who inject drugs;

[A] Due to small numbers (i.e., fewer than 6 new diagnoses in 2023), data for newly diagnosed Native Hawaiian and Pacific Islander people, transgender people, and American Indian/Alaskan Native people and Native Hawaiian or Pacific Islander people among MSM were combined over a 5-year period. Therefore, for these specified groups, the number of new diagnoses is the total number of diagnoses between 2019-2023.

[B] Transgender people are those for whom we have data reflecting transgender gender identity, and includes transgender women, transgender men, and people who report another gender identity. All other people are categorized by their sex assigned at birth, and presumptively labeled as cisgender women and cisgender men. For people diagnosed with HIV, the transgender group includes 83% transgender women, 7% transgender men and 10% people who report another gender identity. For new HIV diagnoses, the transgender group includes 79% transgender women, 8% transgender men, and 13% people who report another gender identity.

[C] Race/ethnicity categories are not mutually exclusive and people reporting multiple racial and ethnic identities are represented in each group.

[D] U.S.-born includes individuals where the country of birth is unknown.

[E] All transmission risk categories are mutually exclusive. MSM includes cisgender and transgender men who report sex with men. Other transmission risks include pediatric, transfusion, no identifiable risk and all transmission risks among transgender women.

[F] Information on methamphetamine use has been collected since 2009 and reflects reported use at or since diagnosis to present.

Out-of-Care and Unsuppressed PLWH

Table 5-3 summarizes the characteristics of PLWH in King County who were either out of care or unsuppressed. PLWH who are out of care or virally unsuppressed often face complex barriers to care, including poverty, homelessness or unstable housing, substance use disorders, and mental health disorders. PHSKC collects some data on these factors; however, information is often limited to what was available at the time of HIV diagnosis through case reporting, partner services interviews, and medical records review. Among PLWH who were out of care or virally unsuppressed, an estimated 17% were homeless or unstably housed, 21% had a history of injecting drugs, and 11% had a history of methamphetamine use.

TABLE 5-3 Characteristics of People Living with Diagnosed HIV Who are Out of Care (OOC) or Not Virally Suppressed, King County, WA, 2023

	Living with Diagnosed HIV	Virally Unsuppressed	Unsuppressed due to Being Out of Care	Unsuppressed due to Viral Load >200	Total Virally Unsuppressed
TOTAL	**7,402**	**1,135**	**10%**	**6%**	**15%**
GENDER					
Cisgender Men	84%	82%	10%	5%	15%
Cisgender Women	14%	16%	9%	8%	18%
Gender Diverse People	2%	2%	9%	9%	18%
AGE AT YEAR END					
13-24	2%	2%	8%	11%	19%
25-34	14%	19%	11%	10%	21%
35-44	22%	27%	12%	7%	19%
45-54	23%	23%	10%	6%	15%
55+	40%	30%	8%	3%	12%
RACE/ETHNICITY[A,B]					
American Indian/Alaska Native	4%	5%	10%	10%	20%
Asian	9%	7%	9%	3%	12%
Black	28%	34%	10%	8%	18%
- U.S.-born	16%	23%	11%	10%	22%
- Foreign-born	12%	11%	9%	5%	14%
Latinx *(all races)*	18%	17%	8%	6%	14%
- U.S.-born	8%	8%	9%	7%	16%
- Foreign-born	10%	8%	8%	6%	13%
Native Hawaiian or Pacific Islander	2%	2%	11%	7%	18%
White	65%	62%	10%	5%	15%
TRANSMISSION RISK[C]					
MSM	65%	55%	9%	4%	13%
PWID	3%	7%	18%	14%	31%
MSM - PWID	8%	12%	12%	10%	22%
Heterosexual Sexual Contact	11%	12%	10%	7%	16%
Other Transmission Risks	12%	15%	12%	6%	18%
OTHER FACTORS					
Methamphetamine use[D]	6%	11%	12%	15%	27%
CURRENT REGION OF RESIDENCE					
Seattle	50%	43%	10%	4%	13%
South King County	29%	30%	10%	6%	16%
East King County	8%	8%	11%	4%	15%
North King County	2%	1%	6%	2%	8%
Homeless or Unstably Housed[E]	10%	17%	9%	16%	25%

Abbreviations: VL = viral load; MSM = men who have sex with men; PWID = people who inject drugs;

[A] Race/ethnicity categories are not mutually exclusive and people reporting multiple racial and ethnic identities are represented in each group.

[B] U.S.-born includes individuals where the country of birth is unknown.

[C] All transmission risk categories are mutually exclusive. MSM includes cisgender and transgender men who report sex with men. Other transmission risks include pediatric, transfusion, and no identifiable risk.

[D] Information on methamphetamine used has been collected since 2009. Methamphetamine use is calculated use of methamphetamine any- time from diagnosis to the present.

[E] Housing status was determined using an individual's most current address. Homelessness or unstable housing status was based on matches with predetermined list of shelters and services that serve the homeless (see Technical Note 4).

Updated Information on People who Were Not Virally Suppressed in Last Year's Report

Each year, we report HIV care continuum outcomes among PLWH in King County based on data accumulated through the end of the calendar year of focus. In each subsequent year after the surveillance report, PHSKC gains additional information about the status of people who appeared to be out of care (and presumed virally unsuppressed) during the previous focus year. Many people who appeared to be out of care are later found to have moved out of the area.

For that reason, we provide a revised estimate of the prior year's care continuum in each surveillance report to update the community and aid our interpretation of the current year's data.

Table 5-4 shows the status of people defined as being out of care or virally unsuppressed at the end of 2022 updated to reflect data through mid- 2024. In summary, of the 1,053 people presumed to be out of care or virally unsuppressed at the end of 2022 (i.e., reported in last year's surveillance report), 12% were confirmed to have moved away, 37% were virally suppressed at the end of 2023, 3% died in 2022 or 2023, and 60% were still out of care or virally unsuppressed at the end of 2023. Revised estimates of viral suppression are typically ~2% higher than initial estimates. In 2022, approximately 87% of PLWH were virally suppressed.

TABLE 5-4 Initial and Updated Estimates of the Percentage of People Diagnosed with HIV who were Out of Care (OOC) or Virally Unsuppressed, and Outcomes in the Subsequent Year, King County, WA, 2017-2022

	Initial Estimate OOC/ Virally	Found to Have Moved Away	Updated Estimate of OOC/Virally Unsupressed	Status at the End of Subsequent Year		
Year	(% of all People with Diagnosed HIV)	(% of OOC/Virally Unsuppressed)	(% of all People with Diagnosed HIV)	Deceased	Virally Suppressed	Not Virally Suppressed
			PERCENT OF REVISED ESTIMATE			
2017	1,046 (15%)	142 (14%)	909 (14%)	33 (4%)	427 (47%)	449 (49%)
2018	1,122 (16%)	241 (21%)	879 (13%)	20 (2%)	397 (45%)	462 (53%)
2019	1,052 (15%)	207 (20%)	843 (12%)	32 (4%)	367 (45%)	444 (55%)
2020	958 (14%)	151 (16%)	805 (12%)	19 (2%)	313 (39%)	473 (59%)
2021	945 (13%)	128 (14%)	813 (11%)	24 (3%)	287 (35%)	502 (62%)
2022	1,053 (15%)	127 (12%)	924 (13%)	27 (3%)	346 (37%)	551 (60%)

TABLE 5-5

Key Metrics of HIV Care by King County Cities, 2023

	People Living with Diagnosed HIV	Out of Care or Virally Unsuppressed	Virally Unsuppressed	Out of Care	Population Living in Poverty[A]
	N	N	%	%	%
CITY					
Seattle	4,564	653	8%	6%	10%
Kent	364	65	7%	10%	11%
Federal Way	322	48	7%	8%	12%
Renton	297	52	10%	8%	8%
Auburn	223	47	10%	11%	8%
Bellevue	188	19	4%	6%	7%
Burien	166	26	4%	11%	11%
Tukwilla	150	19	7%	6%	13%
Seatac	125	19	4%	11%	11%
Shoreline	125	8	5%	2%	8%
Kirkland	111	22	14%	6%	7%
Des Moines	103	19	9%	10%	12%
Redmond	92	11	4%	8%	6%
Sammamish	23	4	4%	13%	4%
Other Cities or Unincorporated	387	41	5%	6%	--

Data for PLWH by city in King County that had a population size above 50,000 or more than 100 PLWH in 2023.

[A] Population estimates and percent of population living in poverty from the U.S. Census data

Summary

Most PLWH in King County rapidly link to care following HIV diagnosis and 85% are virally suppressed. This level of suppression is higher than recent estimates from other urban areas in the western U.S. (64-77%; Los Angeles County, San Francisco and Portland) and vastly higher than the 2022 national estimates of viral suppression (65%).[6]

Despite this success, King County has made relatively little progress increasing this number over the last three years. Intersecting social and structural factors continue drive disparities in HIV-related care, with U.S.-born Black people, people who were homeless or unstably housed, PWID, and people who use methamphetamine having the lowest rate of viral suppression. Through EHE, PHSKC is continuing to adapt and innovate approaches to HIV care to better serve people facing complex barriers to care.

6. Ending the HIV Epidemic Pillar 3: Prevent

KEY POINTS

- Half of MSM are currently on PrEP for HIV prevention.
- Two-thirds (67%) of MSM who met criteria for being a priority population for PrEP are currently using PrEP.
- In 2023, the PHSKC SSP sites distributed over 1.5 million syringes and had over 18,000 participant encounters. Compared to 2020, SSPs had similar numbers of client counters but distributed 71% fewer syringes. These numbers highlight the continued demand of prevention services among people who use drugs as injection drug use decreases and other routes of drug ingestion increase.
- In 2023, PHSKC SSPs distributed 5,337 naloxone kits, a 37% increase from 2022; 1,945 SSP clients reported using a kit to reverse an opioid overdose, a 145% increase from the previous year.
- In 2023, PHSKC distributed over 1.1 million external condoms, 23,000 internal condoms, and 70,500 packs of lubricants (lube) across King County.

Introduction

The prevention pillar of the EHE initiative focuses on two highly effective, evidence-based HIV prevention approaches: PrEP and syringe services programs (SSP). The first approach, PrEP, consists of taking a medication to prevent HIV acquisition, and the EHE initiative aims to increase the use of PrEP among populations who may most benefit from it. In King County, efforts to expand PrEP use have focused on men who have sex with men, transgender people who have sex with men, and people who inject drugs with additional indications for PrEP (e.g., women who exchange sex). The second approach, SSPs, seeks to provide harm reduction services to reduce the risk of infectious diseases and other outcomes, including overdose, among people who use drugs. Services offered at SSPs typically include syringe access, naloxone (overdose reversal medication) distribution and training, treatment for substance use disorders, HIV and hepatitis C testing and linkage to care, and wound care. The goal of EHE is to increase access to and the quality of SSPs among people who use drugs. A third HIV prevention approach, condom distribution, is not included in EHE but remains an important component of prevention efforts for both HIV and other STIs. Here we highlight progress that King County has made toward increasing access to, and use of, each of these interventions to prevent HIV.

TABLE 6-1 King County Progress Towards HIV Prevention Goals

Goals and Evaluation Metrics	2019	2023	2025 Goal
PrEP use, MSM meeting PrEP priority criteria	47%	67%	>70%
Disparities in PrEP use among MSM who meet PrEP priority criteria by race/ethnicity		AI/AN: 50% Latinx: 68% Asian: 70% NH/PI: 60% Black: 56% White: 68%	<5% difference between groups and overall rate
Syringe coverage	283/PWID	319/PWID	>365/PWID

2019 is the first year for the EHE initiative. AI/AN = American Indian/Alaska Native; NH/PI = Native Hawaiian or Pacific Islander; MSM = men who have sex with men; PWID = people who inject drugs. Note: The goal for disparity-related indicators is for no difference between each racial/ethnic group and the estimate for the entire population for each indicator. This is defined as having all racial/ethnicity specific estimates within 5% of the overall estimate. Detailed definitions for metrics can be found in the Technical Notes to the Dashboard (page 11).

Pre-Exposure Prophylaxis (PrEP)

Background

People who are at risk for HIV can take a medication to reduce their risk of acquiring HIV. This prevention strategy, PrEP, usually involves taking a single pill daily. In 2021, an injectable version of PrEP received approval by the U.S. Food and Drug Administration (FDA). Multiple clinical trials showed that PrEP medications are safe and effective at reducing the risk of acquiring HIV through sexual behavior or injection drug use.

When people take PrEP consistently, their risk of HIV is decreased by at least 90%. PHSKC and WA DOH PrEP implementation guidelines recommend PrEP initiation for the specific priority populations and recommend providers discuss the possibility of PrEP initiation with other populations (Figure 6-1).

FIGURE 6-1 PHSKC and WA DOH PrEP implementation guidelines

Medical providers should recommend that individuals initiate PrEP if they meet the following criteria:	• MSM, transgender or non-binary people who have sex with men (or any partners with a penis) if the person has any of the following in the past 12 months:
	  ◦ Diagnosis of gonorrhea or early syphilis
	  ◦ Methamphetamine use
	  ◦ Condomless receptive anal sex with someone other than a mutually monogamous partner
	  ◦ >10 sex partners
	  ◦ Trading sex for money, drugs, housing, or other things of value
	• People in ongoing sexual partnerships with a person who is living with HIV and who is not on antiretroviral therapy (ART), is on ART but is not virologically suppressed, or who is within 2 months of initiating ART

Medical providers should discuss PrEP with any person seeking a prescription for PrEP or based on any of the following:	• MSM, transgender or non-binary people who have sex with men (or any partners with a penis), outside of a long-term, mutually monogamous relationship with another HIV-negative person • People who inject drugs • Women who exchange sex for money or drugs • Persons in HIV-serodifferent relationships who are planning to get pregnant • Persons diagnosed with syphilis

Monitoring PrEP Use

PHSKC uses multiple methods to monitor PrEP use among MSM, transgender, and non-binary people who have sex with men in King County. Two surveys assess current PrEP use in these key populations: the annual Pride Survey and the National HIV Behavioral Surveillance (NHBS) surveys.

Additional data on PrEP use among MSM, transgender, and non-binary people who meet local criteria for recommending PrEP (henceforth referred to as "PrEP priority populations") come from data collected from STI case reports, public health interviews following an STI diagnosis (referred to as partner services interviews) and patient data from PHSKC's Sexual Health Clinic.

These surveys and data sources are described in more detail in the Technical Notes. When possible, PrEP outcomes are presented separately for MSM who met the local criteria for being a priority population and those who do not.

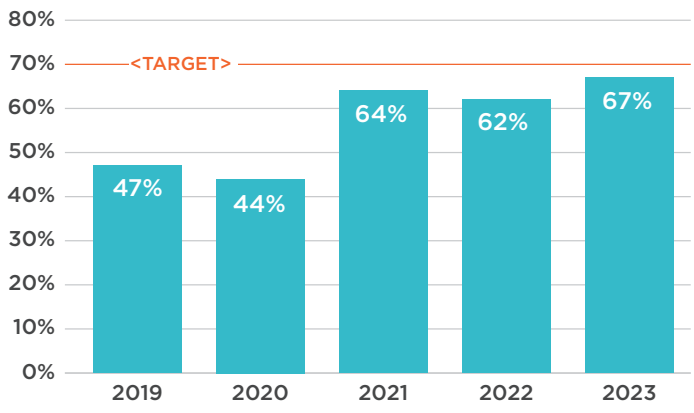
PrEP Use

PrEP Use Among MSM

PHSKC has a goal of having 70% of MSM at who meet PrEP priority criteria to be using PrEP by 2025. Over the past decade, PrEP use has rapidly expanded among King County MSM. In Figure 6-2 and Table 6-2 we summarize recent data on PrEP use among MSM across several data sources: NHBS participants, PHSKC Sexual Health Clinic patients, and Pride Survey participants.

We estimate that 67% of MSM who meet PrEP priority criteria are currently using PrEP and that 50% of all MSM are on PrEP. We observed moderate differences in current PrEP use by race/ethnicity among MSM PrEP priority populations: 56% of Black MSM, 68% of Latinx MSM, and 68% of White MSM.

FIGURE 6-2
Current PrEP use Among MSM meeting "PrEP priority population criteria," King County, WA, 2019-2023



Priority population criteria include ≥ 10 sex partners in the past 12 months, methamphetamine use in the past 12 months, gonorrhea or syphilis diagnosis in the past 12 months, condomless receptive intercourse in the last 12 months. Trading sex for money, drugs, housing, or other things of value not included as part of priority population assessment as it is not systematically captured across data sources. The percentage for MSM meeting PrEP priority population was calculated based on a weighted average of the NHBS-MSM survey, Pride Survey, PHSKC SHC data.

PrEP use among MSM PrEP priority populations can also be estimated using data collected when people are diagnosed with an STI (partner services interview data). Among MSM with a recent diagnosis of gonorrhea or syphilis, 80% reported currently being on PrEP (Figure 6-3). This PrEP use estimate was higher than estimates in Table 6-2 due to the overrepresentation of MSM who receive frequent STI screening as part of being on PrEP and consequently are more likely to be diagnosed with asymptomatic STIs. Because urethral gonorrhea is usually symptomatic (i.e., people seek testing and treatment because of symptoms), it provides an estimate of PrEP use that is less likely to be influenced by frequent STI screening routinely done in people on PrEP. Seventy-five percent of MSM diagnosed with urethral gonorrhea in 2023 were on PrEP.

TABLE 6-2
Estimated PrEP Use Among MSM, King County, WA, 2023-2024

	NHBS-MSM Survey 2023[A]	PHSKC Sexual Health Clinic 2023	Pride Survey 2024[A]	Combined Estimate of MSM Currently on PrEP[B]
MET PrEP PRIORITY CRITERIA*				
American Indian/Alaska Native	28%	70%	75%	50%
Asian	60%	75%	38%	70%
Black	53%	56%	75%	56%
Latinx	64%	70%	54%	68%
Native Hawaiian or PI	0%	65%	25%	60%
White	65%	69%	63%	68%
All	62%	69%	62%	67%
DID NOT MEET PrEP PRIORITY CRITERIA*				
All other MSM	27%	35%	21%	33%
ALL MSM				
All MSM	52%	59%	46%	50%

* Race/ethnicity categories are not mutually exclusive and individuals reporting multiple racial and ethnic identities are represented in each group. Priority population criteria include >= 10 sex partners in the past 12 months, methamphetamine use in the past 12 months, gonorrhea or syphilis diagnosis in the past 12 months, condomless receptive intercourse in the last 12 months. Trading sex for money, drugs, housing, or other things of value not included as part of priority population assessment as it is not systematically captured across data sources.

[A] The number of NHBS and Pride respondents who identified as American Indian/Alaska Native, Black, or Native Hawaiian or Pacific Islander and who were higher risk for HIV was ≤10 in each respective category. Given the small number of respondents, the estimates for these populations may not be representative and should be interpreted with caution.

[B] The percentage for all MSM was calculated based on a weighted average of the NHBS-MSM survey and Pride Survey, which are the data sources most representative of the entire population of MSM. The estimates for MSM meeting PrEP priority population criteria also included PHSKC SHC data.

PrEP Use Among Transgender and Gender Diverse People Who Have Sex with Men

Data on PrEP use among transgender and gender diverse populations are available in multiple data sources (Table 6-3). Among people seeking care at PHSKC's Sexual Health Clinic, current PrEP use was 43% among HIV-negative transgender or non-binary/genderqueer people who reported sex with male partners. Among those who met local PrEP priority criteria, two-thirds (66%) were currently using PrEP.

People Who Inject Drugs and Women who Exchange Sex for Money or Drugs

PrEP awareness and use remained very low among local populations of PWID (non-MSM) and women who exchange sex, including women who both exchange sex and inject drugs. Data from the 2022 NHBS survey of PWID showed that only 34% of HIV-negative PWID were aware of PrEP and 1% had used PrEP in the past year. Among the subset of 61 women who reported exchanging sex for money or drugs, 34% had heard of PrEP and none had used PrEP in the last year.

Public Health Activities to Promote Access to and Use of PrEP

PHSKC and the WA DOH engage in a range of activities to increase PrEP use among those who may benefit most, including directly providing of PrEP, outreach efforts and PrEP navigation designed to increase the use of PrEP, dissemination of information, and financial assistance to make PrEP more accessible.

TABLE 6-3

PrEP Use Among Transgender, Non-Binary, And Genderqueer People Who Have Sex With Men, King County, WA, 2023–2024

Data Source	Population	Proportion Currently on PrEP
Pride Survey, 2024	Transgender or non-binary/genderqueer; reported sex with cisgender man, transgender women, and/or nonbinary assigned male at birth (AMAB) sex partners (N=151)	26%
	Transgender women, transgender men or non-binary/genderqueer people AMAB; reported sex with cisgender man, transgender women, and/or nonbinary AMAB sex partners (N=86)	41%
PHSKC Sexual Health Clinic, 2023	Transgender or non-binary/genderqueer; reported sex with men (N=241)	43%
	Transgender or non-binary/genderqueer; reported sex with men; and met PrEP priority criteria for being at higher risk for HIV (N=105)	66%
STI partner services data, 2023	Transgender or non-binary/genderqueer; reported sex with men; diagnosed with gonorrhea or syphilis (N=113)	65% 58% of transgender women 63% of transgender men 72% of non-binary/genderqueer
NHBS survey of transgender women, 2023-2024	Transgender women (N=148)	30% (past year) 24% (past 30 days)
	Transgender women; met criteria for being a PrEP priority population (N=96)	42% (past year) 34% (past 30 days)

PrEP Program in PHSKC's Sexual Health Clinic

PHSKC's Sexual Health Clinic started prescribing PrEP in October 2014. The racial and ethnic composition of the population of receiving PrEP in the Sexual Health Clinic in 2023 is shown in Table 6-4.

Overall, these estimates are similar to the racial/ethnic composition of the population of MSM diagnosed with HIV in King County in 2023 (Table 1-6).

TABLE 6-4

PrEP Services Provided by Public Health – Seattle & King County, WA, 2023

DATA FROM PHSKC SEXUAL HEALTH CLINIC	# or %
Patients completing initial intake	
Ever (October 2014 – December 2023)	2,913
2023 only	587
Patients currently receiving PrEP[A,B]	1,213
MSM	92%
American Indian/Alaska Native	2%
Asian	15%
Black	10%
Latinx	26%
Native Hawaiian or Pacific Islander	5%
White	60%
DATA FROM STI CASE REPORTS AND PARTNER SERVICES INTERVIEWS IN 2023[C]	
HIV-negative MSM diagnosed with syphilis or gonorrhea	2,261
Already using PrEP	1,817 (80%)

[A] MSM defined as cisgender men reporting sex with men, including cisgender or transgender men.

[B] Race and ethnicity categories were not mutually exclusive (i.e., a person who reported more than one race is represented in each reported racial category).

[C] Public health interview with an individual following an STI diagnosis.

Community-Based PrEP Programs and PrEP Navigation

The WA DOH supports several community-based programs to promote PrEP use and make PrEP more accessible in King County. The primary intervention is PrEP navigation, which connects current and prospective PrEP clients with PrEP navigators in their community. PrEP navigators counsel clients about PrEP, help clients obtain health insurance and funding for PrEP and associated medical services, and increase continued PrEP use through reminders and ongoing support.

PrEP navigators currently operate at multiple agencies in King County: Entre Hermanos, POCAAN, Lifelong, LGBTQ+ Center (formerly Gay City), Madison Clinic at Harborview Medical Center, Country Doctor, and CMCH. In 2023, 1,031 unique clients received PrEP navigation services among whom 63% filled a PrEP prescription.

PrEP Information and Resources supported by PHSKC

PHSKC maintains a web page with PrEP information and resources, available here: www.kingcounty.gov/prep. The website includes facts about PrEP, a link to the "We are 1" decision tool to help people decide if PrEP is right for them, information about paying for PrEP, and clinical guidelines for providers.

The web page also includes a list of medical providers who are willing to prescribe and manage patients on PrEP, and a searchable map of these medical providers. A 2023 campaign highlighted "Easier Access" to HIV testing, treatment, and PrEP and can be found here: Easy access to HIV testing, treatment and PrEP - King County, Washington.

PrEP Discontinuation

Increases in PrEP use, especially among those who may benefit most, are signs of successful public health efforts; however, PrEP discontinuation among people who continue to be at risk for HIV remains a challenge. Of the 2,977 patients enrolled in the Sexual Health Clinic PrEP program from October 2014 to December 2023, the median time from PrEP initiation to discontinuation was only 7 months with 52% of patients discontinuing PrEP within 12 months of initiation (Table 6-5).

American Indian/Alaska Native and Black patients had shorter times to discontinuation compared to other groups. Notably, people who were unhoused had the shortest time to discontinuation, with 83% discontinuing PrEP within 12 months of initiation. Multi-level approaches are needed to better support people interested in using PrEP.

TABLE 6-5

PrEP Discontinuation Among PHSKC SHC PrEP Patients, 2014-2023

	Median (IQR) to PrEP discontinuation (months)	% discontinuing PrEP < 12 months after starting
All Patients	7 (3-16)	52%
AGE (years)		
15-19	6 (2-12)	69%
20-24	7 (4-16)	55%
25-34	7 (4-16)	51%
35-44	7 (4-14)	50%
45-54	7 (3-17)	50%
55+	8 (4-22)	31%
RACE/ETHNICITY*		
American Indian/Alaska Native	5.5 (2.5-12)	64%
Asian	8 (4-16)	47%
Black	5 (2-12)	62%
Latinx	7 (3-17)	51%
Native Hawaiian or Pacific Islander	7 (4-14)	50%
White	7 (4-16)	51%
OTHER FACTORS		
Experiencing homelessness/unstable housing	3 (1-7)	83%
Stable housing	8 (4-16)	50%
Methamphetamine use	5 (1-9.5)	71%
No methamphetamine use	8 (4-16)	50%

*Race/ethnicity categories are not mutually exclusive and individuals reporting multiple racial and ethnic identities are represented in each group.

Summary

King County is close to meeting its goal of having 70% of MSM at higher risk for HIV on PrEP, with approximately 67% of MSM who meet PrEP priority criteria and 50% of all MSM in King County on PrEP. Notably, 80% of MSM diagnosed with a bacterial STI — perhaps the population at highest risk for HIV — reported being on PrEP. Data also showed higher levels of PrEP use among Latinx MSM, a population in King County that has experienced high rates of HIV and STIs. King County and Washington state provide robust services and options for people to access PrEP, including offering PrEP at the PHSKC Sexual Health Clinic, promotion of PrEP prescribing though large healthcare organizations, and community-based PrEP navigation services.

Despite high levels of PrEP use among MSM in King County, there remain challenges in PrEP uptake and continuation. Published research suggests that PrEP use is lower among some subpopulations of MSM, particularly Black MSM, younger MSM, and MSM who use methamphetamine, populations at particularly higher risk for HIV infection.[7] Local data show lower PrEP use among Black and American Indian/Alaska Native MSM, as well as higher rates of PrEP discontinuation among Black MSM, MSM who use methamphetamine, and MSM who are unstably housed.

Syringe Service Programs (SSP)

SSPs are public health programs for people who use drugs, including PWID. One component of SSPs is the distribution of new, sterile syringes and other injection equipment, which reduces the spread of HIV and other blood-borne infections among PWID. To reduce the frequency of injection and its associated risks, SSPs can also provide safer smoking equipment (e.g., pipes, foil).

As shown in Figure 6-4, SSPs provide many other harm reduction services to people who use drugs. In 2023, there were four major SSPs in King County, including the PHSKC SSP, People's Harm Reduction Alliance (PHRA), Hepatitis Education Project (HEP), and Project NEON.

FIGURE 6-4

Harm Reduction Services Provided by PHSKC SSP

- **SYRINGES**
- **OTHER INJECTION EQUIPMENT**
- **SAFE DISPOSAL OF INJECTION EQUIPMENT**
- **SAFER SMOKING SUPPLIES (pipes, foil)**
- **NALOXONE AND OVERDOSE PREVENTION**
- **HIV/HCV TESTING**
- **LINKAGE TO DRUG TREATMENT**
- **WOUND CARE**
- **HYGIENE SUPPLIES**
- **VACCINATIONS**
- **CASE MANAGEMENT SERVUCES**
- **DRUG TESTING**

TABLE 6-6

Number of Syringes Distributed at King County Syringe Services Programs, 2020-2023

SSP*	2020	2021	2022	2023	% change 2020-2023	Average annual % change
PHSKC SSP Overall	5,442,766	5,158,262	2,642,206	1,591,004	↓71%	↓31%
Downtown	2,071,717	1,873,482	1,096,093	800,445	↓61%	↓26%
Capitol Hill	935,086	926,180	504,377	291,030	↓69%	↓30%
South King County (SCORE) mobile	1,808,736	1,514,200	731,749	394,987	↓78%	↓38%
North Seattle (NORE) mobile	627,227	844,400	309,987	104,542	↓83%	↓32%
People's Harm Reduction Alliance (PHRA)	2,781,515	1,767,424	891,408	638,769	↓77%	↓38%
Hepatitis Education Project (HEP)	509,132	393,681	289,926	255,393	↓50%	↓20%
TOTAL	**8,733,413**	**7,319,367**	**3,823,540**	**2,485,166**	**↓72%**	**↓33%**

*Project NEON provided syringes but did not track all syringe distribution numbers.

Number of Syringes Distributed and Client Encounters

Figure 6-5 shows the trends in syringe distribution at the PHSKC SSP since its inception in 1989. The number of syringes distributed peaked in 2020 at nearly 5.5 million syringes and has declined substantially since then. Table 6-6 includes the annual number of syringes distributed by each King County SSP in 2020-2023 with the total percent change since 2020 and the average annual percent change since 2020. In 2023, the PHSKC SSP distributed 1,591,004 syringes at its four sites, which reflected a 71% decrease since 2020. This large decrease in syringe distribution was seen across all PHSKC SSP sites and other King County SSPs.

The World Health Organization (WHO) recommends that SSPs provide 300 sterile syringes per PWID per year by 2030 to control HIV infection in the population. The PHSKC HIV/STI/HCV Program has a goal to distribute 365 syringes per PWID by 2025. In 2023, we utilized a new local estimate of the number of PWID in King County (7,800 PWID). This methodology is described in more detail in Technical Note 4. This resulted in an estimated syringe coverage in King County of 319 syringes per PWID. This is very similar to our last estimate of syringe coverage in 2021 which was 316 syringes per PWID.

FIGURE 6-5 Annual Number of Syringes Distributed at PHSKC Syringe Services Programs, 1994-2023

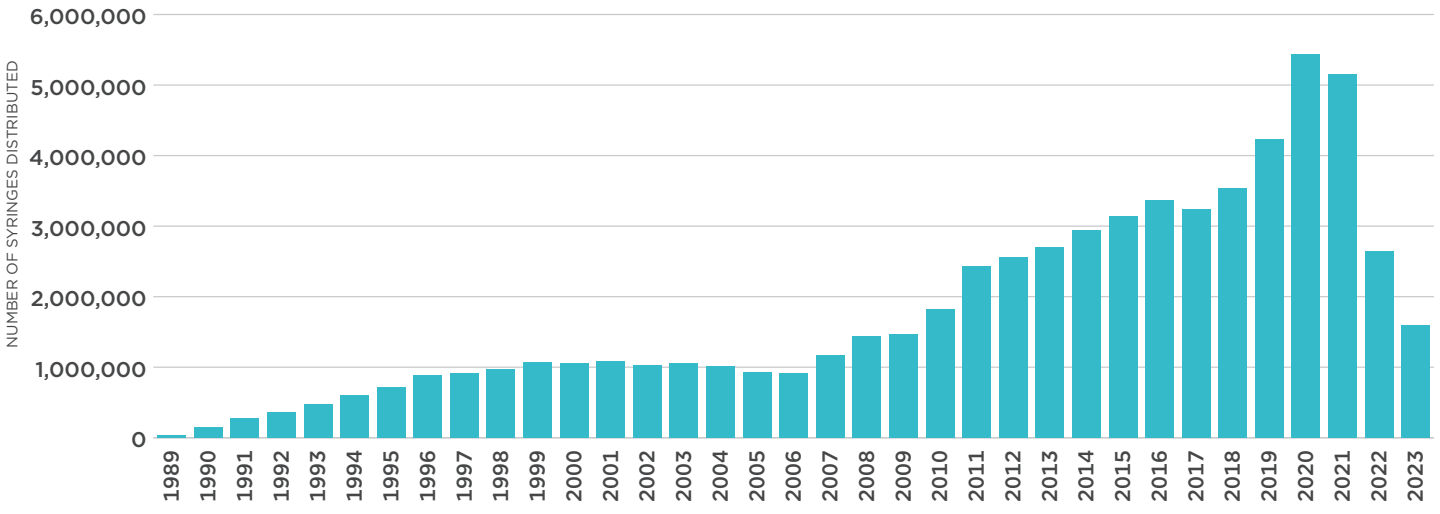


Table 6-7 includes the number of client encounters at the PHSKC SSP in 2023 and the percent change from 2021. There were 18,579 total encounters in 2023, which was a 29% increase from the previous year and similar to the number of encounters in 2021.

The increase from 2022 was driven by a notable increase at the downtown SSP following several years of declining numbers of client encounters.

TABLE 6-7

Annual Number of Client Encounters at the PHSKC SSP, 2020-2023

SSP	2020	2021	2022	2023	% change 2020-2023	Average annual % change
PHSKC SSP Overall	19,708	18,018	14,424	18,579	↓6%	0%
Downtown	11,104	9,996	9,232	14,889	↓61%	↑15%
Capitol Hill	2,921	2,623	1,724	1,589	↑46%	↓17%
South King County (SCORE) mobile	2,974	2,295	1,052	687	↓77%	↓37%
North Seattle (NORE) mobile	2,709	3,104	2,416	1,414	↓48%	↓16%

Safer Smoking Supplies

Fentanyl was introduced into the Seattle-area drug market in the mid/late-2010s, but its use increased substantially around 2020. During this time, there was a substantial shift in the prevalence of injection drug use, with many people switching to smoking fentanyl. At the same time, there was a large increase in the fatal overdose rate in King County, largely attributed to fentanyl use. (See King County overdose dashboard at https://tinyurl.com/kcoverdose.) Since October 2022, the PHSKC SSP has distributed pipes to clients. The goals of this new effort are to reduce the frequency of drug injection and related infections (e.g., HIV and HCV) and attract new SSP clients who might benefit from harm reduction services (e.g., naloxone, linkage to treatment for opioid use disorder). This change in service was instituted in large measure to address the county's epidemic of overdose death and reflects the program's effort to prioritize overdose prevention as a critical public health objective.

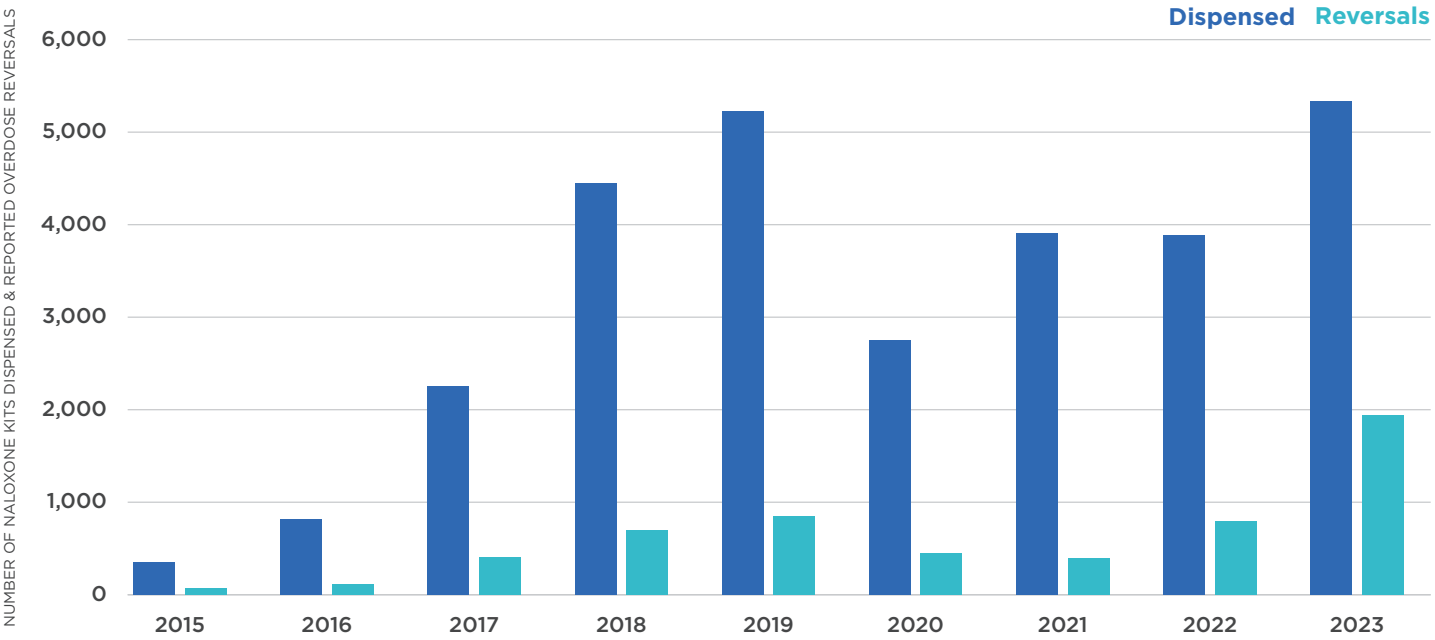
In 2023, SSP staff distributed 4,807 pipes. This includes 1,312 pipes from January to July (monthly average of 187 pipes) and 3,495 pipes from August to December (monthly average of 699 pipes) when the pipe program increased its cap on the number of pipes distributed each day. At 8% of all pipe encounters, the person reported that it was their first time receiving services at the SSP. The majority (77%) of people who received a pipe received another service, including 12% who received naloxone at that visit. People who were at the SSP for the first time were significantly more likely to receive naloxone with a pipe (21%) than returning participants who received a pipe (12%).

Naloxone

In 2023, King County reached a grim milestone of 1,339 fatal overdoses, the highest number of overdose deaths ever recorded in the county. As noted in the Overview of HIV in King County chapter, fatal overdoses have also increased among people living with HIV, including an approximate six-fold increase between 2017 and 2021. Naloxone is an opioid-antagonist medication used to reverse the effects of an opioid overdose.

PHSKC SSP sites have been offering naloxone kits and training to clients since 2012. Figure 6-6 shows the number of naloxone kits distributed at PHSKC SSP sites since 2015. In 2023, the PHSKC SSP distributed 5,337 naloxone kits, which was a 37% increase from 2022 and a record high. In 2023, 1,945 clients self-reported using a kit to reverse an opioid overdose, a 145% increase from the previous year.

FIGURE 6-6 Annual Naloxone Distribution at PHSKC SSP Sites, 2015-2023



Other Harm Reduction Services

Table 6-8 summarizes the volume of other harm reduction services provided at the PHSKC SSP in 2023.

TABLE 6-8

Number of Harm Reduction Services Provided by the PHSKC SSP, 2021-2023

Harm Reduction Services	2021	2022	2023	Average Annual Percent Change
Social work services				
Number of unique clients	93	77	115	16%
Number of contacts per client	1-8	1-4	1-5	--
Referrals to medication for opioid use disorder	49	42	34	-16%
On-site buprenorphine treatment (Pathways)				
Number of unique clients (end of 2023)	455	490	543	9%
Client visits	2,582	3,844	2,866	12%
Medical care encounters at downtown SSP[A]	--	887	869	-2%

[A] Starting in 2022, we began tracking medical care visits of SSP clients at the Pioneer Square Downtown medical clinic.

- Social workers provide referrals to treatment for substance use disorder (medication for opioid use disorder, intensive outpatient, and detox), as well as primary and mental health care. They also help people sign up for health insurance, provide resource information, and talk with people who are in crisis and offer support and encouragement.
- Pathways (formerly known as Bupe Pathways) provides low-barrier access to buprenorphine, a medication for opioid use disorder. Pathways is in the same building as the Downtown PHSKC SSP and is staffed by an interdisciplinary team. Buprenorphine prescriptions can be dispensed at the on-site pharmacy. The program moved into a new, larger clinical space in 2021, which has resulted in an increase in the number of clients and client visits.
- The downtown SSP partners with the Pioneer Square Downtown medical clinic to provide medical services to clients, including injection-related wound care.
- Other PHSKC staff provide HIV and HCV testing services at the PHSKC SSP and assist clients with linkage to follow-up care and treatment, including onsite at the SSP.
  - PHSKC staff tested 62 clients for HIV in 2023. Based on data from the 2023 SSP Survey, 53% of all participants who used drugs had tested for HIV in the past year.
  - Among 46 clients who expressed interest in the HCV treatment process in 2023 at the PHSKC SSP, 21 (46%) were prescribed treatment, 17 (37%) completed treatment, and 15 (33%) had a final laboratory test that indicated they were cured. More detail is available in the annual PHSKC HCV Report at: https://tinyurl.com/kchcvreport.

Participant Drug Use Trends

In December 2023, the PHSKC SSP team conducted its biennial survey of SSP participants to provide a snapshot of participant demographics, substance use patterns, health outcomes, and service needs.

A comprehensive report of these findings can be found here: https://tinyurl.com/KCSSPsurvey. Four key findings included:

- Methamphetamine use was reported by 86% of participants who used drugs, and fentanyl use was reported by 76%. Fentanyl was the most common "main" drug.
- 59% of participants who used drugs reported that they had only smoked drugs in the past seven days, while 35% reported any injection drug use.
- 9% of people who injected drugs reported sharing syringes in the past three months, reflecting a declining trend since 2015.
- 71% of participants who were homeless or unstably house said they would use less or quit their drug use completely if they had stable housing.

Summary

Over the past year, the PHSKC SSP has continued to update and expand services to meet the needs of the growing number of people who smoke drugs by providing safer smoking supplies, including pipes and foils. This year (2023) was the first full year of pipe distribution. The need for and impact of this program was evident from the high numbers of smoking supplies distributed as well as the overall increase in the number of participants at the downtown SSP, which was a significant reversal from previous years. Data from the pipe program demonstrated that the new service attracted new clients to the SSP and successfully provided clients with critical services, including naloxone.

The volume of naloxone distribution continued to increase after a dramatic decline during the COVID-19 pandemic, a critical response to the record high number of fatal opioid overdoses in King County.

The data presented above demonstrate how PHSKC SSPs have dramatically altered the services they provide to sustain and grow the program's engagement with people who use drugs and focus services on preventing overdose deaths, the most urgent problem confronting drug users in King County.

Condom Use and Distribution

Background

When used correctly and consistently, condoms are highly effective in preventing HIV, other sexually transmitted infections (STI, e.g., syphilis, gonorrhea, chlamydia, genital herpes, and human papillomavirus), and unwanted pregnancies.

Although many people do not use condoms every time they have sex, condom use remains widespread and are a low-cost intervention well-suited for use in a diverse population that includes persons of all ages, genders, and sexual orientations.

King County Condom Distribution Projects

Overall, in 2022, the PHSKC HIV/STI Condom Distribution Program dispensed a ~1.1 million external condoms, 3,000 internal condoms, and 70,500 packs of lubricants (lube) across King County. In addition, the Condom Distribution Program distributed 30,328 external condoms to attendees of Seattle Pride Fest 2023. Condoms distributed by the Condom Distribution Program increased by 78% from 2021 to 2022. This increase is attributed to the expansion of several condom distribution projects.

- In 2019, the PHSKC HIV/STI Condom Distribution Program launched the Condom Cube Project (www.condomcubes.com.) This project aims to promote the availability, accessibility, and acceptability of free condoms to increase condom use and decrease HIV/STI transmission. One priority of the Condom Cube Project was to expand availability of free condoms specifically to King County zip codes with high rates of bacterial STIs and HIV, and areas where free condoms were not previously available. The project places Condom Cubes, custom acrylic open-top boxes that hold 500 free condoms of 20 different types, in a variety of public venues that are easily accessible, particularly for youth. Condom Cubes are available in 20 zip codes in King County. In 2023, there were 216 Condom Cubes at venues throughout the county that facilitated distribution of 856,500 external condoms.
- The Condom Distribution Program developed condom “Fit Kits” to encourages people to find the condom that fits them the best and maximizes their pleasure with the goal of increasing condom use and decreasing the transmission of HIV and STIs. The kits provide 20 varieties of condoms, two types of lube, a syphilis testing and treatment resource card, an information card on how to use the kit, instructions on how to correctly use a condom, PrEP information, and additional sexual health resources. In 2023, Fit Kits were distributed to PHSKC Sexual Health Clinic patients and HIV/STI community partner testing sites for their clients. A total of 1,000 Fit Kits (20,000 condoms and 2,000 packets of lube) were distributed.

Summary

PHSKC and the WA DOH remain committed to condoms as part of a broad-based prevention program for HIV and other STIs. Inadequate access to free condoms can be a barrier to condom use for some populations.

PHSKC has launched new initiatives to promote condom use by expanding access to free condoms with methods that are acceptable to the populations affected by HIV/STI.

7. Ending the HIV Epidemic Pillar 4: Respond

KEY POINTS

- Since 2021, PHSKC has incorporated molecular HIV analysis into cluster detection and response (CDR) activities. These activities seek to identify groups of people with HIV (clusters) who may be linked to one another in sexual or drug using network. CDR is designed to identify clusters of infection with recent and rapid growth and allow public health to intervene to prevent transmission.
- To date, PHSKC has received HIV genetic sequences from 76% of people newly diagnosed with HIV, with some differences in sequence availability across populations
- CDR has identified several recent clusters, most of which were comprised predominantly of men who have sex with men.
- Initial experiences with molecular HIV analysis as part of CDR suggest that this multi-faceted approach can help to connect people with HIV-related services. Among 244 people investigated by PHSKC as part of CDR February 2021 through June 2024, 36 (15%) were successfully contacted and linked to services.
- Among people who completed a cluster interview, most agreed that it was important for the health department to follow up with people who may be part of HIV clusters.

Background

Pillar 4 of the EHE Initiative promotes novel methods of identifying quickly growing HIV clusters. This identification is then followed by a rapid response to provide prevention and treatment resources to individuals linked to the cluster through their sexual and/or drug use networks.

This strategy is often referred to as cluster detection and response (CDR) and combines established and newer methods for cluster identification and response. In 2021, PHSKC introduced metrics to evaluate our CDR program (Table 7-1). Here we describe PHSKC's efforts to identify HIV clusters that include King County residents and respond through the provision of appropriate HIV-related services.

TABLE 7-1 King County Progress Towards HIV Response Goals

Goals and Evaluation Metrics	2021	2023[A]	2025 Goal
Cluster members living with HIV and meeting eligibility criteria assessed for follow-up within 30 days of identification	78%	78%	> 90%
Cluster members eligible for cluster interview contacted by DRIS by June 30th of the following year	68%	27%	>70%

[A] Goals for pillar 4 were put in place in 2021 rather than 2019 as with the other EHE pillars.

Approach to HIV Cluster Identification

PHSKC uses multiple methods for cluster identification, including:

- **Medical provider reports.** Providers and public health staff may notice an increase in HIV diagnoses in a specific population.
- **Time-space cluster analyses.** Public health analyses look for geographic areas with counts of recent diagnoses that are higher than expected. These analyses are conducted by the Washington State Department of Health (WA DOH) and can identify new patterns of HIV transmission, especially when occurring in non-urban areas or crossing jurisdictional boundaries.
- **Public health analysis of HIV surveillance and case investigation data.** Public health attempts to investigate all newly diagnosed cases of HIV infection. The information collected as part of these investigations can help to identify clusters.
- **Molecular HIV analysis.** Linkages of HIV viral genetic sequences.

Below we provide additional details on the use of partner services interviews/case reports and HIV genetic sequences for cluster detection. Regardless of the method of identification, PHSKC responds to identified clusters to ensure that impacted individuals receive appropriate HIV testing, prevention and/or treatment services.

Partner Services Cluster Identification

When people are newly diagnosed with HIV or selected other sexually transmitted infections, health department staff contact them to offer assistance notifying their sex and/or syringe-sharing partners and helping both the person with HIV and their contacts get medical and prevention services.

This activity also allows PHSKC staff to collect information about people with newly diagnosed HIV and their partners, including geography, potential HIV exposures, substance use, and reason for HIV testing. In some instance, this information allows the health department to identify clusters of related cases.

Molecular Analysis, Cluster Identification, and Prioritization

Genetic sequencing of HIV to identify possible drug resistance is a standard part of clinical HIV care. Laboratories report HIV genetic sequences to the health department. Over time, as the virus replicates within a person's body, changes (i.e., mutations) accumulate in the virus' genetic sequence. These changes mean that infections with very similar viral sequences are likely to be closely related or linked. The viruses in two people can be very similar even in the absence of a direct link (e.g., sex or syringe sharing) between the people with the infections.

Therefore, these data cannot be used to determine if a person transmitted HIV to another person or if two people had any direct contact through sex or drug use. However, they can still be useful for guiding public health action. When PHSKC observes a cluster of new HIV diagnoses with related viruses, it suggests that HIV may be rapidly spreading in a network. This ideally prompts a public health and community response to address the needs of affected individuals and communities. Details on the methods and tools used by PHSKC to identify potential clusters using molecular analysis and time/space analyses are provided in Technical Note 6.

Cluster Identification and Response

Completeness and Timing of Viral Sequencing

While molecular HIV cluster analysis has the potential to facilitate the provision of needed resources to affected communities, these analyses can be limited by incomplete reporting of viral sequences. Table 7-2 describes the population of King County residents diagnosed with HIV from 2014-2023 and if an HIV genetic sequence was submitted to public health. Overall, 76% of residents diagnosed with HIV during this period had an HIV genetic sequence available, with differences in reporting across self-reported race, age at diagnosis, and HIV transmission category.

Timely collection of sequences may also impact PHSKC's ability to identify clusters with recent and rapid growth. Table 7-2 also presents the proportion of sequences available within 90 days of diagnosis among individuals with an available sequence. Between 2020 to 2023, when routine molecular HIV analyses were added to PHSKC's CDR efforts, initial genotypic sequences for King County residents newly diagnosed with HIV were reported to PHSKC a median of 32 days after being collected, with 93% received within about three months.

TABLE 7-2 (Part 1 of 2) Report and Timeliness of HIV Viral Sequences for King County Residents Newly Diagnosed with HIV, 2014-2023

	All		Have a Sequence Reported		Sequence Reported Within 90 Days of Diagnosis	
	N	% (col)	N	% (row)	N	% (of those with a sequence)
TOTAL	1,822	100%	1,392	76%	1,244	89%
GENDER						
Cisgender Men	1,512	83%	1,169	77%	1,054	90%
Cisgender Women	271	15%	195	72%	164	84%
Transgender Men	4	<1%	2	50%	2	100%
Transgender Women	30	2%	23	77%	22	96%
Another Gender Identity	5	<1%	3	60%	2	67%
AGE AT HIV DIAGNOSIS (years)						
< 13	1	<1%	0	0%	0	0%
13-24	263	14%	206	78%	184	89%
25-34	686	38%	530	77%	472	89%
35-44	409	22%	324	79%	287	89%
45-54	271	15%	201	74%	177	88%
55+	192	11%	131	68%	124	95%
RACE/ETHNICITY[A]						
American Indian/Alaska Native	66	4%	55	83%	45	82%
Asian	179	10%	122	68%	113	93%
Black	486	27%	361	74%	318	88%
Latinx or Hispanic *(all races)*	358	20%	296	83%	273	92%
Native Hawaiian or Pacific Islander	36	2%	31	86%	30	97%
White	1,114	61%	878	79%	778	89%

[A] Racial/ethnic categories are not mutually exclusive and individuals reporting multiple racial and ethnic identities are represented in each group

TABLE 7-2 (Part 2 of 2) Report and Timeliness of HIV Viral Sequences for King County Residents Newly Diagnosed with HIV, 2014-2023

	All		Have a Sequence Reported		Sequence Reported Within 90 Days of Diagnosis	
	N	% (col)	N	% (row)	N	% (of those with a sequence)
TOTAL	1,822	100%	1,392	76%	1,244	89%
TRANSMISSION CATEGORY						
MSM	1,103	61%	860	78%	800	93%
PWID	104	6%	88	85%	59	67%
MSM and PWID	151	8%	125	83%	94	75%
Heterosexual Sexual Contact	197	11%	137	70%	123	90%
Perinatal	3	<1%	2	67%	2	100%
No Identified Risk	229	13%	154	67%	142	92%
Transgender Women *(all transmission categories)*	30	2%	23	77%	22	96%
Another Gender Identity *(all transmission categories)*	5	<1%	3	60%	2	67%
REGION OF RESIDENCE AT HIV DIAGNOSIS[B]						
Central Seattle	375	21%	288	77%	267	93%
North Seattle	195	11%	156	80%	140	90%
South Seattle	113	6%	90	80%	84	93%
West Seattle	76	4%	59	78%	56	95%
North King County	41	2%	32	78%	30	94%
South King County	544	30%	389	72%	350	90%
East King County	175	10%	132	75%	118	89%
Homeless or Unstably Housed	302	17%	246	81%	199	81%

[B] n=1 person has an unknown region of residence at HIV diagnosis as is omitted here. They did not have a sequence reported.

Recent Priority Clusters

For molecular HIV analyses, PHSKC considers a priority cluster as one with recent and rapid growth, which is further defined as three or more linked diagnoses in the preceding 12 months. Additional details on PHSKC's approach to molecular HIV analysis are provided in Technical Note 6. In 2023, cluster analyses identified 14 clusters with recent and rapid growth that had at least one member residing in King County at diagnosis.

These 14 clusters had a total of 87 members newly diagnosed in 2022-2023 with between 3 and 15 people per cluster. Of these 87 cluster members, 29 (33%) were diagnosed in 2023 and 24 (83%) of those 29 were King County residents. By the end of 2023, these clusters varied greatly in total size with between 3 and 177 total members, including persons diagnosed and linked to the cluster in prior years.

Table 7-3 presents demographic characteristics of King County residents newly diagnosed with HIV for whom we have an HIV viral sequence. These characteristics are compared to the subset of residents with newly diagnosed HIV who were linked to rapid cluster growth between 2020 and 2023.

Overall, 26% of residents newly diagnosed with HIV during this period were linked to rapid cluster growth. The proportion of people linked to rapid cluster growth varied across populations.

TABLE 7-3 King County Residents Newly Diagnosed with HIV & Linked to Cluster with Rapid Growth, 2020-23*

	All		Have a Sequence Reported	
	N	% (col)	N	% (row)
TOTAL	512	100%	131	26%
GENDER				
Cisgender Men	425	83%	124	29%
Cisgender Women	72	14%	5	7%
Transgender Men	2	<1%	0	0%
Transgender Women	11	2%	1	9%
Another Gender Identity	2	<1%	1	50%
AGE AT HIV DIAGNOSIS (years)				
13-24	67	13%	19	28%
25-34	204	40%	55	27%
35-44	129	25%	32	25%
45-54	70	14%	17	24%
55+	42	8%	8	19%
RACE/ETHNICITY[A]				
American Indian/Alaska Native	19	4%	7	37%
Asian	49	10%	10	20%
Black	144	28%	18	13%
Latinx or Hispanic *(all races)*	109	21%	22	20%
Native Hawaiian or Pacific Islander	10	2%	2	20%
White	297	58%	103	35%
TRANSMISSION CATEGORY[B]				
MSM	312	61%	92	29%
PWID	19	4%	7	37%
MSM and PWID	42	8%	16	38%
Heterosexual Sexual Contact	47	9%	4	9%
No Identified Risk	79	15%	10	13%
Transgender Women *(all transmission categories)*	11	2%	1	9%
Another Gender Identity *(all transmission categories)*	2	<1%	1	50%
REGION OF RESIDENCE AT HIV DIAGNOSIS				
Central Seattle	101	20%	30	30%
North Seattle	56	11%	17	30%
South Seattle	32	6%	9	28%
West Seattle	19	4%	0	0%
North King County	7	1%	2	29%
South King County	155	30%	30	19%
East King County	155	30%	30	19%
Homeless or Unstably Housed	302	17%	246	81%
YEAR OF HIV DIAGNOSIS				
2020	128	25%	35	27%
2021	127	25%	32	25%
2022	135	26%	37	27%
2023	122	24%	27	22%

*Tables includes individuals newly diagnosed with HIV between 2020-2023 who had an HIV genetic sequence reported. Individuals included in the "Residents linked to rapid cluster growth" were those diagnosed within 12 months of two or more members of the same cluster (either forming a new cluster or adding to an existing cluster).

[A] Racial/ethnic categories are not mutually exclusive and individuals reporting multiple racial and ethnic identities are represented in each group.

[B] The transmission category "men who have sex with men" includes cisgender and transgender men who have sex with men.

Cluster Interviews and Connections to HIV-related Services

Cluster interviews are an integral part of PHSKC's CDR activities. CDR interviews involve identifying members of recent and rapidly growing clusters who live in King County. Currently, individuals eligible for cluster interviews include cluster members diagnosed with HIV in the past 12 months as well as those who are virally unsuppressed or out of HIV care at some point in the year prior to being identified as a cluster member. PHSKC staff contact eligible cluster members for an enhanced partner services interview and provide them with appropriate HIV-related services. This includes HIV testing for partners. For people diagnosed with HIV, services include linkage to HIV care, antiretroviral therapy initiation, and efforts to promote retention in care to ensure sustained viral suppression. For people who are HIV-negative, services include promotion of regular HIV testing, condom use, syringe services (for PWID), and PrEP.

PHSKC seeks to assess at least 90% of people referred for a cluster interview for appropriate follow-up within 30 days of being identified as a new cluster member, and to successfully contact at least 70% of those eligible for interview by June 30th of the year following their referral (Table 7-1). In 2023, our performance on these metrics was 78% and 27%, respectively. While performance on the former metric has recovered from the staffing challenges that adversely impacted it in 2022 the latter metric continues to lag. This may, at least in part, reflect that those referred for a cluster interview in 2023 were harder to reach than those referred in 2021. In 2021, 59% of those referred for a cluster interview were recently diagnosed with HIV and may have been more likely to engage with public health. Whereas in 2023, 66% of those referred were out of care or virally unsuppressed.

Between February 2021 and June 2024, PHSKC referred 307 individuals for a cluster interview, of whom 244 (79%) were confirmed to be eligible upon initial evaluation. The most common reasons for being ineligible were moving out of King County or achieving viral suppression or re-engaging in care prior to being reached for a cluster interview.

Of the 244 eligible for a cluster interview, 91 (37%) were successfully contacted and completed at least part of the interview. Thirty-six (40%) individuals received one or more referrals to resources, including housing support (n=12), case management (n=9), PLWH support groups (n=8), mental health (n=8), food and meal resources (n=4), dental care (n=2), legal assistance (n=2), and maternal health services (n=2). In addition, 29 (32%) interviewed persons provided contact information for at least one sex or syringe sharing partner, to whom PHSKC staff provided referrals for HIV care and other services. During this period, no sex or syringe sharing partners successfully contacted by PHSKC were newly diagnosed with HIV.

In addition to the individuals PHSKC successfully contacted above, public health staff continue to try to contact cluster members who are out of care and who are not virally suppressed to help link them to care. Between February 2021 and December 2023, 81 individuals appeared to be out of care and another 74 had received some medical care but appeared to not be virally suppressed as of the date they met PHSKC criteria for cluster investigation. On initial investigation, 35/81 (43%) of the people who were out of care and 10/74 (14%) of the people who were not virally suppressed were found to have died, moved, or to be receiving HIV medical care (i.e., misclassified as out of care). Of the 46 people who were truly out of care, 28 (61%) had subsequent evidence of receiving care within 6 months of being first linked to a recent cluster. Of the 64 who were not virally suppressed, 33 (52%) had a suppressed viral load within 6 months. These data demonstrate some of the challenges inherent in HIV surveillance and the profound "churn" within the HIV medical care system. The population of people with HIV is dynamic, with people moving in and out of the area and in and out of HIV care.

Community Feedback

Both locally and nationally, some community members and researchers have expressed concern about the use of molecular data for cluster detection and response.[8,9] These concerns have often centered on the potential use of molecular data to attempt to identify individuals who have transmitted HIV and initiate criminal proceedings against them. PHSKC does not share any data with law enforcement agencies, and Washington state law was updated in 2020 to reflect current science on HIV — particularly the understanding that HIV is not sexually transmissible by persons whose viral load is undetectable — and reduce HIV-related stigma. To better understand the experience of individuals contacted for cluster interviews, we asked interviewees to rate their level of agreement (strongly agree, agree neutral, disagree, strongly disagree) with two statements:

1. It is important for the health department to follow up with people who may be part of HIV clusters.
2. It is important to me to know that I may be part of a cluster.

Of 51 individuals who answered these questions since we started asking them, nearly all (96%) agreed with statement #1 (strongly agree or agree) and 71% agree (strongly agree or agree) with statement #2. The high level of agreement with both statements suggests that interviewees believe there is value in reaching out to HIV cluster members to help ensure that people in their network are connected with HIV-related services. However, it is important to note that only a subset of individuals interviewed answered the questions. People who who declined to answer the questions might have different opinions about CDR than people who completed the interview.

Summary

PHSKC has successfully incorporated molecular HIV analysis into its broader HIV cluster detection approach. Cluster detection efforts have successfully connected a small number of King County residents to needed HIV-related and other support services (housing, dental care, etc.). While staffing challenges adversely impacted our CDR outreach in 2022, staffing was more robust in 2023.

This resulted in a high proportion (78%) of people being evaluated for a CDR interview. However, only 27% of eligible people were successfully interviewed, highlighting a continued gap in surveillance efforts. In summary, molecular HIV cluster detection complements PHSKC's established approaches to cluster detection and response to link PLWH and people in their networks to prevention and treatment.

8. Ryan White HIV/AIDS Program

Public Health - Seattle & King County is the recipient of the Ryan White Part A grant. The grant funds services to low-income people living with HIV in the Seattle Transitional Grant Area (TGA), which includes King, Island, and Snohomish counties. In grant year 2023 (March 1, 2023 – February 29, 2024), the Seattle TGA received a total of $7,306,934 in Ryan White funding. Of this, $382,494 was targeted for Minority AIDS Initiative (MAI) services. Part A funding to the Seattle TGA has remained relatively stable over the past 10 years. Table 8-1 shows the Seattle TGA Planning Council's approved service categories (in priority order), the amount spent, number of clients served, and services provided.

TABLE 8-1 (Part 1 of 2) Ryan White Part A Program Services provided in FY 2023*

Service Categories	Amount Spent	Clients Served	Services Provided	
Housing	$743,132	73	1,104	Emergency Housing Bed Nights
			10,351	Transitional Housing Bed Nights
Food Bank/Home-Delivered Meals	$1,361,726	797	16,381	Grocery Bags
			191	Nutrition Skills Building Encounters
			228	Nutrition Consult Encounters
			66,741	Prepared Meals
				Food Vouchers
Emergency Financial Assistance	$96,198	74	47	Rental Assistance Payments
			22	Utilities Assistance Payments
			4	Vision Hardware Payments
Psychosocial Support	$148,310	104	691	One-on-One Peer and non-Peer Counseling Sessions
			170	Support Groups
Non-Medical Case Management (Part A)	$1,418,026	3,063	1,387	Contacts made to other programs/services on behalf of the client
			13,115	Face-to-Face Encounters - Field
			6,387	Face-to-Face Encounters - Office
			34,092	Telephone Encounters
			9,541	Written Communication Encounters

TABLE 8-1 (Part 2 of 2) Ryan White Part A Program Services provided in FY 2023*

Service Categories	Amount Spent	Clients Served	Services Provided	
Non-Medical Case Management (MAI)	$216,299	424	1,870	Contacts made to other programs/services on behalf of the client
			987	Face-to-Face Encounters - Field
			12,596	Face-to-Face Encounters - Office
			1,345	Telephone Encounters
			928	Written Communication Encounters
Oral Health Care	$1,281,130	953	3,416	Dental Appointments
Medical Transportation	$27,796	226	1,284	One-Way Rides
Early Intervention Services (MAI)	$121,921	641	3,007	General Support Encounters
			78	Health Education/Literacy Encounters - Clients Living with HIV
			44	Linkage to Services Encounters - Clients Living with HIV
			66	Referral Encounters - Clients Living with HIV
			389	Targeted HIV Test Encounters
Outpatient/Ambulatory Health Services – Treatment Adherence	$775,992	367	14,883	Medication Adherence Assessments/Encounters

*Service categories presented in order of highest to lowest priority as determined by the Planning Council

The Part A grant funds services for over 3,000 people living with HIV, with most of the funding being used to support case management, housing, food, oral health, and treatment adherence support.

Ryan White part A clients are generally similar to the larger population of PLWH in King County with respect to age, gender identity and race/ethnicity (Table 8-2).

TABLE 8-2
Select Demographic Characteristics of Seattle TGA Clients receiving Ryan White Part A services in FY 2023 compared to all PLWH in King County*

	Ryan White Part A Clients	PLWH in King County
GENDER		
Cisgender Men	78%	85%
Cisgender Women	20%	13%
Transgender Men	2%	1%
Transgender Women	<1%	<1%
AGE (years)		
13-24	2%	2%
25-34	12%	14%
35-44	23%	22%
45-54	22%	25%
55+	40%	39%
RACE/ETHNICITY**		
American Indian/Alaska Native	3%	4%
Asian	5%	8%
Black	28%	27%
Latinx or Hispanic *(all races)*	21%	17%
Native Hawaiian or Pacific Islander	1%	1%
White	63%	67%

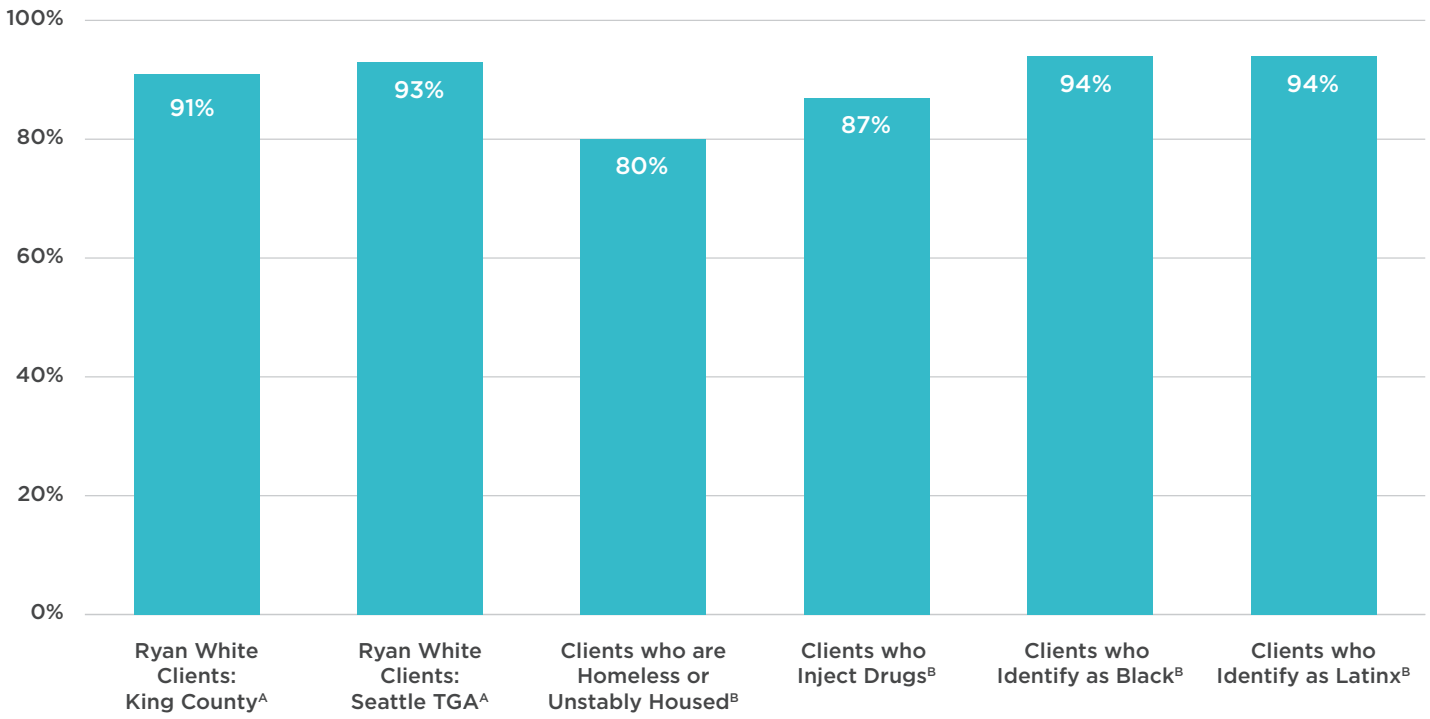
* Seattle TGA clients include those residing in King, Island and Snohomish counties.

**Race and ethnicity categories were not mutually exclusive (i.e., a person who reported more than one race is represented in each reported racial category). Four clients were missing data on race/ethnicity and gender identity.

A key outcome for PLWH in King County, including Ryan White clients, is viral suppression. The Ryan White program uses epidemiological data to identify populations in the Seattle TGA that are disproportionately affected by HIV, referred to as priority populations. These populations are the focus of enhanced services designed to ensure individuals achieve viral suppression. Based on local data, people who inject drugs (PWID) and those who are homeless or unstably housed are two priority populations for the TGA.

In addition, a subset of Ryan White funds (Minority AIDS Initiative, or MAI) is used to provide enhanced services to Black and Latinx/Hispanic populations in support of public health's goal of reducing racial disparities in viral suppression; these groups are also considered priority populations. Figure 8-1 presents viral suppression for all four priority populations compared to all Ryan White Clients (TGA) and all PLWH in King County. Among Ryan White clients, these estimates are restricted to persons who received a Ryan White funded service in 2023.

FIGURE 8-1 Viral Suppression Among Ryan White Priority Populations in FY 2023*



[A] Ryan White Clients are PLWH who received one more services in FY 2023.

[B] Priority populations for the Seattle TGA.

Summary

Ryan White Part A funds support services for a diverse clientele. Funded services play a critical role in ensuring that low-income PLWH are able to overcome barriers to care, maintain engagement with primary care to obtain life-saving medications, and achieve viral suppression.

9. Key HIV/AIDS Data in Washington State

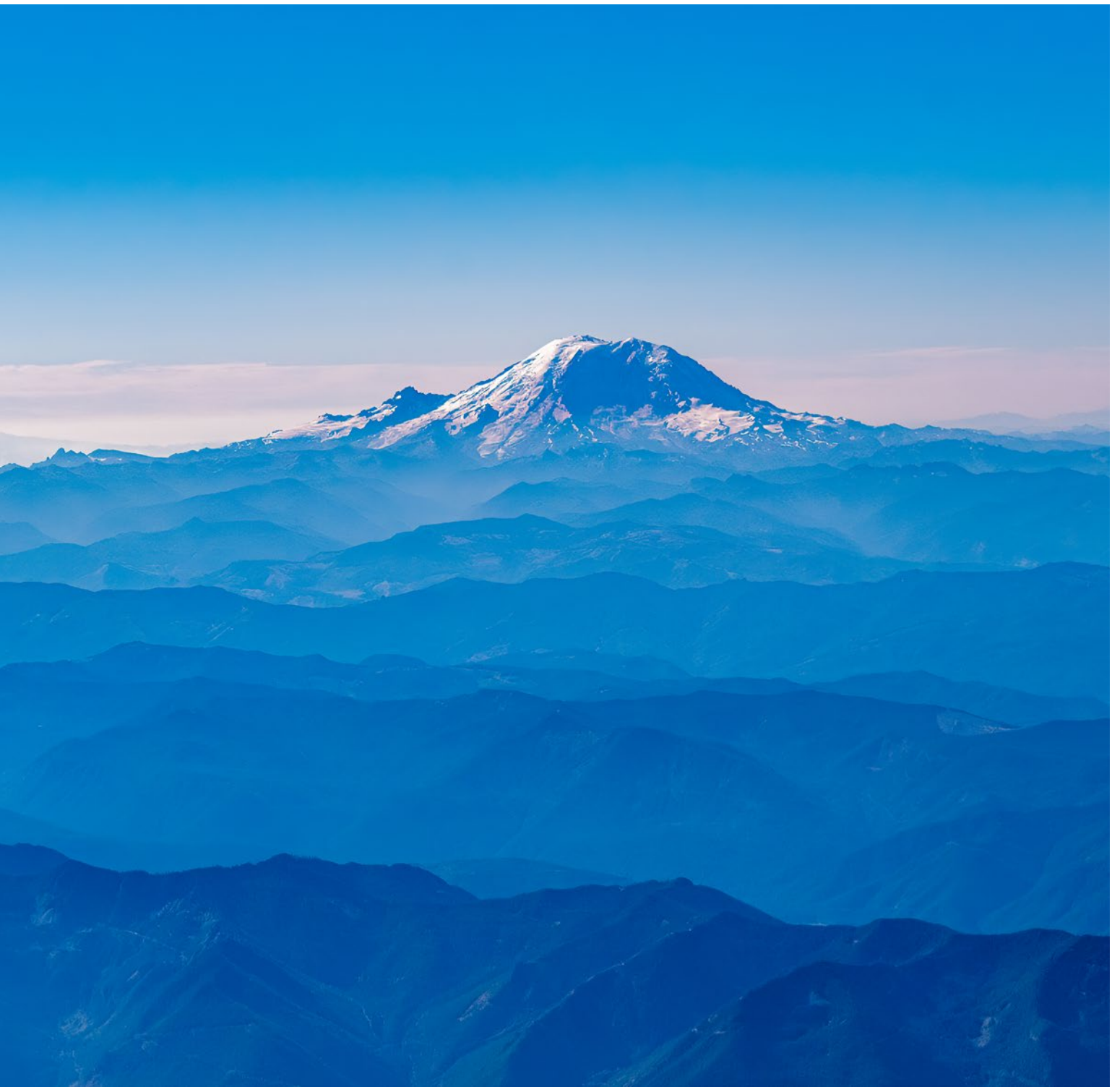


TABLE 9-1 (Part 1 of 2)

HIV/AIDS Diagnoses, Washington State, 2023

	HIV DIAGNOSES									
	Total			Without AIDS		Late HIV Diagnoses[A]		AIDS Diagnoses		
	N	Col %	Rate	N	Row %	N	Row %	N	Col %	Rate
TOTAL	412	100%	5.2	291	71%	121	29%	242	100%	3.1
GENDER										
Cisgender Men	309	75%	7.8	214	69%	95	31%	182	75%	4.6
Cisgender Women	92	22%	2.3	66	72%	26	28%	58	24%	1.5
Transgender Men	1	<1%	n/a	--	--	--	--	0	0%	n/a
Transgender Women	9	2%	n/a	--	--	--	--	1	<1%	n/a
Another Gender Identity	1	<1%	n/a	--	--	--	--	1	<1%	n/a
AGE AT DIAGNOSIS (years)										
< 13	0	0%	0.0	0	0%	0	0%	0	0%	0.0
13-24	33	8%	2.8	26	79%	7	21%	14	6%	1.2
25-34	153	37%	13.4	115	75%	38	25%	64	26%	5.6
35-44	106	26%	9.8	74	70%	32	30%	66	27%	6.1
45-54	67	16%	7.1	42	63%	25	37%	51	21%	5.4
55+	53	13%	2.3	34	64%	19	36%	47	19%	2.0
RACE/ETHNICITY[B]										
American Indian/Alaska Native	17	4%	3.4	15	88%	2	12%	12	5%	2.4
Asian	31	8%	2.8	25	81%	6	19%	13	5%	1.2
Black	127	31%	22.7	82	65%	45	35%	79	33%	14.1
- U.S.-Born[B,C]	59	14%	25.9	40	68%	19	32%	39	16%	17.1
- Foreign-Born[B,C]	60	15%	81.1	36	60%	24	40%	38	16%	51.4
Latinx or Hispanic *(all races)*	110	27%	9.7	76	69%	34	31%	68	28%	6.0
- U.S.-Born[B,C]	38	9%	4.9	29	76%	9	24%	19	8%	2.4
- Foreign-Born[B,C]	62	15%	19.6	40	65%	22	35%	45	19%	14.2
Native Hawaiian or Pacific Islander	6	1%	3.9	--	--	--	--	5	2%	3.3
White	229	56%	3.6	163	71%	66	29%	141	58%	2.2

TABLE 9-1 (Part 2 of 2)

HIV/AIDS Diagnoses, Washington State, 2023

	HIV DIAGNOSES									
	Total			Without AIDS		Late HIV Diagnoses[A]		AIDS Diagnoses		
	N	Col %	Rate	N	Row %	N	Row %	N	Col %	Rate
TOTAL	412	100%	5.2	291	71%	121	29%	242	100%	3.1
TRANSMISSION CATEGORY										
Cisgender Men										
MSM	180	44%	n/a	132	73%	48	27%	103	43%	n/a
PWID	18	4%	n/a	8	44%	10	56%	18	7%	n/a
MSM and PWID	23	6%	n/a	20	87%	3	13%	13	5%	n/a
Heterosexual Sexual Contact	66	16%	n/a	37	56%	29	44%	39	16%	n/a
Perinatal	0	0%	n/a	0	0%	0	0%	1	<1%	n/a
Transfusion/Transplant	0	0%	n/a	0	0%	0	0%	0	0%	n/a
No Identified Risk	22	5%	n/a	17	77%	5	23%	8	3%	n/a
Cisgender Women										
PWID	10	2%	n/a	8	80%	2	20%	9	4%	n/a
Heterosexual Sexual Contact	74	18%	n/a	52	70%	22	30%	44	18%	n/a
Perinatal	0	0%	n/a	0	0%	0	0%	2	1%	n/a
Transfusion/Transplant	0	0%	n/a	0	0%	0	0%	0	0%	n/a
No Identified Risk	8	2%	n/a	--	--	--	--	3	1%	n/a
Transgender Men										
All Transmission Types	1	<1%	n/a	--	--	--	--	--	--	--
Transgender Women										
All Transmission Types	9	2%	n/a	--	--	--	--	1	<1%	n/a
Another Gender Identity										
All Transmission Types	1	<1%	n/a	--	--	--	--	1	<1%	n/a

Abbreviations: MSM = people assigned male at birth who have sex with men; PWID = people who inject drugs

n/a Rate cannot be calculated due to no available population estimate

-- Due to the small number of HIV cases, the count and percentage based on the count is not shown

Due to the delayed release of 2023 population numbers, all rates are calculated using 2022 population estimates.

NR Not reliable, RSE ≥25

[A] Late HIV diagnoses = AIDS diagnoses within 12 months of HIV diagnoses

[B] Race/ethnicity categories are not mutually exclusive. Individuals reporting multiple racial and ethnic identities are represented in each group, therefore percentages will sum >100%.

[C] Country of origin data are missing for approximately 6% and 9% of newly diagnosed cases among Black and Latinx or Hispanic individuals, respectively

TABLE 9-2 (Part 1 of 2)

Number of People Living with HIV and Deaths, Washington State, 2023

	People Living with HIV			Deaths		
	N	Col %	Rate	N	Col %	Rate[A]
TOTAL	15,150	100%	192.6	242	100%	16.0
GENDER						
Cisgender Men	12,419	82%	315.1	197	81%	15.9
Cisgender Women	2,499	16%	63.7	42	17%	16.8
Transgender Men	23	<1%	n/a	0	0%	0.0
Transgender Women	189	1%	n/a	2	1%	10.6
Another Gender Identity	20	<1%	n/a	1	<1%	50.0
AGE GROUP (years)[B]						
< 13	17	<1%	1.4	0	0%	0.0
13-24	242	2%	20.7	1	0%	4.1
25-34	1,874	12%	164.3	17	7%	9.1
35-44	3,134	21%	288.9	32	13%	10.2
45-54	3,390	22%	360.6	39	16%	11.5
55+	6,493	43%	280.0	153	63%	23.6
RACE/ETHNICITY[C]						
American Indian/Alaska Native	574	4%	113.4	19	8%	33.1
Asian	1,045	7%	94.0	16	7%	15.3
Black	3,609	24%	644.5	44	18%	12.2
- U.S.-Born[D]	1,907	13%	836.8	37	15%	19.4
- Foreign-Born[D]	1,556	10%	2103.9	6	2%	3.9
Latinx or Hispanic *(all races)*	2,688	18%	235.8	21	9%	7.8
- U.S.-Born[D]	1,106	7%	142.5	16	7%	14.5
- Foreign-Born[D]	1,396	9%	440.5	3	1%	2.1
Native Hawaiian or Pacific Islander	235	2%	152.9	5	2%	21.3
White	10,608	70%	165.5	196	81%	18.5

Abbreviations: MSM = people assigned male at birth who have sex with men; PWID = people who inject drugs

Due to the delayed release of 2023 population numbers, all rates are calculated using 2022 population estimates

n/a Rate cannot be calculated due to no available population estimate

NR Not reliable, RSE ≥25

[A] Case fatality rate- per 1,000

[B] For people living with HIV, age at the end of the calendar year; for deaths, age at death.

[C] Race/ethnicity categories are not mutually exclusive. Individuals reporting multiple racial and ethnic identities are represented in each group, therefore percentages will sum >100%.

[D] Country of origin data are missing for approximately 4% and 7% of Black and Latinx or Hispanic people living with HIV, respectively

TABLE 9-2 (Part 2 of 2)

Number of People Living with HIV and Deaths, Washington State, 2023

	People Living with HIV			Deaths		
	N	Col %	Rate	N	Col %	Rate[A]
TOTAL	412	100%	5.2	242	100%	3.1
TRANSMISSION CATEGORY						
Cisgender Men						
MSM	9,057	60%	n/a	121	50%	13.4
PWID	473	3%	n/a	18	7%	38.1
MSM and PWID	1,208	8%	n/a	36	15%	29.8
Heterosexual Sexual Contact	1,279	8%	n/a	16	7%	12.5
Perinatal	78	1%	n/a	2	1%	25.6
Transfusion/Transplant	30	<1%	n/a	0	0%	0.0
No Identified Risk	294	2%	n/a	4	2%	13.6
Cisgender Women						
PWID	324	2%	n/a	12	5%	37.0
Heterosexual Sexual Contact	1,947	13%	n/a	27	11%	13.9
Perinatal	100	1%	n/a	1	<1%	10.0
Transfusion/Transplant	14	<1%	n/a	0	0%	0.0
No Identified Risk	114	1%	n/a	2	1%	17.5
Transgender Men						
Male Sex Partner	16	<1%	n/a	0	0%	0.0
Female Sex Partner	0	0%	n/a	0	0%	0.0
PWID	5	<1%	n/a	0	0%	0.0
Male Sex Partner and PWID	0	0%	n/a	0	0%	0.0
Perinatal	1	<1%	n/a	0	0%	0.0
No Identified Risk	1	<1%	n/a	0	0%	0.0
Transgender Women						
Male Sex Partner	145	1%	n/a	1	<1%	6.9
Female Sex Partner	4	<1%	n/a	0	0%	0.0
PWID	1	<1%	n/a	0	0%	0.0
Male Sex Partner and PWID	37	<1%	n/a	1	<1%	27.0
No Identified Risk	2	<1%	n/a	0	0%	0.0
Another Gender Identity						
Male Sex Partner	14	<1%	n/a	0	0%	0.0
Female Sex Partner	1	<1%	n/a	0	0%	0.0
PWID	2	<1%	n/a	1	<1%	500.0
Male Sex Partner and PWID	3	<1%	n/a	0	0%	0.0
No Identified Risk	0	0%	n/a	0	0%	0.0

Abbreviations: MSM = people assigned male at birth who have sex with men; PWID = people who inject drugs

Due to the delayed release of 2023 population numbers, all rates are calculated using 2022 population estimates

n/a Rate cannot be calculated due to no available population estimate

NR Not reliable, RSE ≥25

[A] Case fatality rate- per 1000

[B] For people living with HIV, age at the end of the calendar year; for deaths, age at death.

[C] Race/ethnicity categories are not mutually exclusive. Individuals reporting multiple racial and ethnic identities are represented in each group, therefore percentages will sum >100%.

[D] Country of origin data are missing for approximately 4% and 7% of Black and Latinx or Hispanic people living with HIV, respectively

TABLE 9-3

HIV Care Continuum Metrics, Washington State, 2023

	Newly Diagnosed People Linked to Care[A]		Engaged in Care[B]		Suppressed Viral Load[C]	
	N	% of New Cases	N	% of PLWH	N	% of PLWH
TOTAL	330	80%	13,234	87%	11,931	79%
GENDER						
Cisgender Men	252	82%	10,853	87%	9,825	79%
Cisgender Women	68	74%	2,182	87%	1,932	77%
Transgender Men	--	--	21	91%	19	83%
Transgender Women	--	--	164	87%	143	76%
Another Gender Identity	--	--	14	70%	12	60%
AGE GROUP (years)[D]						
< 13	0	0%	17	100%	17	100%
13-24	25	76%	213	88%	176	73%
25-34	122	80%	1,559	83%	1,361	73%
35-44	87	82%	2,624	84%	2,307	74%
45-54	53	79%	2,962	87%	2,662	79%
55+	43	81%	5,859	90%	5,408	83%
RACE/ETHNICITY[E]						
American Indian/Alaska Native	11	65%	502	87%	440	77%
Asian	22	71%	921	88%	859	82%
Black	97	76%	3,132	87%	2,753	76%
- U.S.-Born[F,G]	44	75%	1,633	86%	1,390	73%
- Foreign-Born[F,G]	48	80%	1,386	89%	1,260	81%
Latinx or Hispanic *(all races)*	93	85%	2,340	87%	2,110	78%
- U.S.-Born[F,G]	32	84%	973	88%	864	78%
- Foreign-Born[F,G]	55	89%	1,215	87%	1,110	80%
Native Hawaiian or Pacific Islander	--	--	202	86%	179	76%
White	187	82%	9,326	88%	8,430	79%
TRASMISSION CATEGORY[H]						
Cisgender Men						
MSM	153	85%	8,016	89%	7,332	81%
PWID	16	89%	393	83%	324	68%
MSM and PWID	16	70%	1,054	87%	919	76%
Heterosexual Sexual Contact	52	79%	1,081	85%	978	76%
Perinatal	0	0%	65	83%	55	71%
Transfusion/Transplant	0	0%	28	93%	25	83%
No Identified Risk	15	68%	216	73%	192	65%
Cisgender Women						
PWID	6	60%	267	82%	215	66%
Heterosexual Sexual Contact	59	80%	1,713	88%	1,542	79%
Perinatal	0	0%	91	91%	77	77%
Transfusion/Transplant	0	0%	12	86%	12	86%
No Identified Risk	--	--	99	87%	86	75%

-- Due to the small numbera (<10), the count and percentage are not shown

[A] Late HIV diagnoses = AIDS diagnoses within 12 months of HIV diagnoses

[B] Engaged in care = at least one reported CD4 or VL result within calendar year

[C] Suppressed viral load = last reported viral load result in calendar year was < 200 copies/mL

[D] For linked to care, age at diagnosis; for engaged and suppressed, age at the end of the calendar year

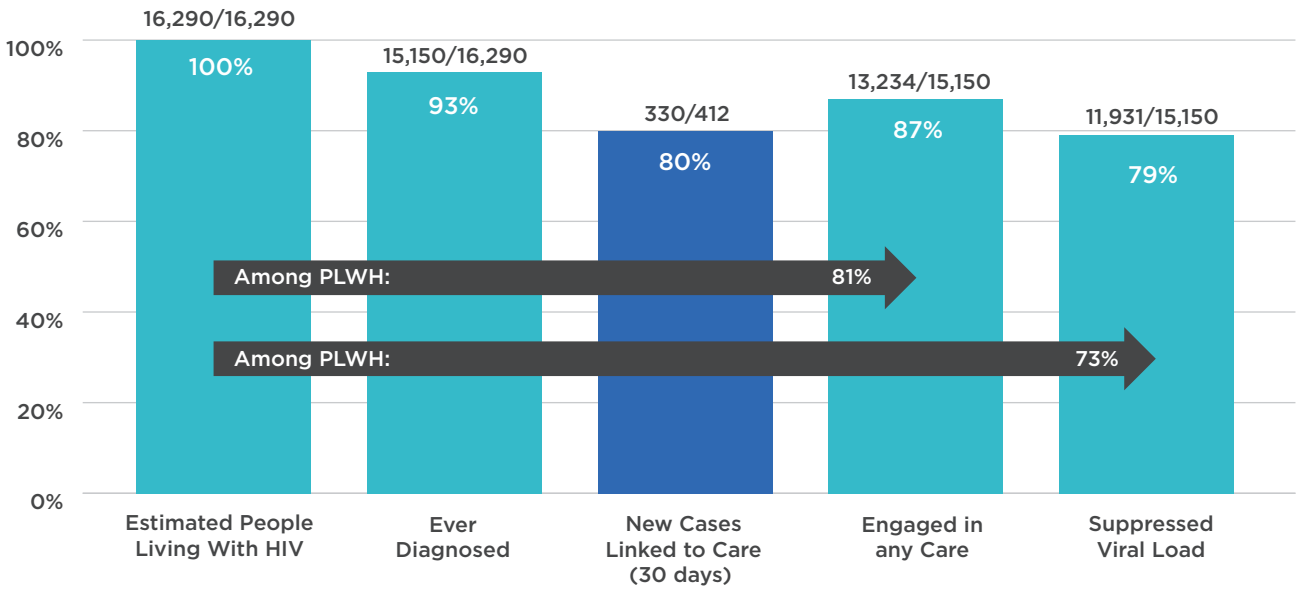
[E] Race/ethnicity categories are not mutually exclusive. Individuals reporting multiple racial and ethnic identities are represented in each group, therefore percentages will sum >100%.

[F] Country of origin data are missing for approximately 6% and 9% of newly diagnosed cases among Black and Latinx or Hispanic individuals, respectively

[G] Country of origin data are missing for approximately 4% and 7% of Black and Latinx or Hispanic people living with HIV, respectively

[H] Care continuum metrics not presented for transgender women, transgender women and people who report another gender identity due to small numbers

FIGURE 9-1 HIV Care Continuum, Washington State, 2023



10. Technical Notes

This section provides more details on methodology related to the estimates provided and select data sources referenced in this report.

A general note about comparing data presented in this report with past reports. HIV surveillance data are dynamic with databases often being updated with new data, including data on characteristics of people living with HIV laboratory results, and causes of death. Health departments may also change their definitions for defining outcomes, including new HIV diagnoses. These changes can affect current calculations of estimates from prior years. Thus, differences between report for estimates for a given year are expected.

Methodology

1. Calculating HIV Prevalence in King County:

Federal, Washington state and King County estimates of the number of people living with HIV (PLWH) residing in King County differ due to differences in data cleaning, record access, and/or date of analysis. PHSKC removes people from the total number of PLWH in King County based on case investigations for individuals who have had no HIV care for at least 1.5 years and were found likely to be no longer living in King County based on a search of publicly available records. However, in accordance with national HIV surveillance protocols, PHSKC does not change the official residence of the individual unless a health department in another jurisdiction confirms that the individual has relocated. Thus, federal count and state counts of PLWH in King County will be slightly higher than the estimates reported by PHSKC in this report.

2. Calculating new HIV Diagnoses in King County:

The first HIV diagnoses among King County residents were in 1982. Licensed HIV tests were not available until 1985, so diagnoses between 1982-1984 were made either due to presentation with AIDS-defining illness or due to a diagnosis in a clinical trial. People who test positive for HIV in King County are investigated to determine if they have tested positive previously in another state or country. People who previously tested positive for HIV in another state or country are excluded from PHSKC's count of new HIV diagnoses that year. As described in Technical Note 1, Washington state and King County numbers of new HIV diagnoses in King County differ due to differences in data cleaning, record access, and/or date of analysis. HIV diagnosis rates are calculated by dividing the number of new HIV diagnoses in a population by the estimated population size of people at risk for HIV in that population.

Data from the U.S. Census and American Community Survey, which provides reliable estimates of the size of each population, is used for estimates by demographic characteristics (i.e., age, race/ethnicity). Due to a lack of data on transgender gender identity in U.S. Census data, rates are only presented using sex assigned at birth. Calculating HIV diagnosis rates by transmission risk categories (e.g., men who have sex with men [MSM], people who inject drugs [PWID], heterosexual sexual contact) involves more uncertainty since the size of these populations are not precisely known. Details on the approach used to estimate the number of people who are MSM are described in Technical Note 3, and the approach used to estimate the number of people who are PWID is described in Technical Note 4.

TABLE 10-1 Population Size for Select Demographics in King County, WA

Population	Estimated Population Size, King County, 2023	Data Source
Men who have sex with men (MSM)	83,622	PHSKC estimate of the percentage of all men who are MSM based on BRFSS (Behavioral Risk Factor Surveillance System) sexual orientation metrics applied to U.S. Census data of males aged 15 years and over
Latinx	190,561	King County's Population Interim Estimates (PIE), a combination of Census 2020 population estimates and Census 2010-based population estimates from OFM. American Community Survey data was used to estimate nativity.
U.S.-Born Latinx	101,635	
Foreign-Born Latinx	88,926	
Single Race, non-Latinx American Indian Alaska Native	11,431	
Single Race, non-Latinx Black/African American	158,299	
Single Race U.S.-Born Black	111,053	
Single Race Foreign-Born Black	47,246	
Non-Latinx Multiracial	161,306	
Single Race, non-Latinx White	1,231,286	
Single Race, non-Latinx Asian	497,305	
Single Race, non-Latinx Pacific Islander	21,711	
Male (sex assigned at birth)	1,178,948	
Female (sex assigned at birth)	1,168,852	
Total Population	2,347,800	

3. Estimating the Number of People who are MSM:

The rate of new HIV diagnoses among MSM, calculated as diagnoses per 1,000 per year, was based on U.S. Census estimates of the number of men living in King County and Behavioral Risk Factor Surveillance Survey (BRFSS) estimates of the proportion of the adult male population that are MSM.

Between 2013 and 2021, the proportion of MSM ranged from 5.7 - 6.7%. We assume that the percentage of men who are MSM does not vary by race/ethnicity.

4. Estimating the Number of People who Inject Drugs:

The rate of new HIV diagnoses among PWID, calculated as diagnoses per 1,000 per year, was based on a new PWID population size estimate conducted by a University of Washington graduate student. Prior to this estimate, previous reports had used a methodology that relied on national estimates of injection drug use and some local estimates of injection drug use among select populations (e.g. MSM). Due to significant changes in drug use patterns in King County in the early 2020s, this population size estimate of people who inject drugs in King County was no longer reliable. To address this gap, a UW graduate student performed a series of studies to derive multiple population size estimates, and these estimates were then combined into a single population size estimate for Seattle.

The studies used for the individual population size estimates used diverse methodologies including capture-recapture, network scale-up, and service multiplier, and utilized both new and existing data sources (e.g., NHBS). The final estimate for the PWID population size in Seattle was 5,000 in 2023 (These data will be published in a forthcoming peer-reviewed manuscript.) To estimate the total PWID population size for King County, we used data on the ratio of overdose in Seattle versus King County (excluding Seattle). The ratio of overdoses in Seattle vs King County (excluding Seattle) was 1.8, thus we estimated a total of 7,800 PWID in King County.

5. Estimating Homelessness and Housing Instability:

To estimate the burden of homelessness and housing instability among PLWH in King County, several data sources were used. These include (1) addresses reported with laboratory results in HIV surveillance data, (2) self-reported housing information from partner services interviews of newly diagnosed persons, and (3) data on housing status from Ryan White clients.

To assess homelessness among all PLWH, PHSKC compared address data on lab reports with a list of homeless service centers, food banks, day centers, transitional housing facilities, shelters, medical facilities, and other addresses associated with housing instability.

6. Defining Viral Suppression Among People Living with HIV:

Estimates of viral suppression in 2022 also incorporate data from 2021 and 2023.

In addition to people with documented viral loads <200 in 2022, people who (1) have no viral load reported in 2022 but were suppressed as of a last viral load in 2021 and a first viral load in 2023 or (2) were diagnosed in the last quarter of 2022 and achieved suppression in the first quarter of 2023 were classified as achieving viral suppression.

7. Methods and Tools for Molecular HIV Cluster Identification:

In alignment with CDC methodology, clusters with recent and rapid growth were identified using the first available HIV sequence for those people diagnosed in the prior three years. Starting in 2019, response efforts have focused on these more recently diagnosed cluster members as well as people diagnosed in prior years (i.e., people diagnosed more than three years earlier) whose first HIV sequence linked directly to that of a more recently diagnosed person. In 2020, earlier-diagnosed people were included in response efforts on the basis of linkages via any of their HIV sequences (i.e., not just their first). Additionally, in 2021, we started linking earlier diagnosed people living with HIV (PLWH) even if only indirectly linked to the most recent diagnoses in the cluster. This broadening of criteria was motivated by a desire to ensure that analyses included all people who may be connected to a cluster and reflects our increasing capacity for cluster response. The tools used to identify molecular HIV clusters are the CDC-sponsored Secure HIV TRACE (HIV TRAnsmission Cluster Engine, created by University of California - San Diego and Temple University) and DIVEIN, a University of Washington-created tool. HIV TRACE is used by HIV surveillance groups for cluster identification across the nation.

HIV TRACE can identify and visualize clusters. HIV TRACE was built to function best for the entire state, thus its utility at the county level is limited. The CDC periodically identifies molecular clusters which are of national priority and expects all HIV surveillance jurisdictions to also identify local clusters monthly. The CDC can identify inter-jurisdictional clusters which may not be visible to individual jurisdictions. National priority clusters are limited to those that are “recent and rapid”, those that include five linked new diagnoses in the past year. For the level of HIV morbidity King County experiences, PHSKC has elected to use a lower threshold of three members (i.e., casting a wider net) for King County to become aware more quickly of new populations with HIV transmission and quickly initiate interventions. King County also generally casts a broader net with the genetic cluster distance of 1.5% (relative to 0.5%), which may result in more distal and indirect linkages being included in King County clusters. Genetic distance refers to how similar the genetic sequences are for two or more PLWH. A genetic difference of 0.5% or less indicates HIV strains that are 99.5% or more alike; the genetic difference of 1.5% indicates 98.5% similarity.

11. Data Sources

Evaluation Web:
Data from HIV testing funded by the WA DOH and conducted at agencies within King County are captured in WA DOH's Evaluation Web data system and shared with PHSKC.

HIV Core Surveillance:
Data are collected as part of investigations of people with newly diagnosed HIV or AIDS. These investigations are informed and augmented by HIV-related test results reported to PHSKC by laboratories, including HIV diagnostic tests and CD4 counts.

National HIV Behavioral Surveillance (NHBS):
NHBS is a national, CDC funded surveillance project that includes King County, WA. Survey participants include diverse samples of people at increased risk for HIV and rotate each year between MSM, PWID, and heterosexually active people at higher risk for HIV. Recent surveys have included MSM (2017, 2021, 2023), PWID (2018, 2022), heterosexually-active people (2019), and ad hoc surveys of transgender women (2019-2020, 2023-2024) and women who exchange sex for money or drugs (2016).

Partner Services Data:
Partner services seek to ensure that people with bacterial STIs and HIV receive appropriate treatment and that their sex and needle sharing partners are notified, tested, and treated.

Partner services interviews also allow PHSKC staff to collect information about people with newly diagnosed HIV infection, including their reason for HIV testing and their testing history. For people who are HIV-negative, partner services interviews also present an opportunity to monitor PrEP use among a population at higher risk for HIV acquisition. PHSKC staff who conduct partner services interviews among HIV-negative MSM diagnoses with STIs routinely ask if they are currently taking PrEP.

Partner services interview data are used to monitor PrEP use among MSM with bacterial STIs. In March 2020, current PrEP use was added to the STI case report form which allows for monitoring PrEP use among MSM diagnosed with STIs who were not interviewed for as part pf partner services outreach.

PHSKC Medical and Laboratory Records:
Data from HIV testing conducted at jails and at clinics operated by PHSKC are extracted from the PHSKC medical record system, and HIV testing data from teen health centers and the juvenile detention center are provided by the PHSKC public health laboratory.

Pride Survey:
Local data from the King County Pride surveys provide insight into PrEP use and sexual behavior among MSM, transgender, and non-binary individuals. The 2023 Pride survey is an online survey that is advertised online and at select in-person pride events in Seattle. In 2023, 735 King County residents participated, among whom 222 (30%) identified as a cisgender or transgender man who was sexually active with a man in the past 12 months. Overall, 69 (9%) participants identified as transgender and/or non-binary.

References

1 *What is Ending the Epidemic: A Plan for American?* https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

2 Golden MR, Lechtenberg R, Glick SN, Dombrowski J, Duchin J, Reuer JR, Dhanireddy S, Neme S, Buskin SE. Outbreak of Human Immunodeficiency Virus Infection Among Heterosexual Persons Who Are Living Homeless and Inject Drugs - Seattle, Washington, 2018. MMWR Morb Mortal Wkly Rep. 2019 Apr 19;68(15):344-349. doi: 10.15585/ mmwr. mm6815a2. PMID: 30998671; PMCID: PMC6476056.

3 World Health Organization. Global Guidance. Available at: https:// differentiatedservicedelivery.org/Guidance/Globalguidance. Accessed 12/16/21

4 Bree Collaborative LGBTQ Health Care Report and Recommendations. Available at: https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2020/06/LGBTQ-health-care-recommendations-Final-20-06.pdf

5 Fellows IE, et al. A New Method for Estimating the Number of Undiagnosed HIV Infected Based on HIV Testing History, with an Application to Men Who Have Sex with Men in Seattle/King County, WA. PLoS One. 2015 Jul 21;10 (7):e0129551. Erratum in: PLoS One. 2015;10(8):e0135878.

6 Centers for Disease Control and Prevention. Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data—United States and 6 Dependent Areas, 2021: National Profile. Available at: https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-28-no-4/content/national-profile.html; accessed 01 November 2023.

7 Fanfair R and Mermin J. Expanding PrEP Coverage in the United States to Achieve EHE Goals. Available at: https://www.hiv.gov/blog/expanding-prep-coveragein-the-united-states-to-achieve-ehe-goals/? utm_source=email&utm_medium=email&utm_campaign=Daily20231018; accessed 13 November 2023.

8 Shook AG. Community and Provider Perspectives on Molecular HIV Surveillance and Cluster Detection and Response for HIV Prevention, Journal of the Association of Nurses in AIDS Care: October 26, 2021 doi: 10.1097/JNC.0000000000000030.

9 Evans, D., & Benbow, N. (2018). Ethical considerations for a public health response using molecular HIV surveillance: A multi-stakeholder approach. Project Inform and Northwestern University. Available at: https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-Ethical-Considerations-Report.pdf; accessed 01 November 2023.