



PHILADELPHIA

# HIV

## 2022 SURVEILLANCE REPORT

Cases reported through June 2023

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## Definitions

**Acute HIV Infection:** Acute HIV infection typically describes the interval between the first possible detection of virus by virologic assay and development of a mature antibody response. Signs and symptoms of acute HIV infection can include fever, headache, sore throat, adenopathy, anorexia, and rash and often develop about 2 weeks after the start of the infection.

**AIDS (Acquired Immune Deficiency Syndrome):** A result of Human Immunodeficiency Virus (HIV) infection, which disables the immune system from effectively fighting numerous opportunistic infections and cancers.

**AIAN (American Indian/Alaska Native):** A racial/ethnic group. Also identify as First Nations/Indigenous.

**CDC (Centers for Disease Control and Prevention):** A federal disease prevention agency, which is part of the U.S. Department of Health and Human Services that provides national laboratory and health and safety guidelines and recommendations; tracks diseases throughout the world; and performs basic research involving laboratory, behavioral science, epidemiology and other studies of disease.

**Confidentiality:** Keeping medical information confidential or private.

**Diagnosis:** Determination of the nature of a case of a disease based on signs, symptoms, and laboratory findings during life. A diagnosis of AIDS for an adult is being HIV antibody-positive in addition to having one opportunistic infection, condition, or disease (e.g. wasting syndrome, PCP, Kaposi's sarcoma, CD4 T-lymphocyte count below 200 or 14%).

**DHH (Division of HIV Health):** The office within the Philadelphia Department of Public Health responsible for administering the City's HIV Programs.

**EHE (Ending the HIV Epidemic):** The U.S. Department of Health and Human Services (HHS) launched the Ending the HIV Epidemic in the U.S. (EHE) initiative in 2019. The initiative aims to reduce new HIV infections in the U.S. by 90% by 2030 by scaling up key HIV prevention and treatment strategies.

**Epidemiology:** The branch of medical science that deals with the study of incidence, distribution and control of a disease in a population.

**Equity:** The state in which everyone has the opportunity to attain their highest level of health while centering justice and dignity.

**Gender Identity:** One's innermost concept of self as male or female or both or neither—how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different than the sex assigned at birth.

**HBV Co-Infection:** Hepatitis B Virus Co-infection. Refers to a person with HIV who has current or past HBV infection evidenced by a positive HBV surface antigen, HBV DNA or HBV e-antigen.

**HCV Co-Infection:** Hepatitis C Virus Co-Infection. Refers to a person with HIV who has current or past HCV infection evidenced by a positive HCV antibody, HCV RNA, or HCV genotype test.

**Heterosexuals at Increased Risk for HIV Infection:** As defined by National HIV Behavioral Surveillance, the population of individuals 18 and older living below poverty level.

**HIV (Human Immunodeficiency Virus):** The retrovirus that causes AIDS by infecting the T-helper cells.

**Incidence:** The number or rate of new cases of a disease over defined period of time.

**MSM (Men who have sex with men):** An HIV transmission category.

**MSM/PWID (Men who have sex with men who are also people who inject drugs):** An HIV transmission category.

**NHPI (Native Hawaiian/ Pacific Islander):** A racial/ethnic group.

**NRR (No Reported Risk):** Indicates when documentation is insufficient to assign an HIV transmission category based on CDC guidelines.

**Outbreak:** An increase in diagnoses above what is normally expected in a geographic area or population during a particular period

**Perinatal Transmission of HIV:** Term used to describe the spread of HIV from a mother to her baby that can occur during pregnancy, labor, delivery or breastfeeding; also known as vertical transmission.

**PWDH:** People with diagnosed HIV.

**PWH:** People with HIV, both diagnosed and undiagnosed.

**PrEP:** Pre-exposure prophylaxis. Antiretroviral medication taken daily by individuals at increased risk for HIV infection to lower their chances of getting infected.

**Prevalence:** Total number of cases of a disease in a population over a period of time.

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

**Risk Behavior:** Used here to describe behaviors that put people at risk of contracting HIV.

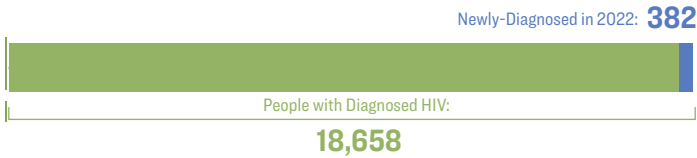
**Sexual Orientation:** The sexual attraction people feel for others, whether of their own sex, the opposite sex, or both sexes.

**Stigma:** An attitude of disapproval and discontent toward a person or group because of the presence of an attribute perceived as undesirable.

**Transmission Category:** A system that classifies cases by possible HIV transmission risk factors or mode(s) of infection; e.g. PWID, MSM/PWID, perinatal transmission, heterosexual contact.

## INTRODUCTION

The Philadelphia Department of Public Health (PDPH) Division of HIV Health (DHH), formerly known as the AIDS Activities Coordinating Office (AACO), Surveillance Report is the annual report presenting data on human immunodeficiency virus (HIV) diagnoses in the City of Philadelphia. Data in this report include persons diagnosed through December 31, 2022 and reported through June 30, 2023.



Today, there are 18,658 people with diagnosed HIV (PWDH) in Philadelphia. During 2022, there were 382 new diagnoses of HIV. Despite the slight increase from 2021 to 2022, new diagnoses of HIV have decreased by 12.8% since 2018. The largest burden of HIV disease continues to impact men who have sex with men (MSM) and increasingly, persons who inject drugs (PWID) (Table 4). Overall, both newly diagnosed and prevalent disease disproportionately affect Black and Brown communities.

Racism, including racism in health care settings, and structural inequities are key drivers of the disproportionate impact of HIV and poor HIV outcomes along the care continuum among Black and Brown communities.

During 2022, PDPH made strides toward meeting goals outlined in the Ending the HIV Epidemic: A Plan for America (EHE) initiative, which began in 2019. The plan ultimately looks to achieve a 75% reduction in new HIV diagnoses by 2025 and a 90% reduction in new HIV diagnoses by 2030. Locally, activities are centered on 5 Key Pillars: Diagnosis, Treatment, Prevention, Response, with an additional pillar representing an approach centered in health equity and radical customer service.

More specifically, PDPH has improved strategies to:

**1) Diagnose persons with HIV early through new and increased testing opportunities.**

Through the following activities: the PDPH HIV and STI self-test kit distribution program, implementation of community-based low-threshold sexual health services and status-neutral testing programs, promotion of HIV testing in clinical settings including emergency departments, implementation of HIV testing in pharmacies, and increased HIV testing in substance use treatment sites and in the Philadelphia Department of Prisons.

**2) Treat persons with HIV quickly and effectively**

Through the following linkage activities: Immediate linkage to care and ART within 96 hours of the first positive HIV test as the standard of care.

Through the following activities to retain PWH in care:

- a) implementation of low-threshold HIV treatment programs,
- b) implementation of engagement and re-engagement programs that address structural barriers to HIV care,
- c) implementation of the PDPH Data to care program,
- d) addressing health equity disparities in HIV treatment agencies, promotion of rights-based education and availability of HIV treatment and supportive services for PWH,
- e) and continuing to fund, support, and improve HIV treatment and supportive services throughout the Philadelphia area.

### 3) Prevent new HIV by promoting pre- and post-exposure prophylaxis and syringe services.

Through the following activities: implementation of low threshold sexual health services, and the non-occupational post-exposure prophylaxis center of excellence, the PDPH TelePrEP program, promotion and provision of PrEP in health care and behavioral health locations, expansion of access to harm reduction services, and condom distribution.

### 4) Identify outbreaks of HIV and initiate cross-divisional responses.

Through the following activities: Maintenance of a robust HIV public health data system to identify outbreaks of HIV and maintenance of the Philadelphia HIV outbreak response plan.

For more information about the Philadelphia EHE Plan, please visit: [https://ehe.hivphilly.org/media/documents/Ending-the-HIV-Epidemic-in-Philadelphia-A-Community-Plan\\_w96jEee.pdf](https://ehe.hivphilly.org/media/documents/Ending-the-HIV-Epidemic-in-Philadelphia-A-Community-Plan_w96jEee.pdf)

For more information about the Philadelphia Eligible Metropolitan Area Integrated Plan, please visit: <https://www.hivphilly.org/plan/>

A new addition to the Philadelphia EHE Community Plan in 2024 is a focus on aging with HIV. More than one-half of people with HIV in Philadelphia today are over age 50. This statistic is the success of modern HIV treatment, but also signals the need to tailor services to individuals within this population not only to continue their engagement in care and viral suppression but also to address the comorbidities and psycho-social needs often associated with aging. As part of Philadelphia's EHE Community plan, we plan to expand capacity to provide whole-person care to older adults with HIV and long-term Survivors.

Further, PDPH and our partners enhanced existing EHE initiatives, the HIV and STI self-test kit program, re-engagement activities and low threshold sexual health services, and the non-occupational post-exposure prophylaxis center of excellence. For more information about the national EHE initiative please visit: <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>.









## REPORT UPDATES

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- The HIV Care Continuum (Figure 1A) presented in this report continues to reflect HIV outcomes among persons with diagnosed infection to allow for comparison to national values.
- PDPH has updated the way that prevalent cases of HIV for 2022 were defined for this report. Unlike in previous iterations, the 2022 HIV prevalence data presented includes all PWDH that were alive at any point during the 2022 calendar year.
- Estimates of the number of individuals with HIV who are unaware of their status (undiagnosed) were generated for 2020 and 2021 and presented in Table 1. However, estimates by subpopulation are unreliable due to the impact of COVID-19 on the testing and care system during 2020, and are therefore not shown in this report.
- Population denominators used to derive rate ratios have been updated as of this report using 2020 U.S. Census data.
- As with last year's report, all data and trends over time should be interpreted with caution due to the impact of the COVID-19 pandemic. Please read all table titles and footnotes carefully to ensure a complete understanding of the displayed data.

Table 1 | Ending the HIV Epidemic Dashboard

Notable improvements include decreased stigma among PWDH and increases in knowledge of status, viral suppression, and PrEP coverage for those at risk.

GOAL:	BASELINE 2017	2018	2019	2020	2021	2022	Progress	2025 Target	2030 Target
Reduce new HIV infections by 75% in five years and by 90% in ten years	470	440	440	310*	290*		 IMPROVING	(118)	(47)
Increase knowledge of status to 95% by 2025	88.6%	88.4%	88.5%	88.5%	89.8%		 IMPROVING	(95.0%)	
Decrease confirmed HIV diagnoses to 25% by 2025 and 8% by 2030	509	435	446	332	365	382	 STABLE	(127)	(41)
Increase linkage to care to 95% by 2025	86.3%	86.1%	81.3%	82.5%	81.4%	77.0%	 NOT IMPROVED	(95.0%)	
Increase viral suppression to 95% by 2025**	72.3%	70.1%	72.3%	67.3%	70.1%	73.5%	 IMPROVING	(95.0%)	
Decrease stigma among PWDH by 50%, Median††		32.9	31.0	31.7	28.4		 IMPROVING	(18.8)	
Decrease homelessness among PWDH by 50%†	9.9%	13.6%	8.1%	6.7%	13.5%		 NOT IMPROVED	(4.9%)	
Increase PrEP coverage to 50%§			37.2%	35.5%	41.2%	50.8%	 IMPROVING	(50.0%)	

\* Incidence estimate results have a relative standard error greater than 30, and should be interpreted with caution

\*\* Among PWDH who have evidence of care in the last 5 years

† Among PWDH in Philadelphia between 2015-2021, using data from the Medical Monitoring Project (MMP)

‡ MMP has updated stigma scores for 2018 surveillance cycles onward

§ PrEP coverage is defined as the proportion of persons prescribed PrEP among those with a PrEP indication.

Centers for Disease Control and Prevention. Core indicators for monitoring the Ending the HIV Epidemic initiative (preliminary data): National HIV Surveillance System data reported through March 2023; and preexposure prophylaxis (PrEP) data reported through December 2022. HIV Surveillance Data Tables 2023;4(2). <https://www.cdc.gov/hiv/library/reports/surveillance-data-tables/>. Published June 2023. Accessed August 2023.

**Notes**

Values in parentheses represent a goal number or percentage.

## HIV Continuum of Care

The HIV Continuum of Care is a data driven tool focusing on the various levels of engagement in HIV care among persons with diagnosed HIV (PWDH) in Philadelphia (denominator) and compares to the most recently published national outcomes. The continuum includes the percentage of newly diagnosed people who were linked to care, defined as a CD4 or viral load collected within 1 month of initial HIV diagnosis; the percentage of PWDH who received care, evidenced by at least one CD4 or viral load result in the calendar year; the percentage of PWDH who were retained in care, defined as two or more laboratory results at least 91 days apart in the calendar year; and the percentage of PWDH who were virally suppressed, defined as a viral load of <200 copies/mL at last measure in 2022.

In 2022, 77.0% of persons who were newly diagnosed with HIV were linked to HIV medical care within 1 month of their diagnosis (Figure 1A). Among all PWDH, 66.3% received at least 1 care lab during 2022 and 45.5% were considered retained in HIV medical care. Finally, 57.3% of PWDH were virally suppressed at last measure (regardless of retention in care status) in 2022. While the comparison to national data is an important reference, it is necessary to note that the most recently released data from the CDC reflects outcomes for 2021.

Figure 1B is a modified HIV Continuum of Care assessing outcomes among PWDH with evidence of recent HIV care in Philadelphia, defined as having at least 1 care lab during the last 5 years (2018-2022). HIV case reporting data alone can overestimate the number of PWDH due to duplicate case reporting, migration, and missed deaths. By excluding individuals without evidence of recent care, we hope to evaluate HIV care outcomes more precisely and better identify individuals in need of re-linkage to care and other services. Receipt of care, retention in HIV care, and viral suppression outcomes all increased from 2021 and were 85.1%, 58.4%, and 73.5%, respectively (Figure 1B). Identifying new opportunities to improve outcomes along the continuum of care is vital to improving the health of persons with HIV and reducing the rate of HIV transmission.

## Diagnoses of HIV Infection and AIDS (Stage 3)

In 2022, the largest proportion of new HIV diagnoses were in people assigned male sex at birth (75.4%), Non-Hispanic (NH) Black (58.6%) individuals, those aged 30-39 (35.3%), and among MSM (51.0%) (Table 4). Notably, Hispanic/Latinx individuals accounted for a larger proportion of cases in 2022 (19.9% from 14.2%) and new diagnoses have continued to rise since 2020.

Disparities among new diagnoses become more apparent when considering the underlying population size. Compared to the declining rate of new HIV diagnoses among MSM (1,484.4 per 100,000), the rates of new diagnoses in PWID (245.2), and at-risk heterosexuals (34.3), defined as individuals over the age of 18 who are living in poverty, have increased from 2021 (Figure 11). Racial/ethnic health disparities in Philadelphia persist. In 2022, the highest rates of new HIV diagnoses were among NH Black persons (37.2 per 100,000), followed by Hispanic/Latinx individuals (32.3), and NH White persons (11.9) (Table 5).

During 2022, new AIDS diagnoses (regardless of date of HIV diagnosis) in Philadelphia increased and were primarily among persons assigned male sex at birth (70.8%), NH Black individuals (68.3%), MSM (41.6%), and those aged 50 and over (32.7%) (Table 8). The proportion of individuals diagnosed concurrently with HIV and AIDS, representing missed opportunities for early testing and care, has increased in recent years, but remained stable from 2021 to 2022 (Table 7).

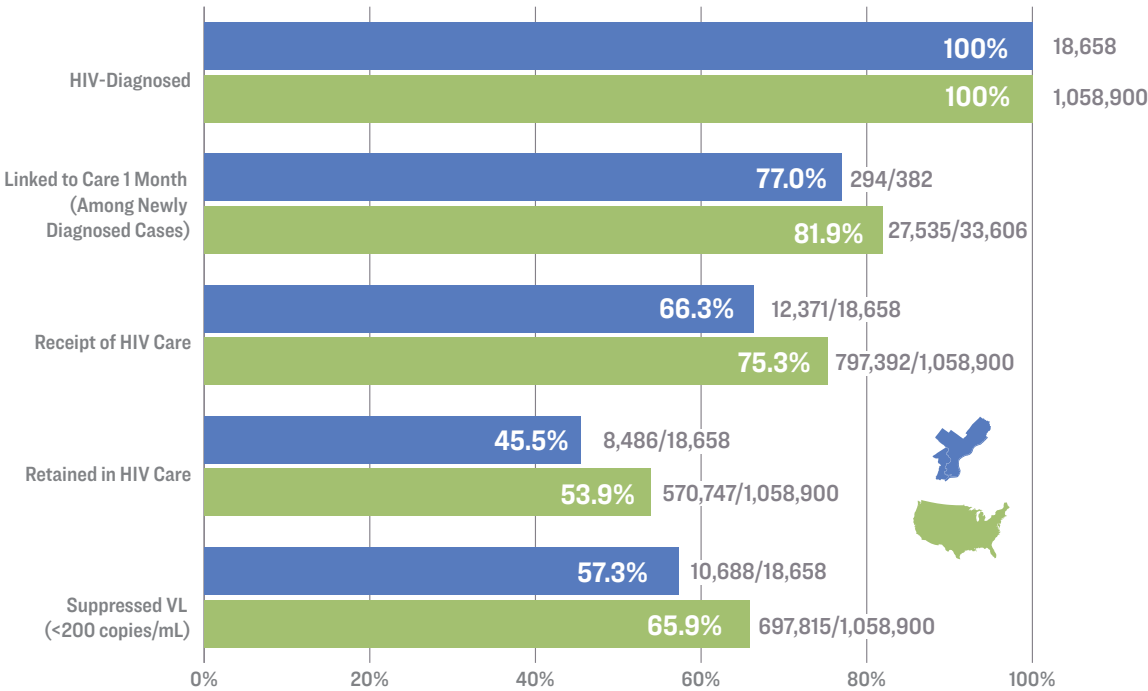
## Prevalence of HIV Infection among Philadelphia Residents

The demographic makeup of PWDH in Philadelphia through 2022 remains static from the 2021 Surveillance Annual Report. PWDH were mostly assigned male sex at birth (72.3%), NH Black (63.2%), aged 50 and older (56.2%), and MSM (39.8%) (Table 9). HIV prevalence rates are disproportionately higher among racial and ethnic minorities and continue to be highest among NH Black individuals (1,921.5 per 100,000) and Hispanic/Latinx individuals (1,294.7) (Table 13). Among all groups, NH Black MSM continue to have the highest rates of HIV (30,785.1 per 100,000 population) (Figure 15).



# HIV Care Continuum

Figure 1A | Philadelphia 2022 vs the United States 2021



About 10.2% of people with HIV (about 1,903) have not been diagnosed.

**Linked to Care**  
Persons diagnosed with HIV in a given calendar year who had one or more documented viral load or CD4 tests within one month of diagnosis.

**Receipt of HIV Care**  
Persons who have at least one CD4 or viral load during the calendar year.

**Retained in HIV Care**  
Persons who have 2 or more CD4 or viral loads during the calendar year, at least 91 days apart.

**Suppressed Viral Load (VL)**  
Last reported viral load of the calendar year being <200 copies/mL. Individuals with no evidence of a viral load in the calendar year are considered not suppressed.

Figure 1B | Philadelphia HIV Care Continuum (Recent Care) | 2022

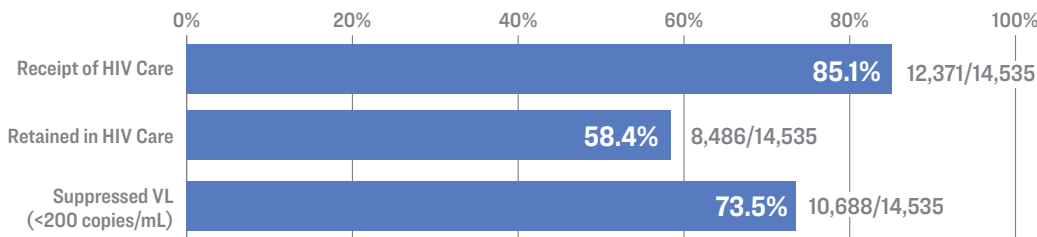


Figure 1A

**Sources**

Philadelphia Data: Philadelphia Department of Public Health, Division of HIV Health  
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. HIV Surveillance Supplemental Report, 2023; 28(No. 4). <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2023. Accessed August 2023.  
United States Data: Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2017–2021. HIV Surveillance Supplemental Report, 2023; 28 (No.3). <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2023. Accessed August 2023.

Figure 1B

**Note**

Care Continuum Outcomes are Among PWDH with a reported CD4 or Viral Load in the last 5 years (Jan 1, 2018 - Dec 31, 2022).

**Source**

Philadelphia Department of Public Health, Division of HIV Health

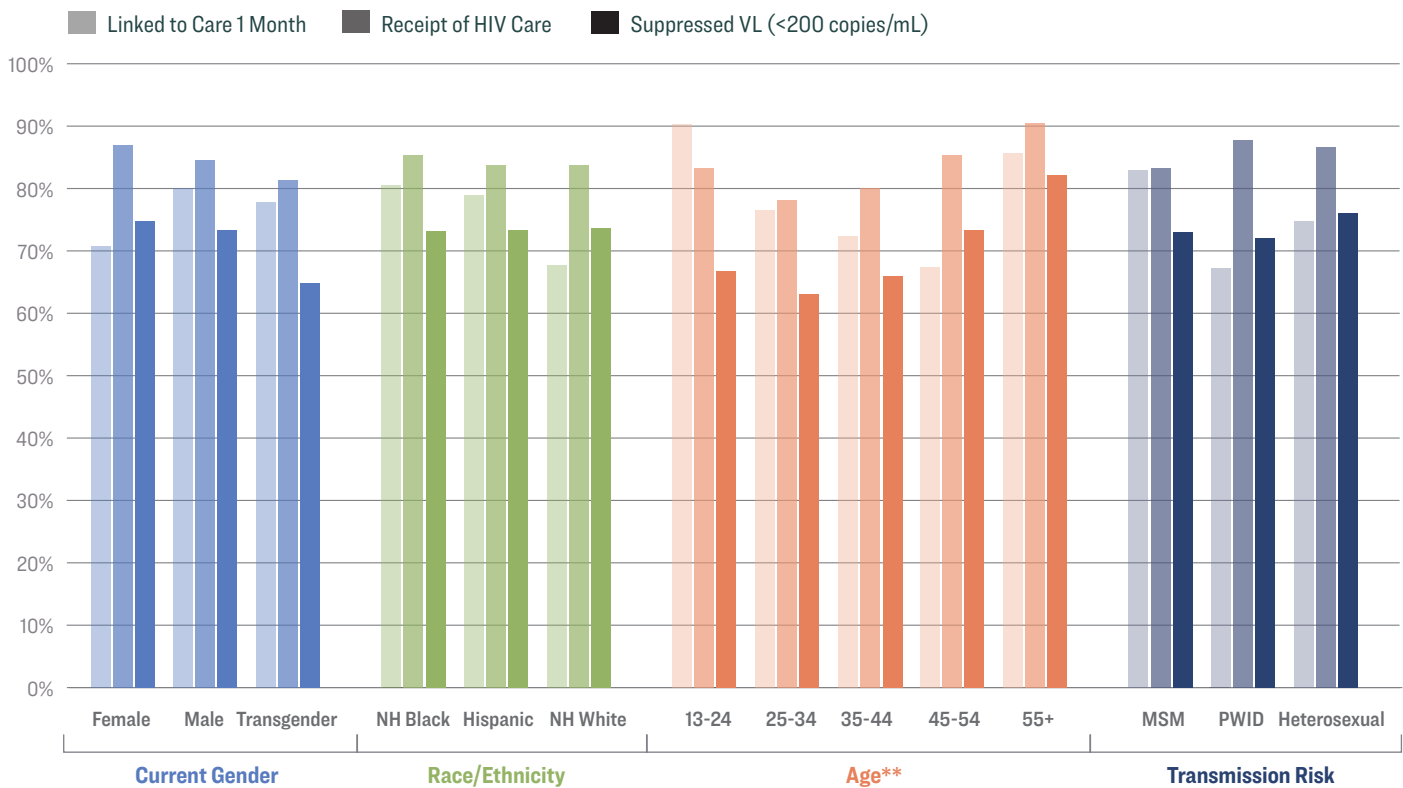
To achieve federal EHE initiative goals and reduce HIV transmission locally, PDPH is dedicated to ensuring that health equity is a foundational element of surveillance, prevention, and care practices. DHH has expanded the definition of health equity (Page 3) to include justice and dignity. This requires structural and systemic changes that aim to mitigate drivers of health disparities including racism, discrimination, poverty, homelessness, and access to quality education, employment, and health care. This starts with how PDPH collects, analyzes, and disseminates HIV data to inform health department policies, practices, and services. The tables and graphs presented below provide critical quantitative and qualitative data that can highlight existing disparities and barriers within the HIV prevention and care infrastructure.

### Modified Continuum by Subgroup

Figure 2 illustrates the Modified Continuum of Care by selected characteristics. Disaggregating data by race/ethnicity, current gender, age group, and transmission risk can highlight disparities within care outcome measures.

During 2022, NH White individuals, those aged 44-54, and PWID had the lowest rates of linkage to care, while individuals aged 25-44 and transgender persons had the lowest rates of receipt of HIV care and viral suppression.

Figure 2 | Care Continuum Indicators by Select Demographics, 2022



**Note** Care Continuum Outcomes are among PWDH with a reported CD4 or Viral Load in the last 5 years (Jan 1, 2018 - Dec 31, 2022).  
**\*\*Age** as of December 31, 2022

**Source** Philadelphia Department of Public Health, Division of HIV Health

Table 2 | Data to Care Barriers and Resources, 2022

Data to Care

Data to Care is a public health strategy that uses data to identify people with HIV who have not had recent medical care. The Field Services Program (FSP), initiated in July 2020, provides linkage, re-linkage, and other outreach to people with HIV who are out of care using a strengths-based approach. Through Data to Care efforts, 862 individuals were identified as out-of-care and enrolled in Field Services for re-engagement in 2022. After receiving outreach services, 49.0% were re-linked to care (receiving a CD4 or viral load within 90 days of enrollment). The lowest rates of re-linkage were among Transgender individuals (37.0%), among individuals aged 25-29 years old (39.7%), NH White individuals (43.1%), and MSM (45.2%) (Figure 3).

Qualitative data collected through the Data to Care and Field Services programs indicate that 53.6% of barriers faced by out-of-care individuals are provider/structural barriers, 36.1% are patient rights/education barriers, 25.5% are supportive services/SES barriers, and 7.7% are behavioral health barriers.

Through Field Services outreach, PDPH works to re-engage these out-of-care individuals and connect them to resources including medical case management, emergency food vouchers, housing assistance, and more. EHE funds were also provided to Ryan White HIV treatment sites to support individualized plans to remove structural-level barriers to care within their facilities including adding extended hours and readily available appointment slots.

Barriers

Barrier Domain	N	% of Barriers Reported
Provider/Structural Barrier	147	53.6%
Patient Rights/Education	99	36.1%
Supportive Services/SES	70	25.5%
Behavioral Health	21	7.7%
<b>Total Barriers Reported*</b>	<b>274</b>	

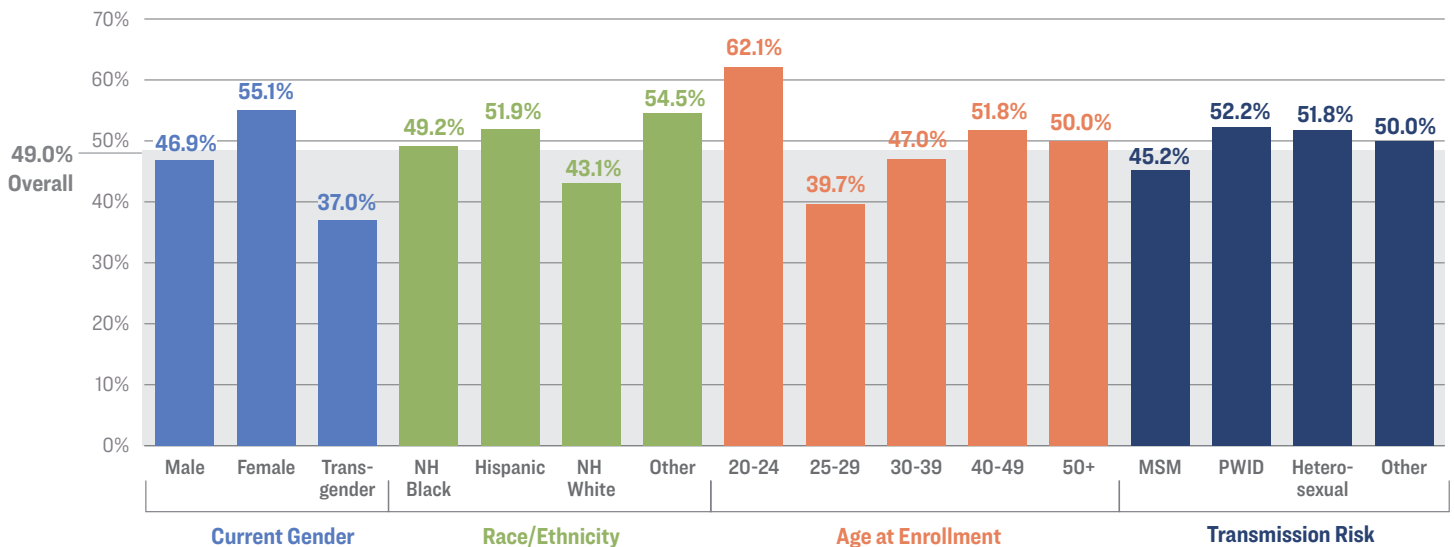
\* Some barriers are in more than one domain, percentages total to more than 100%

Resources Provided

Resource Type	N	% of Resources Reported
Child Care	1	0.4%
Drug and Alcohol Treatment	3	1.1%
Emergency Food/Pantry	8	3.0%
Governmental Services	2	0.7%
Health Insurance	3	1.1%
Housing Services	6	2.2%
Legal Services	2	0.7%
Medical Case Management	220	81.8%
Mental Health Services	1	0.4%
Other	20	7.4%
Self Help/Support Groups	1	0.4%
Utility Support	2	0.7%
<b>Total Resources Provided</b>	<b>269</b>	<b>100.0%</b>

Source Philadelphia Department of Public Health, Division of HIV Health, Data to Care (D2C)

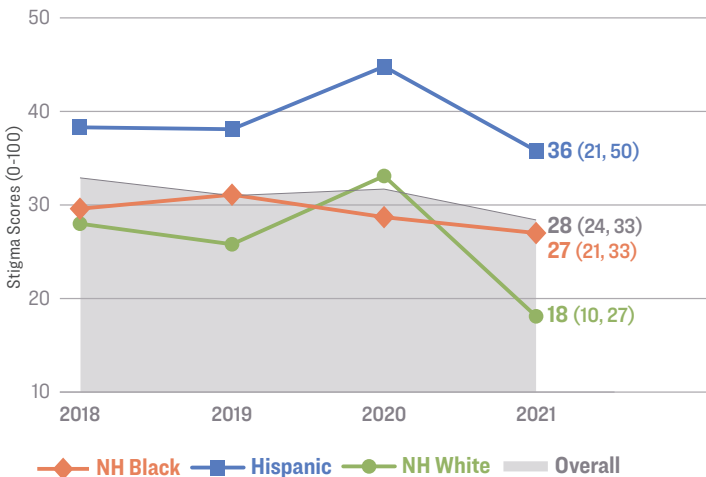
Figure 3 | Re-Linked to HIV Care Within 90 Days of Enrollment in Data to Care



## Stigma and Housing Stability

Two major components of the EHE initiative look to reduce HIV-related stigma and unstable housing among PWDH. The tables below illustrate stigma scores and unstable housing by race/ethnicity from 2018 to 2021, collected through the Medical Monitoring Project (MMP). MMP collects data about behaviors, clinical outcomes, and quality of care from PWDH living in Philadelphia. Stigma among NH Whites was the lowest in 2021, with Hispanic/Latinx individuals having the highest stigma scores on average across all four years (Figure 4). NH Black individuals report stigma at or just below the overall average score. Although we report overall homelessness among selected racial/ethnic groups, our finding is uncertain regarding any trends (Figure 5). Therefore, due to small denominators among subgroups within each year's sample, estimates have wide confidence intervals and should be interpreted with caution.

**Figure 4** Trends of Stigma Scores in PWDH by Race/Ethnicity, 2018–2021



**Note**

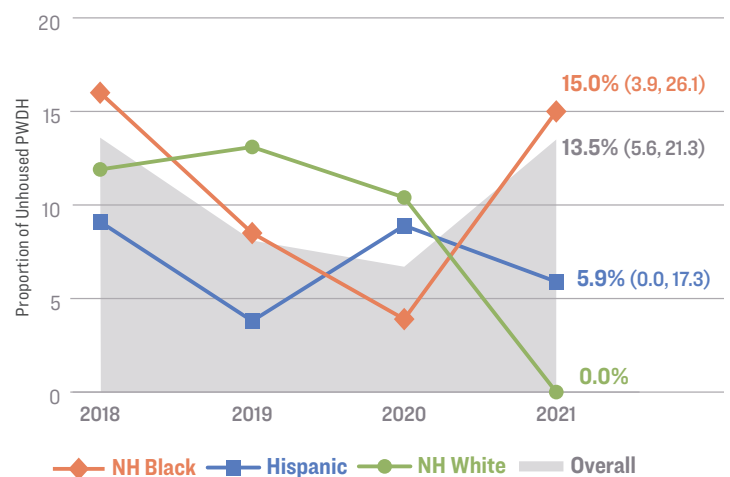
HIV-related stigma is defined as the weighted median score on a 10-item scale ranging from 0 (no stigma) to 100 (high stigma) that measures 4 dimensions of HIV stigma: personalized stigma during the past 12 months, current disclosure concerns, current negative self-image, and current perceived public attitudes about people with HIV, measured among persons aged ≥18 years with diagnosed HIV infection living in the United States and Puerto Rico. The HIV stigma scale used for this indicator is discussed in: Wright, K., Naar-King, S., Lam, P., Templin, T., & Frey, M. (2007). Stigma scale revised: reliability and validity of a brief measure of stigma for HIV+ youth. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, 40(1), 96–98. <https://doi.org/10.1016/j.jadohealth.2006.08.001>

For more information on MMP methodology, see: Beer L, Johnson C, Fagan J, Frazier E, Nyaku M, Craw J, Sanders C, Luna-Gierke R, Shouse R. A National Behavioral and Clinical Surveillance System of Adults With Diagnosed HIV (The Medical Monitoring Project): Protocol for an Annual Cross-Sectional Interview and Medical Record Abstraction Survey. *JMIR Res Protoc* 2019;8(11):e15453. URL: <https://www.researchprotocols.org/2019/11/e15453>. DOI: 10.2196/15453

**Source**

Philadelphia Department of Public Health, Division of HIV Health, Medical Monitoring Project (MMP)

**Figure 5** Trends in Proportion of Unhoused PWDH by Race/Ethnicity, 2018–2021



**Note**

MMP uses the McKinney definition of homelessness. It states that a person is homeless if they lack a fixed, regular, and adequate nighttime residence or has a steady nighttime residence that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodation; (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., one's automobile, under a bridge) (Stewart B. McKinney Act, 42 USC § 11301, et seq.).

**Source**

Philadelphia Department of Public Health, Division of HIV Health, Medical Monitoring Project (MMP)

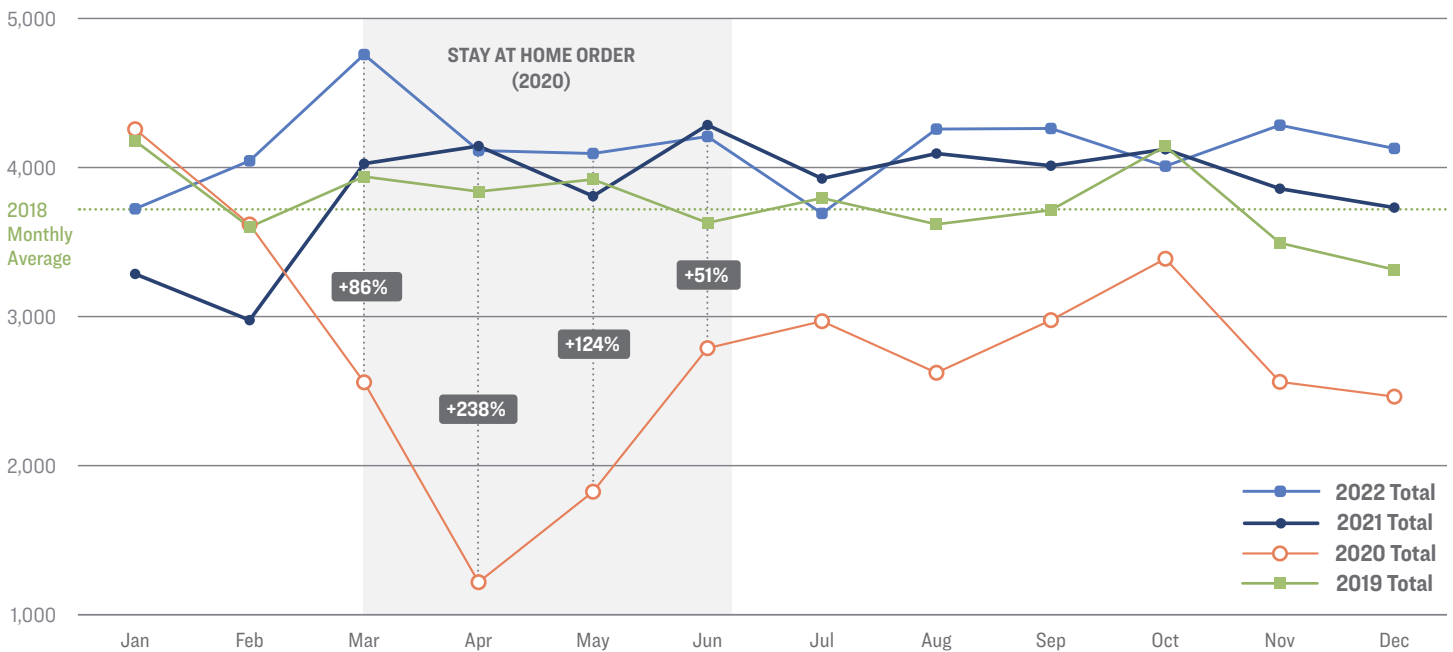
### Impact of COVID-19 on HIV Surveillance Data

COVID-19 had a substantial impact on the HIV prevention and care infrastructure in Philadelphia during 2020, especially during the local stay-at-home order that went into effect on March 23, 2020. Efforts to restore HIV services and improve access to care were the focus of 2021 and continued into 2022.

PDPH monitors laboratory result volume which can serve as an indicator of access to HIV care across the city. Currently, negative results of HIV screenings tests are not reportable to the health department and therefore city-wide screening volume cannot be assessed. However, viral load volume has surpassed pre-pandemic levels, including a notable increase from 2021 to 2022, pointing to continued improvement in access to HIV care (Figure 6).

During 2022, PDPH promoted testing and care engagement opportunities through low threshold sexual health sites, the nPEP Center of Excellence, the HIV self-test kit program, and through outreach via the Field Services Program.

Figure 6 | HIV Viral Load Testing Volume, Philadelphia, 2019 – 2022



**Note** Percentage increase represents the change in viral load testing from 2020 to 2022.

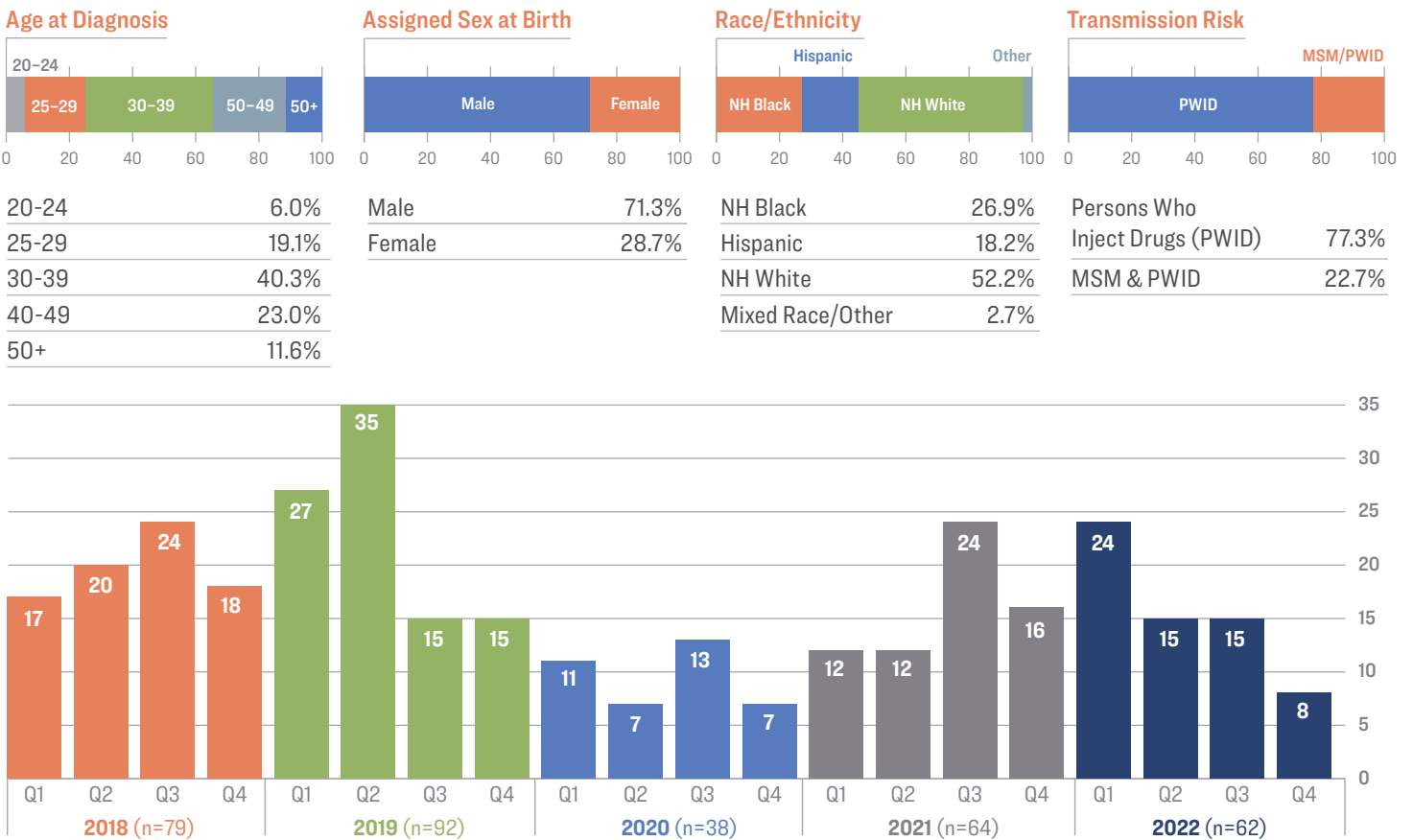
**Source** Philadelphia Department of Public Health, Division of HIV Health

### HIV Outbreak Among People Who Inject Drugs

The number of new HIV diagnoses among PWID, including men who inject and have sex with men (MSM/PWID), has remained stable in 2022 (Figure 7). Since the identification of an outbreak in 2018, the number of new HIV diagnoses among this population grew to a high of 92 new diagnoses in 2019. This represented a 188% increase from 32 cases reported in 2016, or the last year that a decrease was observed. Among the outbreak cases diagnosed from 2018 to 2022, the vast majority were assigned male sex at birth (71.3%), NH White (52.2%), and aged 30 and older (74.9%).

The ongoing outbreak continues to highlight the risk for HIV infection among PWID and their sexual and syringe sharing partners. PDPH utilizes data-driven approaches to assess and intervene as part of the ‘Respond’ pillar in the EHE plan. During 2022, PDPH has prioritized the expansion of harm reduction services and implementation of low threshold HIV prevention services.

**Figure 7** | Demographic Characteristics and HIV Epidemiological Curve among PWID, 2018–2022



Source: Philadelphia Department of Public Health, Division of HIV Health

### Transgender Persons

The quality of data on transgender individuals has not improved at the same pace as surveillance data on the overall population. Some of these differences are attributed to the lack of a gender identity variable in the surveillance system and most medical records prior to 2009, making it difficult to determine gender identity for individuals diagnosed prior to the addition of these variables to the current data system. Furthermore, many transgender women are misclassified as MSM. [Table 12](#) presents demographic information based on available gender identity and reclassifies transmission risk reported as MSM and heterosexual contact into one category termed sexual contact. Efforts to improve surveillance data on transgender individuals—including matching data to other sources such as the Ryan White CAREware database and other available health department databases, internal and external trainings on standardized collection of gender identity data and medical chart review, and additional abstractions from medical record data when necessary—have made a significant impact on identifying transgender PWDH and are ongoing.

Notably, Philadelphia was one of seven sites that was funded for the National HIV Behavioral Surveillance (NHBS) pilot cycle among transgender women. The cycle began in 2019, with data collection completed in February 2020. We completed 220 quantitative surveys, as well as HIV and hepatitis testing, among transgender women. These data were used to establish the PrEP continuum in Transgender Women ([Figure 8](#)) and will continue to provide valuable information for monitoring and evaluating national and local EHE goals and for guiding prevention efforts. A factsheet detailing findings from the 2019-2020 NHBS cycle among transgender women, and a companion implications document, will be released in the Spring of 2024; The NHBS cycle among transgender women is being repeated and data collection will finish in June 2024.

Briefly,

- Being transgender does not constitute a risk behavior for HIV. Many contextual factors related to HIV transmission are highly prevalent among transgender women in Philadelphia, including unstable housing (31%), living below the federal poverty level (62%), discrimination (36%), and abuse (40% verbal; 19% physical). Addressing factors that are the root causes of HIV transmission and barriers to HIV treatment adherence is the only way to prevent new HIV infections.
- Sixty percent of transgender women reported non-injection drug use and 17 percent reported recent binge drinking. Substance abuse may be an important mediator in the relationship between mental health and poorer outcomes in HIV care and prevention. As such, it is important for providers to routinely monitor their patients for these behaviors and refer them to culturally informed treatments.
- Most transgender women are aware of HIV prevention strategies like PrEP (97% aware). While HIV care and prevention are necessary components of healthcare for transgender women, providers must come to the table with the culturally competent knowledge and resources necessary to address the needs and concerns of their transgender patients.

### PrEP Indications










Pre-Exposure Prophylaxis, or PrEP, is a daily medication taken by individuals at high risk for HIV infection to lower their chances of getting infected. In May of 2018, CDC published estimates of adults with indications for PrEP by transmission risk group and race/ethnicity.

Based on this methodology, PDPH estimates that there were 8,750 HIV negative persons in Philadelphia during 2022 with a PrEP indication, with HIV-negative, NH Black MSM having the greatest proportion of PrEP indications (66.6%) (Table 3).

PDPH continues to use the PrEP Monitoring and Evaluation plan, developed in 2019 through collaborations with other health departments and academic institutions, to track the progress of PrEP usage in the City of Philadelphia. While PrEP can reduce an individual’s chances of acquiring HIV, it is only effective when taken as directed.

*Adherence to PrEP must be stressed by providers and condom usage must be encouraged to prevent other sexually transmitted infections.*

**Table 3** | Estimates of Adults with Indications for HIV PrEP by Race/Ethnicity and Transmission Category, Philadelphia 2022\*

	Negative At Risk			PrEP Indication			% Negative At Risk Population with a PrEP Indication		
	MSM	PWID	Heterosexual	MSM	PWID	Heterosexual	MSM	PWID	Heterosexual
NH Black	4,777	7,574	108,703	3,180	390	1,510	66.6%	5.1%	1.4%
Hispanic	2,104	4,370	47,727	1,020	310	340	48.5%	7.1%	0.7%
NH White	5,475	10,753	54,652	620	830	130	11.3%	7.7%	0.2%
									
<b>TOTAL**</b>	12,897	23,300	230,106	5,080	1,610	2,060	39.4%	6.9%	0.9%

\* Methods based on Smith, D.K., Handel, M.V., & Grey, J. (2018). Estimates of adults with indications for HIV pre-exposure prophylaxis by jurisdiction, transmission risk group, and race/ethnicity, United States 2015. *Annals of Epidemiology*.

\*\* Totals presented represent data for all racial/ethnic groups of a given population, and therefore will be greater than the sum of the three racial/ethnic groups presented.

**Note** The population of individuals 18 and older living below poverty level is used as a proxy for the at risk heterosexual population estimate. The MSM population denominator is based on the estimated number of MSM who have had sex with a man in the past year. Racial/ethnic population estimates for HIV negative MSM are based on the proportion of MSM who were HIV negative by race/ethnicity in the National HIV Behavioral Surveillance (NHBS) data in 2017. Racial/ethnic population composition for all active PWID is based on race/ethnicity data for individuals with a primary diagnosis of opioid use disorder who participated in any Medicaid-funded outpatient services in Philadelphia in 2022. Racial/ethnic population estimates for HIV negative PWID are based on the proportion of PWID who were HIV negative by race/ethnicity in the National HIV Behavioral Surveillance (NHBS) data for Philadelphia in 2022.

**Source** Philadelphia Department of Public Health, Division of HIV Health



## PrEP Continuum

The PrEP continuum is similar to the HIV continuum of care but was developed using data from the CDC funded National HIV Behavioral Surveillance (NHBS) project and is used to help monitor efforts to increase PrEP awareness, use, and adherence among HIV negative individuals at risk for HIV. There are four metrics along the PrEP continuum:

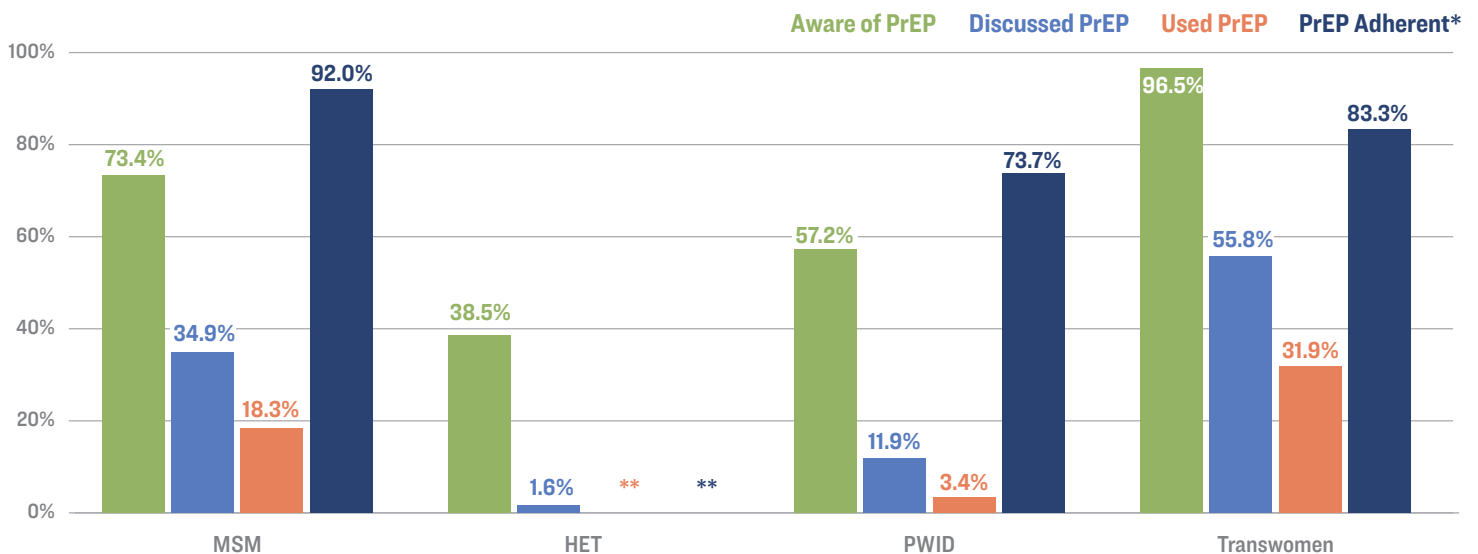
- 1) Awareness of PrEP,
- 2) discussing PrEP with a medical provider in the past year,
- 3) using PrEP in the past year, and
- 4) PrEP adherence in the past year.

The PrEP continuum is presented for HIV negative individuals in four at-risk populations, including MSM, at-risk heterosexuals, PWID, and transwomen.

Due to the impact of COVID-19 on the ability to conduct routine NHBS activities, the scheduled 2020 MSM NHBS cycle was postponed to 2021. However, due to the small sample size resulting from COVID-19, the 2021 data are unreliable. The next MSM cycle for NHBS will be in 2023. Therefore, MSM data reported here remain unchanged from last report; the NHBS PWID cycle has been completed, and PWID data is updated below. PrEP awareness, discussions about PrEP, and PrEP usage were highest among transwomen, while PrEP adherence was highest among MSM. Both at-risk heterosexuals and PWID reported the lowest levels of awareness, discussions about, and usage of PrEP. Less than half of all MSM, PWID, and heterosexuals interviewed had discussed PrEP with their provider in the past year.

**Identifying and removing barriers to PrEP for under-served populations is necessary to improve the PrEP continuum among all groups.**

Figure 8 | Continuum of PrEP Awareness and Usage



\*Among those who reported PrEP use in the past year Adherent is defined as taking PrEP every day or almost every day.

\*\*Numbers become too small to present stable population estimates.

**Note**  
These numbers are presented as percentages, with the denominator being all HIV negative persons interviewed (with the exception of 'PrEP Adherent').

Source Philadelphia Department of Public Health, Division of HIV Health and National HIV Behavioral Surveillance Project (NHBS)

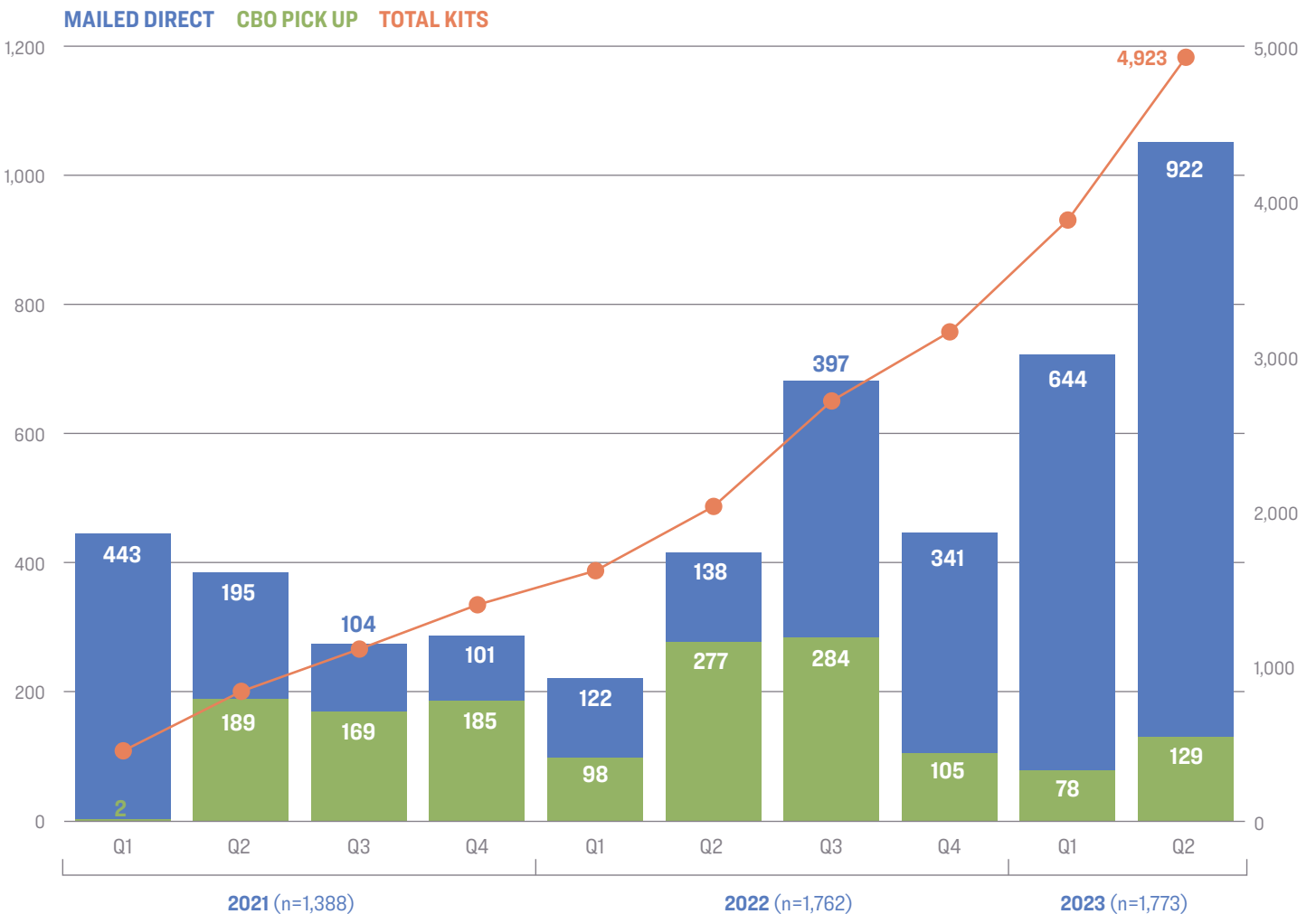


### HIV Self Test Program

During 2022, PDPH continued expansion of the HIV self-test program, which increases HIV testing opportunities by providing an alternative for people at higher risk for acquiring HIV who may be unwilling or decline to get tested in other venues. In addition to increasing awareness of HIV status, the program destigmatizes HIV screening by providing a personal and private experience. From January 2021 through June 2023, PDPH supplied nearly 2,652 self-test kits to community-based partner agencies (data not shown). During this period, 3,407 kits were requested and mailed direct to consumer and an additional 1,516 were picked up from a community-based partner agency (Figure 9).

Consumers can request an in-home test kit to be mailed to their home address through the campaign website: <http://www.PhillyKeepOnLoving.com> or kits can be picked up at one of our community-based partner agencies.

Figure 9 | HIV Self-Test Kit Requests, January 2021–June 2023



Source Philadelphia Department of Public Health, Division of HIV Health

## Newly Diagnosed Cases

Table  
4

# By Year and Selected Characteristics (regardless of AIDS status) | 2018 –2022

Year of Diagnosis	2018		2019		2020		2021		2022		
	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %	
<b>Total Cases</b>	438	100.0 %	445	100.0 %	337	100.0 %	366	100.0 %	382	100.0 %	
<b>Sex Assigned at Birth</b>											
Female	107	24.4%	108	24.3%	83	24.6%	76	20.8%	94	24.6%	
Male	331	75.6%	337	75.7%	254	75.4%	290	79.2%	288	75.4%	
<b>Race/Ethnicity</b>											
NH Black	258	58.9%	280	62.9%	228	67.7%	229	62.6%	224	58.6%	
Hispanic	88	20.1%	80	18.0%	54	16.0%	52	14.2%	76	19.9%	
NH White	78	17.8%	73	16.4%	46	13.6%	75	20.5%	65	17.0%	
Multi-race	6	1.4%	9	2.0%	*	*	*	*	8	2.1%	
Asian	6	1.4%	*	*	*	*	*	*	6	1.6%	
Other/Unknown	*	*	*	*	*	*	*	*	*	*	
<b>Age Category</b>											
0-12	*	*	*	*	*	*	*	*	*	*	
13-19	22	5.0%	32	7.2%	19	5.6%	19	5.2%	14	3.7%	
20-24	92	21.0%	76	17.1%	50	14.8%	66	18.0%	49	12.8%	
25-29	83	18.9%	100	22.5%	74	22.0%	77	21.0%	72	18.8%	
30-39	119	27.2%	116	26.1%	101	30.0%	112	30.6%	135	35.3%	
40-49	49	11.2%	58	13.0%	44	13.1%	40	10.9%	59	15.4%	
50+	73	16.7%	63	14.2%	48	14.2%	50	13.7%	52	13.6%	
<b>Transmission Risk</b>											
MSM	213	48.6%	237	53.3%	192	57.0%	206	56.3%	195	51.0%	
PWID	59	13.5%	75	16.9%	27	8.0%	45	12.3%	53	13.9%	
MSM/PWID	20	4.6%	17	3.8%	11	3.3%	19	5.2%	9	2.4%	
Heterosexual	86	19.6%	87	19.6%	81	24.0%	62	16.9%	79	20.7%	
Pediatric	*	*	*	*	*	*	*	*	*	*	
No Reported Risk	60	13.7%	29	6.5%	25	7.4%	33	9.0%	45	11.8%	

**Note** \*Cell sizes <6 (including 0) are suppressed.  
Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

Bar graphs show  
2022 percentages

Table 5 | By Race/Ethnicity and Selected Characteristics (regardless of AIDS status) | 2022

	NH Black		Hispanic		NH White	
	N	Col %	N	Col %	N	Col %
<b>Total N</b>						
Total	224	100.0%	76	100.0%	65	100.0%
<b>Sex Assigned at Birth</b>						
Female	56	25.0%	16	21.1%	20	30.8%
Male	168	75.0%	60	78.9%	45	69.2%
<b>Age Category</b>						
0-12	*	*	*	*	*	*
13-19	10	4.5%	*	*	*	*
20-24	40	17.9%	7	9.2%	*	*
25-29	43	19.2%	16	21.1%	10	15.4%
30-39	64	28.6%	28	36.8%	34	52.3%
40-49	31	13.8%	12	15.8%	11	16.9%
50+	36	16.1%	9	11.8%	7	10.8%
<b>Transmission Risk</b>						
MSM	122	54.5%	39	51.3%	24	36.9%
PWID	13	5.8%	10	13.2%	28	43.1%
MSM/PWID	*	*	*	*	*	*
Heterosexual	58	25.9%	13	17.1%	*	*
Pediatric	*	*	*	*	*	*
No Reported Risk	29	12.9%	11	14.5%	*	*

**Note** \*Cell sizes <6 (including 0) are suppressed.  
Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

**Racial/ethnic health disparities in Philadelphia persist and mirror those observed across the nation.**

NH Black and Hispanic/Latinx people have substantially higher rates of new HIV diagnoses compared to NH White people. In 2022, the highest rates of new HIV diagnoses were among NH Black people (37.2 per 100,000), followed by Hispanic/Latinx (32.3) and NH White people (11.9).

Figure 10 | By Race/Ethnicity | 2022

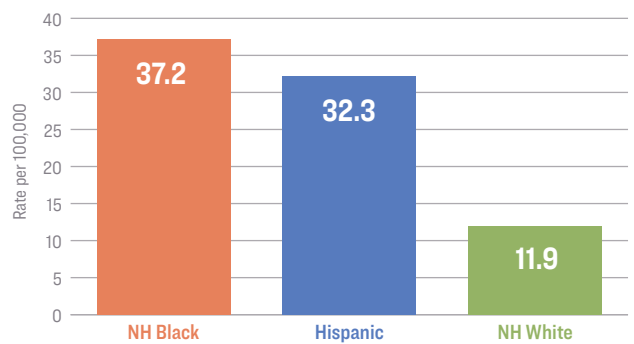


Table 6 | By Sex Assigned at Birth and Selected Characteristics | 2022

Assigned males at birth comprised the majority of all new HIV diagnoses (75.4%), with the highest rates among MSM. Assigned females at birth comprised 24.6% of new diagnoses, with highest rates among NH Black and heterosexual women.

	Assigned female at birth			Assigned male at birth		
	N	Col %	Rate †	N	Col %	Rate †
<b>Total N</b>						
Total	94	100.0%	11.2	288	100.0%	38.6
<b>Race/Ethnicity</b>						
NH Black	56	59.6%	16.9	168	58.3%	62.1
Hispanic	16	17.0%	13.2	60	20.8%	52.6
NH White	20	21.3%	7.1	45	15.6%	16.9
Multi-race	*	*	*	6	2.1%	24.2
Asian	*	*	*	6	2.1%	9.4
Other/Unk	*	*	*	*	*	*
<b>Age Category</b>						
0-12	*	*	*	*	*	*
13-19	*	*	*	13	4.5%	19.2
20-24	8	8.5%	11.8	41	14.2%	66.1
25-29	17	18.1%	20.4	55	19.1%	74.0
30-39	31	33.0%	23.0	104	36.1%	84.5
40-49	16	17.0%	17.4	43	14.9%	52.2
50+	20	21.3%	7.1	32	11.1%	14.8
<b>Transmission Risk</b>						
MSM	-	-	N/A	195	67.7%	1484.4
PWID	22	23.4%	N/A	31	10.8%	N/A
MSM/PWID	-	-	N/A	9	3.1%	N/A
Heterosexual	67	71.3%	48.0	12	4.2%	13.2
Pediatric	*	*	*	*	*	*
No Reported Risk	*	*	N/A	41	14.2%	N/A

**Note** \*Cell sizes <6 (including 0) are suppressed.

† Rates for age and race/ethnicity by sex assigned at birth were calculated using the 2020 decennial census. **MSM** rates were calculated using estimates of MSM activity among males 13 and older in the last year. **Heterosexual** rates were calculated using the number of individuals 18 and older living below the federal poverty level from the 2021 American Community Survey.

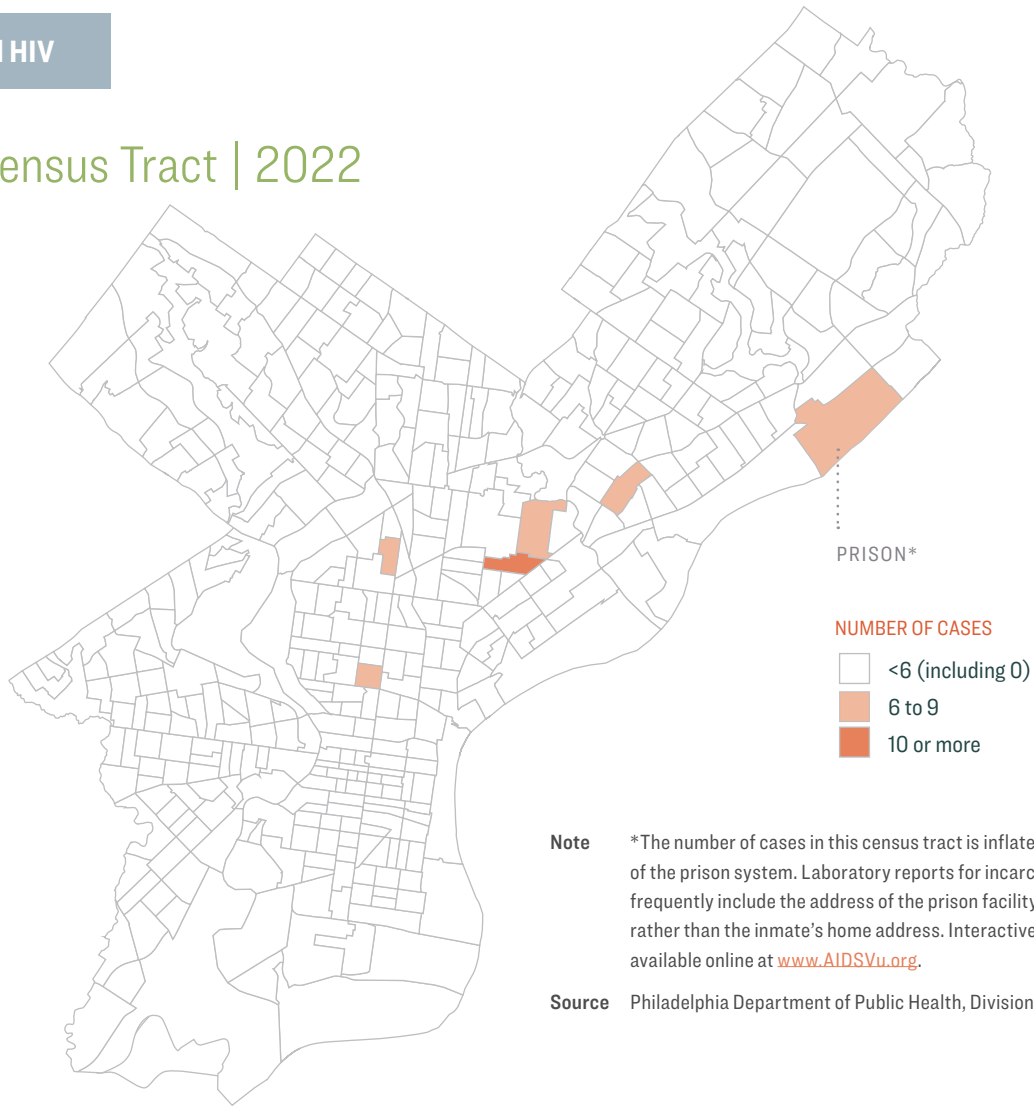
New diagnosis rates that cannot be calculated due to unavailable or otherwise unfeasible population estimates are marked as N/A.

Due to rounding, percentages may not add up to exactly 100%.

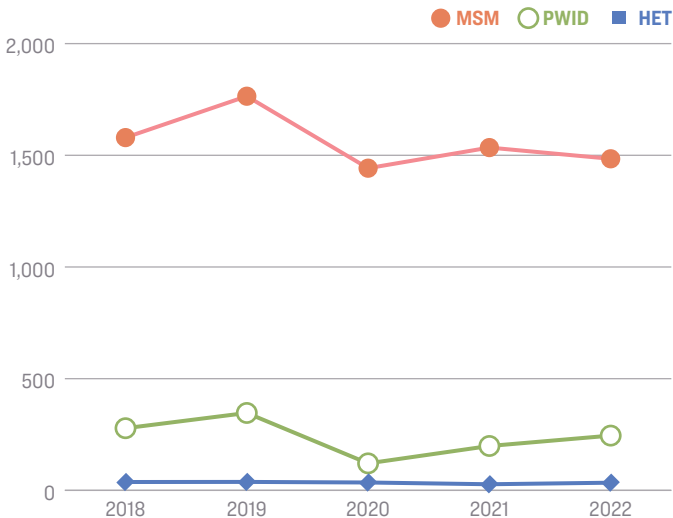
**Source** Philadelphia Department of Public Health, Division of HIV Health

## Newly Diagnosed HIV

### Map 1 | By Census Tract | 2022



### Figure 11 | Rates of Newly Diagnosed HIV per 100,000 People by Year of Diagnosis and Risk Group, 2018 – 2022



**Note**

MSM population size based on estimates of MSM activity among males 13 and older in the last year. Active PWID population size estimated as 25,000 citywide. Individuals 18 and older living below the poverty level was used as a proxy for at-risk heterosexuals.

More information on MSM population estimates can be found here: Purcell DW, Johnson CH, Lansky A, Prejean J, Stein R, Denning P, et al. Estimating the population size of men who have sex with men in the United States to obtain HIV and syphilis rates. *Open AIDS J* 2012;6:98-107

More information on PWID population estimate can be found here: Bradley H, Hall EW, Asher A, Furukawa NW, Jones CM, Shealey J, Buchacz K, Handanagic S, Crepaz N, Rosenberg ES. Estimated Number of People Who Inject Drugs in the United States. *Clin Infect Dis*. 2023 Jan 6;76(1):96-102.

**Source** Philadelphia Department of Public Health, Division of HIV Health

Table 7

# Concurrent HIV/AIDS, Demographics and Transmission Risk 2018–2022

2018				2019				2020				2021				2022			
Non-concurrent		Concurrent HIV/AIDS		Non-concurrent		Concurrent HIV/AIDS		Non-concurrent		Concurrent HIV/AIDS		Non-concurrent		Concurrent HIV/AIDS		Non-concurrent		Concurrent HIV/AIDS	
N	Row%	N	Row%	N	Row%	N	Row%	N	Row%	N	Row%	N	Row%	N	Row%	N	Row%	N	Row%

**Total**

376	85.8%	62	14.2%	388	87.2%	57	12.8%	276	81.9%	61	18.1%	294	80.3%	72	19.7%	311	81.4%	71	18.6%
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**Sex Assigned at Birth**

Female	93	86.9%	14	13.1%	98	90.7%	10	9.3%	64	77.1%	19	22.9%	60	78.9%	16	21.1%	78	83.0%	16	17.0%
Male	283	85.5%	48	14.5%	290	86.1%	47	13.9%	212	83.5%	42	16.5%	234	80.7%	56	19.3%	233	80.9%	55	19.1%

**Race/Ethnicity**

NH Black	219	84.9%	39	15.1%	247	88.2%	33	11.8%	191	83.8%	37	16.2%	179	78.2%	50	21.8%	177	79.0%	47	21.0%
Hispanic	74	84.1%	14	15.9%	63	78.8%	17	21.3%	47	87.0%	7	13.0%	38	73.1%	14	26.9%	65	85.5%	11	14.5%
NH White	69	88.5%	9	11.5%	67	91.8%	6	8.2%	33	71.7%	13	28.3%	68	90.7%	7	9.3%	57	87.7%	8	12.3%
Multi-race	6	100.0%	*	*	8	88.9%	*	*	*	*	*	*	*	*	*	*	7	87.5%	*	*
Asian	6	100.0%	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Other/Unknown	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*

**Age at HIV Dx**

0-12	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
13-19	21	95.5%	*	*	31	96.9%	*	*	18	94.7%	*	*	16	84.2%	*	*	13	92.9%	*	*
20-24	83	90.2%	9	9.8%	70	92.1%	6	7.9%	46	92.0%	*	*	60	90.9%	6	9.1%	42	85.7%	7	14.3%
25-29	77	92.8%	6	7.2%	88	88.0%	12	12.0%	64	86.5%	10	13.5%	70	90.9%	7	9.1%	64	88.9%	8	11.1%
30-39	97	81.5%	22	18.5%	96	82.8%	20	17.2%	83	82.2%	18	17.8%	90	80.4%	22	19.6%	112	83.0%	23	17.0%
40-49	38	77.6%	11	22.4%	49	84.5%	9	15.5%	30	68.2%	14	31.8%	30	75.0%	10	25.0%	44	74.6%	15	25.4%
50+	60	82.2%	13	17.8%	54	85.7%	9	14.3%	34	70.8%	14	29.2%	26	52.0%	24	48.0%	35	67.3%	17	32.7%

**Transmission Risk**

MSM	184	86.4%	29	13.6%	202	85.2%	35	14.8%	165	85.9%	27	14.1%	168	81.6%	38	18.4%	155	79.5%	40	20.5%
PWID	53	89.8%	6	10.2%	70	93.3%	*	*	23	85.2%	*	*	39	86.7%	6	13.3%	48	90.6%	*	*
MSM/PWID	18	90.0%	*	*	16	94.1%	*	*	8	72.7%	*	*	19	100.0%	*	*	7	77.8%	*	*
Heterosexual	73	84.9%	13	15.1%	76	87.4%	11	12.6%	60	74.1%	21	25.9%	48	77.4%	14	22.6%	64	81.0%	15	19.0%
Pediatric	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
No Reported Risk	48	80.0%	12	20.0%	24	82.8%	*	*	19	76.0%	6	24.0%	19	57.6%	14	42.4%	36	80.0%	9	20.0%

**Note** \*Cell sizes < 6 (including 0) are suppressed.

Non-concurrent diagnoses are defined as only a diagnosis of HIV. Concurrent HIV/AIDS is defined as diagnosis of AIDS within 90 days of initial diagnosis of HIV.

Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

Table 8 | By Year and Selected Characteristics | 2018 – 2022

During 2022, new AIDS diagnoses in Philadelphia were primarily among persons assigned male sex at birth (70.8%), NH Black individuals (68.3%), MSM (41.6%), and those aged 50 and over (32.7%).

Year of Diagnosis	2018		2019		2020		2021		2022		
	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %	
<b>Total Cases</b>	156	100.0%	167	100.0%	155	100.0%	172	100.0%	202	100.0%	
<b>Sex Assigned at Birth</b>											
Female	44	28.2%	42	25.1%	48	31.0%	44	25.6%	59	29.2%	
Male	112	71.8%	125	74.9%	107	69.0%	128	74.4%	143	70.8%	
<b>Race/Ethnicity</b>											
NH Black	106	67.9%	102	61.1%	112	72.3%	109	63.4%	138	68.3%	
Hispanic	31	19.9%	36	21.6%	19	12.3%	33	19.2%	26	12.9%	
NH White	19	12.2%	25	15.0%	19	12.3%	24	14.0%	27	13.4%	
Multi-race	*	*	*	*	*	*	*	*	6	3.0%	
Asian	*	*	*	*	*	*	*	*	*	*	
Other/Unknown	*	*	*	*	*	*	*	*	*	*	
<b>Age Category</b>											
13-19	*	*	*	*	*	*	*	*	*	*	
20-24	15	9.6%	12	7.2%	*	*	8	4.7%	14	6.9%	
25-29	17	10.9%	34	20.4%	23	14.8%	15	8.7%	20	9.9%	
30-39	46	29.5%	50	29.9%	49	31.6%	54	31.4%	63	31.2%	
40-49	26	16.7%	25	15.0%	33	21.3%	28	16.3%	38	18.8%	
50+	51	32.7%	43	25.7%	44	28.4%	64	37.2%	66	32.7%	
<b>Transmission Risk</b>											
MSM	59	37.8%	73	43.7%	58	37.4%	83	48.3%	84	41.6%	
PWID	28	17.9%	26	15.6%	18	11.6%	22	12.8%	36	17.8%	
MSM/PWID	*	*	*	*	8	5.2%	*	*	8	4.0%	
Heterosexual	46	29.5%	52	31.1%	56	36.1%	45	26.2%	59	29.2%	
Pediatric	*	*	*	*	*	*	*	*	*	*	
No Reported Risk	16	10.3%	10	6.0%	12	7.7%	17	9.9%	13	6.4%	

**Note** \*Cell sizes <6 (including 0) are suppressed.  
 A proportion of AIDS diagnoses in each year were diagnosed with HIV in a previous year and later progressed to AIDS.  
 Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

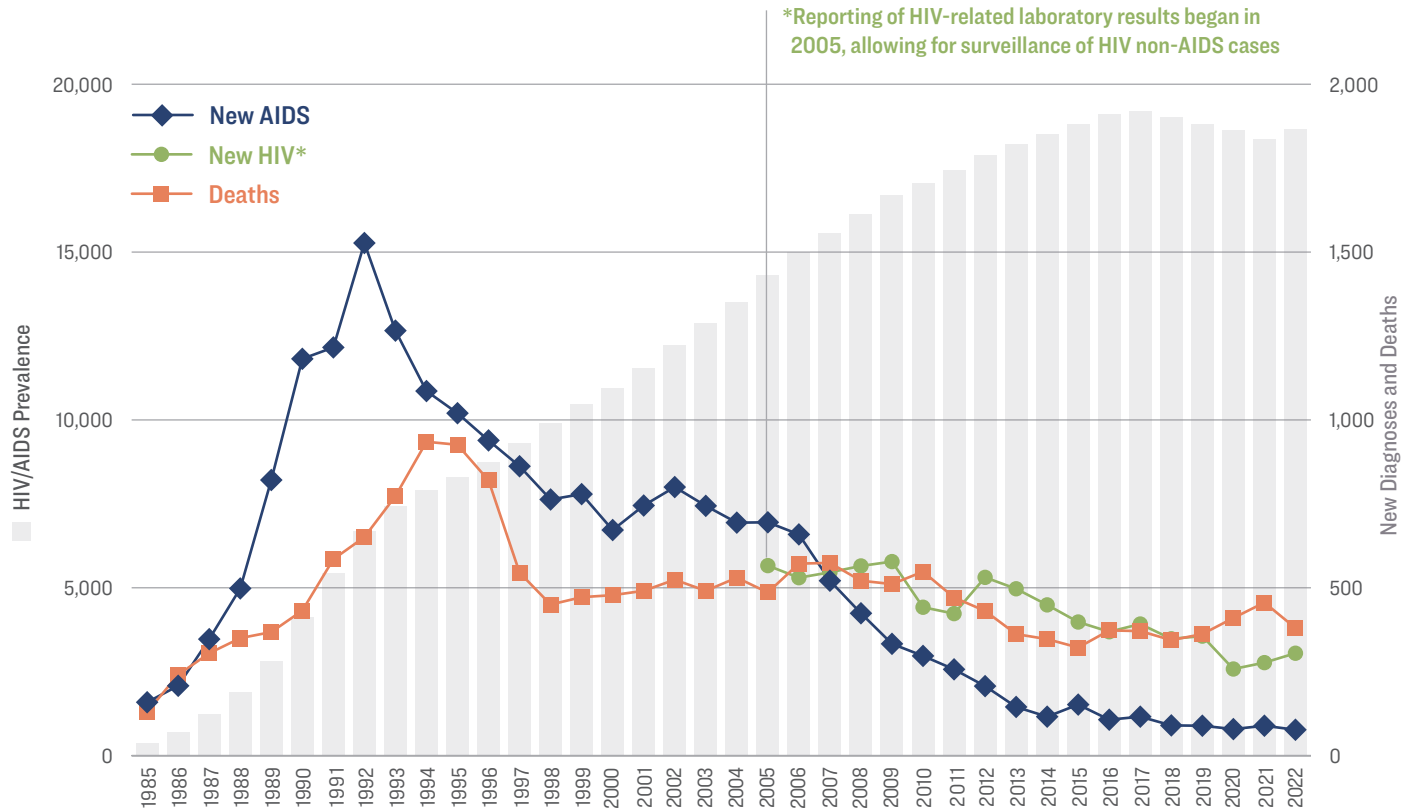
Bar graphs indicate 2022 percentages



## Persons with Diagnosed HIV

Figure 12


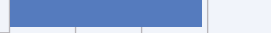
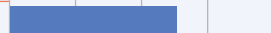









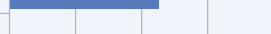






# Philadelphia HIV and AIDS Diagnoses, Deaths, and Prevalence by Year | 1985 – 2022



Source Philadelphia Department of Public Health, Division of HIV Health

## Persons with Diagnosed HIV

Table 9 | HIV (non-AIDS) and AIDS Cases by Selected Characteristics | 2022

	HIV (Non-AIDS)		AIDS		HIV/AIDS		
	N	Col %	N	Col %	N	Col %	
<b>Total N</b>							
Total	8,776	100.0%	9,882	100.0%	18,658	100.0%	
<b>Sex Assigned at Birth</b>							
Female	2,420	27.6%	2,745	27.8%	5,165	27.7%	
Male	6,356	72.4%	7,137	72.2%	13,493	72.3%	
<b>Race/Ethnicity</b>							
NH Black	5,449	62.1%	6,346	64.2%	11,795	63.2%	
Hispanic	1,517	17.3%	1,568	15.9%	3,085	16.5%	
NH White	1,462	16.7%	1,588	16.1%	3,050	16.3%	
Multi-race	209	2.4%	261	2.6%	470	2.5%	
Asian	107	1.2%	99	1.0%	206	1.1%	
Other/Unknown	32	0.4%	20	0.2%	52	0.3%	
<b>Age Category**</b>							
<13	10	0.1%	*	*	10	0.1%	
13-19	41	0.5%	9	0.1%	50	0.3%	
20-24	309	3.5%	47	0.5%	356	1.9%	
25-29	741	8.4%	181	1.8%	922	4.9%	
30-39	2,373	27.0%	1,141	11.5%	3,514	18.8%	
40-49	1,765	20.1%	1,552	15.7%	3,317	17.8%	
50+	3,537	40.3%	6,952	70.4%	10,489	56.2%	
<b>Transmission Risk</b>							
MSM	3,953	45.0%	3,480	35.2%	7,433	39.8%	
PWID	1,161	13.2%	2,220	22.5%	3,381	18.1%	
MSM/PWID	296	3.4%	504	5.1%	800	4.3%	
Heterosexual	2,937	33.5%	3,302	33.4%	6,239	33.4%	
Pediatric	108	1.2%	139	1.4%	247	1.3%	
Other	*	*	8	0.1%	10	0.1%	
No Reported Risk	319	3.6%	229	2.3%	548	2.9%	

**Note** \*Cell sizes <6 (including 0) are suppressed.  
 \*\*Age as of December 31, 2022  
 Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

Bar graphs indicate 2022 percentages

## Persons with Diagnosed HIV

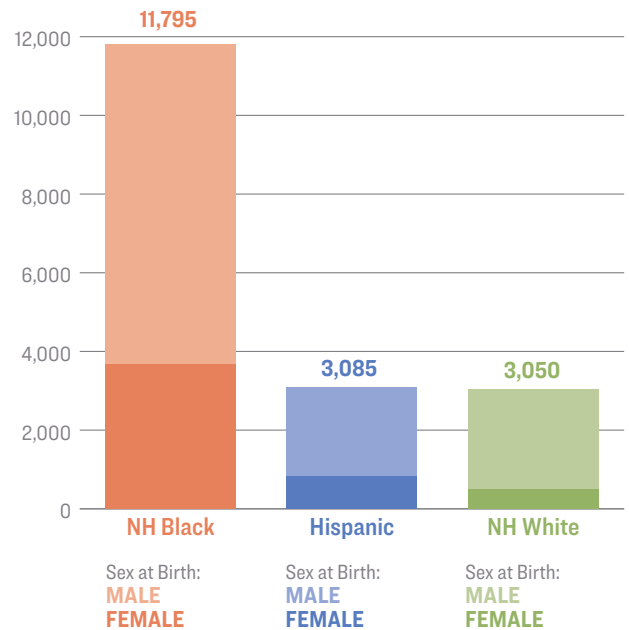
**Table 10** | By Race/Ethnicity and Selected Characteristics | 2022

	NH Black		Hispanic		NH White	
	N	Col %	N	Col %	N	Col %
<b>Total N</b>						
Total	11,795	100.0%	3,085	100.0%	3,050	100.0%
<b>Sex Assigned at Birth</b>						
Female	3,681	31.2%	821	26.6%	483	15.8%
Male	8,114	68.8%	2,264	73.4%	2,567	84.2%
<b>Age Category**</b>						
<13	*	*	*	*	*	*
13-19	39	0.3%	9	0.3%	*	*
20-24	272	2.3%	60	1.9%	16	0.5%
25-29	660	5.6%	147	4.8%	75	2.5%
30-39	2,329	19.7%	554	18.0%	475	15.6%
40-49	2,000	17.0%	635	20.6%	533	17.5%
50+	6,491	55.0%	1,675	54.3%	1,950	63.9%
<b>Transmission Risk</b>						
MSM	4,317	36.6%	1,037	33.6%	1,767	57.9%
PWID	1,972	16.7%	749	24.3%	556	18.2%
MSM/PWID	401	3.4%	168	5.4%	187	6.1%
Heterosexual	4,556	38.6%	972	31.5%	466	15.3%
Pediatric	177	1.5%	49	1.6%	16	0.5%
Other	6	0.1%	*	*	*	*
No Reported Risk	366	3.1%	110	3.6%	55	1.8%

**Note** \*Cell sizes <6 (including 0) are suppressed.  
 \*\* Age as of December 31, 2022  
 Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

**Figure 13** | By Sex Assigned at Birth and Race/Ethnicity 2022



## Persons with Diagnosed HIV

Table 11

### By Sex Assigned at Birth and Selected Characteristics | 2022

	Assigned Female at Birth		Assigned Male at Birth	
	N	Col %	N	Col %
<b>Total N</b>				
Total	5,165	100.0%	13,493	100.0%
<b>Race/Ethnicity</b>				
NH Black	3,681	71.3%	8,114	60.1%
Hispanic	821	15.9%	2,264	16.8%
NH White	483	9.4%	2,567	19.0%
Multi-race	134	2.6%	336	2.5%
Asian	35	0.7%	171	1.3%
Other/Unk	11	0.2%	41	0.3%
<b>Age Category**</b>				
<13	8	0.2%	*	*
13-19	18	0.3%	32	0.2%
20-24	64	1.2%	292	2.2%
25-29	173	3.3%	749	5.6%
30-39	707	13.7%	2,807	20.8%
40-49	1,004	19.4%	2,313	17.1%
50+	3,191	61.8%	7,298	54.1%
<b>Transmission Risk</b>				
MSM	–	–	7,433	55.1%
PWID	1,236	23.9%	2,145	15.9%
MSM/PWID	–	–	800	5.9%
Other	*	*	8	0.1%
Heterosexual	3,748	72.6%	2,491	18.5%
Pediatric	128	2.5%	119	0.9%
No Reported Risk	51	1.0%	497	3.7%

**Note** \*Cell sizes <6 (including 0) are suppressed.

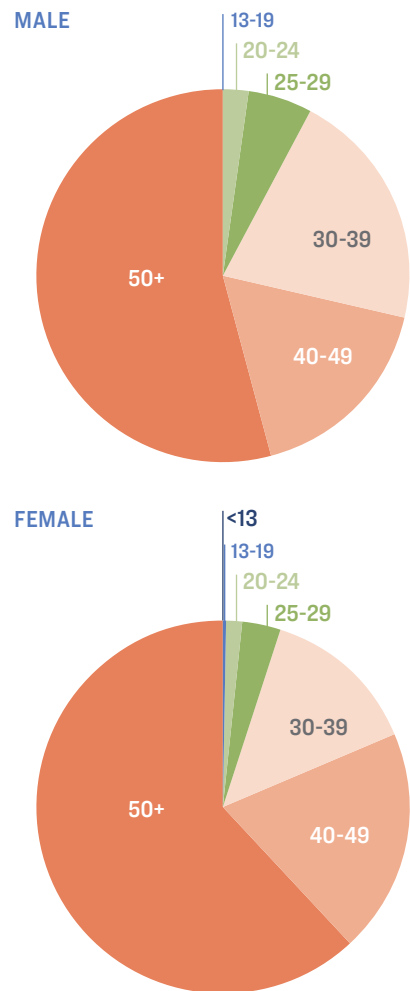
\*\* Age as of December 31, 2022

Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

Figure 14

### By Sex Assigned at Birth and Age Category



## Persons with Diagnosed HIV

Table 12 | By Gender Identity and Selected Characteristics | 2022

	Cisgender Men		Cisgender Women		Transgender Women		Transgender Men	
	N	Col %	N	Col %	N	Col %	N	Col %
<b>Total N</b>								
Total	13,076	100.0%	5,118	100.0%	422	100.0%	24	100.0%
<b>Race/Ethnicity</b>								
NH Black	7,812	59.7%	3,653	71.4%	304	72.0%	14	58.3%
Hispanic	2,198	16.8%	814	15.9%	67	15.9%	*	*
NH White	2,540	19.4%	474	9.3%	29	6.9%	*	*
Multi-race	322	2.5%	131	2.6%	14	3.3%	*	*
Asian	167	1.3%	35	0.7%	*	*	*	*
Other/Unknown	37	0.3%	11	0.2%	*	*	*	*
<b>Age Category**</b>								
<13	*	*	9	0.2%	*	*	*	*
13-19	32	0.2%	22	0.4%	*	*	*	*
20-24	306	2.4%	66	1.3%	17	4.2%	*	*
25-29	759	5.9%	177	3.5%	49	12.2%	*	*
30-39	2,601	20.2%	710	14.1%	158	39.4%	13	59.1%
40-49	2,125	16.5%	1,011	20.0%	75	18.7%	*	*
50+	7,033	54.7%	3,060	60.5%	102	25.4%	*	*
<b>Transmission Risk</b>								
Sexual Contact	9,440	73.4%	3,663	72.5%	324	80.8%	17	77.3%
PWID	2,850	22.2%	1,214	24.0%	72	18.0%	*	*
Other	8	0.1%	*	*	*	*	*	*
Pediatric	120	0.9%	129	2.6%	*	*	*	*
No Reported Risk	441	3.4%	46	0.9%	*	*	*	*

**Note** \*Cell sizes <6 (including 0) are suppressed.

\*\*Age as of December 31, 2022

Due to rounding, percentages may not add up to exactly 100%.

Gender identity is often not recorded in medical records. Sex assigned at birth was used to determine gender identity where no additional information was present. The prevalence among transgender women, transgender men, and those cases with additional gender identities is assumed to be higher. Individuals identifying as non-binary (n=18) were excluded from the table due to small cell sizes.

**Source** Philadelphia Department of Public Health, Division of HIV Health

## Persons with Diagnosed HIV

Table 13 | Prevalence by Sex Assigned at Birth and Race/Ethnicity | 2022

	Population	PWDH	Rate Per 100,000	
<b>Total</b>	1,603,797	18,658	1,163.4	
<b>Sex Assigned at Birth</b>				
Female	843,414	5,165	612.4	
Male	760,383	13,493	1,774.5	
<b>Race/Ethnicity</b>				
NH Black	613,835	11,795	1,921.5	
Hispanic	238,277	3,085	1,294.7	
NH White	550,828	3,050	553.7	
Asian	132,408	206	155.6	
AIAN	2,596	41	1,579.4	
NHPI	579	10	1,727.1	
Other Race	11,419	*	*	
Multi-racial	53,855	470	872.7	
<b>Sex Assigned at Birth and Race/Ethnicity</b>				
NH Black Female	335,134	3,681	1,098.4	
Hispanic Female	122,032	821	672.8	
NH White Female	281,240	483	171.7	
Asian Female	68,668	35	51.0	
AIAN Female	1,406	8	569.0	
NHPI Female	*	*	*	
Other race Female	5,881	*	*	
Multi-racial Female	28,728	134	466.4	
NH Black Male	278,701	8,114	2,911.4	
Hispanic Male	116,245	2,264	1,947.6	
NH White Male	269,588	2,567	952.2	
Asian Male	63,740	171	268.3	
AIAN Male	1,190	33	2,773.1	
NHPI Male	*	*	*	
Other race Male	5,538	*	*	
Multi-racial Male	25,127	336	1,337.2	

**Note** \*Cell sizes <6 (including 0) are suppressed. Rates and case counts in categories with <500 population are also suppressed. Rates were calculated using population data from the 2020 decennial census data.

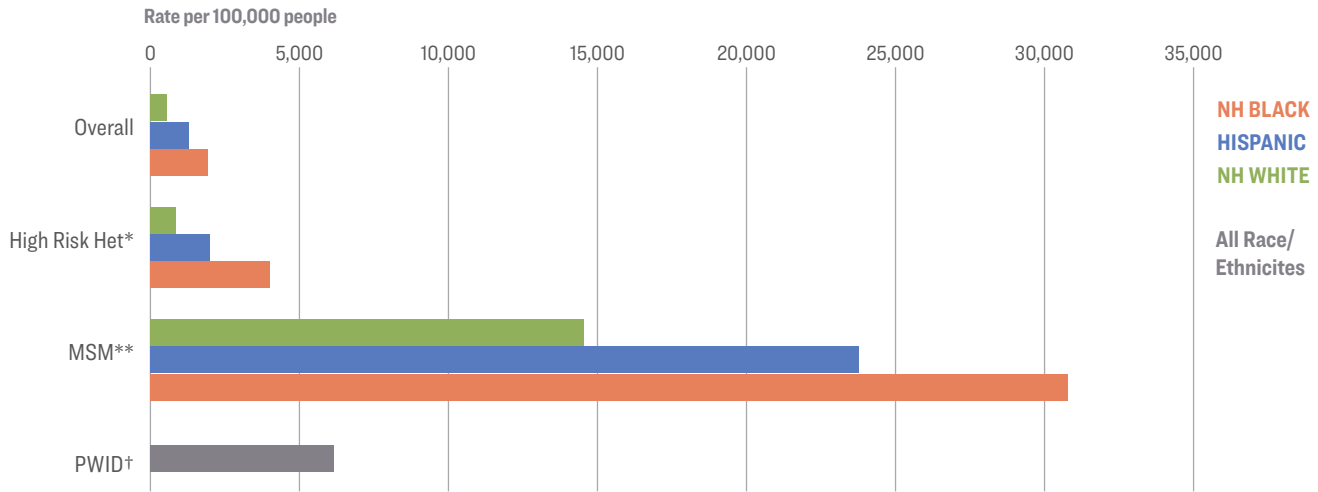
**Source** Philadelphia Department of Public Health, Division of HIV Health

**Prevalence Rate per 100,000**

## Persons with Diagnosed HIV

Figure 15

### Prevalence by Race/Ethnicity and Transmission Category | 2022



**Note** \*The population of individuals 18 and older living below poverty level is used as a proxy for heterosexuals at increased risk for HIV infection (ACS 2021 5-year data).

\*\*MSM total population based on estimated number of active MSM in the past 5 years.

† The total number of Philadelphia residents who have ever injected drugs is estimated to be 55,000. Estimation methods based on Lansky A, Finlayson T, Johnson C, Holtzman D, Wejnert C, Mitsch A, et al. (2014) Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections. PLoS ONE 9(5): e97596. For HIV prevalence, ever PWID is used instead of active PWID since many people who acquired HIV through injection drug use no longer inject drugs. This is roughly 4.5% of Philadelphia residents 18 and older. Since the demographic composition of PWID has shifted overtime, estimates of ever PWID by race/ethnicity are not reliable.

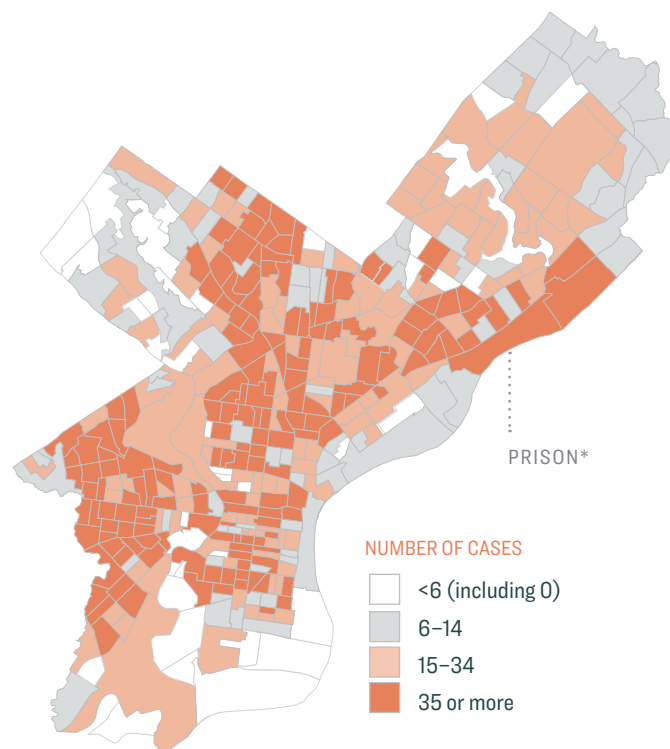
**Source** Philadelphia Department of Public Health, Division of HIV Health

Map 2

### By Census Tract | 2022

**Note** \*The number of cases in this census tract is inflated due to the location of the prison system. Laboratory reports for incarcerated individuals frequently include the address of the prison facility as address at diagnosis rather than the inmate's home address. Interactive mapping data are available online at [www.AIDSVu.org](http://www.AIDSVu.org).

**Source** Philadelphia Department of Public Health, Division of HIV Health



## Persons with Diagnosed HIV

Table  
14

### By Hepatitis B or C Co-Infection and Selected Characteristics | 2022

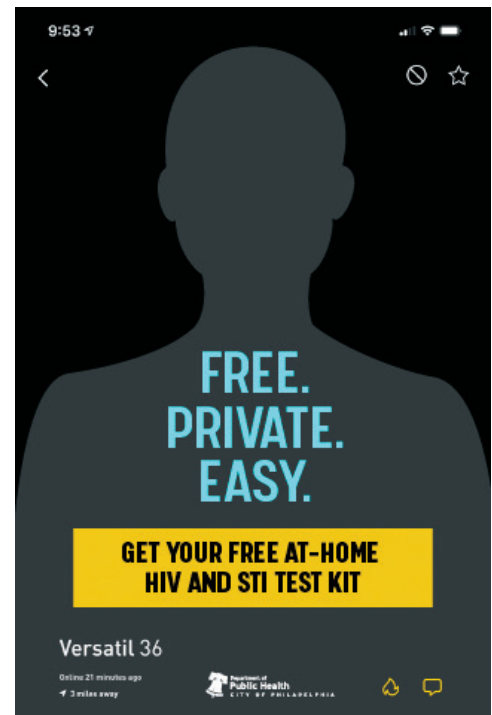
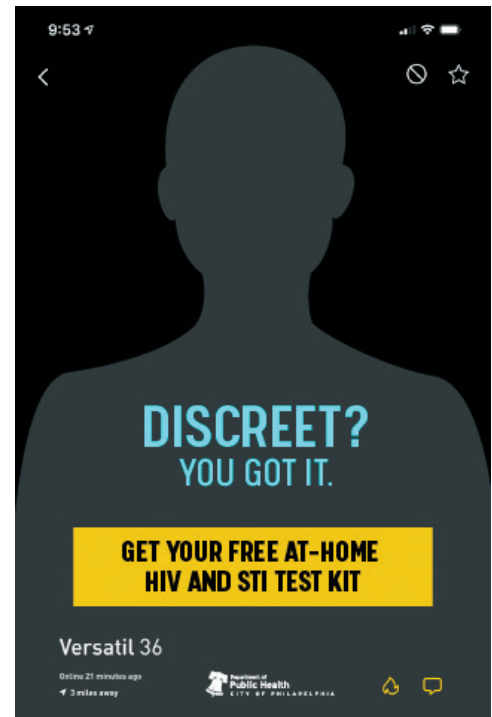
	Hepatitis B/HIV		Hepatitis C/HIV		HIV Total	
	N	Row %	N	Row %	N	Row %
<b>Total</b>						
Total	848	4.5%	2,583	13.8%	18,658	100.0%
<b>Sex Assigned at Birth</b>						
Female	195	3.8%	772	14.9%	5,165	100.0%
Male	653	4.8%	1,811	13.4%	13,493	100.0%
<b>Race/Ethnicity</b>						
NH Black	586	5.0%	1,359	11.5%	11,795	100.0%
Hispanic	101	3.3%	553	17.9%	3,085	100.0%
NH White	123	4.0%	559	18.3%	3,050	100.0%
Multi-race	19	4.0%	86	18.3%	470	100.0%
Asian	18	8.7%	24	11.7%	206	100.0%
Other/Unknown	*	*	*	*	52	100.0%
<b>Age Category**</b>						
<13	*	*	*	*	10	100.0%
13-19	*	*	*	*	50	100.0%
20-24	6	1.7%	9	2.5%	356	100.0%
25-29	10	1.1%	42	4.6%	922	100.0%
30-39	74	2.1%	278	7.9%	3,514	100.0%
40-49	163	4.9%	418	12.6%	3,317	100.0%
50+	595	5.7%	1,833	17.5%	10,489	100.0%
<b>Transmission Risk</b>						
MSM	323	4.3%	463	6.2%	7,433	100.0%
PWID	226	6.7%	1,244	36.8%	3,381	100.0%
MSM/PWID	39	4.9%	233	29.1%	800	100.0%
Heterosexual	232	3.7%	598	9.6%	6,239	100.0%
Pediatric	*	*	6	2.4%	247	100.0%
Other	*	*	*	*	10	100.0%
No Risk Reported	23	<0.1%	34	6.2%	548	100.0%

**Note** \*Cell sizes <6 (including 0) are suppressed.

\*\*Age as of December 31, 2022

Data represents proportion of PWDH with current HBV and/or HCV infection as of December 31st, 2022. Row, not column, percentages are presented here.

**Source** Philadelphia Department of Public Health, Division of HIV Health; Philadelphia Department of Public Health, Division of Disease Control, Viral Hepatitis Program.





## By Selected Demographics | 2018 – 2022

Perinatal exposures represent instances where HIV transmission might have occurred from pregnant mother/parent to child during pregnancy, labor and delivery (L&D), or breast/chest feeding. Incidence of HIV infection among perinatally exposed children in Philadelphia has remained low in the past five years due to local perinatal prevention efforts. Case definitions for infant HIV status are based on recommended clinical and/or laboratory diagnostic algorithms. HIV negative definitive, HIV negative presumptive, and HIV indeterminate are detailed classifications of perinatal exposures, while confirmed HIV infection reflects a true pediatric parent-to-child transmission of HIV to an infant.

For more information on HIV case definitions, please visit: <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6303a1.htm>

This table shows both demographic and clinical characteristics for the mother/parent and child before, during, and after birth. Maternal/Parental viral load represents the most recent viral load before birth; prenatal care was defined as at least 1 medical visit during pregnancy.

Year of Exposure	2018		2019		2020		2021		2022	
	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %
<b>Total</b>										
Total	92	100.0%	67	100.0%	81	100.0%	76	100.0%	61	100.0%
<b>Infant Sex Assigned at Birth</b>										
Female	52	56.5%	30	44.8%	45	55.6%	37	48.7%	38	62.3%
Male	40	43.5%	37	55.2%	36	44.4%	39	51.3%	23	37.7%
<b>Mother/Parent's Age at Delivery</b>										
13 - 19	*	*	*	*	*	*	*	*	*	*
20 - 24	12	13.0%	7	10.4%	6	7.4%	7	9.2%	7	11.5%
25 - 34	55	59.8%	38	56.7%	46	56.8%	45	59.2%	37	60.7%
35+	24	26.1%	19	28.4%	27	33.3%	24	31.6%	17	27.9%
<b>Mother/Parent's Race/Ethnicity</b>										
NH Black	64	69.6%	47	70.1%	59	72.8%	56	73.7%	46	75.4%
Hispanic	8	8.7%	6	9.0%	8	9.9%	9	11.8%	*	*
NH White	15	16.3%	9	13.4%	11	13.6%	9	11.8%	7	11.5%
Multi-race	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*
<b>Mother/Parent's Transmission Risk</b>										
PWID	12	13.0%	7	10.4%	7	8.6%	9	11.8%	*	*
Heterosexual	69	75.0%	51	76.1%	64	79.0%	62	81.6%	49	80.3%
Pediatric	9	9.8%	7	10.4%	7	8.6%	*	*	6	9.8%
NRR/Unk	*	*	*	*	*	*	*	*	*	*

**Note** \*Cell sizes <6 (including 0) are suppressed. Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

## Perinatal Exposures

Table  
16

### By Selected Clinical Characteristics | 2018 – 2022

Year of Exposure	2018		2019		2020		2021		2022	
	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %
<b>Total</b>										
Total	92	100.0%	67	100.0%	81	100.0%	76	100.0%	61	100.0%

#### Infant Diagnosis Status

HIV positive, definitive	0	0.0%	0	0.0%	1	1.2%	1	1.3%	1	1.6%
HIV indeterminate	2	2.2%	1	1.5%	6	7.4%	6	7.9%	1	1.6%
HIV negative, definitive	55	59.8%	42	62.7%	35	43.2%	28	36.8%	36	59.0%
HIV negative, presumptive	35	38.0%	24	35.8%	39	48.1%	41	53.9%	23	37.7%

#### Maternal/Parental Viral Load

>=1000	8	8.7%	6	9.0%	10	12.3%	12	15.8%	5	8.2%
<1000	80	87.0%	56	83.6%	64	79.0%	58	76.3%	54	88.5%
Unknown	4	4.3%	5	7.5%	7	8.6%	6	7.9%	2	3.3%

#### Maternal/Parental Prenatal Care

No	15	16.3%	5	7.5%	4	4.9%	3	3.9%	0	0.0%
Yes	77	83.7%	62	92.5%	77	95.1%	73	96.1%	61	100.0%

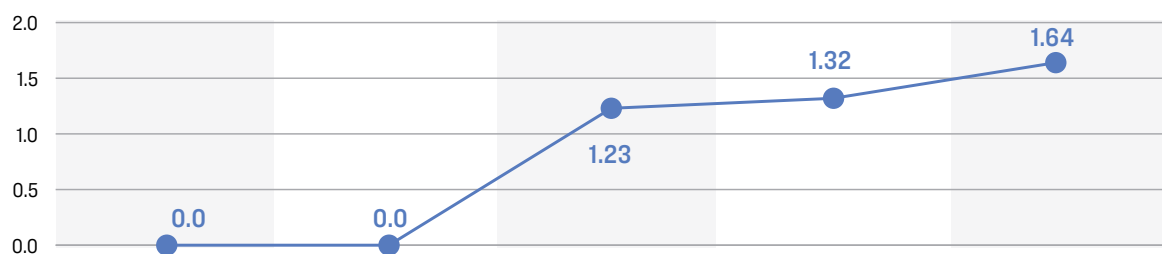
#### ARV Medications During Pregnancy

No	3	3.3%	3	4.5%	6	7.4%	6	7.9%	1	1.6%
Unknown	7	7.6%	0	0.0%	1	1.2%	1	1.3%	0	0.0%
Yes	82	89.1%	64	95.5%	74	91.4%	69	90.8%	60	98.4%

#### Neonatal ARV

Unknown	2	2.2%	1	1.5%	4	4.9%	2	2.6%	0	0.0%
Yes	90	97.8%	66	98.5%	77	95.1%	74	97.4%	61	100.0%

#### Rate of HIV per 100 Exposed Births



**Note** Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

## HIV-Related Deaths

### Table 17 | By Year and Selected Characteristics, Philadelphia | 2019 – 2021

It is important to monitor the proportion of deaths among PWDH for which HIV is noted as an underlying cause of death. The most recent complete death information available is 2021. Unknown causes of death have been omitted from the data table below due to small cell sizes.

	2019 (n=362)				2020 (n=410)				2021 (n=456)			
	No		Yes		No		Yes		No		Yes	
	N	Col%	N	Col%	N	Col%	N	Col%	N	Col%	N	Col%
<b>Total</b>												
Total	308	100.0%	50	100.0%	358	100.0%	47	100.0%	388	100.0%	61	100.0%
<b>Sex Assigned at Birth</b>												
Female	78	25.3%	16	32.0%	91	25.4%	24	51.1%	103	26.5%	17	27.9%
Male	230	74.7%	34	68.0%	267	74.6%	23	48.9%	285	73.5%	44	72.1%
<b>Race/Ethnicity</b>												
NH Black	189	61.4%	32	64.0%	224	62.6%	35	74.5%	246	63.4%	39	63.9%
Hispanic	39	12.7%	6	12.0%	54	15.1%	7	14.9%	48	12.4%	*	*
NH White	64	20.8%	9	18.0%	65	18.2%	*	*	86	22.2%	16	26.2%
Multi-race	12	3.9%	*	*	14	3.9%	*	*	7	1.8%	*	*
Other/Unk	*	*	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*	*	*
<b>Age at HIV Dx</b>												
0-12	*	*	*	*	*	*	*	*	*	*	*	*
13-19	*	*	*	*	8	2.2%	*	*	7	1.8%	*	*
20-24	24	7.8%	*	*	32	8.9%	*	*	17	4.4%	*	*
25-29	41	13.3%	*	*	44	12.3%	8	17.0%	55	14.2%	7	11.5%
30-39	105	34.1%	14	28.0%	115	32.1%	16	34.0%	104	26.8%	15	24.6%
40-49	71	23.1%	13	26.0%	100	27.9%	12	25.5%	124	32.0%	15	24.6%
50+	62	20.1%	12	24.0%	58	16.2%	7	14.9%	79	20.4%	16	26.2%
<b>Transmission Risk</b>												
MSM	80	26.0%	12	24.0%	101	28.2%	7	14.9%	94	24.2%	22	36.1%
PWID	120	39.0%	16	32.0%	126	35.2%	13	27.7%	122	31.4%	14	23.0%
MSM/PWID	13	4.2%	*	*	23	6.4%	*	*	28	7.2%	*	*
Heterosexual	92	29.9%	18	36.0%	103	28.8%	23	48.9%	130	33.5%	19	31.1%
Pediatric	*	*	*	*	*	*	*	*	*	*	*	*
Other	*	*	*	*	*	*	*	*	*	*	*	*
No Reported Risk	*	*	*	*	*	*	*	*	12	3.1%	*	*

**Note** \*Cell sizes <6 (including 0) are suppressed.  
2022 data not shown due to delays in reporting cause of death.  
Due to rounding, percentages may not add up to exactly 100%.

**Source** Philadelphia Department of Public Health, Division of HIV Health

### Who Must Report?

All HIV Testing Providers, Health Care Providers & Laboratories

### What Test Results Must Be Reported?

- **All results**, including: Positive, Negative & Indeterminate will be reported to the PDPH including if the patient is determined to have either:
  - a confirmed HIV infection
  - a probable or possible HIV infection (including cases where additional testing is needed to confirm the diagnosis)
- **Preliminary Positive Results** — including instances where no supplemental/confirmatory testing was performed or when supplemental/confirmatory testing was negative
- **Negative and indeterminate Results** — including test results for HIV infection within 180 days of (before, after, or on the same date as) the HIV diagnosis. The negative/indeterminate test results are needed to recognize infections as early or acute when transmission to others is more likely and intervention is more urgent.
- **Results of all CD4 counts and HIV viral loads** including undetectable results
- **HIV genotype sequence data** (FASTA or FASTQ format)

### What Cases Need to be Reported?

- All individuals who are Philadelphia residents AND
- All individuals who are tested in Philadelphia or receive care at a Philadelphia based facility or provider.
- Pregnancy in an HIV-infected person
- New HIV-positive result in a pregnant person
- Birth of an infant to an HIV-infected person

### When Do I Need to Report?

The following tests results or events need to be reported by telephone to the PDPH within 1 business day of the result or the confirmation of the event:

1. **Confirmed or suspected acute HIV infection**  
(Call 215-685-4781 to report a case)
2. **Pregnancy in an HIV-infected pregnant person**  
(Call 215-685-4786 to report a case)
3. **New HIV-positive result in a pregnant person**  
(Call 215-685-4786 to report a case)
4. **Birth of an infant to an HIV-infected person**  
(Call 215-685-4786 to report a case)

All other test results and HIV case reports must be reported to the PDPH within 5 business days of the receipt.

### How Do I Submit a Report?

Mail the completed HIV Case Report Forms to the Philadelphia Department of Public Health.

To mail forms, please use these steps:

1. Place the forms in a sealed envelope that states:  
*Confidential, to be opened by addressee only*
2. Place the first envelope into another sealed envelope and address to:

Philadelphia Department of Public Health  
Attention: Melissa Miller  
P.O. Box 58909  
Philadelphia, PA 19102-8909

For reporting questions, please call Melissa Miller (215-685-4781).

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Additional contributions also made by the following groups: DHH ISU, Prevention, and EHE, as well as PDPH Viral Hepatitis.



## TO OUR READERS:

The DHH Surveillance Unit of the Philadelphia Department of Public Health, which conducts HIV surveillance for the City of Philadelphia, produces this report. The data in this report reflects cases diagnosed through December 2022 and reported through June 2023.

HIV surveillance is the ongoing and systematic collection, analysis, and dissemination of population-based information on HIV. There are two basic types of surveillance; active and passive. Passive surveillance is submission of HIV case reports from physicians, laboratories, and other individuals or institutions without having to regularly contact the reporting sources. Active surveillance employs strategies intended to identify unreported cases, and depends on secondary information sources for leads e.g., hospitals, clinics, physician offices, laboratories. Review of medical charts at provider sites or via telephone with facility staff are completed to establish cases of HIV infection and to obtain information critical to completing HIV case reports.

The HIV case count in Philadelphia results from a combination of active and passive surveillance. Physicians began reporting AIDS cases to the Department of Health in 1983. Name-based HIV reporting began in October, 2005.

New HIV reporting regulations were approved by the City of Philadelphia's Board of Health in November 2016 and went into effect in January of 2017.





Any questions about this report and/  
or requests for data can be directed to:

Melissa Miller, MPH

[AACOEPI@PHILA.GOV](mailto:AACOEPI@PHILA.GOV)

Please allow at least 10 business days  
for all data requests.



Department of  
**Public Health**

CITY OF PHILADELPHIA