

2024 HIV SURVEILLANCE REPORT



Cases reported through June 2025

SECURITY AND CONFIDENTIALITY

All information about people with Human Immunodeficiency Virus (HIV) is strictly confidential and collected for legitimate public health purposes. Federal, state, and local health departments have implemented procedures and policies to ensure the confidentiality and security of HIV data. Prior to submitting data to the Centers for Disease Control and Prevention (CDC), all information is de-identified and encrypted. In addition, strict guidelines govern the release of reports like this one to ensure that HIV data are not presented in such a way as to possibly identify any individual with HIV. Maintenance of confidentiality and security safeguards is critical for federal funding and is a top priority within the Philadelphia HIV Surveillance Unit.

This publication was supported by the Grant or Cooperative Agreement Number, NU62PS924545, funded by the CDC. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC or the U. S. Department of Health and Human Services.

Suggested Citation:

Philadelphia Department of Public Health Division of HIV Health, Surveillance Report, 2024. Philadelphia, PA: City of Philadelphia; November 2025.

TABLE OF CONTENTS

Definitions	4	Newly Diagnosed HIV	20
Executive Summary	5	Table 4: By Year, 2020–2024	20
Ending the HIV Epidemic	6	Table 5: By Race/Ethnicity, 2024	21
Table 1: Ending the HIV Epidemic Dashboard	6	Figure 11: Rates by Race/Ethnicity	21
HIV Care Continuum	7	Table 6: By Sex Assigned at Birth, 2024	22
Figure 1A: HIV Care Continuum, Philadelphia vs. U.S.	7	Map 1: By Census Tract	23
Figure 1B: HIV Care Continuum (Recent Care)	8	Figure 12: Rates by Year and Risk Group, 2020–2024	23
Access to HIV Care	9	AIDS Diagnoses	24
Figure 2: Care Continuum Outcomes by Subpopulation	9	Table 7: Concurrent HIV/AIDS by Year, 2020–2024	24
Figure 3A: Re-Linked to HIV Care within 90 Days of Enrollment in Data to Care, 2024	10	Table 8: By Year, 2020–2024	25
Figure 3B: Locating and Linkage Trends 2021–2024	10	HIV Prevalence	26
Table 2: Data to Care Barriers & Resources	11	Figure 13: HIV and AIDS Diagnoses, Deaths, and Prevalence by Year, 1985–2024	26
Figure 4: Trends of Stigma Scores in PWDH by Race/Ethnicity, 2018–2023	12	Table 9: HIV (non-AIDS) and AIDS Cases	27
Figure 5: Trends in Proportion of Unhoused PWDH, 2018–2023	12	Table 10: By Race/Ethnicity	28
Topics of Continued Focus:		Figure 14: Prevalence Rates by Race/Ethnicity	28
Cluster Detection and Response	13	Table 11: Prevalence Rates by Sex and Race/Ethnicity	29
Figure 6A: HIV Epidemiological Curve among PWID 2016–2024	13	Figure 15: By Sex Assigned at Birth and Age	29
Figure 6B: Demographic Characteristics of PWID 2018–2024	14	Table 12: By Gender Identity	30
Figure 6C: HIV Outcomes Among PWID, 2024	14	Table 13: Prevalence Rates by Sex and Race/Ethnicity	31
Transgender Persons	15	Figure 16: Prevalence Rates by Race/Ethnicity and Transmission Category	32
Prevention	16	Map 2: By Census Tract	32
PrEP Indications	16	Table 14: By Hepatitis B or C Co-Infection	33
Table 3: Estimates of Adults with PrEP Indications	16	Perinatal Exposures	34
PrEP Continuum	17	Table 15: By Year, 2020–2024	34
Figure 7: Continuum of PrEP Awareness and Usage	17	Table 16: By Selected Clinical Characteristics	35
HIV Self Test Program	18	HIV-Related Deaths	36
Figure 8: HIV Self-Test Kit Requests	18	Table 17: HIV Related Deaths, 2020–2023	36
HIV Among the Aging Population	19	Reporting Information	37
Figure 9: Continuum Outcomes by Age Category, 2024	19	Authors and Contributors	38
Figure 10: Late Stage HIV Diagnoses by Age Category, 2020–2024	19		

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.

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

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

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: The population of people 18 and older living below poverty level, used as a proxy for HIV risk.

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 birthing parent to child during pregnancy, labor and delivery, or breast/chest feeding.

PWDH: People with diagnosed HIV.

PWH: People with HIV, both diagnosed and undiagnosed.

PrEP: Pre-exposure prophylaxis. Antiretroviral medication taken by people 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 indicating that a person reported having injected drugs prior to or near the time of HIV diagnosis.

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.

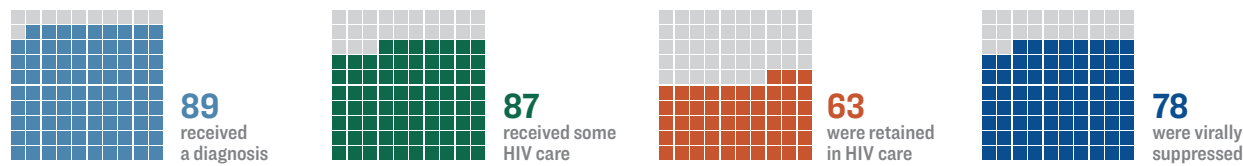
Stigma: An attitude of disapproval and discontent toward a person or group because of the presence of an attribute perceived as undesirable.

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.

EXECUTIVE SUMMARY

The Philadelphia Department of Public Health (PDPH) Division of HIV Health (DHH) Surveillance Report is the annual report presenting data on human immunodeficiency virus (HIV) diagnoses in the City of Philadelphia. Data in this report include people diagnosed through December 31, 2024 and reported through June 30, 2025.

In 2024, for every 100 people with HIV:



As of 2024, 18,064 people in Philadelphia are living with diagnosed HIV (PWDH), with 385 newly diagnosed cases reported during the year. An estimated 1,896 people (10.5%) are living with HIV but remain undiagnosed.

Racial and ethnic disparities persist. Both newly diagnosed and prevalent HIV rates continue to be disproportionately higher among non-Hispanic (NH) Black and Hispanic/Latinx residents (Figures 11 and 14). Among all groups, NH Black men who have sex with men (MSM) experience the highest rates of HIV—30,592.6 per 100,000 people (Figure 16).

In 2024, 83.6% of newly diagnosed cases were linked to care within 30 days of diagnosis (Figure 1A). Among all PWDH who had evidence of recent care (a reported CD4, viral load, or genotype in the past five years), outcomes improved compared with 2023:

- 87.6% received HIV care
- 63.1% were retained in HIV care
- 78.4% achieved viral suppression by year-end (Figure 1B)

Improvements along the continuum reflect the continued commitment of PDPH and community partners to the goals outlined as part of the Ending the HIV Epidemic (EHE): A Plan for America initiative. Initiated 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 by addressing 5 Key Pillars: **Diagnose, Treat, Prevent, and Respond**, with an additional pillar representing an approach centered in health access and radical customer service.

KEY 2024 ACTIVITIES

Diagnose

Expanded early and opt-out testing to non-traditional venues including emergency departments and pharmacies and offered low barrier self-testing options.

Treat

Implemented and scaled up immediate ART (iART) protocols and re-engagement in care initiatives, enhanced resources provided through <https://phillykeeponloving.com/>, and initiated new programs specific to the aging population.

Prevent

Maintained Low-threshold Sexual Health sites and Philadelphia’s TelePrEP program, supported the nPEP Center of Excellence, launched public health vending machines, and expanded technical assistance partnerships.

Respond

Strengthened surveillance-based cluster detection and outbreak response capacity and secured competitive CDC funding for Centers for Cluster and Outbreak Response Enhancement (C-CORE).

Ending the HIV Epidemic

Table 1 | Ending the HIV Epidemic Dashboard

Notable improvements include increased knowledge of HIV status and viral suppression and decreased estimates of unhoused PWDH.

GOAL:	BASELINE 2017	2018	2019	2020	2021	2022	2023	2024	Progress	2025 Target	2030 Target
Reduce new HIV infections by 75% in five years and by 90% in ten years	460	450	410	300*	280*	310*	310*	Data Not Available	 STABLE	(118)	(47)
→ Increase knowledge of status to 95% by 2025	88.7%	88.6%	88.7%	88.8%	88.9%	89.1%	89.5%	Data Not Available	 IMPROVING	(95.0%)	
Decrease confirmed HIV diagnoses to 25% by 2025 and 8% by 2030	509	435	447	342	365	393	385	385	 STABLE	(127)	(41)
→ Increase linkage to care to 95% by 2025	86.3%	86.1%	81.3%	82.5%	81.4%	77.0%	86.0%	83.6%	 NOT IMPROVED	(95.0%)	
→ Increase viral suppression to 95% by 2025**	72.3%	70.1%	72.3%	67.3%	70.1%	73.5%	74.4%	78.4%	 IMPROVING	(95.0%)	
Decrease stigma among PWDH by 50%, Median**	Data Not Available	32.9	31.0	31.7	28.4	30.4	33.4	Data Not Available	 NOT IMPROVED	(18.8)	
→ Decrease Unhoused PWDH by 50%†	9.9%	13.6%	8.1%	6.7%	13.5%	11.7%	8.2%	Data Not Available	 IMPROVING	(4.9%)	
→ PrEP coverage§	Data Not Available	Data Not Available	37.3%	36.0%	41.6%	50.8%	51.3%	Data Not Available	 IMPROVING	(50.0%)	

Notes

Values in parentheses represent a goal number or percentage.

* Incidence estimate results have a relative standard error (RSE) greater than 30 and should be interpreted with caution based on reliability standards from the National Center for Health Statistics.

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

† Among PWDH in Philadelphia between 2015-2023, 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 people 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 September 2023; and preexposure prophylaxis (PrEP) data reported through June 2023. HIV Surveillance Data Tables 2023;4(2). <https://stacks.cdc.gov/view/cdc/136159>. Published December 2023. Accessed September 2024. The CDC is unable to update PrEP coverage for 2024 at this time.

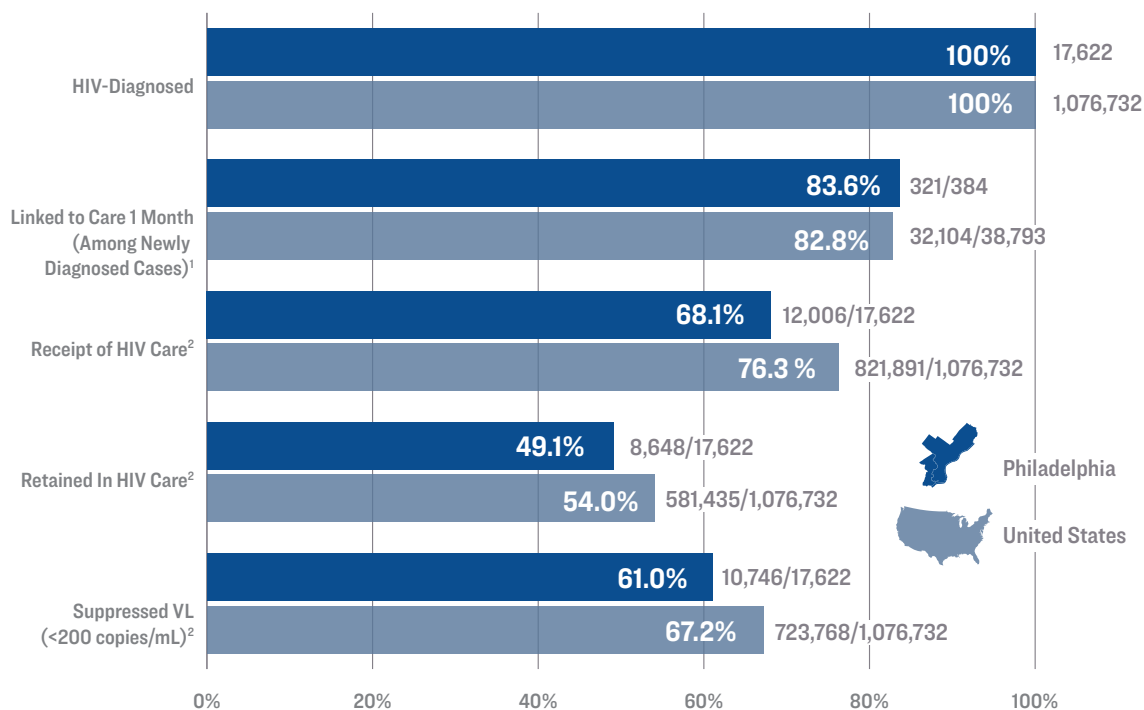
HIV Care Continuum

The HIV Continuum of Care is a data-driven tool focusing on the various levels of engagement in HIV care among people aged 13+ with diagnosed HIV (PWDH) in Philadelphia 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, genotype, or viral load collected within 1 month of initial HIV diagnosis; the percentage of PWDH who received care, evidenced by at least one of the aforementioned laboratory results 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 2024.

In 2024, 83.6% of people who were newly diagnosed with HIV were linked to HIV medical care within 1 month of their diagnosis. Among all PWDH, 68.1% received at least 1 care lab during 2024 and 49.1% were considered retained in HIV medical care. Finally, 61.0% of PWDH were virally suppressed at last measure (regardless of retention in care status) in 2024. 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 2023.

Figure
1A

Philadelphia 2024 vs the United States 2023



DEFINITIONS

Linked to Care

Persons diagnosed with HIV in a given calendar year who had one or more documented CD4, genotype, or viral load tests within 1 month of diagnosis.

Receipt of HIV Care

Persons who have at least one CD4, genotype, or viral load during the calendar year.

Retained in HIV Care

Persons who have 2 or more labs (CD4, genotype, 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.

¹ Among PWH diagnosed Jan 1, 2024- Dec 31, 2024

² Care continuum outcomes are measured among PWH aged 13+ diagnosed by Dec 31, 2023 and alive at year end 2024.

Note

This table reflects diagnosed HIV cases through December 31, 2023 aged 13+ who were alive at year-end 2024 to align with CDC continuum definitions and will differ from 2024 HIV prevalence data found elsewhere in this report (Table 9, n=18,064).

Sources

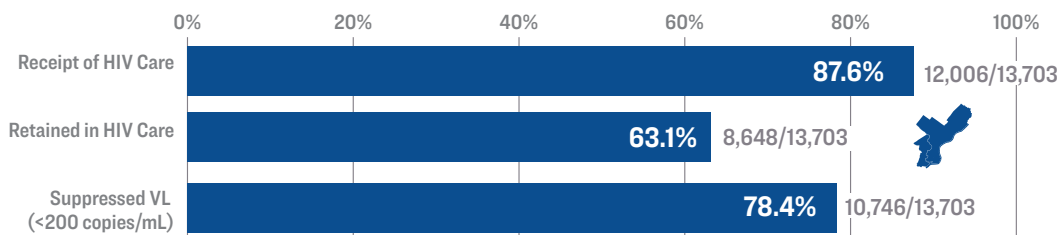
Philadelphia Data: Philadelphia Department of Public Health, Division of HIV Health
Centers for Disease Control and Prevention. Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data—United States and 6 Territories and Freely Associated States, 2023. HIV Surveillance Supplemental Report;30(1). Published April 29, 2025. Accessed August 2024. <https://www.cdc.gov/hiv-data/nhss/national-hiv-prevention-and-care-outcomes.html>

Modified HIV Care Continuum

The modified HIV continuum of care assesses outcomes among PWDH in Philadelphia who had at least 1 care lab during the last 5 years (2020-2024). 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 were 87.6%, 63.1%, and 78.4%, respectively, and all indicate improvements from the 2023 annual report (83.9%, 59.4%, 74.4%). 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.

Figure
1B

Philadelphia HIV Care Continuum (RECENT CARE) | 2024



Note

Care Continuum Outcomes are limited to PWH aged 13+ diagnosed by Dec 31, 2023 and alive at year end 2024 who had at least one reported CD4, Viral Load, or Genotype test during the last 5 years (Jan 1, 2020 - Dec 31, 2024).

Source

Philadelphia Department of Public Health, Division of HIV Health

Access to HIV Care

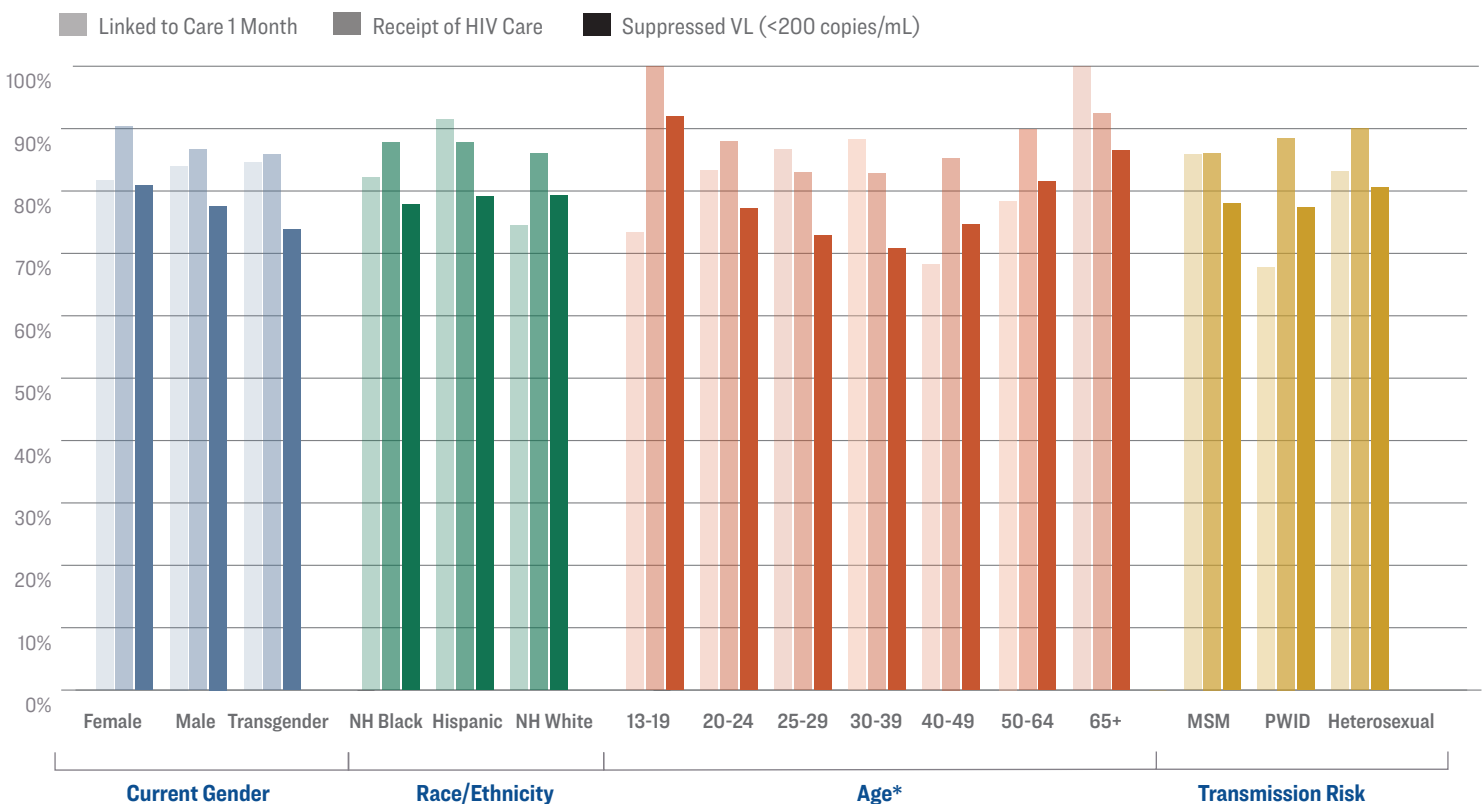
To achieve federal EHE initiative goals and reduce HIV transmission locally, PDPH is dedicated to ensuring that health access is a foundational element of surveillance, prevention, and care practices. DHH defines health access as ‘the state in which everyone has the opportunity to attain their highest level of health while centering 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. PDPH underscores this in the collection, analysis, and dissemination of HIV data to inform health department policies, practices, and services. The tables and graphs presented in this section provide critical quantitative and qualitative data that highlight existing disparities and barriers within Philadelphia’s HIV prevention and care infrastructure.

Modified Continuum by Subgroup

Figure 2 illustrates the 2024 Modified Continuum of Care by selected characteristics. Disaggregating data by race/ethnicity, current gender, age group, and risk factor can highlight disparities within care outcome measures.

Notable disparities were observed in both linkage to care within 30 days of HIV diagnosis and viral suppression. The lowest rates of linkage to care were among PWID, NH-White people, and those aged between 40-49 at diagnosis, while viral suppression rates were lowest among people aged 30-39, Transgender people, and PWID.

Figure 2 | Care Continuum Outcomes by Subpopulation, 2024



Note Care Continuum Outcomes are among PWH aged 13+ diagnosed by Dec 31, 2023 and alive at year end 2024 who had at least one reported CD4/VL during the last 5 years (Jan 1, 2020 - Dec 31, 2024).

*Reflects age at diagnosis for linkage and age as of December 31, 2024 for receipt of care and viral suppression.

Source Philadelphia Department of Public Health, Division of HIV Health

Data to Care

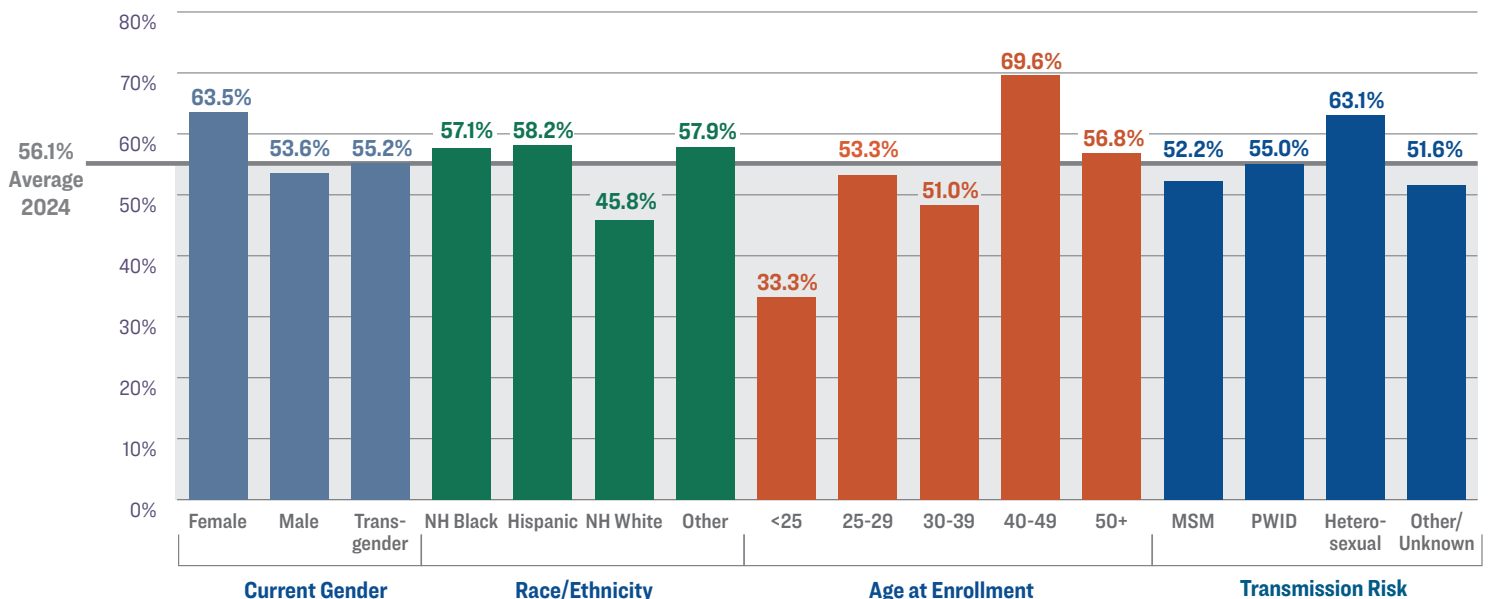
Data to Care is a public health strategy that uses data to identify people with HIV who have not had recent medical care. The Field Services Program (FSP), initiated in May 2021, provides linkage, re-linkage, and other outreach to people with HIV who are out of care using a strengths-based approach.

Through Data to Care efforts, 798 people were identified as out-of-care and enrolled in Field Services for re-engagement in 2024. The highest rates of enrollment were among Males, NH Black people, MSM, and those aged 50+ (data not shown).

After receiving outreach, 56.1% of individuals were relinked to care (receiving a CD4 or viral load within 90 days of enrollment). The lowest rates of relinkage were among those under 25 years old at enrollment (33.3%), NH White (45.8%), and in the Other/Unknown risk group (51.6%) (Figure 3A). The highest rates of relinkage were among ages 40-49 at enrollment (69.6%), female (63.5%), and heterosexual risk (63.1%). Relinkage rates for most groups decreased from 2023 to 2024 (not shown).

Figure
3A

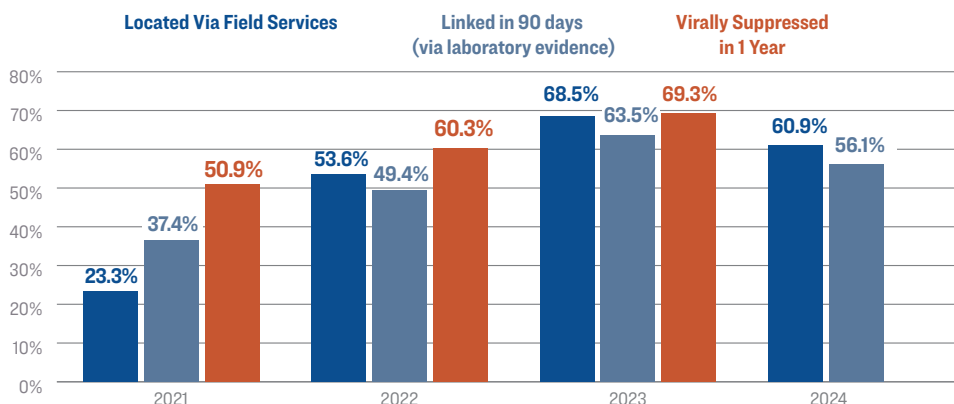
Re-Linked to HIV Care Within 90 Days of Enrollment in Data to Care | 2024



Note Excludes people deceased within 90 days of enrollment.

Figure
3B

Locating, Relinkage, and Suppression Trends | 2021-2024



The rates of locating and re-linkage among enrolled participants increased each year since the Field Services Program was established, but decreased slightly in 2024 (Figure 3B). Viral suppression at 1 year after enrollment has improved steadily from 2021-2023, but is not yet available for 2024.

Access to HIV Care

Qualitative data collected through the Data to Care and Field Services programs indicate that 67.8% of barriers faced by out-of-care people are provider/structural barriers, 38.1% are patient rights/education barriers, 23.1% are supportive services/socioeconomic barriers, and 6.3% are behavioral health barriers.

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

Table
2

Data to Care Barriers and Resources | 2024

Barriers

Barrier Domain	N	% of Barriers Reported
Provider/Structural Barrier	217	67.8%
Patient Rights/Education	122	38.1%
Supportive Services/SES	74	23.1%
Behavioral Health	20	6.3%
Total Barriers Reported*	320	

*Some barriers are in more than one domain. Some patients report more than one barrier, possibly in the same domain.

Note Percentages total to more than 100%.

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

Resources Provided

Resource Type	N	% of Resources Provided
Medical Case Management	69	70.4%
Emergency Food/Pantry	10	10.2%
Transportation	5	5.1%
Health Insurance	4	4.1%
Governmental Services	2	2.0%
Housing Services	2	2.0%
Legal Services	2	2.0%
Utility Support	2	2.0%
Mental Health Services	1	1.0%
Self Help/Support Groups	1	1.0%
Total Resources Provided	98	

Note Excludes multiple offerings of the same resource type per client.

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

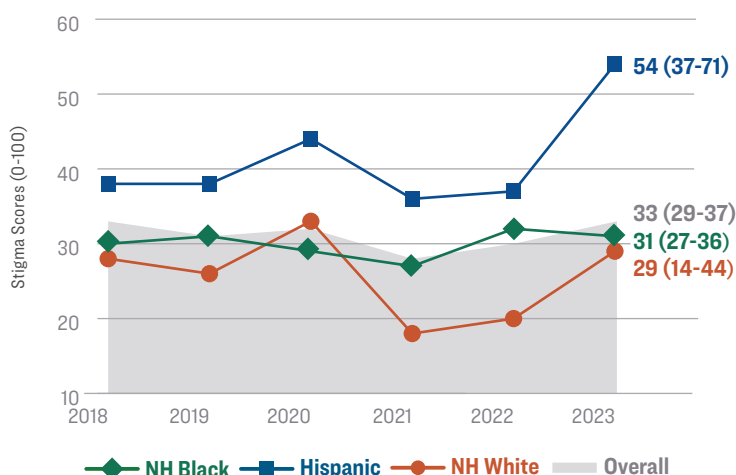


Stigma and Housing Stability

Two major components of the EHE initiative look to reduce HIV-related stigma and unstable housing among PWH. The tables below illustrate stigma scores and unstable housing by race/ethnicity from 2018 to 2023 (most recent data released), collected through the Medical Monitoring Project (MMP). MMP collects data about behaviors, clinical outcomes, and quality of care from PWDH randomly sampled in Philadelphia.

Reported stigma was highest among Hispanic/Latinx people and lowest among NH White people across all years (Figure 4). NH Black individuals report stigma at or just below the overall average score. Overall reported homelessness continued to decrease in 2023, however rates increased among NH White PWDH and remained above the overall rate for NH Black PWDH.

Figure 4 Trends of Stigma Scores in PWDH by Race/Ethnicity, | 2018–2023



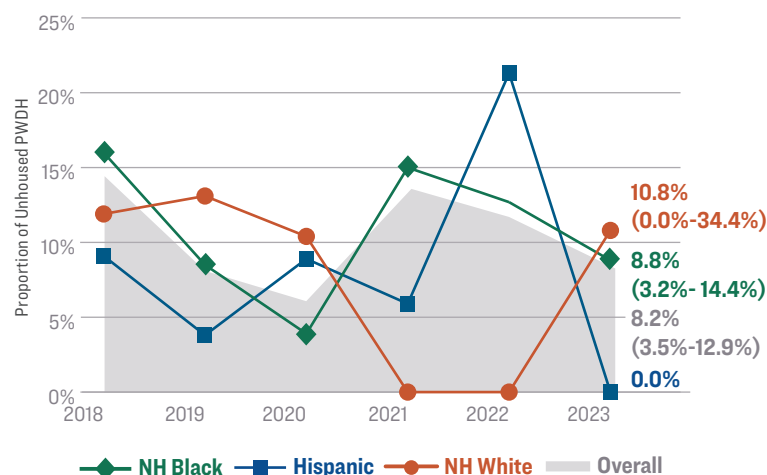
Note

Data provided in parenthesis represents the reported range. 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 living 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>

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 | 2018–2023



Note

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)

HIV Diagnoses Among People Who Inject Drugs (PWID)

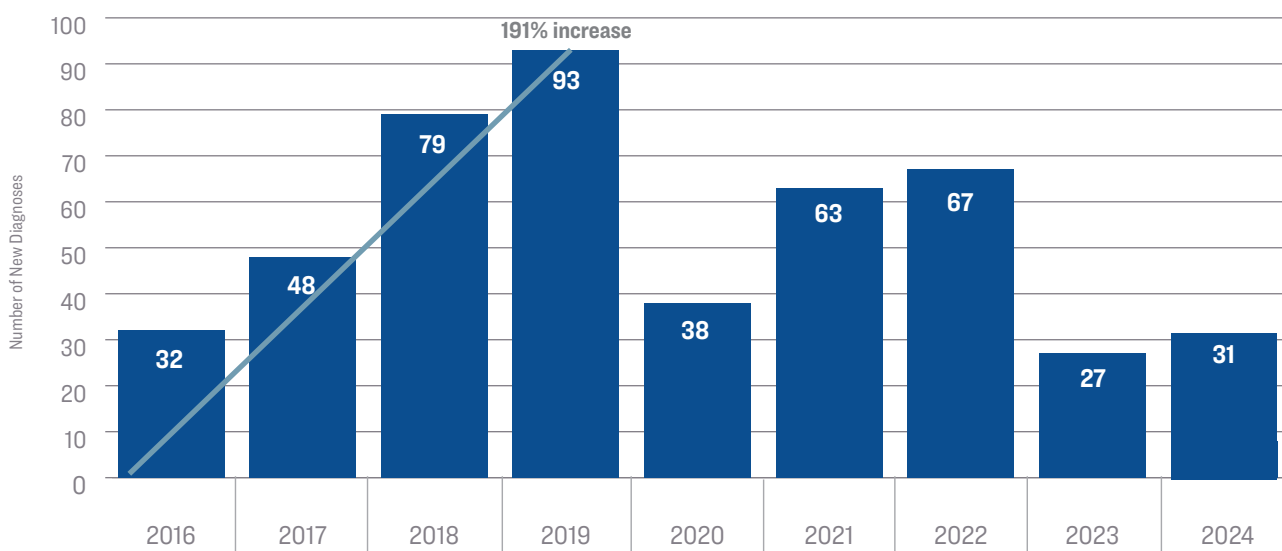
PDPH implements a range of cluster detection and response activities to identify, monitor, and address increases in HIV diagnoses within demographic, geographic, or sexual and social networks. In 2018, PDPH identified an outbreak of HIV among PWID, including men who have sex with men and inject drugs (MSM/PWID). New HIV diagnoses increased by 191% from 2016 to 2019 among this population which prompted an increased response to prevent ongoing transmission.

Despite a slight increase from 2023 to 2024, the number of new HIV diagnoses among PWID mirrors levels observed prior to the outbreak. Individuals newly diagnosed from 2018 to 2024 were primarily among people assigned male at birth (70.9%), NH White (49.8%), and aged 30-39 at diagnosis (39.7%). Among the 243 people residing in Philadelphia as of December 31, 2024 who were diagnosed between 2018 and 2023 (allowing 1 full year of follow up), 49% had evidence of viral suppression by year-end.

PDPH collects qualitative data on networks experiencing recent and rapid HIV transmission through Expanded Interventional Surveillance (ExIS). ExIS employs a multi-disciplinary case-review process to identify missed opportunities for HIV prevention and care among individuals connected to a growing network and identifies trends and themes contributing to network growth. Findings are presented to a Community Action Team to implement action plans to address identified gaps and strengthen prevention and care systems.

Figure
6A

HIV Epidemiological Curve among PWID | 2016–2024



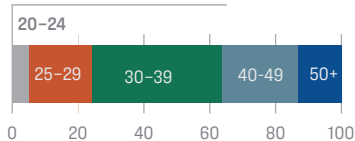
Source: Philadelphia Department of Public Health, Division of HIV Health

Topics of Continued Focus: Cluster Detection and Response

Figure
6B

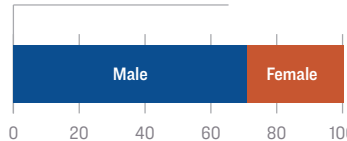
Demographic Characteristics of PWID | 2018–2024

Age at Diagnosis



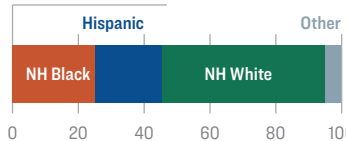
20-24	5.0%
25-29	19.1%
30-39	39.7%
40-49	22.9%
50+	13.3%

Assigned Sex at Birth



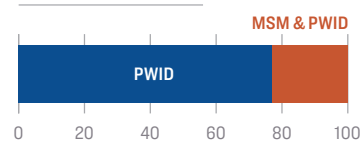
Male	70.9%
Female	29.1%

Race/Ethnicity



NH Black	25.1%
Hispanic	20.1%
NH White	49.8%
Mixed Race/Other	5.0%

Transmission Risk



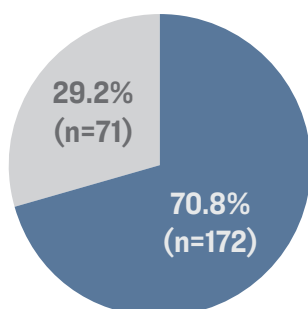
People Who Inject Drugs (PWID)	76.9%
MSM & PWID	23.1%

Figure
6C

HIV Outcomes Among PWID | 2024

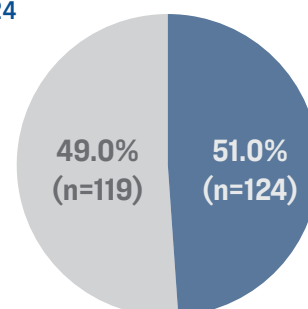
RECEIPT OF HIV CARE IN 2024

- Received HIV Care
- Did Not Receive HIV Care



VIRAL SUPPRESSION IN 2024

- Not Virally Suppressed
- Virally Suppressed



Note Care Outcomes among PWID diagnosed between 2018 and 2023 who were living in Philadelphia as of December 31, 2024.

Source Philadelphia Department of Public Health, Division of HIV Health



Transgender People

The quality of data on transgender people 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.

In 2023/24, Philadelphia was funded for the National HIV Behavioral Surveillance (NHBS) cycle among women of trans experience and transfeminine persons (WTE/TFP). NHBS provides data on access to HIV prevention and care services among WTE/TFP, as well as sexual and drug-use practices that may increase the risk for HIV infection. These data were used to establish the PrEP continuum in WTE/TFP (Figure 7) and will continue to provide valuable information for monitoring and evaluating national and local EHE goals and for guiding prevention efforts.

Based on NHBS data and discussion with our community advisory board,

- Being transgender does not constitute a risk behavior for HIV. Many contextual factors related to HIV transmission are highly prevalent among WTE/TFP in Philadelphia, including unstable housing (31%), living below the federal poverty level (65%), discrimination (45%), and abuse (31% 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.
- Twenty-nine percent of WTE/TFP reported non-injection drug use, excluding cannabis. 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 WTE/TFP are aware of HIV prevention strategies like PrEP (87% aware). While HIV care and prevention are necessary components of healthcare for WTE/TFP, 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

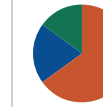
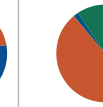
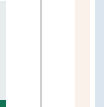
Pre-Exposure Prophylaxis, or PrEP, is a medication taken by individuals at increased risk for HIV infection to lower their chances of getting infected. In May of 2018, CDC published estimates of adults with indications for PrEP by transmission risk group and race/ethnicity. Based on this methodology, PDPH estimates that there were 6,920 HIV negative persons in Philadelphia during 2024 with a PrEP indication, with HIV-negative NH Black MSM having the greatest proportion of PrEP indications (55.3%) (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 use 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 still 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 2024*

	Negative At Risk			PrEP Indication			% Negative At Risk Population with a PrEP Indication		
	MSM	PWID	Heterosexual	MSM	PWID	Heterosexual	MSM	PWID	Heterosexual
NH Black	5,673	8,041	108,967	3,140	100	960	55.3%	1.2%	0.9%
Hispanic	2,186	3,778	48,282	960	100	20	43.9%	2.6%	0.0%
NH White	6,615	10,642	54,172	720	250	100	10.9%	2.3%	0.2%
									
TOTAL**	15,263	23,461	218,281	5,080	510	1,330	33.3%	2.2%	0.6%

*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 estimate is based on number of active MSM 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 2023. 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 2024. 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, discussions about PrEP with providers, and PrEP use among HIV negative individuals. There are three metrics along the PrEP continuum:

- 1) Awareness of PrEP,
- 2) Discussing PrEP with a medical provider in the past year, and
- 3) Using PrEP in the past year

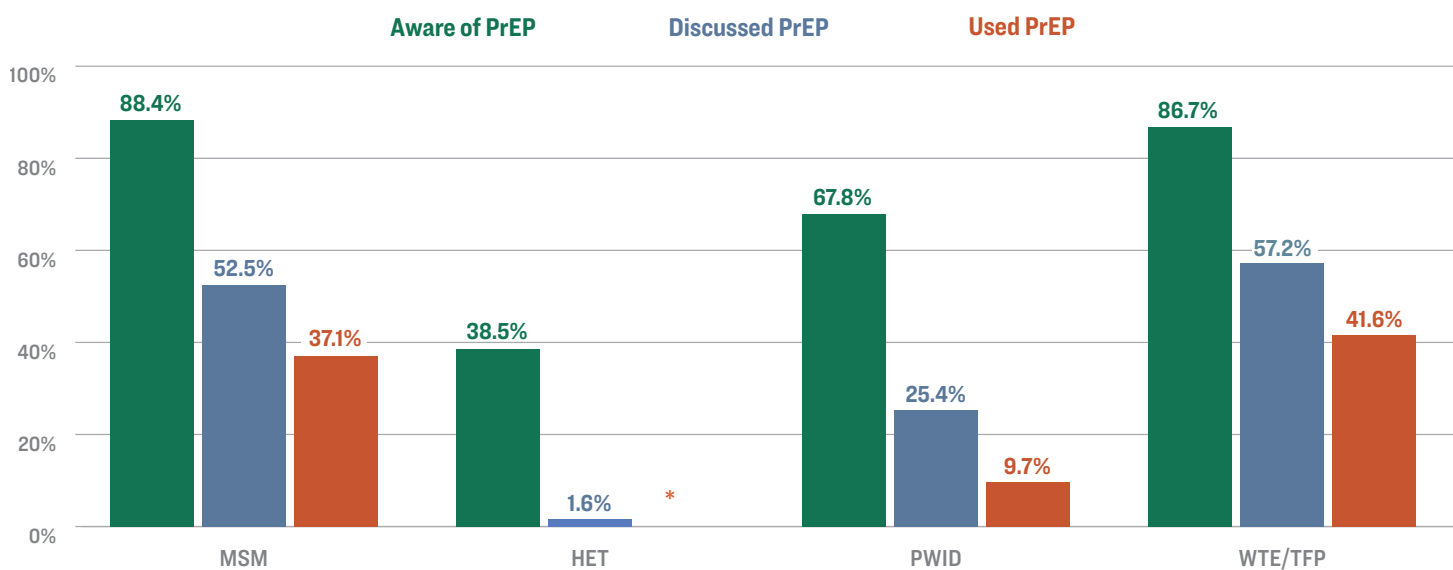
The PrEP continuum is presented for HIV negative individuals in four at-risk populations, including MSM, heterosexuals at increased risk for HIV, PWID, and Women of trans experience and transfeminine persons (WTE/TFP).

PrEP awareness was highest among MSM, while discussions about PrEP and PrEP use were highest among WTE/TFP. At-risk heterosexuals reported the lowest levels of awareness, discussions about, and use of PrEP. It's important to underscore that discussions about PrEP with a medical provider in the last year and PrEP use were also critically low among PWID interviewed.

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

Figure
7

Continuum of PrEP Awareness and Usage



*Numbers become too small to present population proportions.

Note These numbers are presented as percentages, with the denominator being all HIV negative persons interviewed. Graph depicts most recent data available from each cycle; PWID (2024), MSM (2023), WTE/TFP (2023/2024), HET (2019).

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

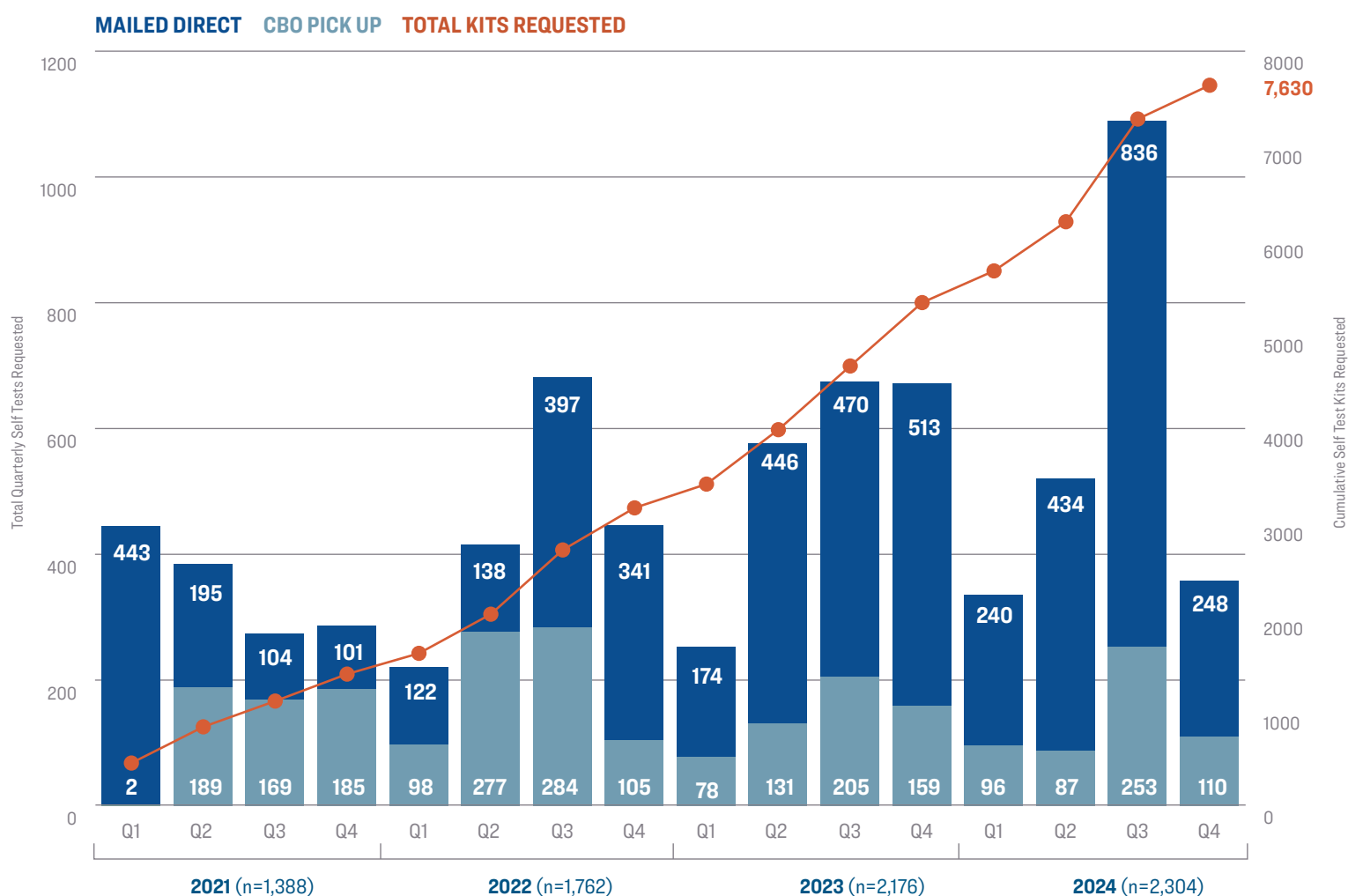
Topics of Continued Focus: Prevention



HIV Self Test Program

During 2024, PDPH continued to offer HIV self testing via (1) Direct mail order by requesting an in-home kit at: <http://www.PhillyKeepOnLoving.com> or (2) through pick up at a participating community-based partner agency. The program increases HIV testing opportunities by providing an alternative for people at increased risk for acquiring HIV who may be unwilling or decline to get tested in other venues. The program destigmatizes HIV screening by providing a personal and private experience. From 2021 to 2024, 5,202 self-test kits were requested and mailed to consumers and an additional 2,428 were distributed through community-based partners.

Figure 8 | HIV Self-Test Kit Requests | 2021–2024



Note Q4 2024 reflects a lower request volume as the self-test kit request form was removed from PhillyKeepOnLoving.com due to capacity constraints. The form has been reestablished in January 2025 and activities remain ongoing.

Source Philadelphia Department of Public Health, Division of HIV Health

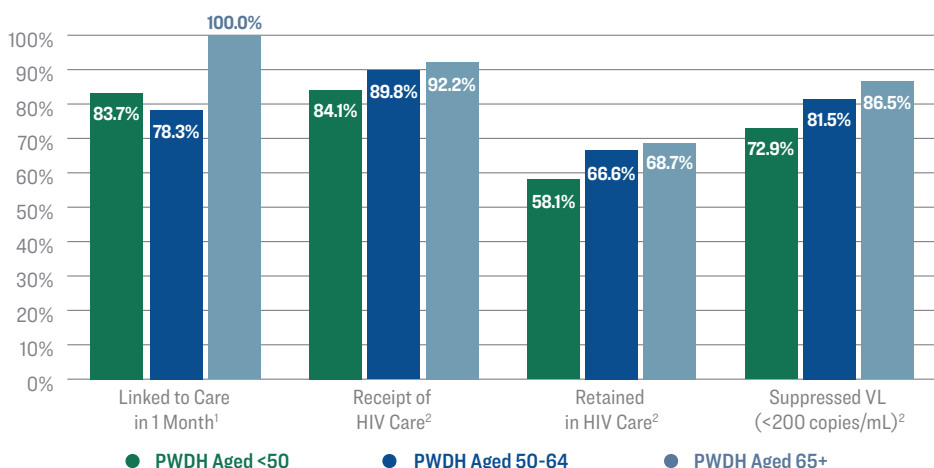
Topics of Continued Focus: HIV Among the Aging Population

HIV and Aging

Notably, 57.0% of PWDH in Philadelphia are over the age of 50. Among them, most are assigned male at birth (69.3%), NH Black (61.4%), between the ages of 50-64 (66.3%), and were exposed through sexual contact (73.0%). Care continuum measures among PWDH with evidence of recent care (1 care lab during the last 5 years) including receipt of HIV care, retention in HIV care, and viral suppression all improved as age increased (Figure 9). However, it is critical to note that people aged 50+ comprised 42.6% of all PWDH not virally suppressed in 2024.

Specific action is necessary to meet the needs of older PWH. The burdens of HIV, aging, and related health comorbidities, combined with the social and structural challenges that aging PWH face, require not only a focus on HIV-related outcomes, but also a coordinated response aimed at treating comorbidities and improving long-term health and quality of life.

Figure 9 | Care Continuum Outcomes by Age Category | 2024



¹Among PWH diagnosed Jan 1, 2024 - Dec 31, 2024

²Outcomes are limited to PWH aged 13+ diagnosed by Dec 31, 2023 and alive at year end 2024 who had at least one reported CD4, genotype, or viral load test during the last 5 years (Jan 1, 2020 - Dec 31, 2024)

Among all PWDH not virally suppressed by year-end 2024, 42.6% were among people aged 50+.

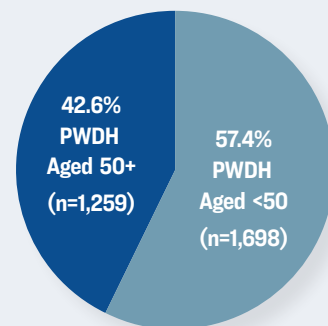
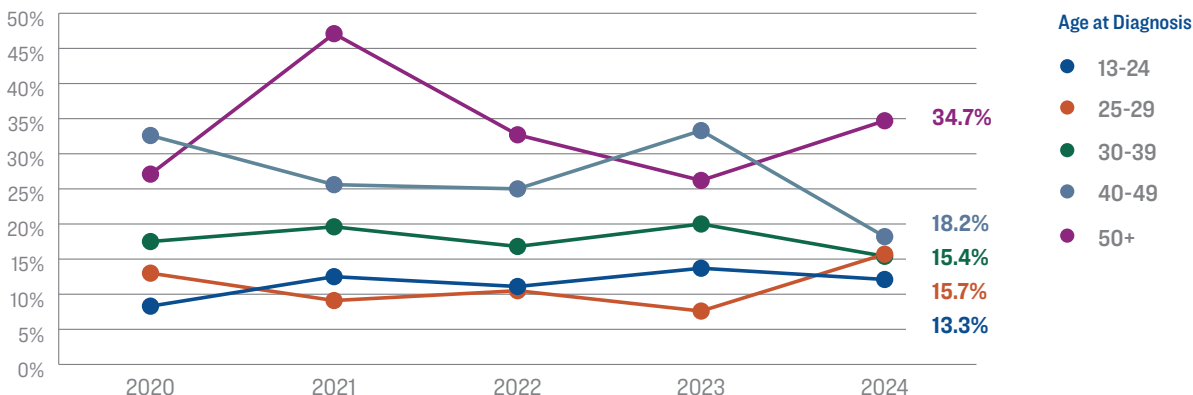


Figure 10 | Late Stage HIV Diagnosis by Age Category | 2020-2024

PWDH aged 50+ accounted for the largest proportion of cases (34.7%) diagnosed with late stage HIV disease (concurrently diagnosed with HIV and AIDS) in 2024.



Newly Diagnosed HIV

In 2024, there were 385 new diagnoses of HIV in Philadelphia, occurring largely among people assigned male at birth (81.3%), NH Black people (62.6%), those aged 30-39 (35.3%), and MSM (64.7%). Compared to 2023, new diagnoses remained stable overall, but decreased among people assigned female at birth (-16.3%), people aged 40+ (-25.6%), and heterosexuals (-19.8%). Some percent changes presented here may represent small absolute differences in diagnoses and should be interpreted with caution.

Table
4

By Year and Selected Characteristics (regardless of AIDS status)

2020–2024

Year of Diagnosis	2020		2021		2022		2023		2024		% change 2023-2024
	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %	
Total Cases	342	100.0%	365	100.0%	393	100.0%	385	100.0%	385	100.0%	0.0%
Sex Assigned at Birth											
Female	83	24.4%	76	20.8%	97	24.7%	86	22.3%	72	18.7%	-16.3%
Male	259	75.6%	289	79.2%	296	75.3%	299	77.7%	313	81.3%	4.7%
Race/Ethnicity											
NH Black	228	66.7%	228	62.5%	229	58.3%	238	61.8%	241	62.6%	1.3%
Hispanic	59	17.3%	53	14.5%	81	20.6%	67	17.4%	71	18.4%	6.0%
NH White	42	12.3%	72	19.7%	65	16.5%	61	15.8%	55	14.3%	-9.8%
NH Multi-race	9	2.6%	7	1.9%	10	2.5%	6	1.6%	*	*	N/A
NH Asian	*	*	*	*	6	1.5%	12	3.1%	13	3.4%	8.3%
Other/Unknown	*	*	*	*	*	*	*	*	*	*	N/A
Age Category											
0-12	*	*	*	*	*	*	*	*	*	*	N/A
13-19	19	5.6%	19	5.6%	14	3.6%	20	5.2%	15	3.9%	-25.0%
20-24	51	14.9%	66	18.1%	50	12.7%	60	15.6%	60	15.6%	0.0%
25-29	77	22.5%	77	21.1%	76	19.3%	79	20.5%	83	21.6%	5.1%
30-39	103	30.1%	112	30.7%	137	34.9%	105	27.3%	136	35.3%	29.5%
40-49	43	12.6%	39	10.7%	60	15.3%	60	15.6%	44	11.4%	-26.7%
50-64	43	12.6%	46	12.6%	45	11.5%	49	12.7%	37	9.6%	-24.5%
65+	*	*	*	*	10	2.5%	12	3.1%	9	2.3%	-25.0%
Transmission Risk											
MSM	198	57.9%	206	56.4%	198	50.4%	230	59.7%	249	64.7%	8.3%
PWID	28	8.2%	43	11.8%	56	14.2%	20	5.2%	25	6.5%	25.0%
MSM/PWID	10	2.9%	20	5.5%	11	2.8%	7	1.8%	6	1.6%	-14.3%
Heterosexual	80	23.4%	63	17.3%	84	21.4%	81	21.0%	65	16.9%	-19.8%
Pediatric	*	*	*	*	*	*	*	*	*	*	N/A
No Reported Risk	25	7.3%	32	8.8%	43	10.9%	47	12.2%	39	10.1%	-17.0%

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

Newly Diagnosed HIV

Table
5

By Race/Ethnicity and Selected Characteristics (regardless of AIDS status) | 2024

	NH Black		Hispanic		NH White	
	N	Col %	N	Col %	N	Col %
Total	241	100.0%	71	100.0%	55	100.0%

Sex Assigned at Birth

Female	47	19.5%	11	15.5%	10	18.2%
Male	194	80.5%	60	84.5%	45	81.8%

Age Category

0-12	*	*	*	*	*	*
13-19	9	3.7%	*	*	*	*
20-24	49	20.3%	8	11.3%	*	*
25-29	46	19.1%	21	29.6%	11	20.0%
30-39	83	34.4%	22	31.0%	21	38.2%
40-49	27	11.2%	8	11.3%	8	14.5%
50-64	23	9.5%	*	*	8	14.5%
65+	*	*	*	*	*	*

Transmission Risk

MSM	154	63.9%	47	66.2%	35	63.6%
PWID	*	*	*	*	12	21.8%
MSM/PWID	*	*	*	*	*	*
Heterosexual	47	19.5%	12	16.9%	*	*
Pediatric	*	*	*	*	*	*
No Reported Risk	33	13.7%	*	*	*	*

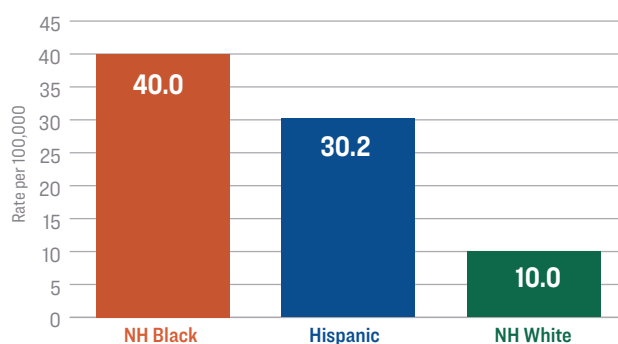
Note *Cell sizes <6 (including 0) are suppressed.
Due to rounding, percentages may not add up to exactly 100%.

Source Philadelphia Department of Public Health, Division of HIV Health

Racial/ethnic disparities in Philadelphia mirror those observed nationally.

Disparities by race/ethnicity become more apparent when considering the underlying population size. In 2024, new diagnosis rates increased among among NH Black people (40.0 per 100,000 from 38.7 in 2023) and Hispanic/Latinx people (30.2 from 25.9 in 2023), but decreased among NH White persons (10.0 from 11.3 in 2023) (Figure 11).

Figure 11 | HIV Diagnosis Rates, by Race/Ethnicity | 2024

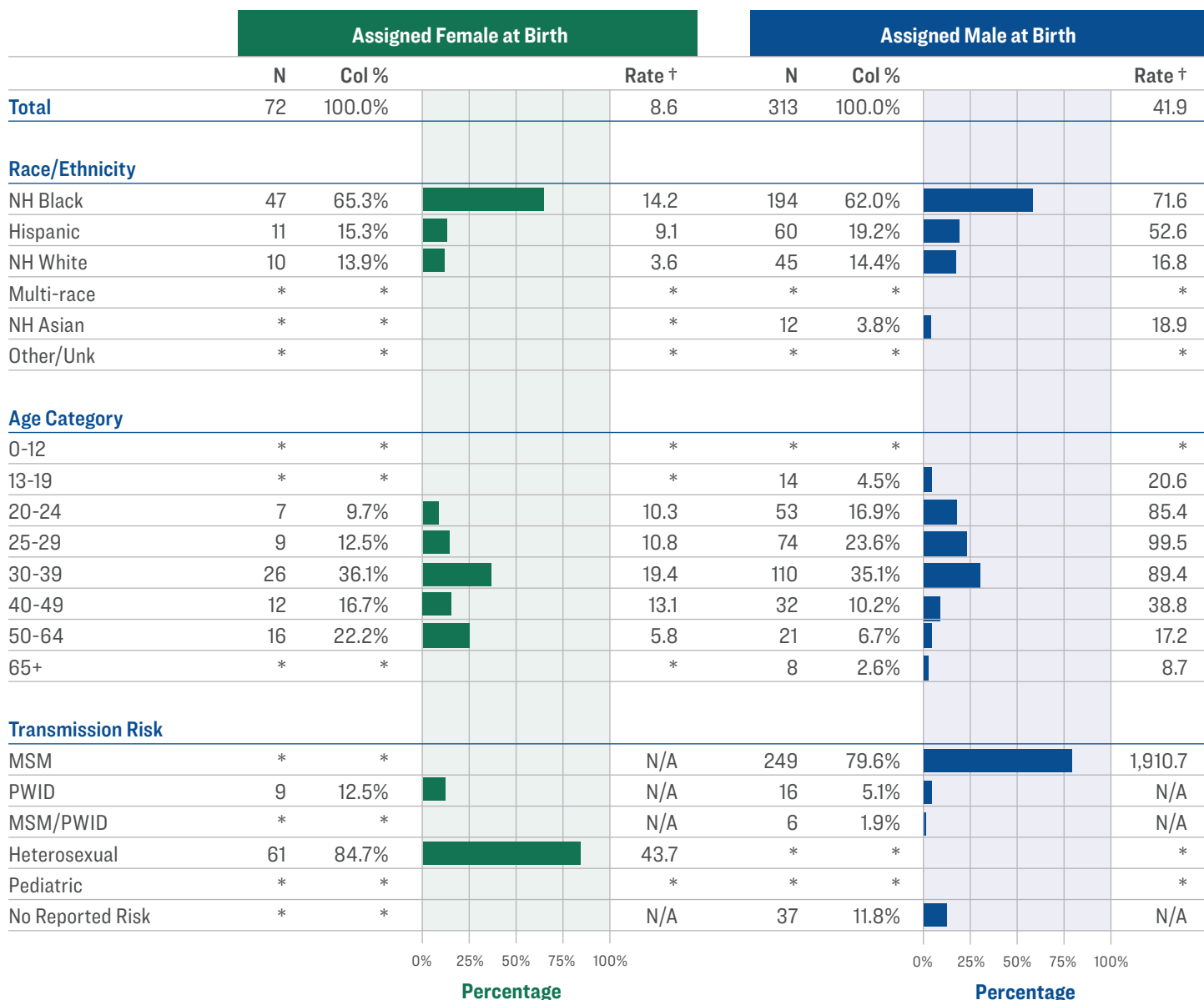


Newly Diagnosed HIV

Table
6

By Sex Assigned at Birth and Selected Characteristics (regardless of AIDS status) | 2024

The majority of all new HIV diagnoses in 2024 were among people assigned male at birth (81.3%), with the highest rates among NH Black males (71.6 per 100,000) and MSM (1,910.7). Assigned females at birth comprised 18.7% of new diagnoses, with the highest rates among NH Black females (14.2) and those with a noted heterosexual risk (43.7) (Table 4).



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 people 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

Newly Diagnosed Cases by Census Tract | 2022–2024

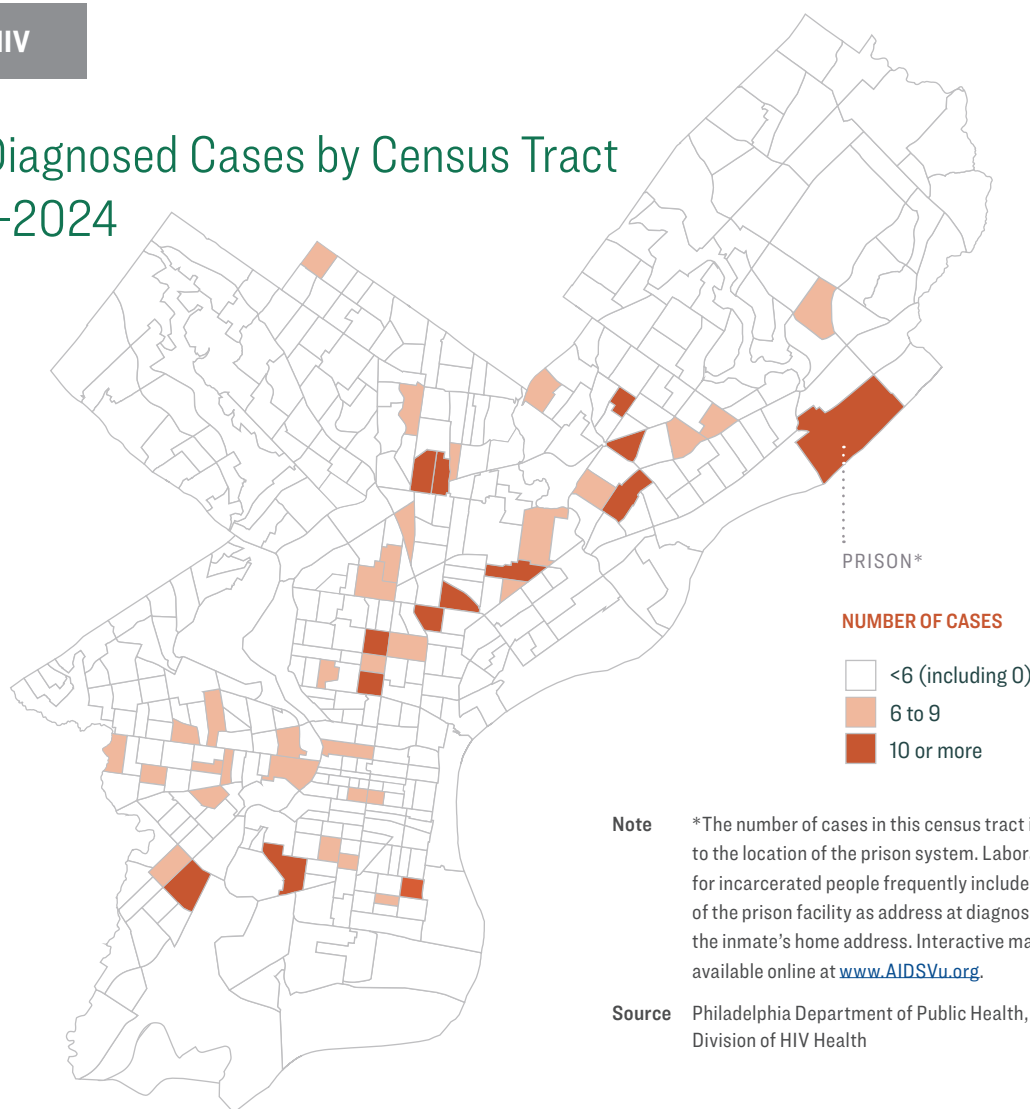
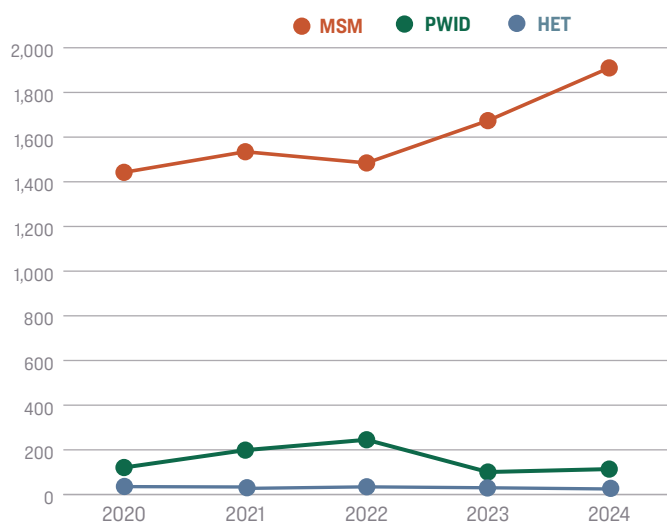


Figure
12

HIV Diagnosis Rates per 100,000 People, by Year of Diagnosis and Risk Group | 2020-2024



Rates of HIV diagnosis increased among MSM in 2024 (1,909.8 per 100,000 from 1,673.8 in 2023) and slightly among PWID (113.8 from 100.7 in 2023), but decreased among heterosexuals at increased risk for HIV (24.9 from 30.2 in 2023).

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.

Source Philadelphia Department of Public Health, Division of HIV Health

AIDS Diagnoses

A concurrent HIV diagnosis is defined as a new AIDS diagnosis on or within 3 months of initial HIV diagnosis. Concurrent HIV/AIDS diagnoses represent missed opportunities for early HIV detection and can be a signal of reduced access to early or routine HIV testing. During 2024, 17.1% of new diagnoses had a concurrent HIV/AIDS diagnosis, the lowest proportion reported since 2020. The highest proportion of concurrent diagnoses were among people assigned female at birth (20.8%), NH White people (20.0%), people aged 50-64 (37.8%), and heterosexuals (24.6%).

Table
7

Concurrent HIV/AIDS, Demographics and Transmission Risk | 2020–2024

	2020				2021				2022				2023				2024			
	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	281	82.2%	61	17.8%	293	80.3%	72	19.7%	321	81.7%	72	18.3%	312	81.0%	73	19.0%	319	82.9%	66	17.1%

Sex Assigned at Birth

Female	64	77.1%	19	22.9%	60	78.9%	16	21.1%	81	83.5%	16	16.5%	68	79.1%	18	20.9%	57	79.2%	15	20.8%
Male	217	83.8%	42	16.2%	233	80.6%	56	19.4%	240	80.8%	57	19.2%	244	81.6%	55	18.4%	262	83.7%	51	16.3%

Race/Ethnicity

NH Black	192	84.2%	36	15.8%	178	78.1%	50	21.9%	182	79.5%	47	20.5%	195	81.9%	43	18.1%	201	83.4%	40	16.6%
Hispanic	50	84.7%	9	15.3%	39	73.6%	14	26.4%	69	85.2%	12	14.8%	52	77.6%	15	22.4%	60	84.5%	11	15.5%
NH White	30	71.4%	12	28.6%	65	90.3%	7	9.7%	57	87.7%	8	12.3%	48	78.7%	13	21.3%	44	80.0%	11	20.0%
NH Multi-race	8	88.9%	*	*	7	100%	*	*	9	90%	*	*	*	*	*	*	*	*	*	*
NH Asian	*	*	*	*	*	*	*	*	*	*	*	*	11	91.7%	*	*	10	76.9%	*	*
Other/Unknown	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*

Age at HIV Dx

0-12	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
13-19	18	94.7%	*	*	16	84.2%	*	*	13	92.9%	*	*	18	90.0%	*	*	13	86.7%	*	*
20-24	47	92.2%	*	*	60	90.9%	6	9.1%	43	86.0%	7	14.0%	52	86.7%	8	13.3%	54	90.0%	6	10.0%
25-29	67	87.0%	10	13.0%	70	90.9%	7	9.1%	68	89.5%	8	10.5%	73	92.4%	6	7.6%	70	84.3%	13	15.7%
30-39	85	82.5%	18	17.5%	90	80.4%	22	19.6%	114	83.2%	23	16.8%	84	80.0%	21	20.0%	115	84.6%	21	15.4%
40-49	29	67.4%	14	32.6%	29	74.4%	10	25.6%	45	75.0%	15	25.0%	40	66.7%	20	33.3%	36	81.8%	8	18.2%
50-64	31	72.1%	12	27.9%	24	52.2%	22	47.8%	31	68.9%	14	31.1%	36	73.5%	13	26.5%	23	62.2%	14	37.8%
65+	*	*	*	*	*	*	*	*	6	60.0%	*	*	9	75.0%	*	*	7	77.8%	*	*

Transmission Risk

MSM	171	86.4%	27	13.6%	168	81.6%	38	18.4%	158	80.6%	40	20.2%	193	83.9%	37	16.1%	216	86.7%	33	13.3%
PWID	24	1.3%	*	*	37	86.0%	6	14.0%	50	89.3%	6	10.7%	16	100.0%	*	*	23	100.0%	*	*
MSM/PWID	7	70.0%	*	*	20	100.0%	*	*	8	72.7%	*	*	6	85.7%	*	*	*	*	*	*
Heterosexual	59	73.8%	21	26.3%	49	77.8%	14	22.2%	69	83.1%	15	17.9%	63	77.8%	18	22.2%	49	75.4%	16	24.6%
Pediatric	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
No Reported Risk	19	76.0%	6	24.0%	18	56.3%	14	43.8%	35	71.4%	8	18.6%	34	72.3%	13	27.7%	27	69.2%	12	30.8%

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

AIDS Diagnoses

Table
8

By Year and Selected Characteristics | 2020–2024

In 2024, there were 179 new AIDS diagnoses in Philadelphia. Most new diagnoses occurred among individuals assigned male at birth (69.8%), NH Black people (59.2%), MSM (45.3%), and people aged 30-39 (31.8%).

Compared with 2023, new AIDS diagnoses decreased slightly overall (-6.1%), with declines observed among individuals assigned male at birth (-13.6%), NH Black people (-15.1%), and people aged 49-64 (-23.4%). Some percent changes presented here may represent small absolute differences in diagnoses and should be interpreted with caution.

Year of Diagnosis	2020		2021		2022		2023		2024		% change 2023-2024
	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %	
Total Cases	154	100.0%	165	100.0%	204	100.0%	190	100.0%	179	100.0%	-5.8%
Sex Assigned at Birth											
Female	48	31.2%	43	26.1%	57	27.9%	48	25.3%	54	30.2%	12.5%
Male	106	68.8%	122	73.9%	147	72.1%	142	74.7%	125	69.8%	-12.0%
Race/Ethnicity											
NH Black	108	70.1%	104	63.0%	133	65.2%	122	64.2%	106	59.2%	-13.1%
Hispanic	21	13.6%	31	18.8%	31	15.2%	27	14.2%	35	19.6%	29.6%
NH White	19	12.3%	22	13.3%	26	12.7%	34	17.9%	28	15.6%	-17.6%
NH Multi-race	*	*	7	4.2%	9	4.4%	*	*	6	3.4%	N/A
NH Asian	*	*	*	*	*	*	*	*	*	*	N/A
Other/Unknown	*	*	*	*	*	*	*	*	*	*	N/A
Age Category											
0-12	*	*	*	*	*	*	*	*	*	*	N/A
13-19	*	*	*	*	*	*	*	*	*	*	N/A
20-24	*	*	8	4.8%	13	6.4%	12	6.3%	9	5.0%	-25.0%
25-29	23	14.9%	15	9.1%	21	10.3%	16	8.4%	21	11.7%	31.3%
30-39	47	30.5%	51	30.9%	61	29.9%	56	29.5%	57	31.8%	1.8%
40-49	33	21.4%	27	16.4%	41	20.1%	48	25.3%	36	20.1%	-25.0%
50-64	38	24.7%	52	31.5%	53	26.0%	46	24.2%	36	20.1%	-21.7%
65+	7	4.5%	9	5.5%	14	6.9%	10	5.3%	17	9.5%	70.0%
Transmission Risk											
MSM	58	37.7%	78	47.3%	85	41.7%	84	44.2%	81	45.3%	-3.6%
PWID	18	11.7%	22	13.3%	36	17.6%	30	15.8%	24	13.4%	-20.0%
MSM/PWID	8	5.2%	*	*	12	5.9%	7	3.7%	7	3.9%	0.0%
Heterosexual	55	35.7%	43	26.1%	57	27.9%	49	25.8%	52	29.1%	6.1%
Pediatric	*	*	*	*	*	*	*	*	*	*	N/A
No Reported Risk	12	7.8%	17	10.3%	12	5.9%	19	10.0%	13	7.3%	-31.6%

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

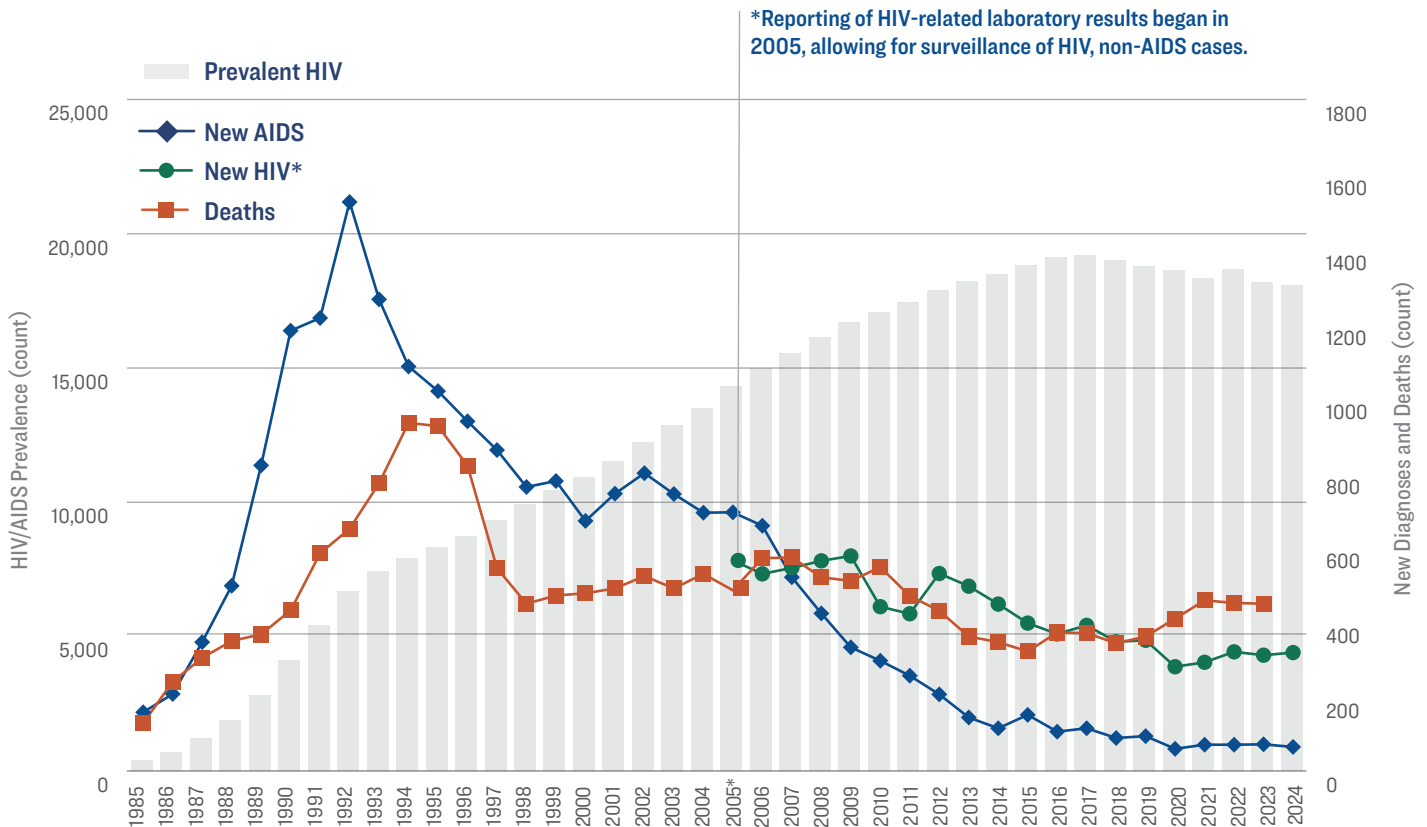
Due to rounding, percentages may not add up to exactly 100%.

A proportion of AIDS diagnoses each year were diagnosed with HIV in a previous year and later progressed to AIDS.

Source Philadelphia Department of Public Health, Division of HIV Health

Persons with Diagnosed HIV

Figure 13 | HIV and AIDS Diagnoses, Deaths, and Prevalence by Year | 1985–2024



Note Prevalent cases are those diagnosed with HIV by December 31, 2024 and alive at year end.

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 | 2024

HIV prevalence in 2024 has decreased slightly from 2023, however the demographic makeup remains consistent. The majority of PWDH were assigned male at birth (72.7%), NH Black (62.7%), aged 50 and older (57.0%), and MSM (41.7%).

	HIV (Non-AIDS)		AIDS		HIV/AIDS	
	N	Col %	N	Col %	N	Col %
Total	8,707	100.0%	9,357	100.0%	18,064	100.0%
Sex Assigned at Birth						
Female	2,339	26.9%	2,596	27.7%	4,935	27.3%
Male	6,368	73.1%	6,761	72.3%	13,129	72.7%
Race/Ethnicity						
NH Black	5,345	61.4%	5,971	63.8%	11,316	62.7%
Hispanic	1,564	18.0%	1,535	16.4%	3,099	17.2%
NH White	1,405	16.1%	1,444	15.4%	2,849	15.8%
NH Multi-race	236	2.7%	295	3.2%	531	2.9%
NH Asian	134	1.5%	97	1.0%	231	1.3%
Other/Unknown	23	0.3%	15	0.2%	38	0.2%
Age Category**						
0-12	8	0.1%	*	*	8	0.0%
13-19	37	0.4%	6	0.1%	43	0.2%
20-24	245	2.8%	44	0.5%	289	1.6%
25-29	686	7.9%	155	1.7%	841	4.7%
30-39	2,370	27.2%	1,013	10.8%	3,383	18.7%
40-49	1,808	20.8%	1,386	14.8%	3,194	17.7%
50-64	2,571	29.5%	4,264	45.6%	6,835	37.8%
65+	982	11.3%	2,489	26.6%	3,471	19.2%
Transmission Risk						
MSM	4,129	47.5%	3,403	36.4%	7,532	41.7%
PWID	1,019	11.7%	2,022	21.6%	3,041	16.8%
MSM/PWID	273	3.1%	466	5.0%	739	4.1%
Heterosexual	2,822	32.4%	3,095	33.1%	5,917	32.8%
Pediatric	104	1.2%	128	1.4%	232	1.3%
Other	*	*	7	0.1%	9	0.0%
No Reported Risk	358	4.1%	236	2.5%	594	3.3%

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

**Age as of December 31, 2024.

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

Source Philadelphia Department of Public Health, Division of HIV Health

Bar graphs indicate HIV/AIDS percentages

Persons with Diagnosed HIV

Table
10

By Race/Ethnicity and Selected Characteristics | 2024

	NH Black		Hispanic		NH White	
	N	Col %	N	Col %	N	Col %
Total	11,316	100.0%	3,099	100.0%	2,849	100.0%

Sex Assigned at Birth

Female	3,488	30.8%	828	26.7%	423	14.8%
Male	7,828	69.2%	2,271	73.3%	2,426	85.2%

Age Category**

0-12	*	*	*	*	*	*
13-19	30	0.3%	10	0.3%	*	*
20-24	215	1.9%	53	1.7%	13	0.5%
25-29	586	5.2%	165	5.3%	62	2.2%
30-39	2,221	19.6%	557	18.0%	425	14.9%
40-49	1,929	17.0%	593	19.1%	499	17.5%
50-64	4,214	37.2%	1,188	38.3%	1,135	39.8%
65+	2,116	18.7%	531	17.1%	714	25.1%

Transmission Risk

MSM	4,318	38.2%	1,131	36.5%	1,725	60.5%
PWID	1,753	15.5%	715	23.1%	461	16.2%
MSM/PWID	371	3.3%	157	5.1%	167	5.9%
Heterosexual	4,292	37.9%	946	30.5%	417	14.6%
Pediatric	166	1.5%	44	1.4%	15	0.5%
Other	6	0.1%	*	*	*	*
No Reported Risk	410	3.6%	106	3.4%	62	2.2%

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

** Age as of December 31, 2024.

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

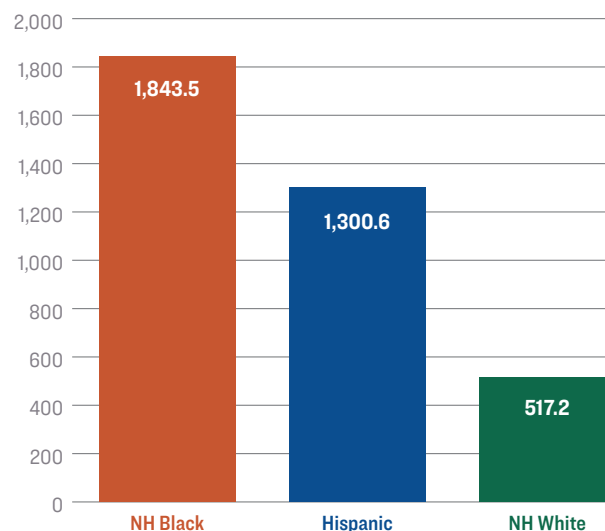
Prevalent cases are defined as those diagnosed with HIV by December 31, 2024 and alive at year end.

Source Philadelphia Department of Public Health, Division of HIV Health

Figure
14

Prevalence By Race/ Ethnicity | 2024

HIV prevalence rates remain disproportionately higher among racial and ethnic minorities. NH Black (1,843.5 per 100,000) and Hispanic/Latinx people (1,300.6) have over 3.5 and 2.5 times the rate of HIV compared to NH White people.



Persons with Diagnosed HIV

Table
11

By Sex Assigned at Birth and Selected Characteristics | 2024

	Assigned Female at Birth		Assigned Male at Birth	
	N	Col %	N	Col %
Total	4,935	100.0%	12,129	100.0%

Race/Ethnicity

NH Black	3,488	70.7%	7,828	59.6%
Hispanic	828	16.8%	2,271	17.3%
NH White	423	8.6%	2,426	18.5%
NH Multi-race	148	3.0%	383	2.9%
NH Asian	39	0.8%	192	1.5%
Other/Unk	9	0.2%	29	0.2%

Age Category**

0-12	6	0.1%	*	*
13-19	16	0.3%	27	0.2%
20-24	50	1.0%	237	1.8%
25-29	142	2.9%	699	5.3%
30-39	652	13.2%	2,731	20.8%
40-49	906	18.4%	2,288	17.4%
50-64	2,232	45.2%	4,603	35.1%
65+	931	18.9%	2,540	19.3%

Transmission Risk

MSM	*	*	7,532	57.4%
PWID	1,119	22.7%	1,922	14.6%
MSM/PWID	*	*	739	5.6%
Heterosexual	3,638	73.7%	2,279	17.4%
Pediatric	122	2.5%	110	0.8%
Other	*	*	7	0.1%
No Reported Risk	54	1.1%	540	4.1%

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

** Age as of December 31, 2024.

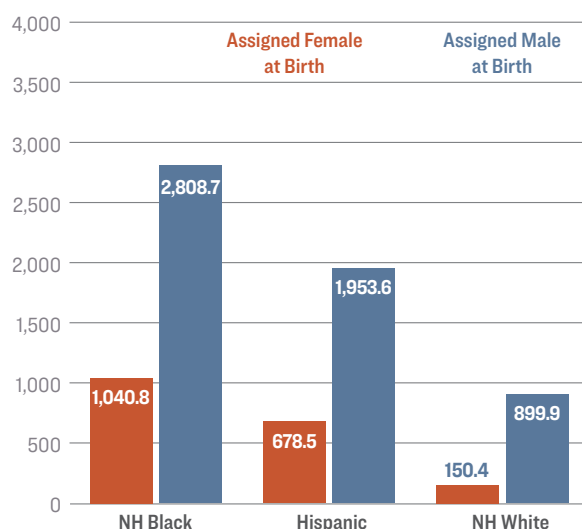
Due to rounding, percentages may not add up to exactly 100%.

Prevalent cases are defined as those diagnosed with HIV by December 31, 2024 and alive at year end.

Source Philadelphia Department of Public Health, Division of HIV Health

Figure
15

Prevalence Rates by Sex Assigned at Birth and Race/Ethnicity



Persons with Diagnosed HIV

Table
12

By Gender Identity and Selected Characteristics | 2024

	Cisgender Men		Cisgender Women		Transgender Women		Transgender Men	
	N	Col %	N	Col %	N	Col %	N	Col %
Total	12,719	100.0%	4,913	100.0%	394	100.0%	21	100.0%

Race/Ethnicity

NH Black	7,536	59.2%	3,475	70.7%	283	71.8%	12	57.1%
Hispanic	2,200	17.3%	826	16.8%	67	17.0%	*	*
NH White	2,403	18.9%	418	8.5%	21	5.3%	*	*
Multi-race	366	2.9%	146	3.0%	16	4.1%	*	*
NH Asian	187	1.5%	39	0.8%	*	*	*	*
Other/Unknown	27	0.2%	9	0.2%	*	*	*	*

Age Category**

0-12	*	*	*	*	*	*	*	*
13-19	25	0.2%	16	0.3%	*	*	*	*
20-24	224	1.8%	48	1.0%	14	3.6%	*	*
25-29	667	5.2%	139	2.8%	27	6.9%	*	*
30-39	2,563	20.2%	640	13.0%	165	41.9%	12	57.1%
40-49	2,201	17.3%	902	18.4%	83	21.1%	*	*
50-64	4,521	35.5%	2,232	45.4%	81	20.6%	*	*
65+	2,517	19.8%	931	18.9%	23	5.8%		

Transmission Risk

Sexual Contact	9,475	74.5%	3,622	73.7%	324	82.2%	16	76.2%
PWID	2,593	20.4%	1,116	22.7%	65	16.5%	*	*
Pediatric	109	0.9%	119	2.4%	*	*	*	*
Other	7	0.1%	*	*	*	*	*	*
No Reported Risk	535	4.2%	54	1.1%	*	*	*	*

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

**Age as of December 31, 2024.

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

Prevalent cases are those diagnosed with HIV by December 31, 2024 and alive at year end.

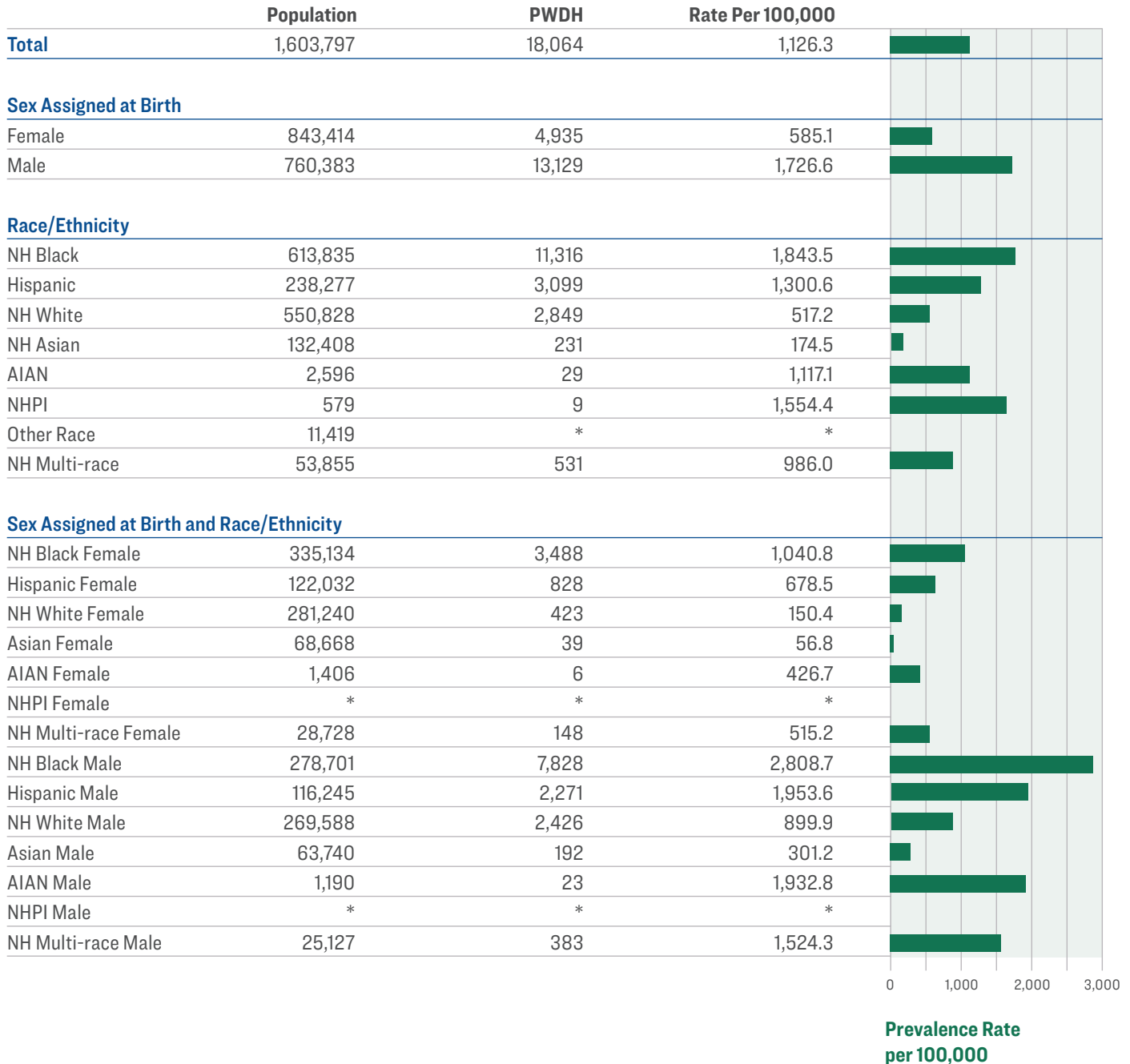
Gender identity is often not recorded in medical records. Sex assigned at birth was used to determine gender identity where no additional information was present. The prevalence among transgender women, transgender men, and those cases with additional gender identities is assumed to be higher. Individuals identifying as non-binary (n=17) 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 | 2024



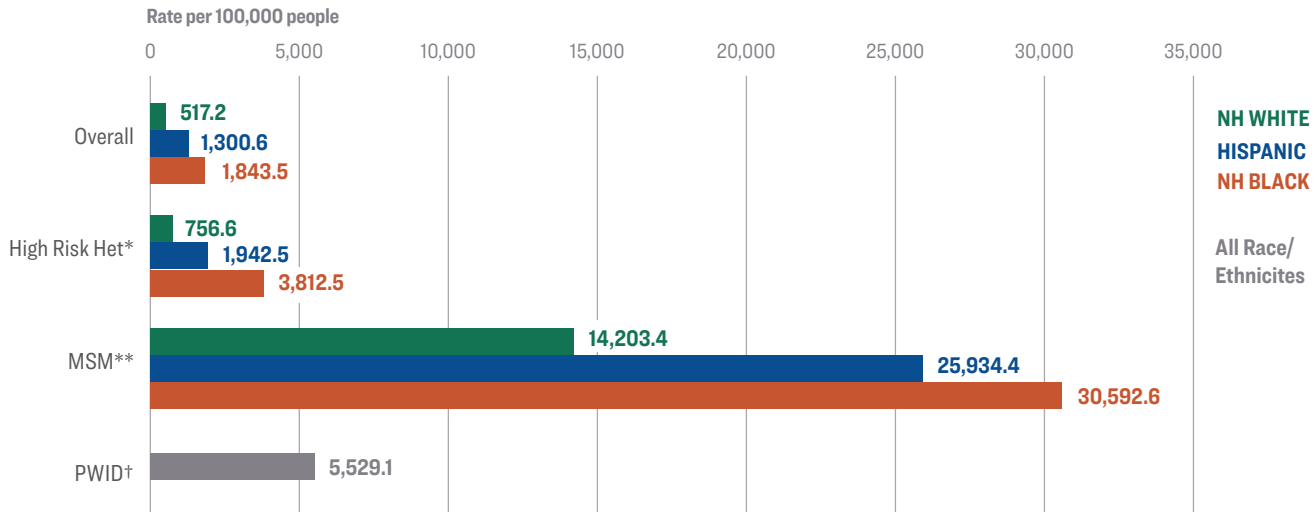
Note *Cell sizes <6 (including 0) are suppressed. Rates and case counts in categories with <500 population are also suppressed. Rates were calculated using population data from the 2020 decennial census data.

Source Philadelphia Department of Public Health, Division of HIV Health

Persons with Diagnosed HIV

Figure
16

Prevalence by Race/Ethnicity and Transmission Category | 2024



Note *The population of individuals 18 and older living below poverty level is used as a proxy for high risk heterosexual population estimates.

**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.

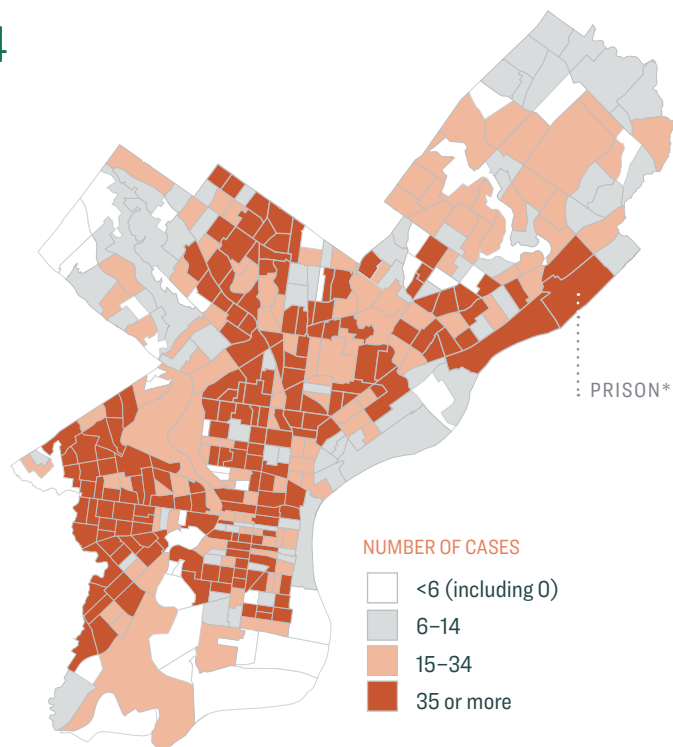
Source Philadelphia Department of Public Health, Division of HIV Health

Map
2

By Census Tract | 2024

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 current address rather than the inmate's home address. Interactive mapping data are available online at www.AIDSVu.org.

Source Philadelphia Department of Public Health, Division of HIV Health



Persons with Diagnosed HIV

Among PWDH in Philadelphia during 2024, 4.6% were coinfecting with Hepatitis B (HBV) and 3.9% were coinfecting with Hepatitis C (HCV). HBV and HCV infections were highest among PWDH aged 40+ and those noting an injection drug related risk. The highest proportions of HBV infection were among NH Asian and NH Black people, whereas HCV was more prominent among NH White and Hispanic people.

Table
14

By Hepatitis B or C Co-Infection and Selected Characteristics | 2024

	Hepatitis B/HIV		Hepatitis C/HIV		HIV Total
	N	Row %	N	Row %	N
Total	832	4.6%	700	3.9%	18,064

Sex Assigned at Birth

Female	195	4.0%	199	4.0%	4,935
Male	637	4.9%	501	3.8%	13,129

Race/Ethnicity

NH Black	578	5.1%	304	2.7%	11,316
Hispanic	99	3.2%	180	5.8%	3,099
NH White	113	4.0%	181	6.4%	2,849
Multi-race	23	4.3%	25	4.7%	531
NH Asian	18	7.8%	10	4.3%	231
Other/Unknown	*	*	*	*	38

Age Category**

<13	*	*	*	*	8
13-19	*	*	*	*	43
20-24	*	*	*	*	289
25-29	13	1.5%	11	1.3%	841
30-39	73	2.2%	98	2.9%	3,383
40-49	149	4.7%	149	4.7%	3,194
50-64	431	6.3%	278	4.1%	6,835
65+	163	4.7%	160	4.6%	3,471

Transmission Risk

MSM	330	4.4%	111	1.5%	7,532
PWID	202	6.6%	362	11.9%	3,041
MSM/PWID	39	5.3%	60	8.1%	739
Heterosexual	230	3.9%	153	2.6%	5,917
Pediatric	7	3.0%	*	*	232
Other	*	*	*	*	9
No Risk Reported	24	4.0%	27	4.5%	594



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

**Age as of December 31, 2024.

Data represents proportion of PWDH and with current HBV or HCV infection as of December 31st, 2024. For HCV, coinfections are defined as having no evidence of HCV treatment or resolution dates that precede date of HIV diagnosis. 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.

Perinatal Exposures

Perinatal exposures represent instances where HIV transmission could have occurred from birthing person 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>

These tables show both demographic and clinical characteristics for the birthing person and child before, during, and after birth. Birthing person's viral load represents the most recent viral load before birth; prenatal care was defined as at least 1 medical visit during pregnancy; birthing person's timing at diagnosis was categorized as early (any time before L&D), late (during or after L&D), and unknown.

Table
15

By Selected Demographics | 2020–2024

Year of Exposure	2020		2021		2022		2023		2024	
	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %
Total	81	100.0%	77	100.0%	71	100.0%	52	100.0%	54	100.0%

Infant Sex Assigned at Birth

Female	44	54.3%	38	49.4%	42	59.2%	26	50.0%	28	51.9%
Male	37	45.7%	39	50.6%	29	40.8%	26	50.0%	26	48.1%

Birthing Person Age at Delivery

13 - 19	*	*	*	*	*	*	*	*	*	*
20 - 24	6	7.4%	7	9.1%	7	9.9%	*	*	6	11.1%
25 - 34	47	58.0%	45	58.4%	44	62.0%	31	59.6%	37	68.5%
35+	26	32.1%	25	32.5%	19	26.8%	15	28.8%	11	20.4%

Birthing Person Race/Ethnicity

NH Black	58	71.6%	57	74.0%	52	73.2%	37	71.2%	44	81.5%
Hispanic	8	9.9%	9	11.7%	*	*	6	11.5%	6	11.1%
NH White	12	14.8%	9	11.7%	8	11.3%	7	13.5%	*	*
Multi-race	*	*	*	*	7	9.9%	*	*	*	*
NH Asian	*	*	*	*	*	*	*	*	*	*

Birthing Person Transmission Risk

PWID	8	9.9%	9	11.7%	6	8.5%	7	13.5%	*	*
Heterosexual	64	79.0%	63	81.8%	57	80.3%	40	76.9%	44	81.5%
Pediatric	7	8.6%	*	*	6	8.5%	*	*	7	13.0%
No Reported Risk	*	*	*	*	*	*	*	*	*	*

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 | 2020–2024

Year of Exposure	2020		2021		2022		2023		2024	
	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %
Total	81	100.0%	77	100.0%	71	100.0%	52	100.0%	54	100.0%

Infant Diagnosis Status

HIV positive, definitive	1	1.2%	1	1.3%	1	1.4%	0	0.0%	1	1.9%
HIV indeterminate	4	4.9%	4	5.2%	2	2.8%	8	15.4%	6	11.1%
HIV negative, definitive	36	44.4%	33	42.9%	44	62.0%	20	38.5%	26	48.1%
HIV negative, presumptive	40	49.4%	39	50.6%	24	33.8%	24	46.2%	21	38.9%

Birth Person Viral Load

≥1000	10	12.3%	12	15.6%	6	8.5%	6	11.5%	2	3.7%
<1000	64	79.0%	59	76.6%	60	84.5%	43	82.7%	50	92.6%
Unknown	7	8.6%	6	7.8%	5	7.0%	3	5.8%	2	3.7%

Birth Person Prenatal Care

Yes	77	95.1%	74	96.1%	70	98.6%	50	96.2%	54	100.0%
No	4	4.9%	3	3.9%	1	1.4%	2	3.8%	0	0.0%

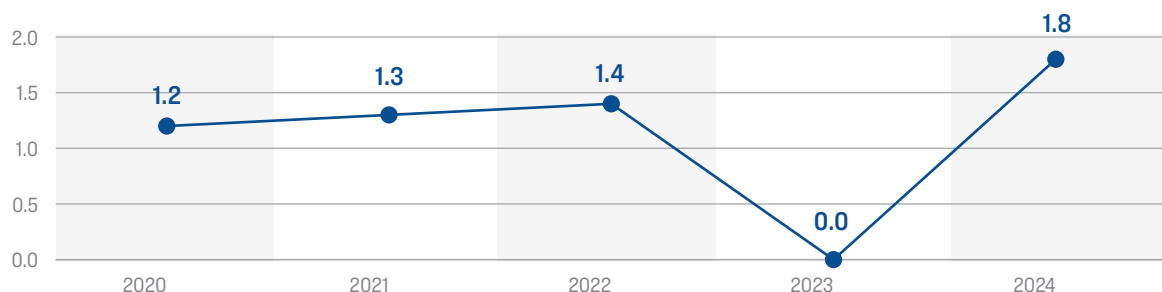
ARV Medications During Pregnancy

Yes	74	91.4%	70	90.9%	69	97.2%	45	86.5%	52	96.3%
No	6	7.4%	6	7.8%	1	1.4%	4	7.7%	2	3.7%
Unknown	1	1.2%	1	1.3%	1	1.4%	3	5.8%	0	0.0%

Neonatal ARV

Yes	77	95.1%	75	97.4%	71	100.0%	52	100.0%	54	100.0%
Unknown	4	4.9%	2	2.6%	0	0.0%	0	0.0%	0	0.0%

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 | 2021–2023

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 2023. Unknown causes of death have been omitted from the data table due to small cell size.

HIV-Related Death	2021 (n=459)				2022 (n=451)				2023 (n=450)			
	No		Yes		No		Yes		No		Yes	
	N	Row%	N	Row%	N	Row%	N	Row%	N	Row%	N	Row%
Total	394	85.8%	63	13.7%	372	82.5%	75	16.6%	381	84.7%	65	14.4%

Sex Assigned at Birth

Female	105	85.4%	18	14.6%	108	78.3%	28	20.3%	105	83.3%	20	15.9%
Male	289	86.0%	45	13.4%	264	84.3%	47	15.0%	276	85.2%	45	13.9%

Race/Ethnicity

NH Black	249	86.2%	38	13.1%	223	80.5%	51	18.4%	235	83.9%	43	15.4%
Hispanic	49	90.7%	*	*	58	84.1%	10	14.5%	52	83.9%	8	12.9%
NH White	88	83.8%	17	16.2%	72	90.0%	8	10.0%	82	86.3%	13	13.7%
Multi-race	7	77.8%	*	*	19	82.6%	*	*	12	92.3%	*	*
Asian	*	*	*	*	*	*	*	*	*	*	*	*
Other/Unknown	*	*	*	*	*	*	*	*	*	*	*	*

Age at Death

0-12	*	*	*	*	*	*	*	*	*	*	*	*
13-19	*	*	*	*	*	*	*	*	*	*	*	*
20-24	*	*	*	*	*	*	*	*	*	*	*	*
25-29	6	75.0%	*	*	*	*	*	*	*	*	*	*
30-39	23	76.7%	7	23.3%	40	72.7%	15	27.3%	32	84.2%	*	*
40-49	54	85.7%	9	14.3%	48	78.7%	12	19.7%	49	89.1%	6	10.9%
50-64	178	90.8%	18	9.1%	166	81.8%	36	17.7%	163	83.2%	31	15.8%
65+	131	82.4%	27	17.0%	112	88.9%	12	9.5%	129	84.3%	23	15.0%

Transmission Risk

MSM	95	81.2%	22	18.8%	95	83.3%	19	16.7%	89	78.8%	21	18.6%
PWID	124	87.3%	17	12.0%	121	87.7%	17	12.3%	121	87.1%	18	12.9%
MSM/PWID	28	84.8%	*	*	27	96.4%	*	*	27	84.4%	*	*
Heterosexual	133	87.5%	19	12.5%	116	74.8%	37	23.9%	133	87.5%	18	11.8%
Pediatric	*	*	*	*	*	*	*	*	*	*	*	*
Other	*	*	*	*	*	*	*	*	*	*	*	*
No Reported Risk	12	92.3%	*	*	12	80.0%	*	*	10	76.9%	*	*

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

2024 data not shown due to delays in reporting cause of death. Due to rounding and the exclusion of unknown cause of death, percentages may not add up to exactly 100%.

Source Philadelphia Department of Public Health, Division of HIV Health

Reporting Information

Who Must Report?

All HIV Testing Providers, Healthcare 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 people who are Philadelphia residents AND
- All people 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?

These 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 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 the following 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).

Authors and Contributors

PRIMARY AUTHORS

Melissa Miller Kim, MPH
Epidemiologist

Tanner Nassau, PhD, MPH
Epidemiologist

Briana Gibson, MPH
Epidemiologist

Gregoire Lamonge, MPH
Data Manager

Erika Y. Solomon, M.Ed
HIV Surveillance Program
Manager

Kathleen A. Brady, MD
Director/Medical
Epidemiologist

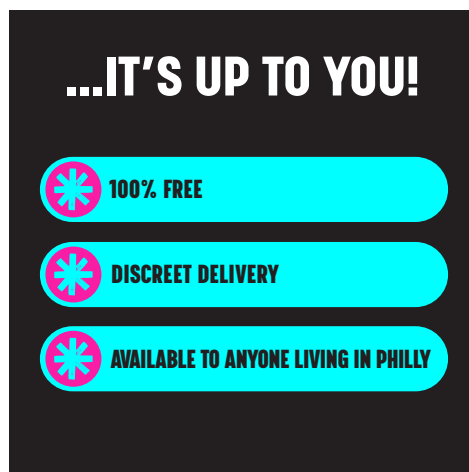
AACO SURVEILLANCE CONTRIBUTORS AND EDITORS FOR THIS ISSUE

HIV Surveillance Staff
Barbara Allen
Juanita Johnson
Nancy Lang
Erika Solomon
Niya Spells
Jinto Thomas
Stephanie Whetts
LaTonya Williams

Data Management Staff
Briana Gibson
Natalie Kratz
Gregoire Lamonge
James McDonnell
Melissa Miller Kim
Denise Mulbah
Tanner Nassau
Ashlyn Nikles
Nitzana Spiegel
Ngwi Tayong
Inaya Wahid

MMP Staff
Kevin Davis
Katina Dorsey
Martell Randolph-Rutter
Ashley Walker-Hamilton
Shareen Wise

NHBS Staff
Andrea Lamour-Harrington
Antonio McFadden



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 2024 and reported through June 2025.

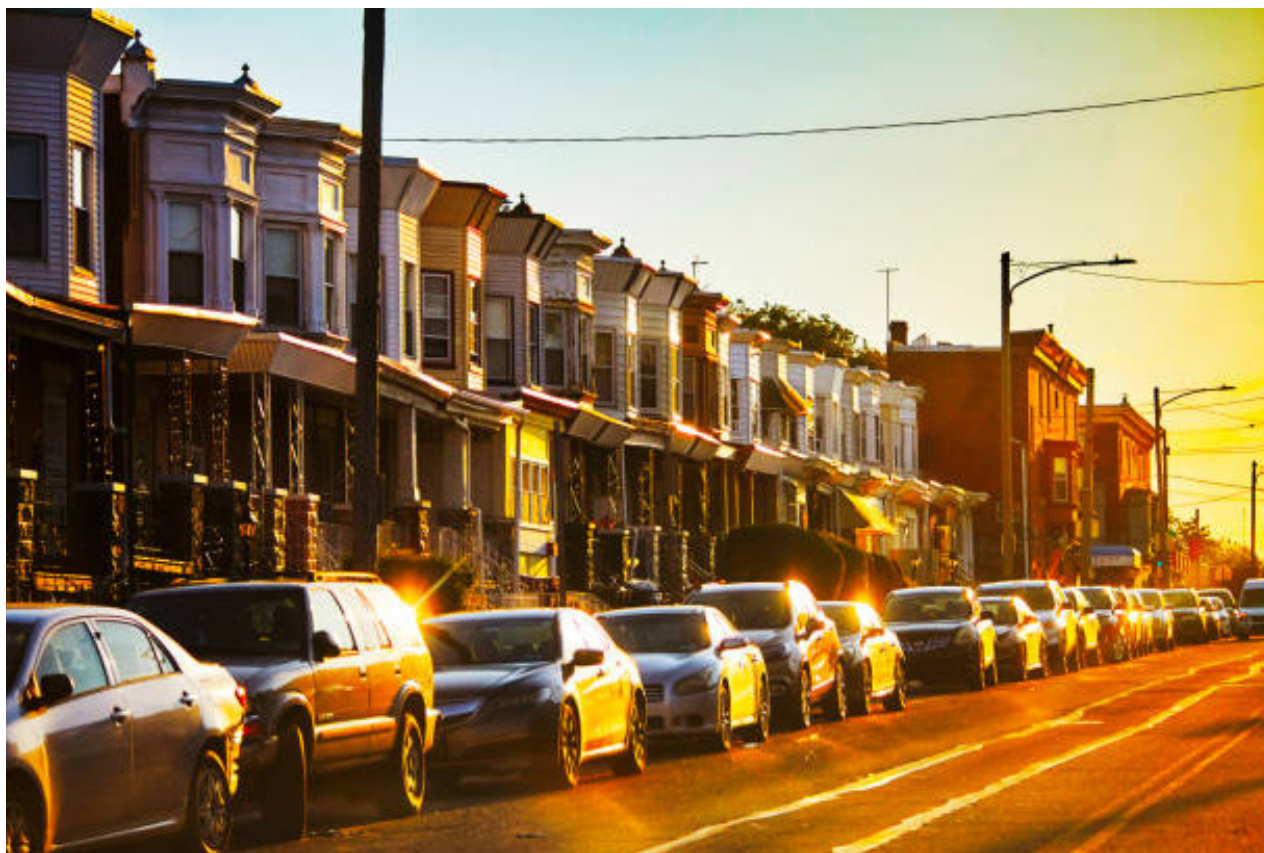
HIV surveillance is the ongoing and systematic collection, analysis, and dissemination of population-based information on HIV. There are two basic types of surveillance; active and passive. Passive surveillance is submission of HIV case reports from physicians, laboratories, and other individuals or 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

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



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

Melissa Miller, MPH

AACOEPI@PHILA.GOV

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



Department of
Public Health
CITY OF PHILADELPHIA