Hepatitis

HIV/AIDS

STDs

Annual Epidemiology and Surveillance Report

Data Through December 2022

Government of the District of Columbia
DC Health
HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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MURIEL BOWSER, MAYOR

TB

Acknowledgments

This report was compiled through the combined efforts of many individuals in the District of Columbia Department of Health's HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration. This report would not have been possible without the hard work, dedication, and contribution of health care providers, community groups, researchers, and members of the community.

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This report is available online at: https://dchealth.dc.gov/service/hiv-reports-and-publications

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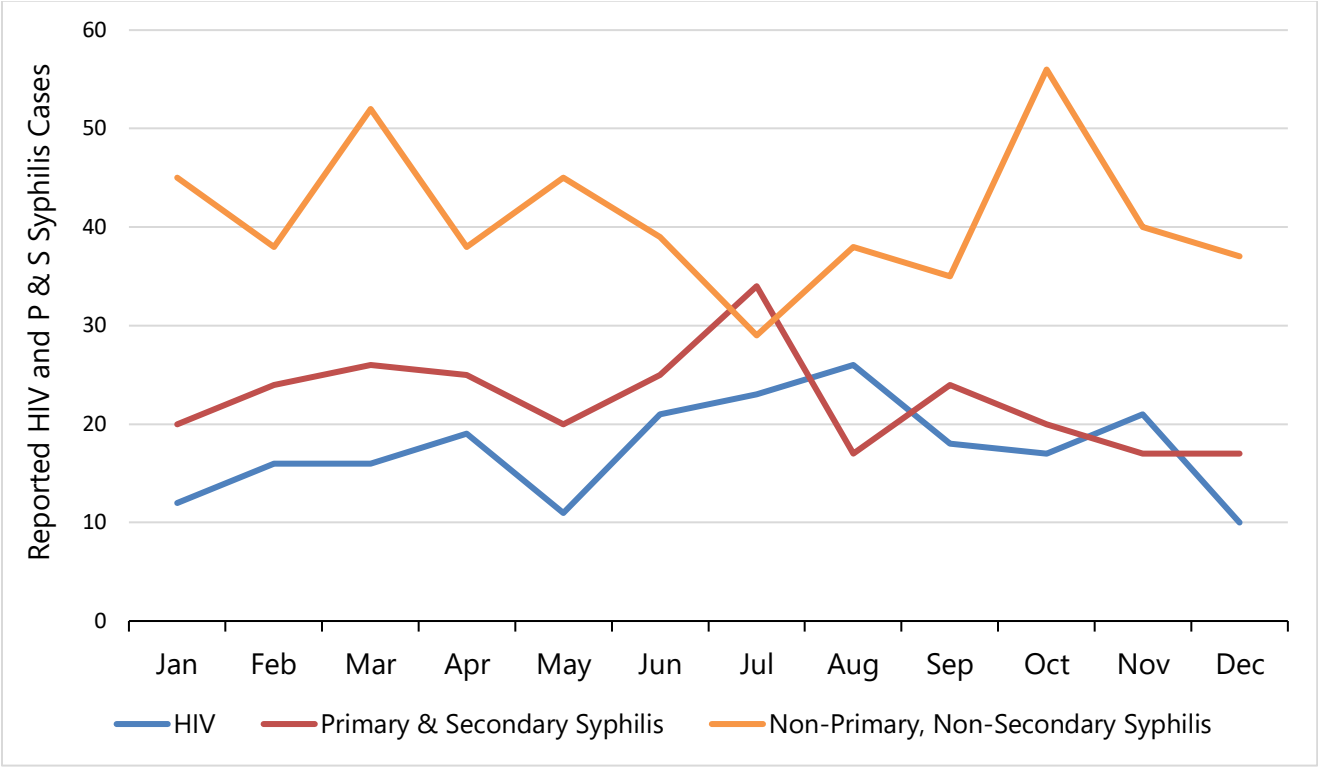
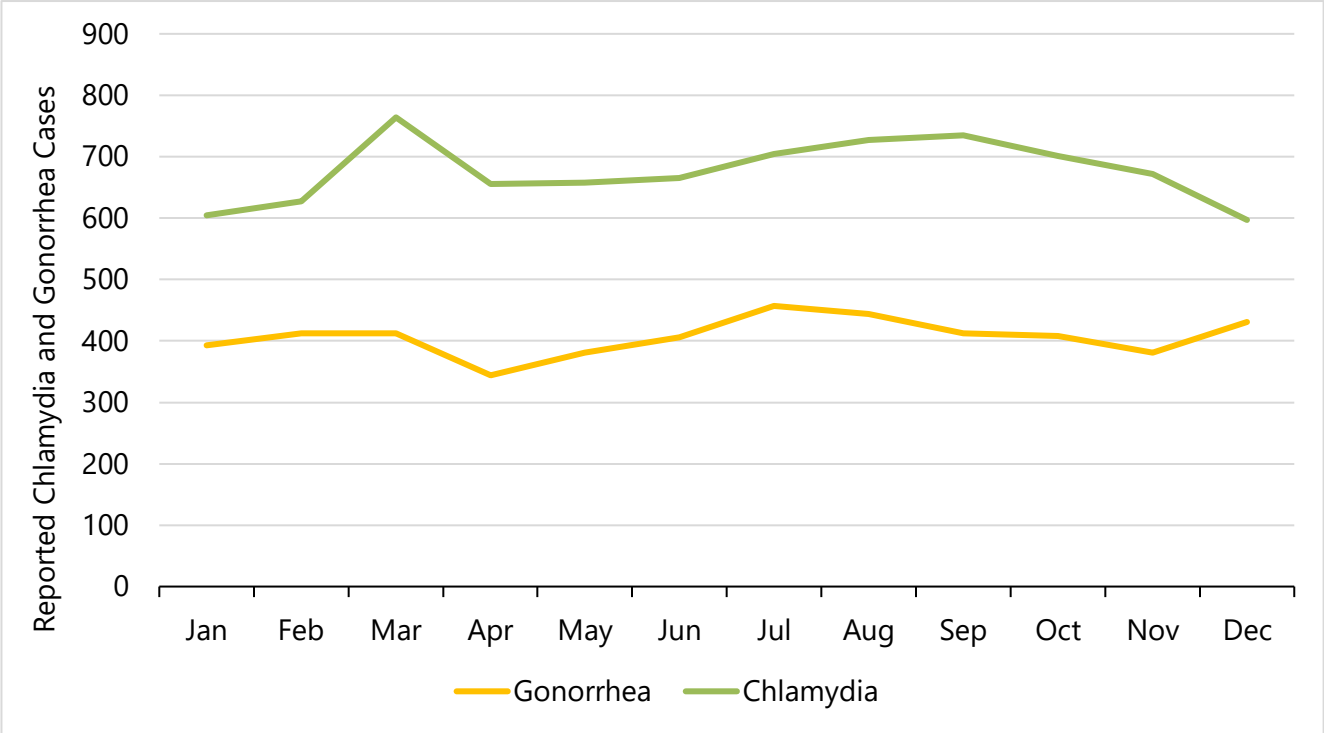
Executive Summary

The Annual HIV, Hepatitis, Sexually Transmitted Infections (STIs), and Tuberculosis (TB) Surveillance Report for the District of Columbia shows the District continues to experience complex epidemics. Annual surveillance data is critical to our understanding of disease trends and to our planning and programmatic efforts to control and prevent disease. The data in this year's report must be examined in the context of the COVID-19 pandemic recovery. The pandemic had an immense impact on the availability, accessibility, and utilization of disease screening, prevention, and care services, which still have not returned to pre-pandemic levels. Care seeking behaviors, especially those surrounding preventive measures are still lagging. DC Health and numerous clinical and community providers are continuing service delivery models to improve access and convenience for residents, such as offering home-based testing and virtual supports, that began during the COVID-19 pandemic.

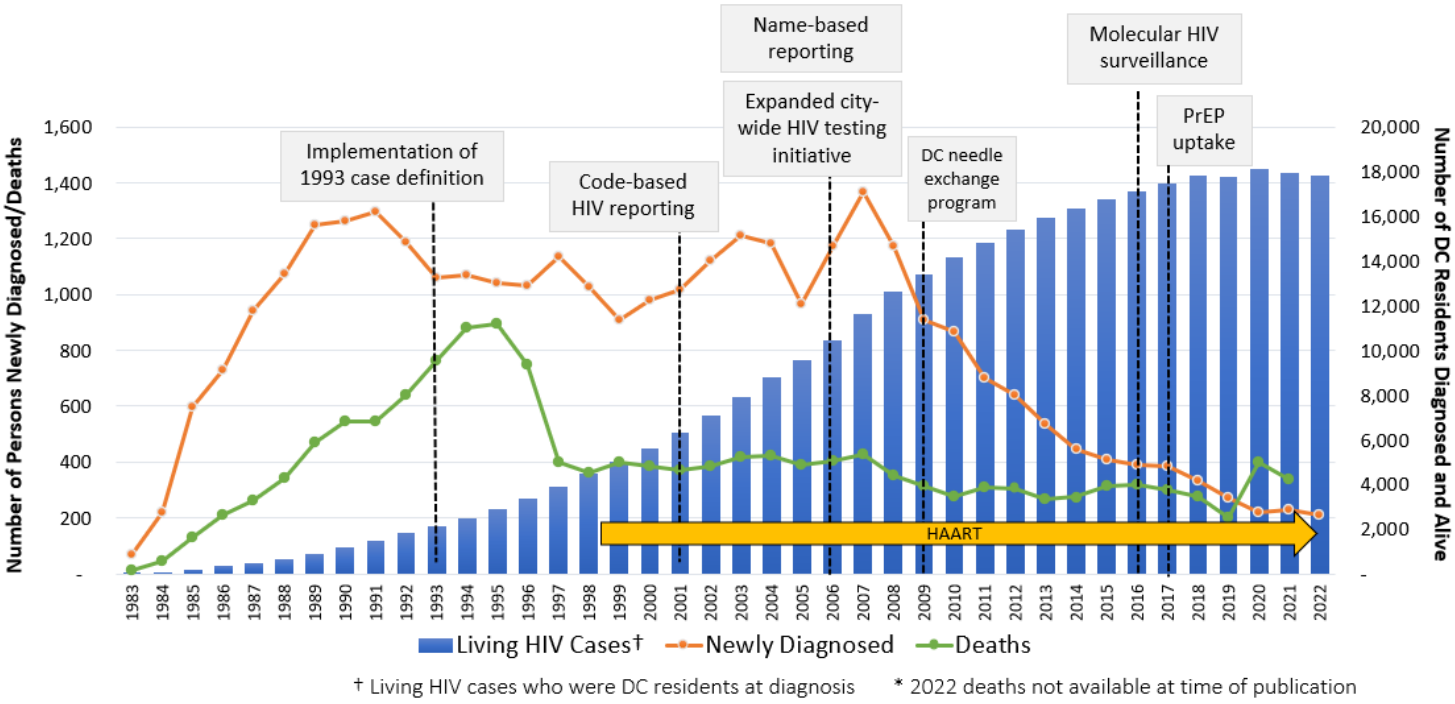
Figure 1. Newly reported HIV, Syphilis, Chlamydia, and Gonorrhea cases by month, District of Columbia, 2022





DC Health continues to closely monitor the impact of HIV, hepatitis, STIs, and TB on our community and to work with District partners to ensure access to prevention and treatment services for all our residents.

Figure 2. Newly Diagnosed HIV Cases, Deaths, and Living HIV Cases, by Year, District of Columbia, 1983-2022



Key points in this surveillance update of the District in the year 2022 include:

- 11,747 current residents of the District of Columbia or 1.7% of the population are living with HIV.
- The number of newly diagnosed HIV cases in the District was 210 cases in 2022, a decline of 85% from the peak of 1,374 cases in 2007.
- There were zero babies born with HIV in 2022.
- The number of newly diagnosed HIV cases attributable to injection drug use or MSM/injection drug use doubled from 7 in 2021 to 15 in 2022.
- Black and Latino individuals living with HIV exceeded 1% of their respective population, at 2.8% and 1.3% respectively.
- Most people living with HIV in DC (74%) are 40 years old and older with 58.5% being over 50 years old.
- Young people aged 17-24 represented 18.6% of newly diagnosed HIV infections in 2022, a 5% increase from 2021.
- Sexual contact is the leading mode of transmission reported among newly diagnosed HIV cases.
- There were 8,111 cases of chlamydia, 4,811 cases of gonorrhea, and 269 cases of primary and secondary syphilis reported in 2022.
- The number of primary, secondary, and early non-primary non-secondary syphilis cases increased by 10% from 692 in 2021 to 761 in 2022.
- 7% of primary, secondary, and early non-primary non-secondary syphilis cases were among women.
- Congenital syphilis cases have quadrupled from 3 in 2019 to 12 in 2022.
- Newly reported hepatitis B cases decreased 22% from 2021 to 2022 from 194 to 152.
- There were 379 people with newly reported hepatitis C in 2022, which is an 8% increase from 2021.
- There were 15 TB cases in 2022, a 60% decrease since 2018.

HIV Care Continuum

DC Health tracks the District's efforts to improve the care continuum for people living with HIV to sustain their health from diagnosis to linkage and retention in care. The care continuum measures people linked to care, engaged in care, and with viral load suppression. Surveillance data includes all people known to be living in the District. DC Health administers the Ryan White CARE Program that serves more than half of all people living with HIV in the District. People achieving viral suppression maintain strong immune systems, achieve healthier outcomes, and cannot transmit HIV sexually to other people, known as Undetectable equals Untransmittable or U=U. The District saw improvements in the HIV care continuum in DC through 2022:

- Among people newly diagnosed with HIV in 2022, 58% were linked to medical care within 7 days of diagnosis and 83% within 30 days.
- Viral suppression in 2022 among all people living with HIV in DC remained at 69% overall and 85% among people with an indication of engagement in care.
- Among people newly diagnosed with HIV in 2022, 55.7% were virally suppressed within 90 days and 71.4% within 6 months.
- Of the 3,035 Ryan White clients with one or more medical visits, 97% were prescribed treatment, and 84% were virally suppressed in 2022.

Ending the HIV Epidemic

The federal Ending the HIV Epidemic: A Plan for America (EHE) offers a new opportunity to accelerate key strategies and promote innovative approaches towards diagnosing, preventing, treating, and responding to HIV. On December 4, 2020, DC Mayor Muriel Bowser announced the release of the District's updated ending the HIV epidemic plan and new community platform DCEndsHIV.org. For this updated plan, Washington, DC follows the four pillars of the federal Ending the HIV Epidemic of Diagnose, Treat, Prevent, and Respond. The Plan values health equity and recognizes structural barriers, such as racism and stigma, to optimize health outcomes and individual success. It also centers on people's life experiences, including social determinants of health. To reflect these critical factors, the DC Ends HIV plan adds a fifth pillar: Engage. In addition, the plan has raised the floor to a minimum of 95%/95%/95% of people knowing their HIV status, people diagnosed being on treatment, and people on treatment reaching viral suppression, respectively. The new plan also has a primary goal of fewer than 21 new HIV diagnoses per year by 2030. To achieve this, DC must increase uptake and use of Pre-Exposure Prophylaxis (PrEP), setting a goal of helping more than 13,000 people get on PrEP. The DC Ends HIV plan was developed and informed through substantial community engagement, and as a public-private partnership among DC Health, DC Appleseed Center, and the Washington AIDS Partnership.

Scaling Up Success

The District Government and its community partners continue to scale up programs to reduce the impact of HIV, STIs, hepatitis, and TB on residents of Washington, DC. These successes are the most recent achievements by the District:

- GetCheckedDC (https://www.getcheckeddc.org/) supported 897 at-home tests for HIV and STIs and 3,393 walk-in tests at LabCorp for HIV, STIs, and hepatitis.
- The DC Health and Wellness Center prescribed PrEP for 1,176 people from October 1, 2021-September 30, 2022.
- DC Health distributed more than 2.2 million male and female condoms in 2022.
- Through the DC needle exchange programs, 746,788 needles were removed from the streets in 2022.
- The Ryan White Program provided HIV medical care and support services to 3,035 people in 2022.

Table 1. Mayor's Ending the HIV Epidemic Plan Goal Update, 2022

Ending the HIV Epidemic Measures	2018	2019	2020	2021	2022	2030 Goal
Goal #1: 95% of HIV-positive District residents know their status*	92.1%	93.0%	93.5%	93.9%	N/A	95%
Goal #2: 95% of District Residents living with HIV are in treatment	77%	80%	76%	78%	81%	95%
Goal #3: 95% of District residents living with HIV who are in treatment reach viral suppression	85%	87%	87%	86%	85%	95%
Goal #4: Reduction in new HIV diagnoses	330	274	213	224	210	21

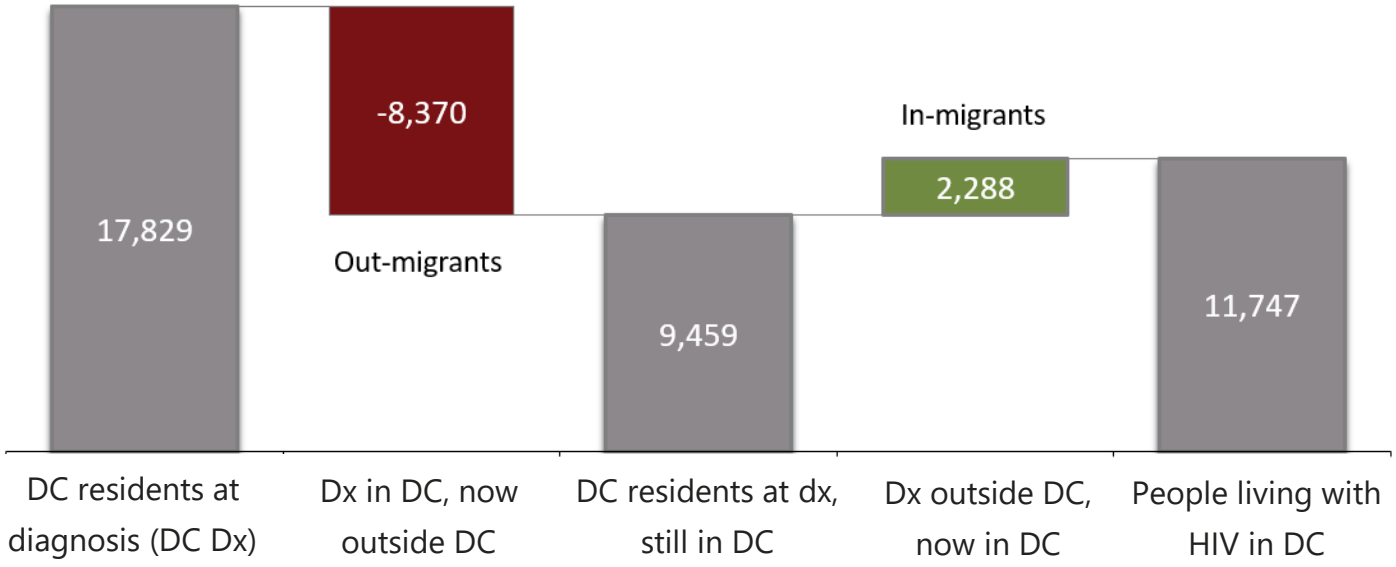
*2022 estimate not available at the time of publication. The number of persons with undiagnosed HIV infection is estimated by subtracting cumulative diagnoses from cumulative infections using a standardized CD4-Based Model developed by CDC.

People Living with HIV in DC

HIV (*Human immunodeficiency virus*) is an infection that can be transmitted sexually, from mother to child during pregnancy and birth, and by sharing needles. HIV weakens the immune system, so if left untreated, it can progress to stage 3 HIV, commonly referred to as AIDS (acquired immunodeficiency syndrome) over time. AIDS allows opportunistic infections (OIs) and cancers to take hold. OIs are illnesses that usually occur in people with weakened immune systems. There is no vaccine or cure for HIV; however, with proper medical care and effective treatment, the disease can be controlled. In DC, men who have sex with men (MSM), heterosexual Black women, transgender people, and youth aged 20-29 years old are particularly at risk of contracting HIV. Among MSM, Black men are at a specific further increased risk.

As presented in Figure 2, the number of all HIV diagnosed stands at 17,829. Figure 3 accounts for new HIV diagnoses among current District residents, reported deaths among those previously diagnosed, and the residential migration of people living with HIV in and out of the District over time. The report uses residence at last lab to more accurately assess the number of individuals diagnosed with HIV living within the District (Figure 3). This methodology not only provides a foundation for understanding the extent of HIV within the District, but also an improved baseline from which to evaluate the population coverage of HIV prevention and care activities.

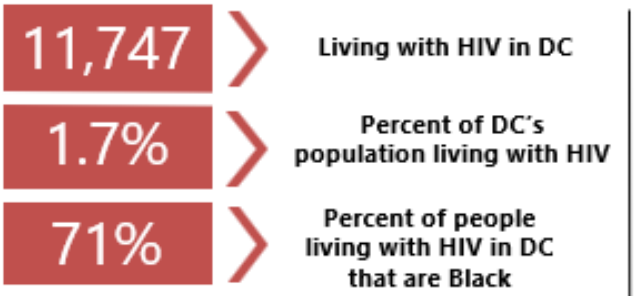
Figure 3. People Living with HIV in the District of Columbia as of December 31, 2022

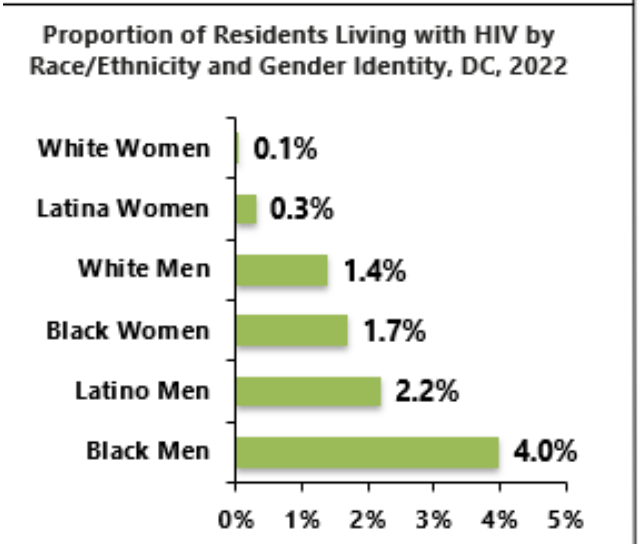


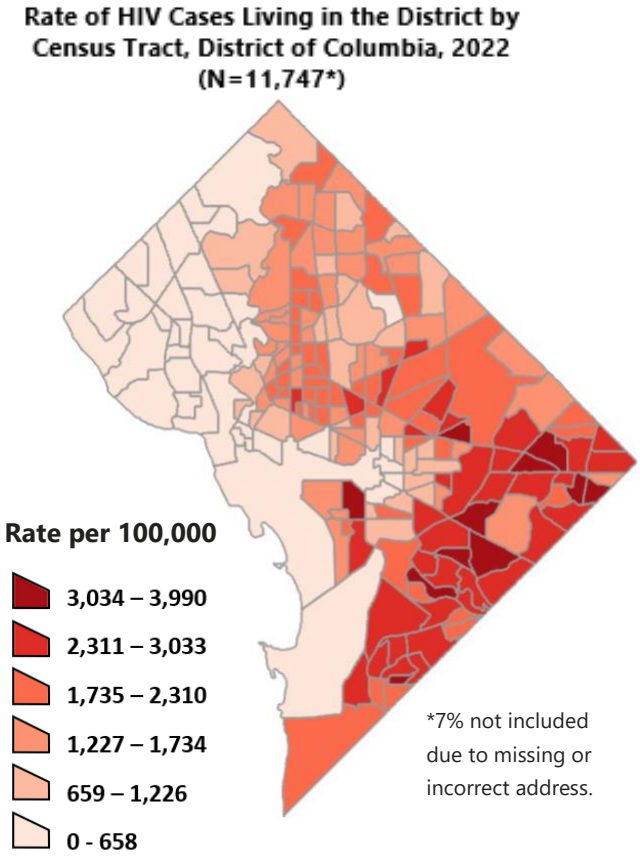
Estimation of the Number of People Living with HIV in DC

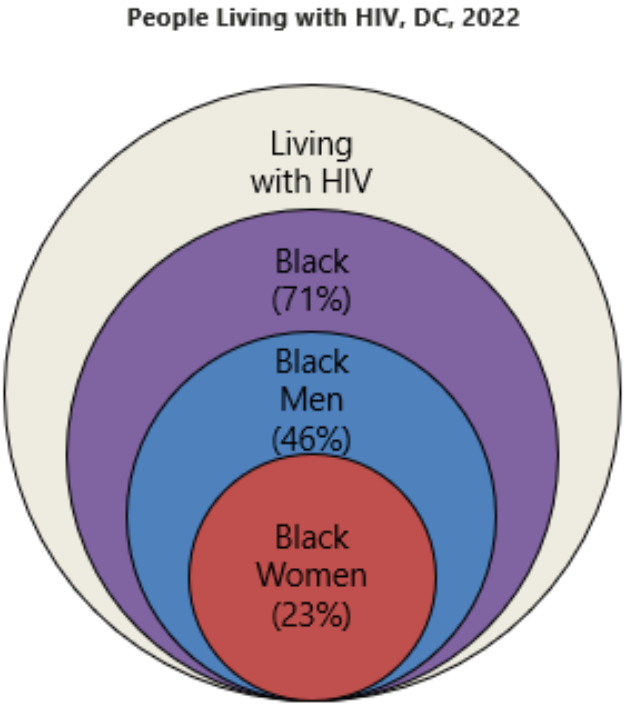
Of the 17,829 individuals diagnosed with HIV while a District resident, approximately 47% (n=8,370) were presumed to have moved outside of the jurisdiction (out-migration) prior to the end of 2022, as evidenced by a non-District residential address on their last reported laboratory report or the lack of any reported laboratory information for more than 5 years. Laboratory data was also used to assess the number of individuals diagnosed with HIV while a resident of other jurisdictions who have moved into the District over time (in-migration); HAHSTA identified 2,288 individuals initially diagnosed with HIV outside of the jurisdiction with a current residential address in the District. As indicated in Figure 3, after adjusting the initial count of all living HIV cases for in- and out-migration, an estimated 11,747 individuals diagnosed with HIV were presumed to be living in the District at the end of 2022. Detailed characteristics of people living with HIV based on residential migration status since diagnosis are included in **appendix tables B1-B4**. In the future, HAHSTA expects to refine the estimates further, as a result of improved data-sharing processes with surrounding jurisdictions and additional information sources for ascertainment of residential addresses.

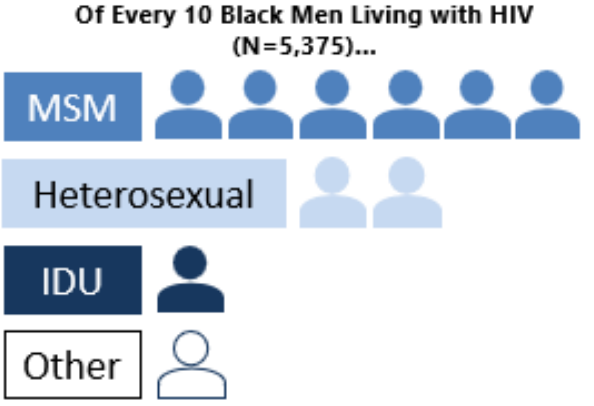
People Living with HIV

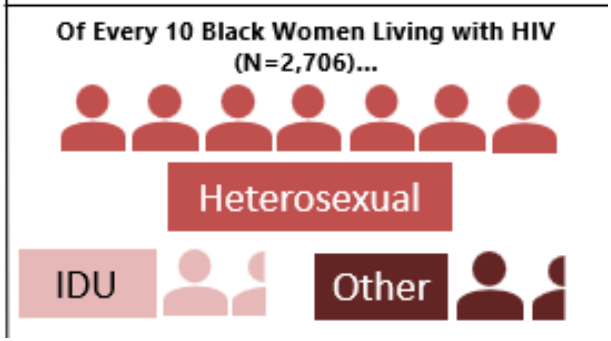






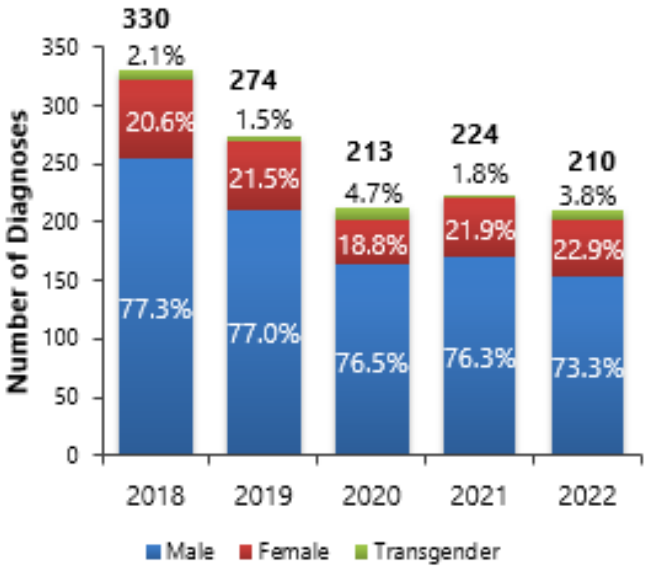






Newly Diagnosed HIV Cases

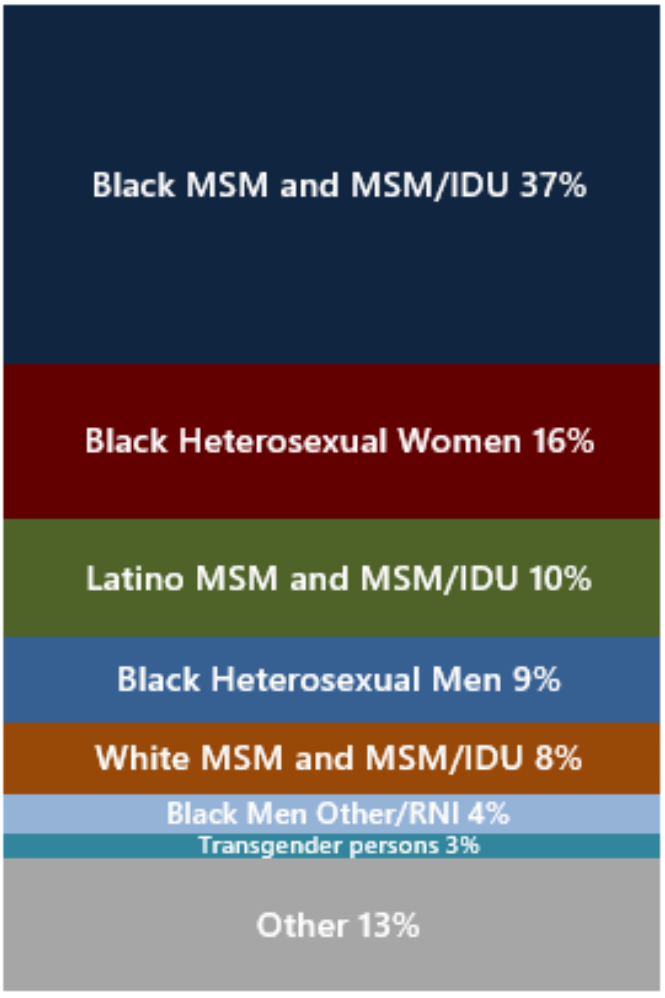
Newly Diagnosed HIV Cases by Year of Diagnosis and Gender Identity, District of Columbia, 2018-2022



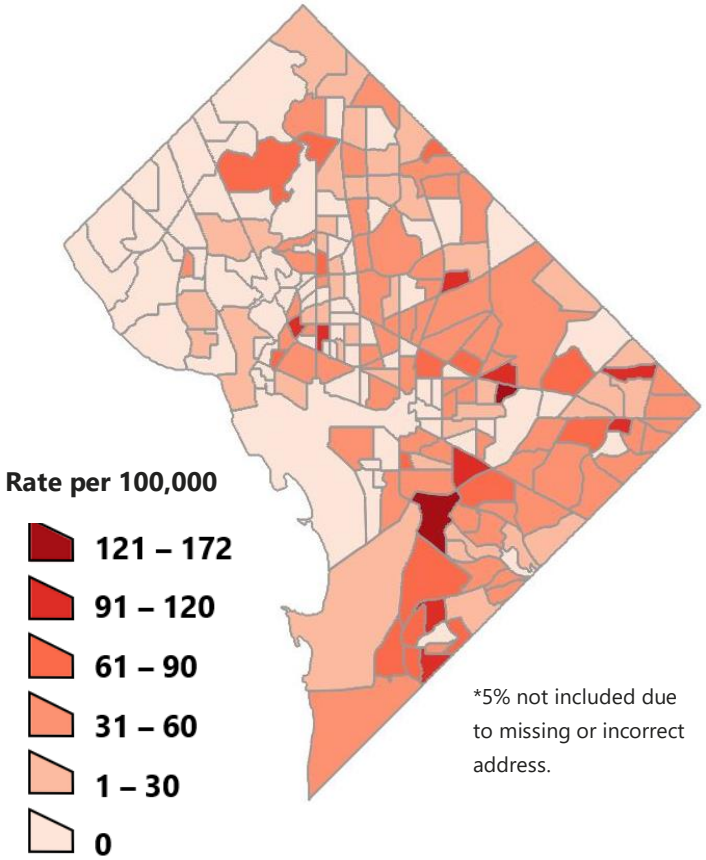
Newly Diagnosed HIV Cases in the District between 2018-2022

1 in 2 were Black Men	**1 in 2** were Men who have sex with men of color	**1 in 3** were aged 30-39	**1 in 5** Were Women of color

Proportion of Newly Diagnosed HIV Cases, by Race/Ethnicity, Gender Identity and Mode of Transmission, District of Columbia, 2018-2022, N=1,251



Rate of Newly Diagnosed HIV Cases in the District by Ward and Census Tract, District of Columbia, 2022 (N=210*)

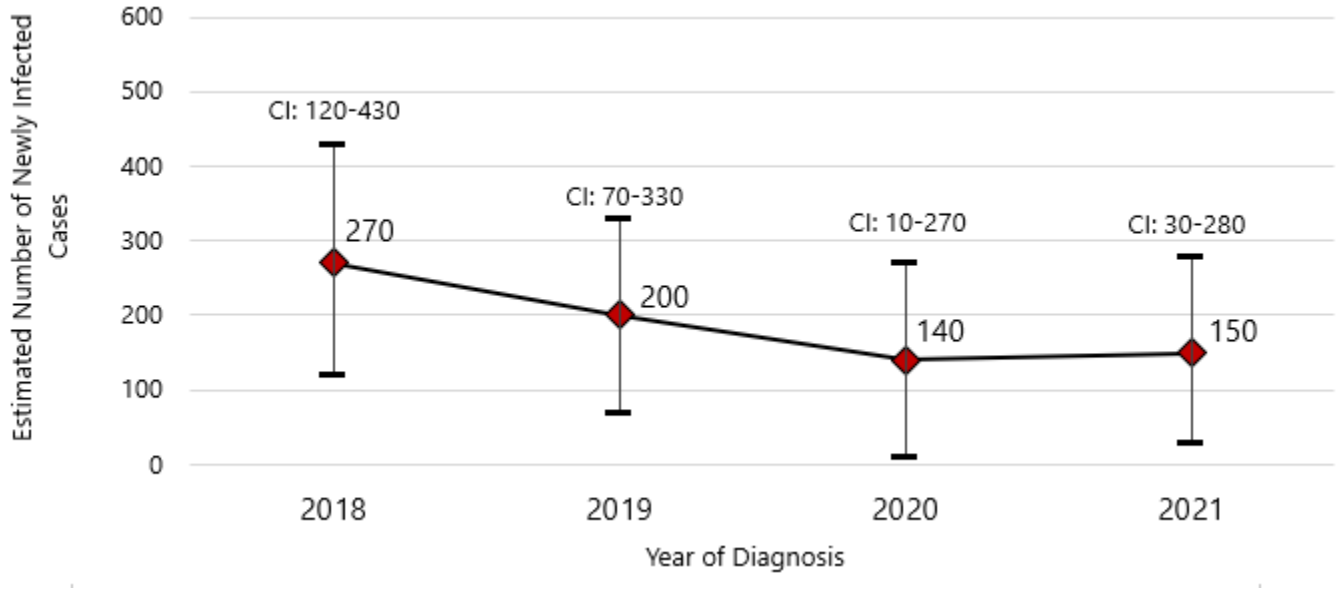


*5% not included due to missing or incorrect address.

Please refer to appendix table **B5-B7** for additional data regarding newly diagnosed HIV cases.

Incidence

Figure 5. Estimated Number of New HIV Infections by Year, District of Columbia, 2018-2021

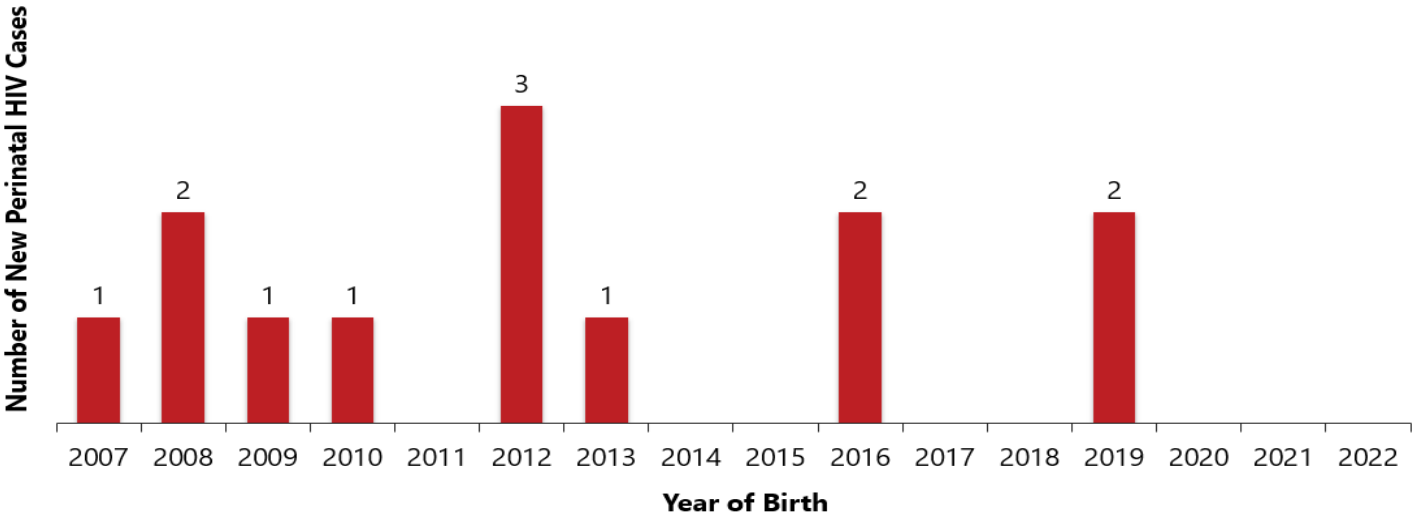


The estimated number of new infections of HIV in the District experienced an observed decrease from 2018 to 2021. The estimated rate of new infections in the District exceeded the national rate in 2021 at 27.0 estimated cases per 100,000 compared with 10.8 estimated cases per 100,000 respectively. The current CDC model for calculating incidence takes the COVID-19 pandemic into account when estimating rates. Since the number of new infections of HIV is an estimate, the 95% confidence interval shows the range within which the estimate may lie after adjusting for variability in sampling and timing of testing. The confidence intervals indicate that while there is an observed decrease in the estimated number of new HIV infections by year, that the actual trend may not exhibit the same trend over time because of the width of the confidence intervals for each estimate. Modeling for a 2022 incidence estimate was not available at time of publication.

Perinatal HIV

Perinatal HIV cases are defined as those in which transmission occurs during pregnancy, labor and delivery, or breastfeeding. Since the introduction of recommendations to provide antiretroviral medication to women during pregnancy, at labor and delivery, and to the infant in the neonatal period, there has been a 95% reduction in mother to child transmission of HIV nationally. Transmission rates among those who receive recommended treatment during pregnancy, at labor and delivery, and in the newborn period are as low as 1%. DC has had no perinatal HIV cases since 2019.

Figure 4. Perinatal HIV Cases by Year of Birth, District of Columbia, 2007-2022



Perinatal HIV Exposure Reporting

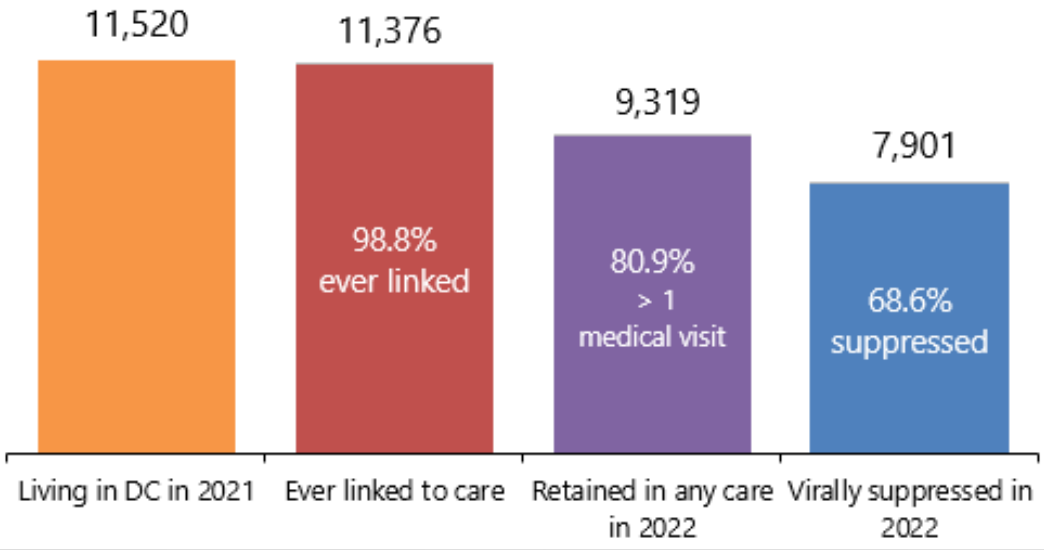
Perinatal HIV Exposure Surveillance is the collection, analysis, and reporting of data about infants born to women living with HIV. Such data allows for the identification of gaps in the prevention of mother-to-child transmission (i.e., inadequate prenatal care, detectable viral during pregnancy, adequate follow-up testing for infants, etc.) and can highlight the number of HIV infections averted when Perinatal Transmission Prevention Guidelines (https://clinicalinfo.hiv.gov/en/guidelines/perinatal/whats-new-guidelines) are followed. All suspected cases are reviewed by a dedicated Perinatal HIV Coordinator to ensure that all opportunities to provide services to both mother and child can be utilized.

Table 2. Perinatal HIV Exposures, District of Columbia, 2021-2022

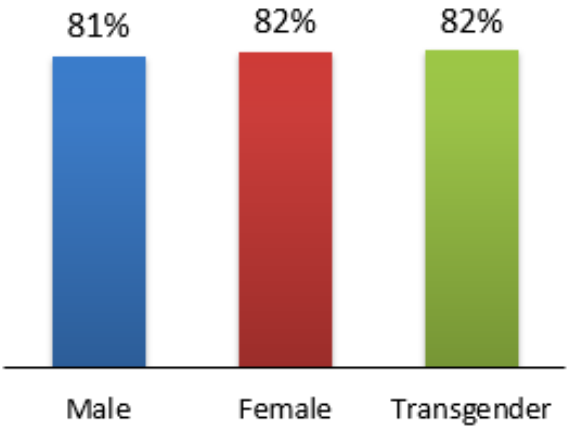
Year of pregnancy or delivery	**2021**	**2022**	**Total**
Number of women with HIV living in DC	3,096	3,015	6,111
Number of women who had live births	39	40	79
Women living with HIV who had live births			
Race/Ethnicity			
Black	35 (90)	32 (80)	67 (85)
White	0 (0)	2 (5)	2 (2)
Latina	2 (5)	1 (2)	3 (4)
Multi-race	2 (5)	5 (13)	7 (9)
Maternal median age at delivery, years	31	31	31
Pregnancy Outcomes			
On ART during pregnancy	32 (82)	34 (85)	66 (84)
Received prenatal care	30 (77)	31 (78)	61 (77)
Suppressed viral load at delivery	31 (79)	33 (83)	64 (81)
Type of delivery			
Vaginal	21 (54)	17 (42)	38 (48)
Cesarean	18 (46)	23 (58)	41 (52)
HIV-Exposed Uninfected (HEU) infants			
Total	40	40	80
Median birth weight, grams	3,065	3,077	3,077
Median follow-up time for infant's HIV tests, days	128	132	131
Tested at 4 months or older	38 (95)	31 (78)	69 (86)
Sex at birth			
Male	25 (62)	15 (38)	40 (50)
Female	15 (38)	25 (62)	40 (50)
Timing of delivery			
Term (≥38 weeks)	26 (65)	28 (70)	54 (68)
Late Preterm (36-37 weeks)	10 (25)	10 (25)	20 (25)
Preterm (≤35 weeks)	4 (10)	2 (5)	6 (7)

HIV Care Continuum

The HIV Care Continuum is the approach of diagnosing people with HIV, linking them into care and treatment, retaining them in care and medication adherence, and achieving viral load suppression, which is the marker of a person's and community's HIV health. Assessing HIV care dynamics is an essential step in understanding the strengths of HIV programs in the District, as well as an opportunity to identify and resolve gaps in the care continuum.



Retention in Any HIV Care among HIV Cases Living in DC, by Gender Identity, District of Columbia, 2022, N=11,520

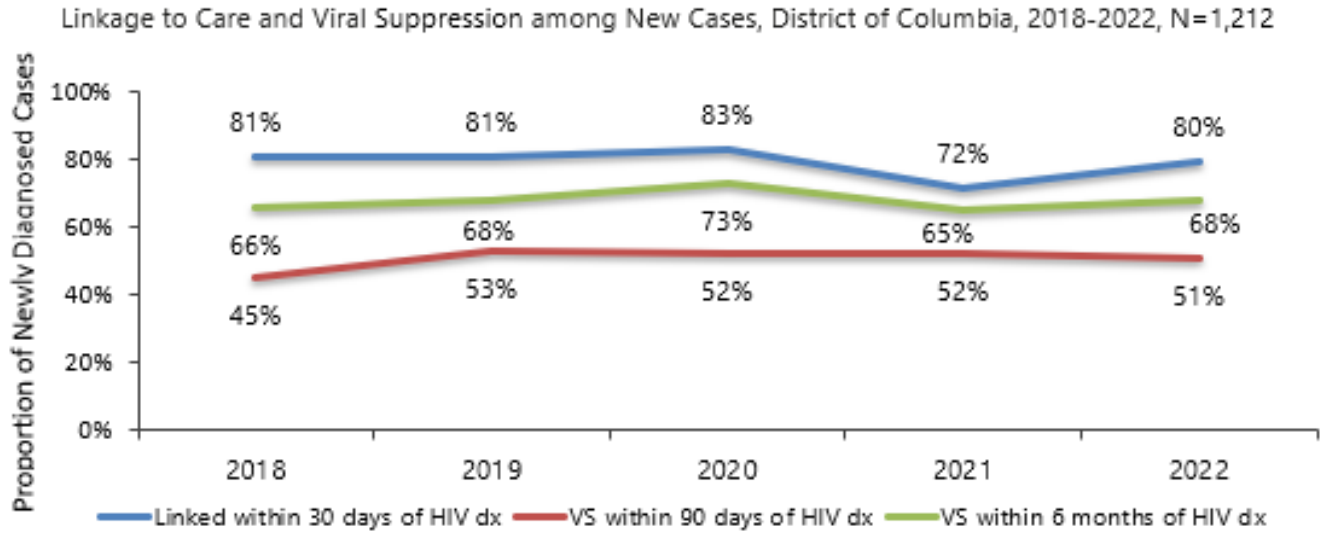


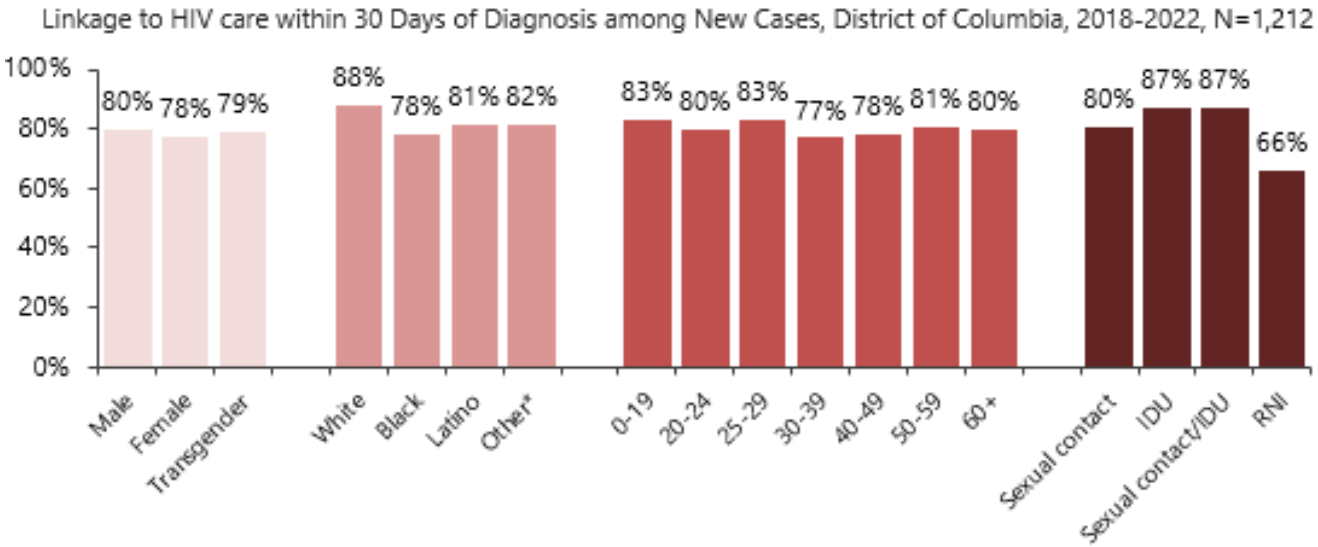
Please refer to appendix table **B8** for additional data regarding HIV care dynamics.

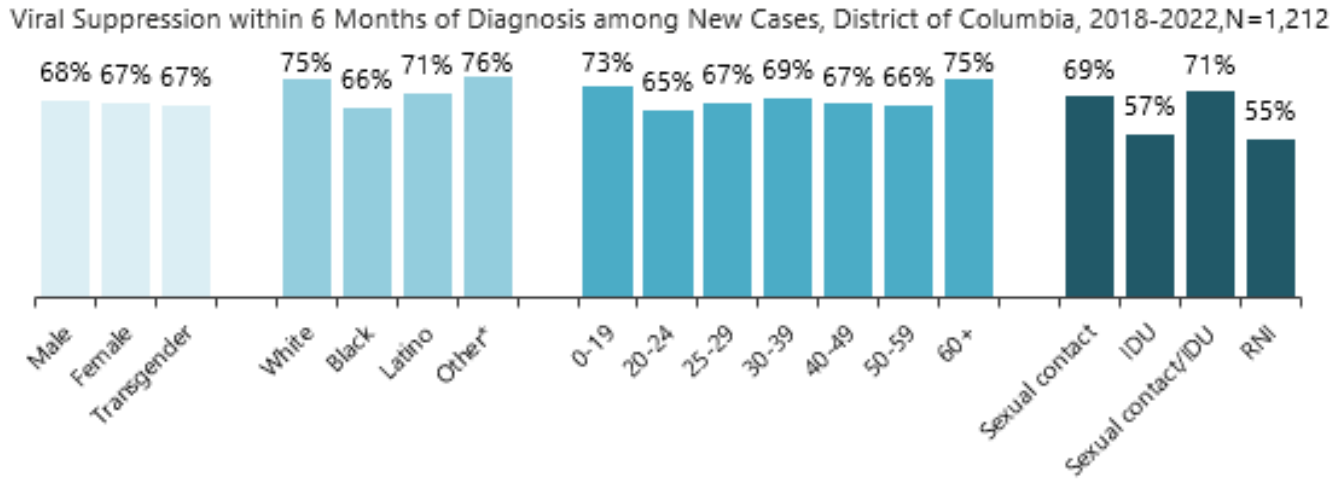
Of those newly diagnosed with HIV between 2018-2022...

57.2%
were linked to HIV care within 7 days of diagnosis

62
the median number of days to viral suppression







*Other race/ethnicity icludes American Indian, Asian, Pacific Islander, Hawaii/Alaska Native, multi-racial and missing

†IDU= Injecting drug user/People who inject drugs

^RNI= Risk not identified

Please refer to appendix table **B8-11** for additional data regarding the HIV care continuum.

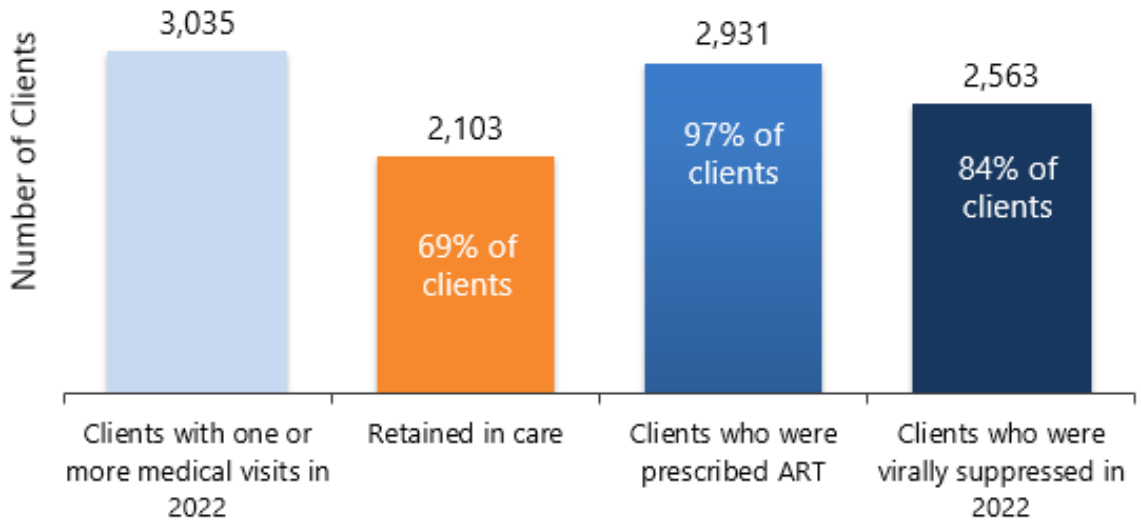
Ryan White Program HIV Care Continuum

HIV care metrics among Ryan White Program clients in the District were examined to evaluate clients on the care continuum. This continuum of care differs from what has been presented on the previous pages in several ways. First, the population used is a subset of the total number of HIV cases living in the District. These cases are not newly diagnosed in a given year, but these are HIV cases who received at least one Ryan White CARE Program-funded medical visit in 2022. Second, care status was measured through documented medical visits, rather than laboratory tests. Finally, information is included on the number of clients who were prescribed HIV treatment.

Table 3. Ryan White Program HIV Care Continuum Measure Definitions

Measure	Definition
Clients with one or more medical visit	Ryan White clients with at least one documented primary care visit in 2022
Retained in care in 2022	Having 2 or more medical visits in 2022 that were at least 90 days apart
Prescribed ART	Ryan White clients with documentation of having been prescribed antiretroviral therapy (ART) to treat HIV
Virally suppressed in 2022	Having a viral load result of <200 copies/mL at most recent viral load test in 2022

Figure 6. HIV Care Continuum among Ryan White Clients, District of Columbia, 2022



Please refer to appendix table **B12** for additional data regarding the HIV Care Continuum among RW clients.

Transmitted Drug Resistance

- A transmitted drug resistance mutation (TDRM) is a HIV sequence mutation identified in an individual with no evidence of antiretroviral (ARV) use within three months of diagnosis.
- Treatment guidelines recommend HIV genotypic testing at entry into care or if treatment failure is suspected.
- HIV genotyping performed >3 months after HIV diagnosis are more likely to be performed due to suspected treatment failure.
- Clinicians tailor ARV treatment for each person based on their individual analysis and report, but population level information is helpful for identifying changes in TDRM trends over time.

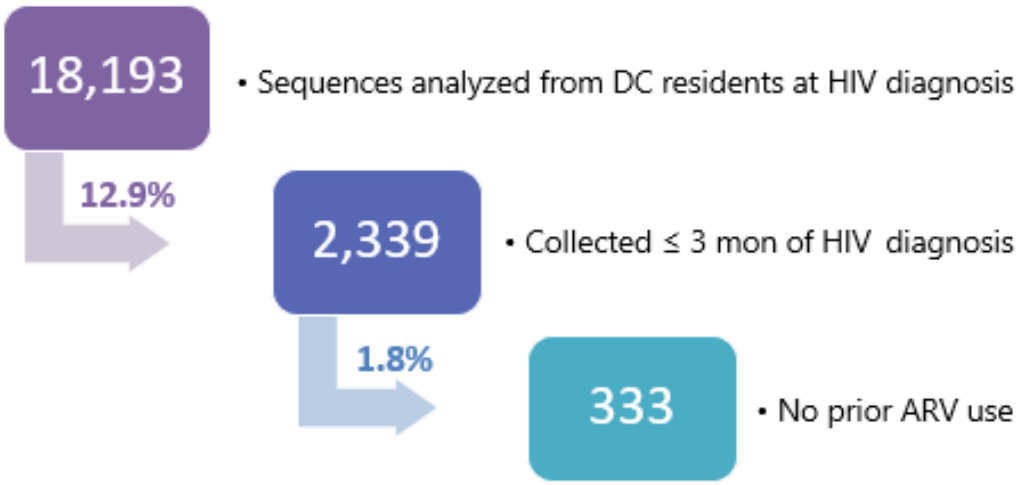


Table 4a. Drug class resistance among TDRMs in individuals with no evidence of ARV use, 2022

Total	Any TDRM		1-Class TDRM		2-Class TDRM		3-Class TDRM		4-Class TDRM	
N	N	%	N	%	N	%	N	%	N	%
333	62	18.6	47	14.1	10	3.0	4	1.2	1	0.3

Table 4b. Drug category resistance among TDRMs* in individuals with no evidence of ARV use, 2022

Total	NNRTI TDRM		NRTI TDRM		PI TDRM		INSTI TDRM	
N	N	%	N	%	N	%	N	%
333	42	12.6	21	6.3	15	4.5	5	1.5

*NNRTI: Non-Nucleoside Reverse Transcriptase Inhibitor
NRTI: Nucleoside and Nucleotide Analogue Reverse Transcriptase Inhibitors
PI: protease inhibitor | INSTI: Integrase inhibitor

- 18.6% of people with an eligible sequence had evidence of at least one TDRM, however, many mutations have no effect on ARV treatment
- The proportion of TDRMs did not differ by gender, age at HIV diagnosis, or race/ethnicity
- Only 4.5% had a mutation that affects more than 1 drug class
- Integrase and protease inhibitors are essential first line HIV treatment components and mutations to these drugs is rare
- Overall ARV combination therapies continue to be highly effective against the strains of HIV seen in the community, both in DC and nationwide.

HIV Mortality

Table 5. Primary Cause of Death among People Diagnosed with HIV by Year of Death, District of Columbia, 2018-2021**

	2018		2019		2020		2021	
Cause of Death	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
HIV-related causes	87	31.1	50	23.7	91	24.1	62	18.4
Non-AIDS Defining Malignancies	37	13.2	19	9.0	46	12.2	41	12.2
Cardiovascular	68	24.3	37	17.5	65	17.2	67	19.9
Substance Use	3	1.1	1	0.5	4	1.1	3	0.9
Accidental Death	28	10.0	23	10.9	45	11.9	60	17.8
Other*	44	15.7	22	10.4	89	23.5	75	22.3
Unknown	13	4.6	59	28.0	38	10.1	29	8.6
Total	280	100	211	100	378	100	337	100

* Other causes of death include suicide, pneumonia, chronic obstructive pulmonary disorder (COPD), diabetes, etc.
** Vital records information has a one year lag time, 2022 deaths were not available at the time of publication.

Please refer to appendix table **B13** for additional data regarding deaths among people diagnosed with HIV.

Sexually Transmitted Infections

Chlamydia

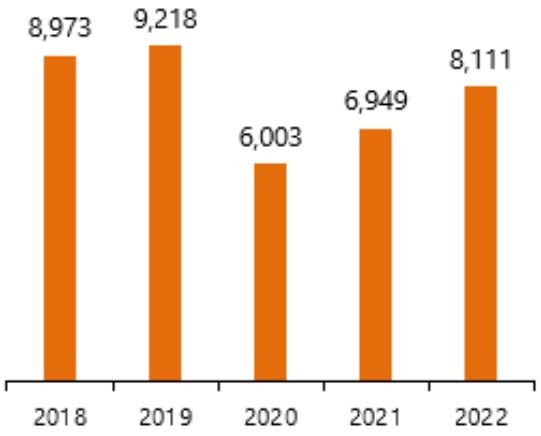
Chlamydia is the most reported sexually transmitted infection. It is caused by the bacteria *Chlamydia trachomatis* and transmitted through vaginal discharge or semen, and from mother to child during birth. Most people with chlamydia do not experience symptoms; however, when they do, symptoms may appear weeks after infection. Symptoms include frequent urination, burning with urination, and genital discharge. Men may also experience pain or swelling in their testicles. If left untreated, it can cause infertility in women. Having chlamydia increases the risk of acquiring HIV. Chlamydia can be cured with antibiotics and prevented with the use of condoms.

8,111 Number of diagnoses reported in 2022

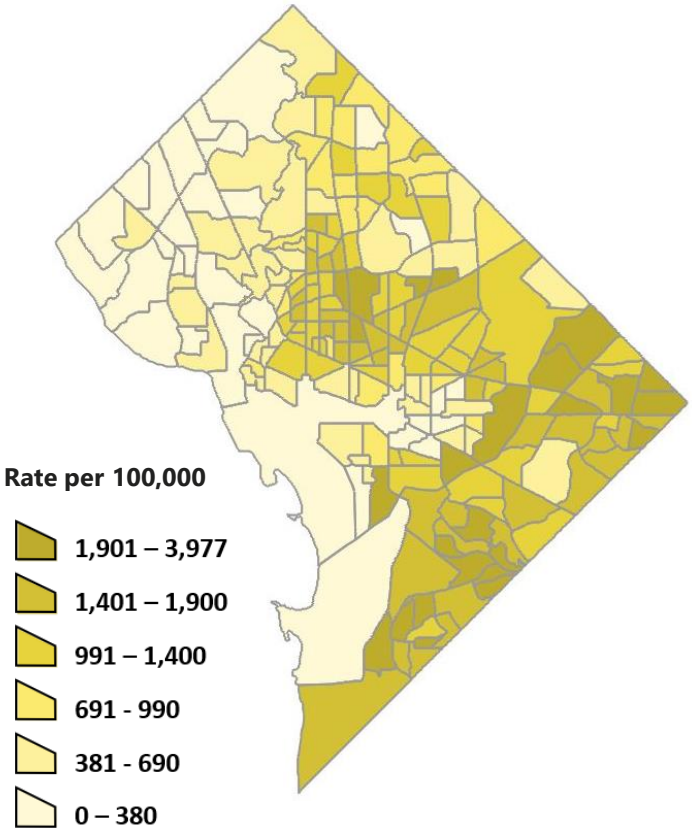
7% % of Chlamydia cases living with HIV in 2022

39,254 Newly diagnosed Chlamydia cases from 2018-2022

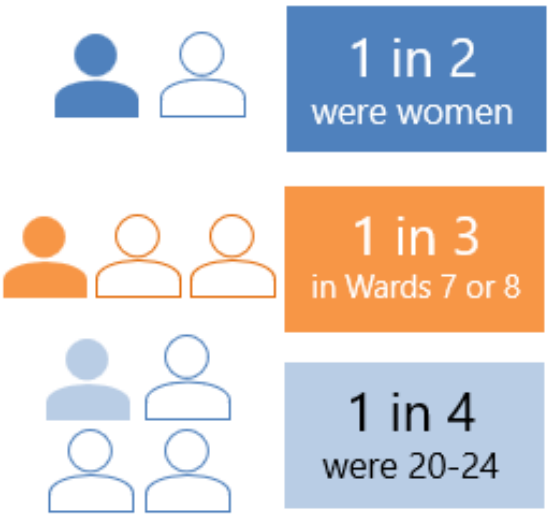
Newly Reported Diagnoses of Chlamydia, by Year, District of Columbia, 2018-2022



Rate of Newly Reported Diagnoses of Chlamydia, by Census Tract, District of Columbia, 2022 (N=8,111)



Of those newly reported with Chlamydia in DC in 2022...



Please refer to appendix table **B14** for additional data regarding newly diagnosed Chlamydia cases.

Gonorrhea

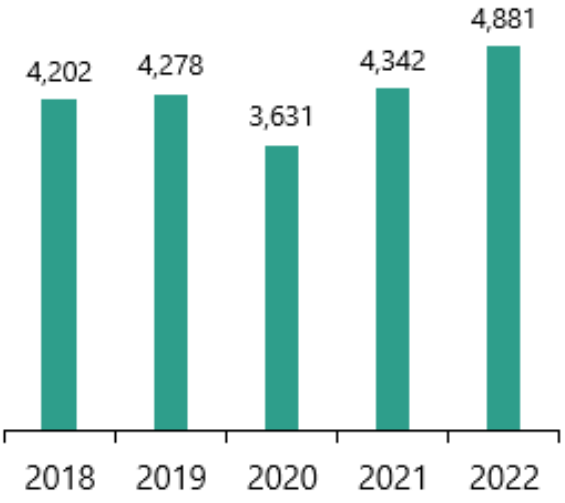
Gonorrhea is a very common infection caused by the bacteria *Neisseria gonorrhoeae* that affects the genitals, rectum, or throat. It is spread through sexual contact and from mother to child during birth. While many people with gonorrhea do not have symptoms, those who do may have pain, genital discharge, or burning with urination. Men may experience testicular pain or inflammation. Most women are asymptomatic, but when they have symptoms, they may experience vaginal bleeds between periods and pelvic pain. If left untreated, it can spread to the joints and other areas of the body, or cause infertility. Gonorrhea increases the risk of acquiring HIV. Gonorrhea can be cured with antibiotics and prevented with the use of condoms. Young people between 15 and 24 years of age are especially at risk.

4,811 Number of diagnoses reported in 2022

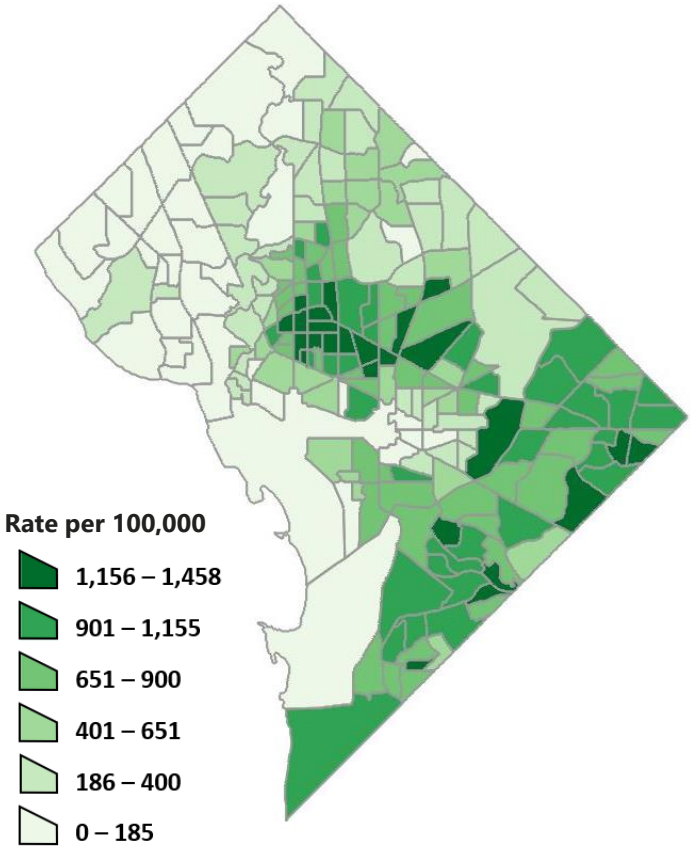
14% % of Gonorrhea cases living with HIV in 2022

26% % of Gonorrhea cases aged 13-19 years

Newly Reported Diagnoses of Gonorrhea, by Year, District of Columbia, 2018-2022



Rate of Newly Reported Diagnoses of Gonorrhea, by Census Tract, District of Columbia, 2022, (N=4,811)



Of those newly reported with Gonorrhea in DC in 2022...

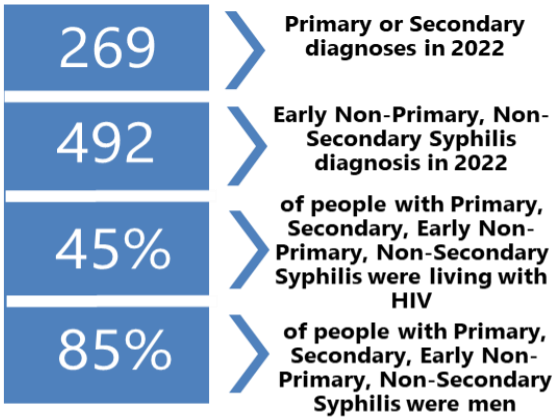
7 in 10 were men

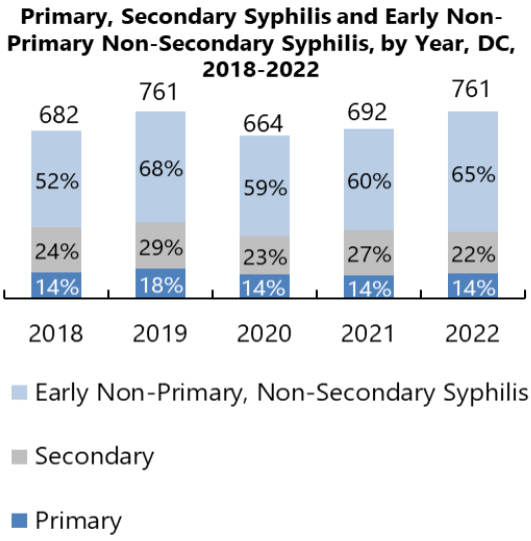
1 in 2 were < 30 yrs

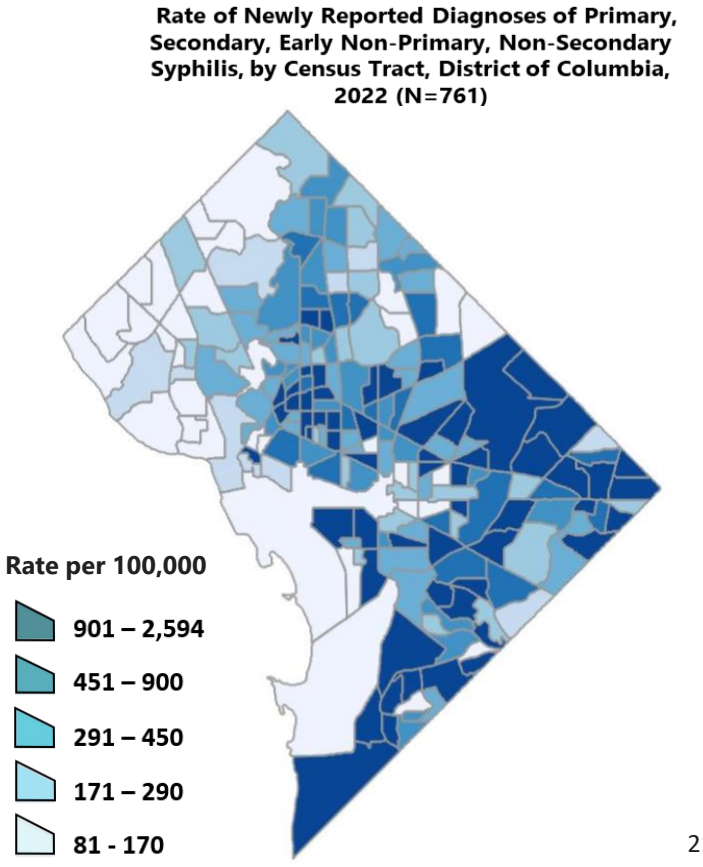
Please refer to appendix table **B15** for additional data regarding newly diagnosed gonorrhea cases.

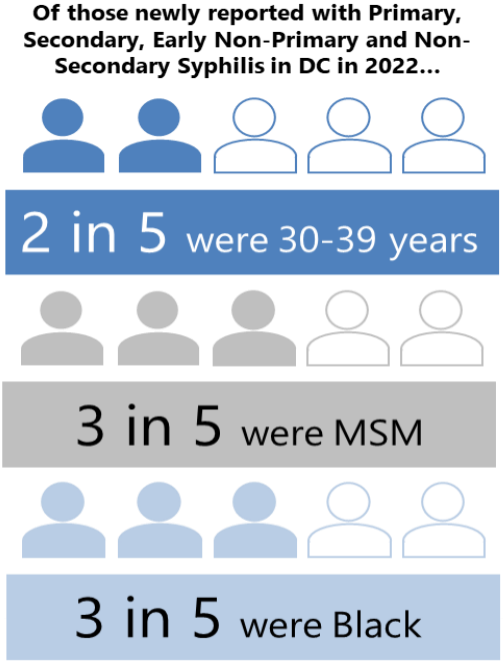
Syphilis

Syphilis is a sexually transmitted infection caused by the bacteria *Treponema pallidum*. Symptoms include a painless sore called "chancre" on the genitals, rectum, or mouth 3-90 days after infection (primary syphilis). A body rash usually in the palms of the hands or soles of the feet may appear 4-10 weeks after infection (secondary syphilis). After symptoms resolve syphilis moves into the early non-primary non-secondary stage. During this stage there are no current signs or symptoms, but there is evidence that the infection occurred within the past 12 months. Other symptoms experienced may include fever, swollen lymph glands, sore throat, and/or headache. After several years, syphilis may affect the brain, nerves, eyes, or heart (tertiary syphilis). Transmission can also occur from mother to child during pregnancy or at birth and result in low-birth weight, premature birth, or stillbirth. Syphilis can be cured with antibiotics.









Please refer to appendix table **B16** for additional data regarding newly diagnosed syphilis cases

Congenital Syphilis

Nationwide, there has been a sharp increase in congenital syphilis (CS) cases. A pregnant woman with syphilis can transmit the infection to her child at any point during the pregnancy and can result in adverse pregnancy outcomes. A baby born with CS may not have any signs and symptoms but can develop health problems later (e.g., blindness, deafness, bone deformity, etc.). DC Municipal Regulations require syphilis testing at the first prenatal visit and in the third trimester. Pregnant women with syphilis should be treated with the recommended penicillin regimen for their stage of infection.

Table 6. Congenital Syphilis Cases by Year of Birth, District of Columbia, 2019-2022

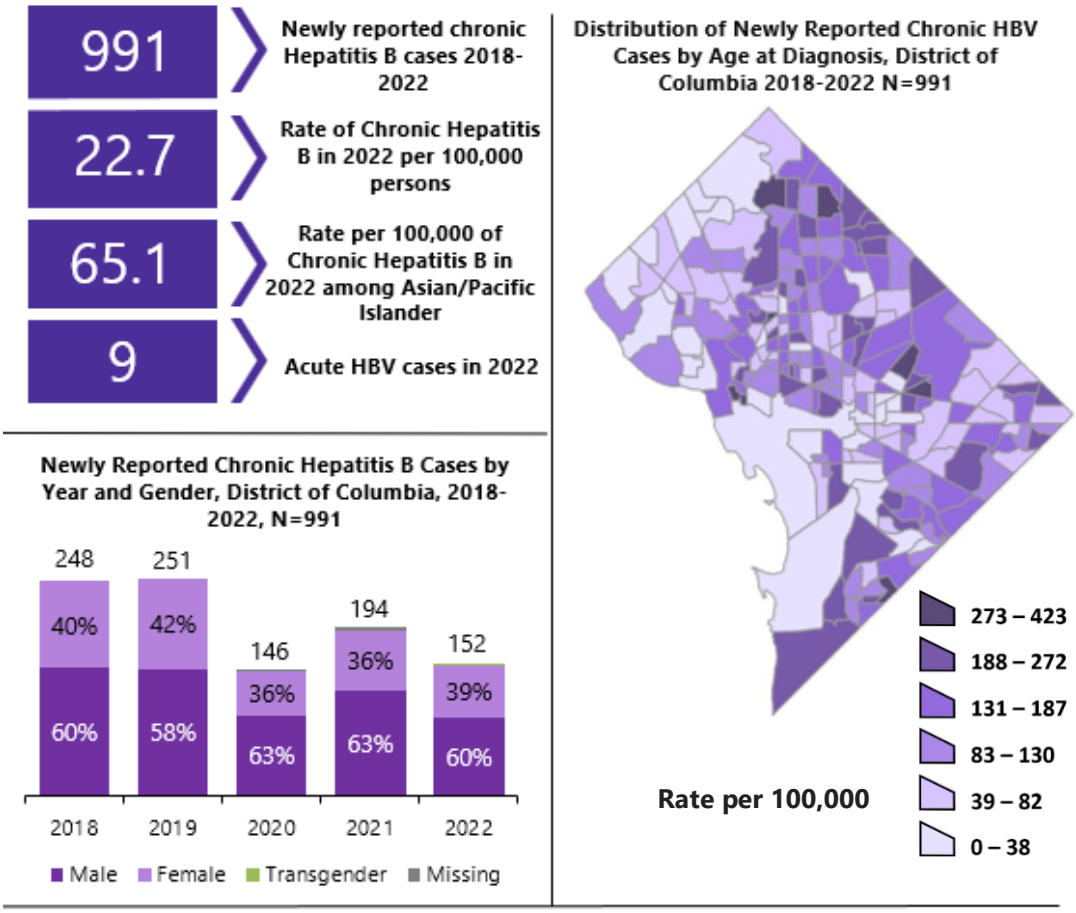
	2019		2020		2021		2022	
	N	%	N	%	N	%	N	%
Pregnant Women Diagnosed with Syphilis	19	100	22	100	18	100	26	100
Mother's Syphilis Stage								
Primary	0	0.0	1	4.5	0	0.0	2	7.7
Secondary	0	0.0	2	9.1	3	16.7	1	3.8
Early Non-Primary Non-Secondary	13	68.4	8	36.4	4	22.2	8	30.8
Late Latent or Unknown Duration	6	31.6	11	50.0	11	61.1	15	57.7
Mother's Race/Ethnicity								
Black	19	100	20	90.9	18	100	21	80.8
Latino	0	0.0	2	9.1	0	0.0	4	15.4
White	0	0.0	0	0.0	0	0.0	0	0.0
Other	0	0.0	0	0.0	0	0.0	1	3.8
Type of Delivery								
Live Birth	15	78.9	13	59.1	13	72.2	25	96.2
Stillbirth/Abortion/Miscarriage	1	5.3	1	4.5	5	27.8	0	0.0
Unknown	3	15.8	8	36.4	0	0.0	1	3.8
Treated Appropriately > 30 days prior to delivery								
Yes	12	63.2	15	68.2	12	66.7	15	57.7
No	5	26.3	4	18.2	6	33.3	11	42.3
Unknown/Other	2	10.5	3	13.6	0	0.0	0	0.0
Infants with Congenital Syphilis	3	100	5	100	6	100	12	100
Classification of Disease								
Probable	2	66.7	5	100	5	83.3	12	100
Confirmed	1	33.3	0	0	0	0	0	0
Syphilis Stillborn	0	0	0	0	1	16.7	0	0
Signs and Symptoms of CS								
Yes	1	33.3	0	0	1	16.7	2	16.7
No	2	66.7	5	100	5	83.3	10	83.3
Infant Vital Status								
Alive	2	66.7	5	100	5	83.3	12	100
Deceased	1	33.3	0	0	0	0	0	0
Stillborn	0	0	0	0	1	16.7	0	0
Sex at Birth								
Male	1	33.3	4	80.0	3	50.0	6	50.0
Female	2	66.7	1	20.0	3	50.0	6	50.0

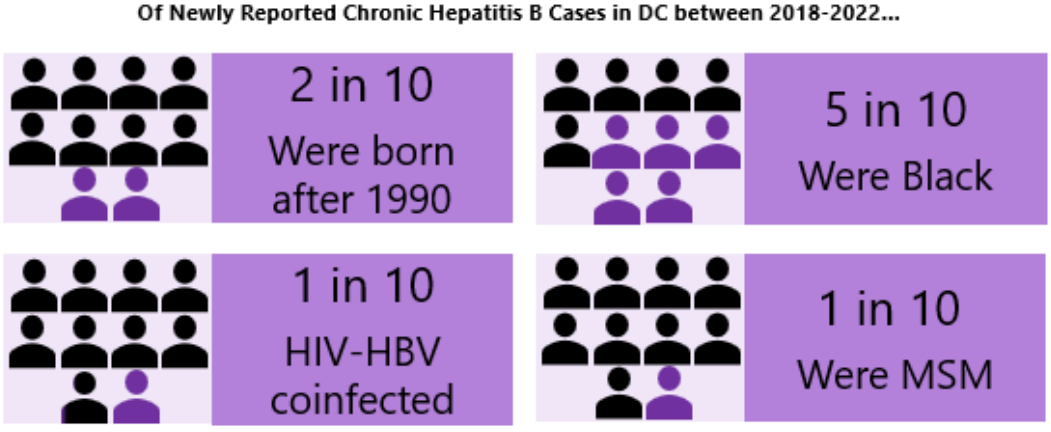
Timing of Delivery								
Term/Post Term (≥ 38 weeks)	1	33.3	2	40.0	5	83.3	6	50.0
Late Preterm (36-37 weeks)	0	0	2	40.0	1	16.7	1	8.3
Preterm (≤ 35 weeks)	2	66.7	0	0	0	0	5	41.7
Unknown	0	0	1	20.0	0	0	0	0
Median Birth Weight (grams)	2,940	NA	3,110	NA	3,213	NA	1,945	NA
Mother's Stage at Diagnosis								
Primary	0	0	0	0	1	16.7	0	0
Secondary	0	0	0	0	1	16.7	0	0
Early Non-Primary, Non-Secondary	3	100	3	60.0	1	16.7	3	25.0
Late Latent or Unknown	0	0	2	40.0	3	50.0	9	75.0
Mother's First Prenatal Care								
First Trimester	0	0	4	80.0	3	50.0	5	41.6
Second Trimester	0	0	1	20.0	0	0	2	16.7
Third Trimester	0	0	0	0	1	16.7	2	16.7
None/Unknown	3	100	0	0	2	33.3	3	25.0
Mother's Race/Ethnicity								
Black/African American	3	100	5	100	5	83.3	10	83.4
White	0	0	0	0	1	16.7	1	8.3
Latino	0	0	0	0	0	0	1	8.3
Mother's Median Age	24	NA	25	NA	28	NA	28	NA
Mother Co-infected with HIV	0	0	0	0	0	0	2	16.7

Viral Hepatitis

Hepatitis B

Hepatitis B is caused by the Hepatitis B virus (HBV). Men who have sex with men (MSM), hemodialysis patients, injection drug users, and babies born to HBV positive women are at increased risk for HBV. HBV infection can go undetected and approximately 2/3 of people infected are unaware of their infection. Most adults (95%) will resolve the infection on their own. However, 90% of infants and 25%-50% of children < 5 years will develop a chronic HBV infection. CDC recommends HBV vaccination for everyone 0 to 59 years of age and individuals 60 and older who have risk factors. HBV is not curable, but there are effective treatments available.





Perinatal Hepatitis B

DC Health's Perinatal Hepatitis B Program aims to identify Hepatitis B surface antigen positive (HBsAg+) women, provide newborn prophylaxis with Hepatitis B vaccine and Hepatitis B Immune Globulin (HBIG), ensure timely completion of Hepatitis B vaccine series, and ensure post-vaccination serologic testing (PVST) within 24 months.

Table 7. Perinatal Hepatitis B exposures, District of Columbia, 2020-2022

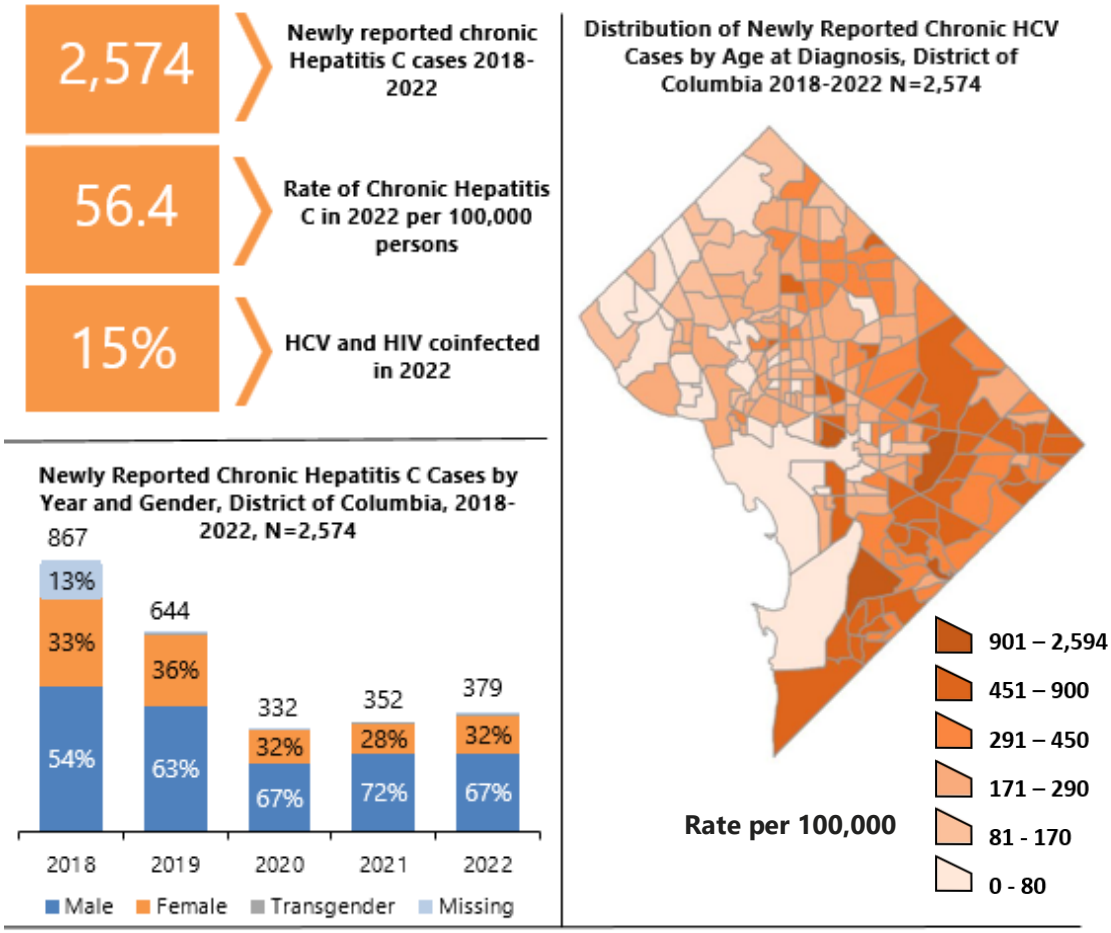
Birth Cohort	**2020**	**2021**	**2022**	**Total**
Mothers (N=58)	**N (%)**	**N (%)**	**N (%)**	**N (%)**
Number of women living in DC who are HBsAg positive	24	19	15	58
Maternal median age at delivery (years)	32	33	33	33
Race/ethnicity				
Black	15 (63)	13 (68)	12 (80)	40 (69)
White	1 (4)	0 (0)	0 (0)	1 (2)
Asian/Pacific Islander	7 (29)	6 (32)	3 (20)	16 (28)
Latina	1 (4)	0 (0)	0 (0)	1 (2)
Birth Country				
United States	6 (25)	3 (16)	2 (13)	11 (19)
Foreign-Born	18 (75)	16 (84)	12 (80)	46 (79)
Unknown	0 (0)	0 (0)	1 (7)	1 (2)
Infants (N=58)				
Birth Weight				
Under 2000 grams	0 (0)	0 (0)	1 (7)	1 (2)
2000 grams and over	24 (100)	19 (100)	14 (93)	57 (98)
Vaccines, exposures, testing				
Received HBIG within 24 hours of birth	24 (100)	18 (95)	14 (93)	56 (97)
Received 1st dose of Hep B vaccine within 24 hours of birth	24 (100)	19 (100)	14 (93)	57 (98)
Received complete Hep B vaccine series within 12 months*	22 (92)	19 (100)	13 (87)	54 (93)
Received post-vaccination serologic testing (PVST) within 24 months*	21 (88)	17 (89)	9 (60)	47 (81)
Tested Hep B Surface Antigen Positive	0 (0)	0 (0)	0 (0)	0 (0)

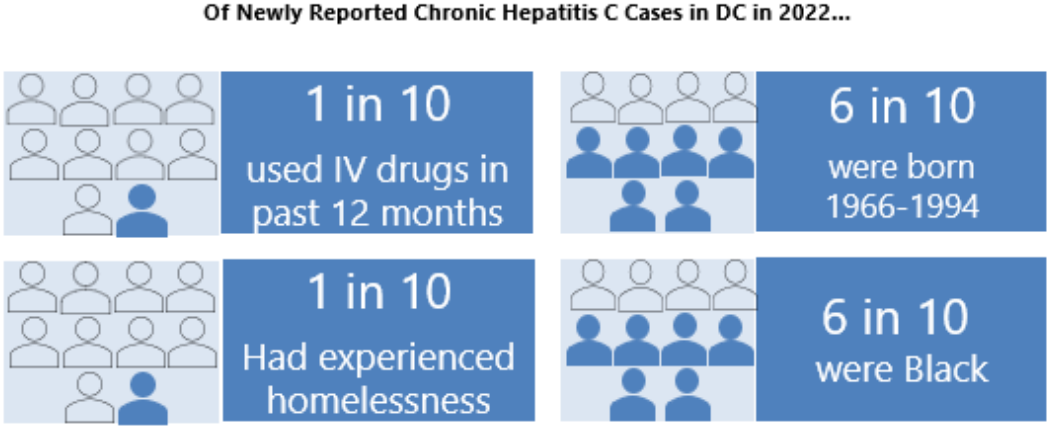
*Infant/mother pairs moved out of jurisdiction and transferred to another program or infants did not meet the age requirement of 9-12 months old for PVST testing.

Please refer to appendix table **B18** for additional data regarding reported Hepatitis B cases

Hepatitis C

Hepatitis C is caused by the Hepatitis C virus (HCV). In Washington DC, groups at highest risk for HCV include injection drug users, Men who have sex with men MSM, hemodialysis patients, and people that are unstably housed or have been incarcerated. Symptoms may include jaundice, dark colored urine, or light-colored stools. Approximately 50% of infected individuals will develop chronic HCV, which can lead to cirrhosis (25%) and hepatocellular carcinoma (4%). There are no vaccines for HCV, but effective treatments are available. There does exist an available and effective treatment for HCV which has been utilized by providers successfully. Due to the relative expense of the drugs used to treat HCV, this has presented a barrier to treatment access by many infected persons who belong to high-risk groups.



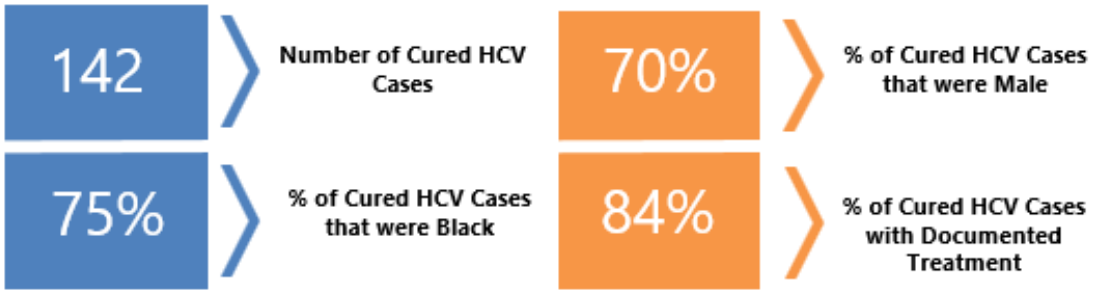


Please refer to appendix table **B19-20** for additional data regarding reported Hepatitis C cases.

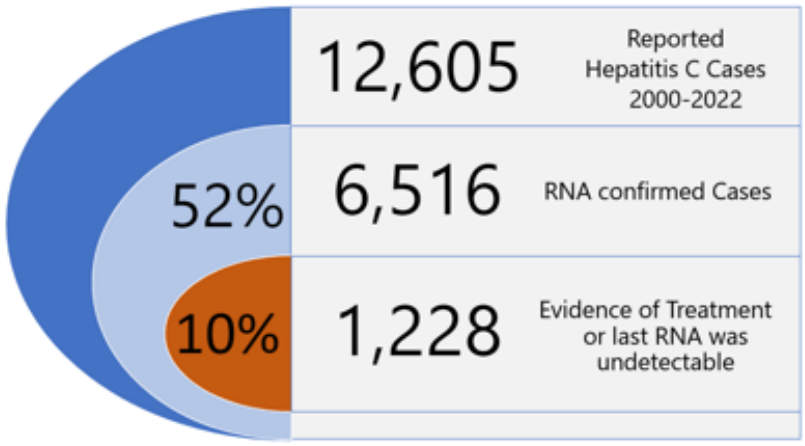
Hepatitis C Cure Cascade

Highly effective oral antivirals have been available to treat and cure hepatitis C (HCV) since 2014, however, access to the treatment has been limited. However, DC Medicaid removed the restrictions to receiving the treatment in 2022, which should lead to higher utilization of HCV treatments and increase the number of DC residents cured. Treatment is an 8–12-week regimen and cure is demonstrated through a negative viral load 12 weeks after treatment has ended. To be considered cured, individuals must have a negative HCV viral load lab ≥ 12 weeks after treatment.

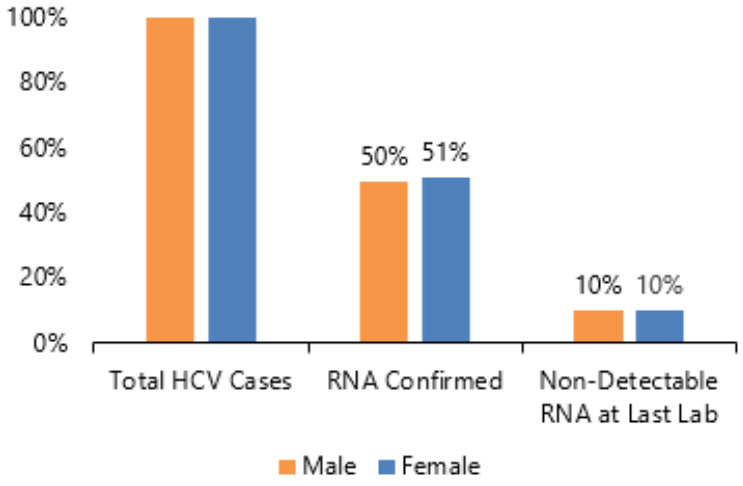
Cured Newly Reported HCV Cases, District of Columbia, 2018-2022



Cure Cascade for all Hepatitis C Cases Ever Reported, District of Columbia, 2022

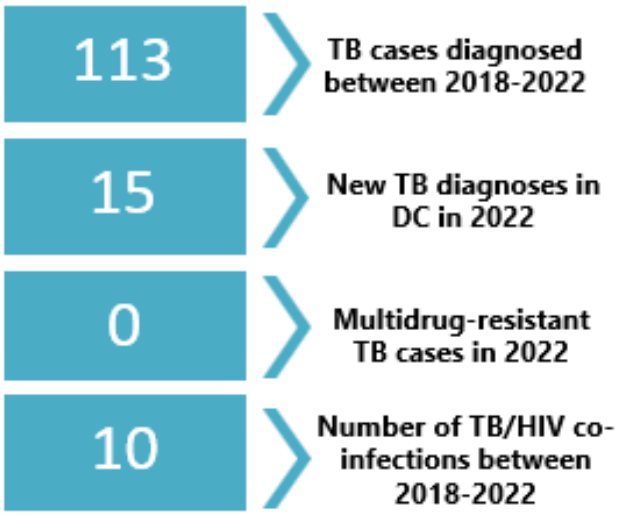


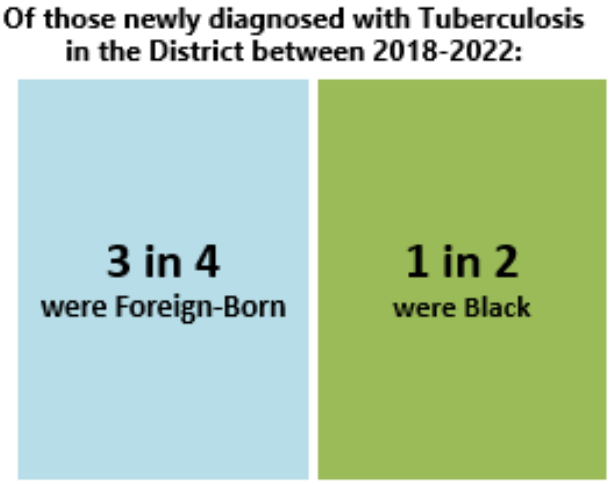
Cure Cascade for all Hepatitis C Cases Ever Reported, by Gender, District of Columbia, 2022

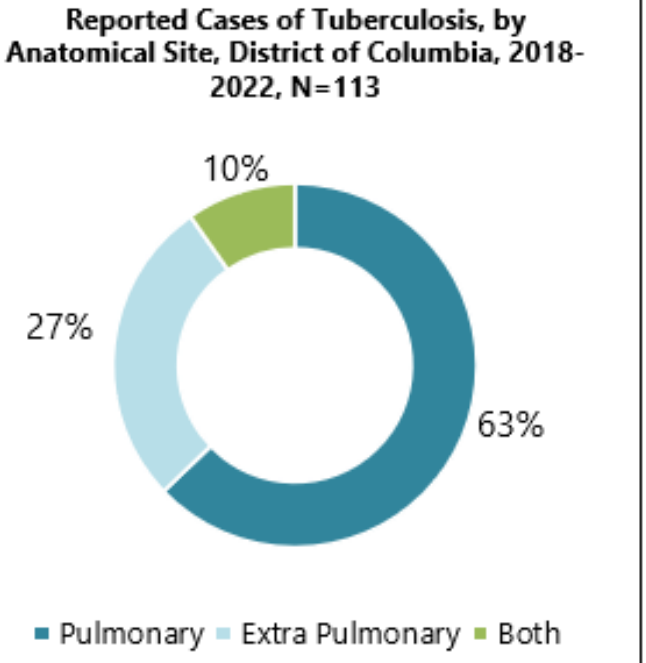


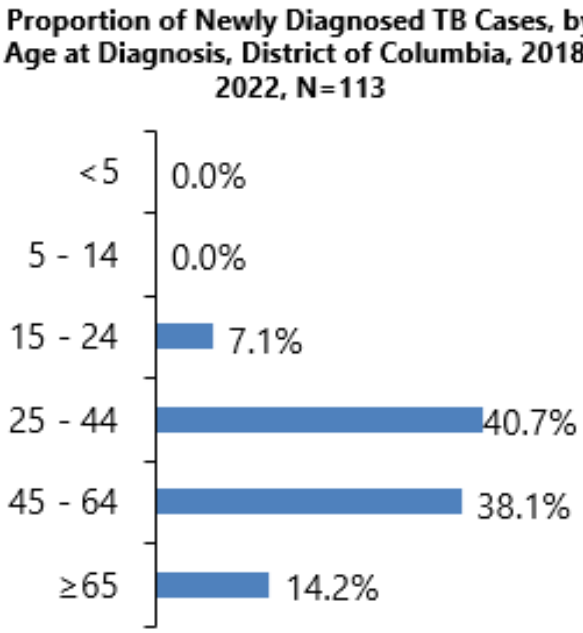
Tuberculosis

Tuberculosis (TB) is caused by the bacteria *Mycobacterium tuberculosis*. TB is spread from person to person through the air where infection can occur by sharing airspace for an extended period of time in an enclosed setting such as one's home or in a small office. TB usually affects the lungs, and bacteria are put into the air when a person with active TB of the lungs, coughs, sneezes, laughs, or sings. TB can also affect other parts of the body (extrapulmonary TB). TB can be cured if treated properly.









Please refer to appendix table **B17** for additional data regarding reported TB cases.

Women

3,016 Women living with HIV in DC in 2022

48 New HIV diagnoses among Women in 2022

3,763 Chlamydia diagnoses among women in 2022

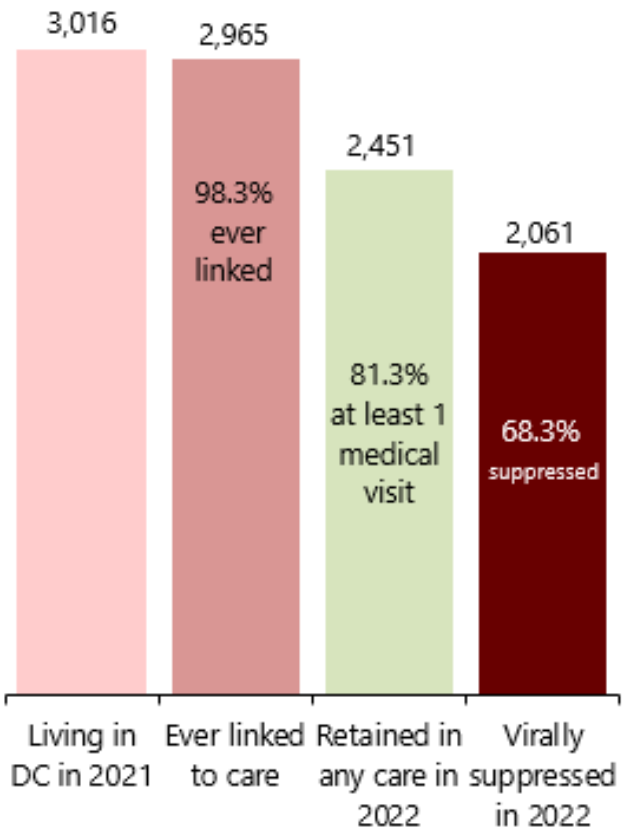
80% % increase in syphilis from 2018 to 2022

Of those Women newly diagnosed with HIV in DC in 2022...

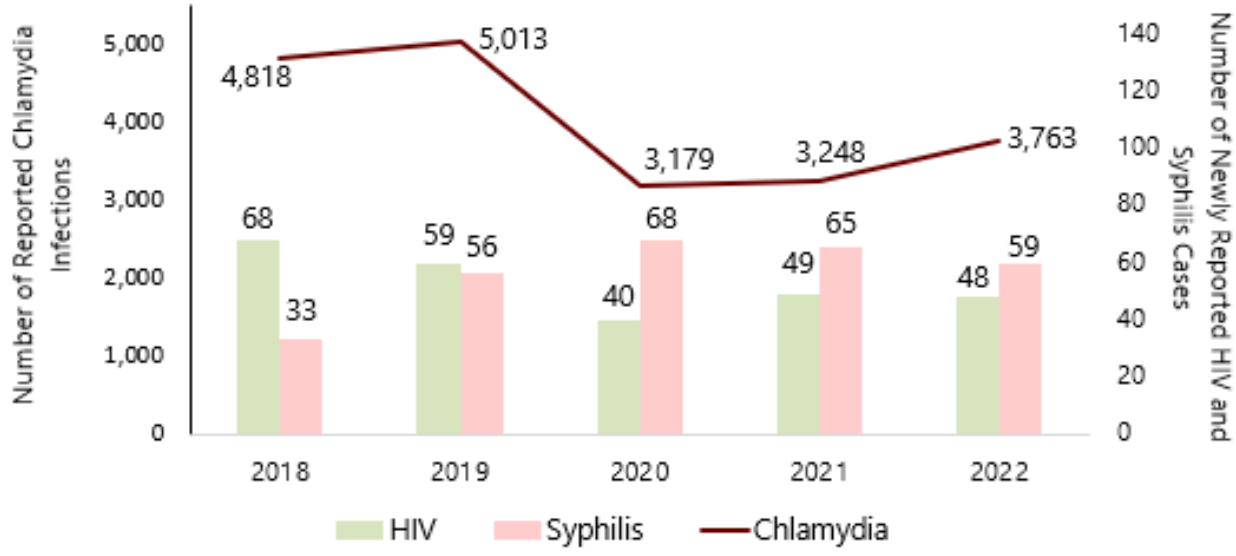
9 in 10 were Black

6 in 10 were aged 50+

HIV Care Continuum among Women Living with HIV in DC, 2022

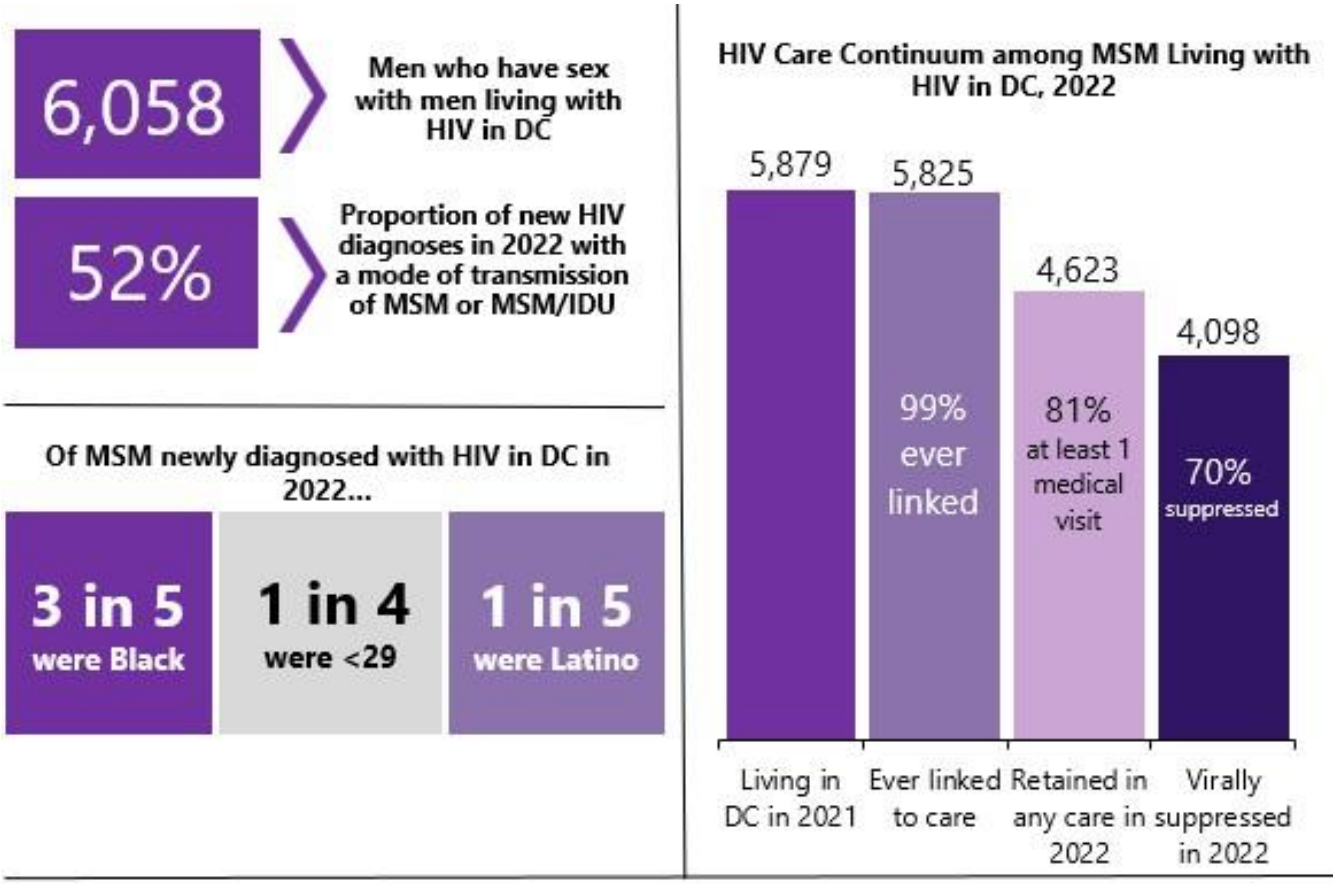


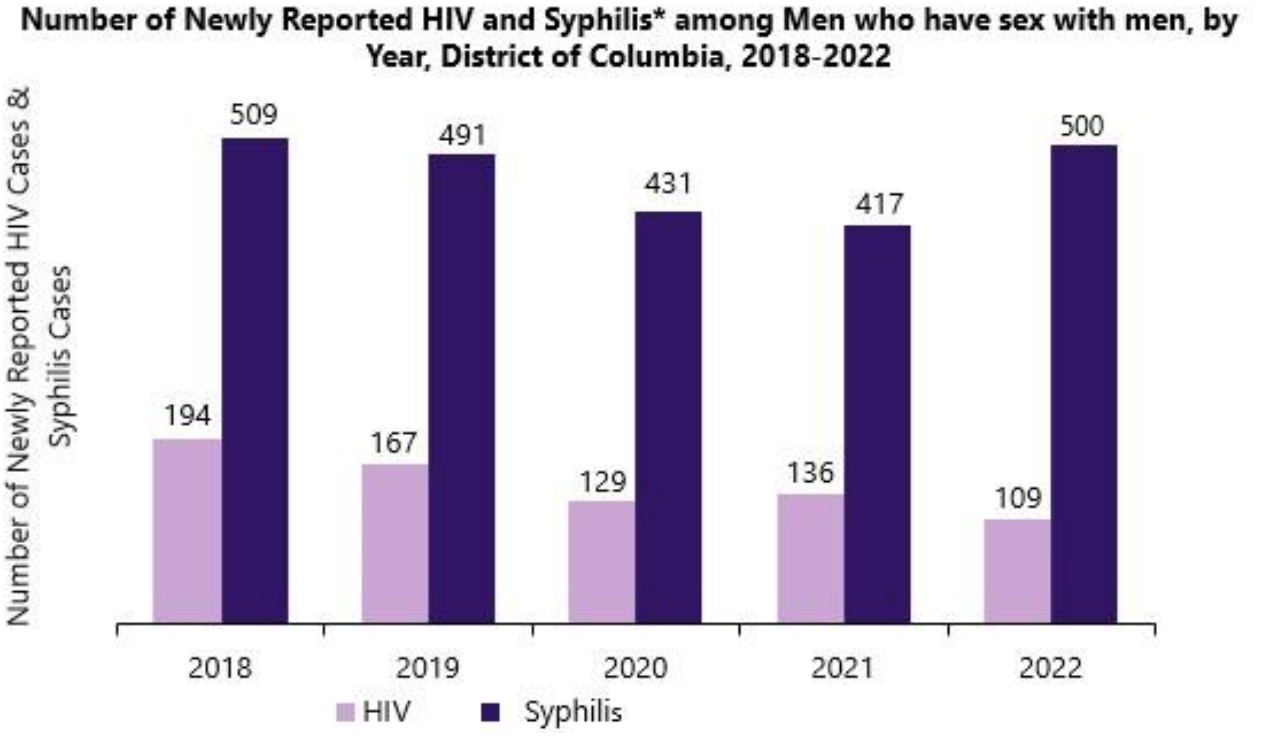
Number of Newly Reported HIV, Chlamydia, and Early Syphilis* cases among Women, by Year, District of Columbia, 2018-2022



*Primary, Secondary and Early Non-Primary Non-Secondary Syphilis

Men Who Have Sex with Men





*Primary, Secondary and Early Non-Primary Non-Secondary Syphilis

People Who Inject Drugs (PWID)

994 — Number of PWID living with HIV in DC in 2022

51% — % of PWID living with HIV that were male

9% — % of newly reported HCV cases in 2022 with a history of IDU

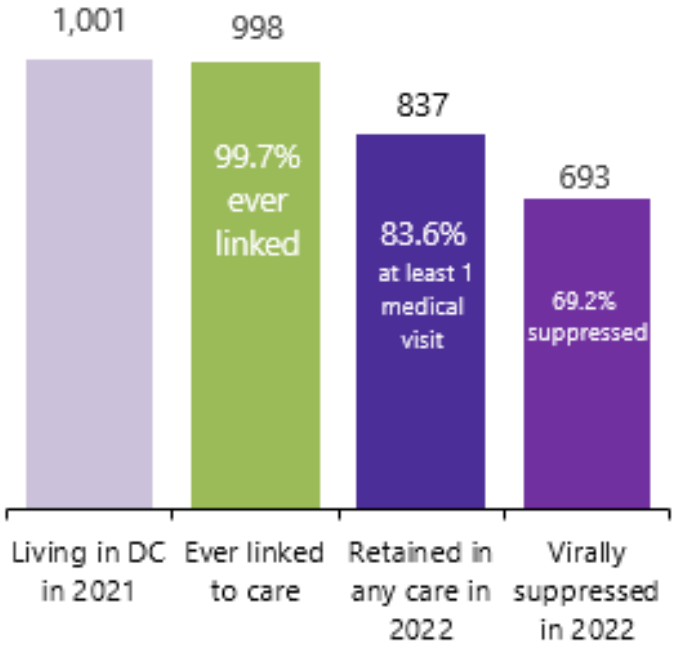
New HIV diagnoses with IDU or MSM/IDU risk in 2008

157

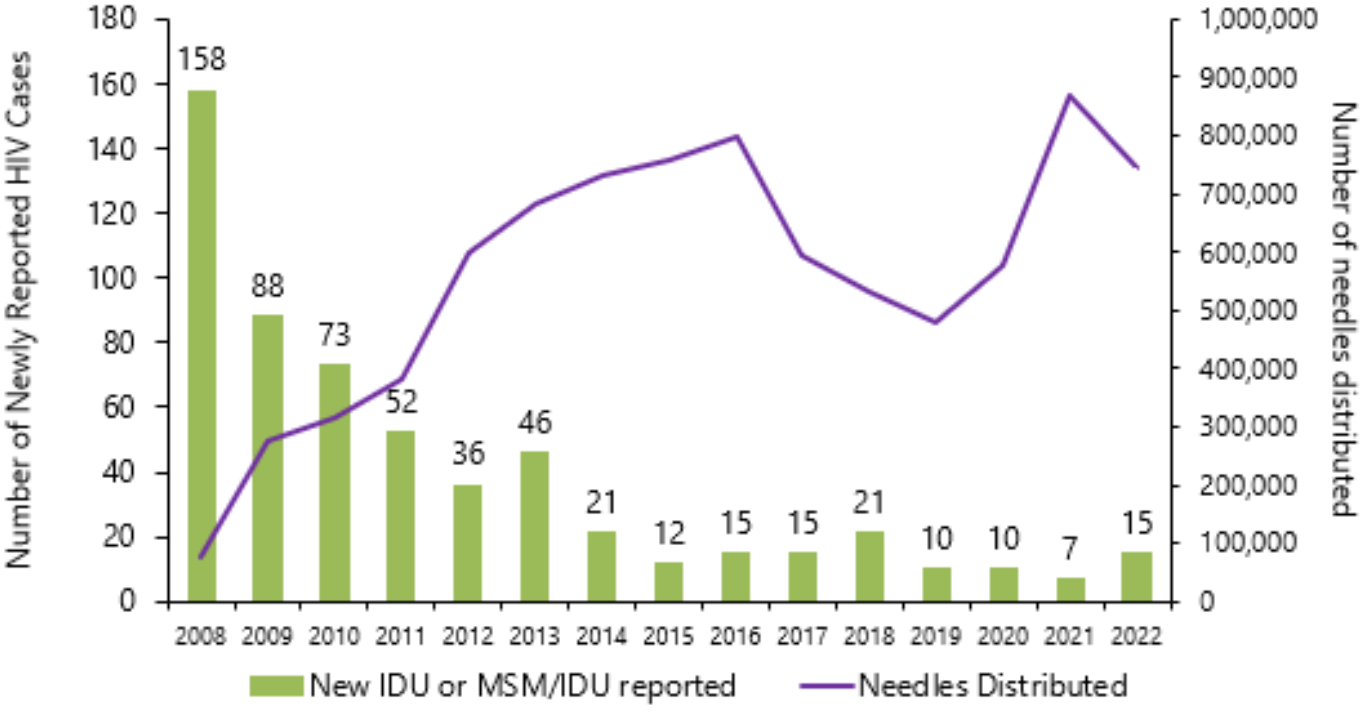
New HIV diagnoses with IDU or MSM/IDU risk in 2022

15

HIV Care Continuum among PWID Living with in DC, 2022



Newly Diagnosed PWID and the Number of Needles Distributed, by Year, District of Columbia, 2008-2022



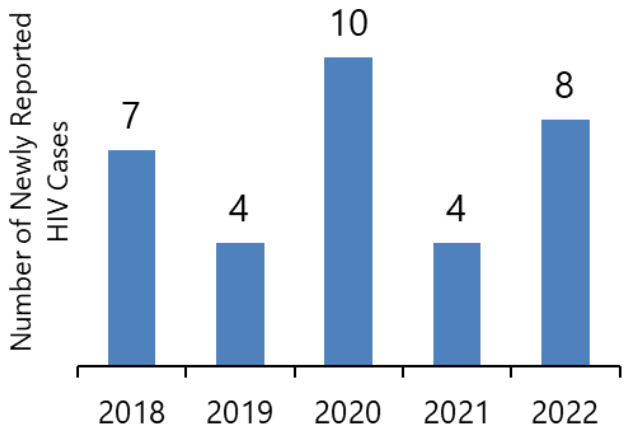
Transgender People

274 Transgender individuals living with HIV in DC in 2022

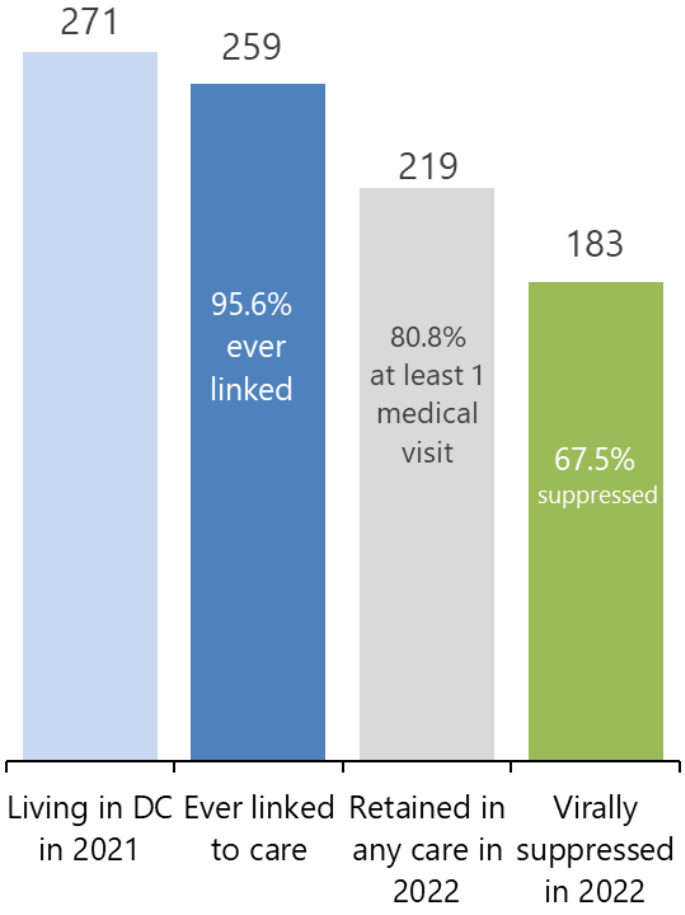
33 Transgender individuals newly diagnosed with HIV between 2018-2022

52 Number of Syphilis* cases in 2022

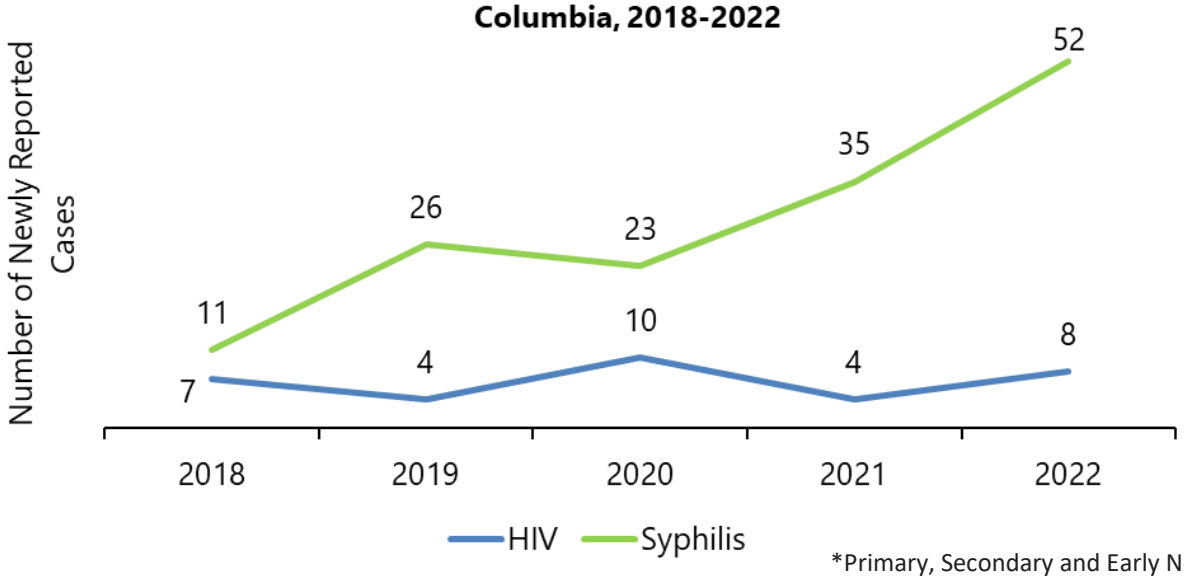
New HIV Diagnoses among Transgender People, by Year, District of Columbia, 2018-2022, N=33



HIV Care Continuum among Transgender People Living with HIV in DC, 2022



Number of Newly Reported HIV and Syphilis* among Transgender People, by Year, District of Columbia, 2018-2022



*Primary, Secondary and Early Non-Primary Non-Secondary Syphilis

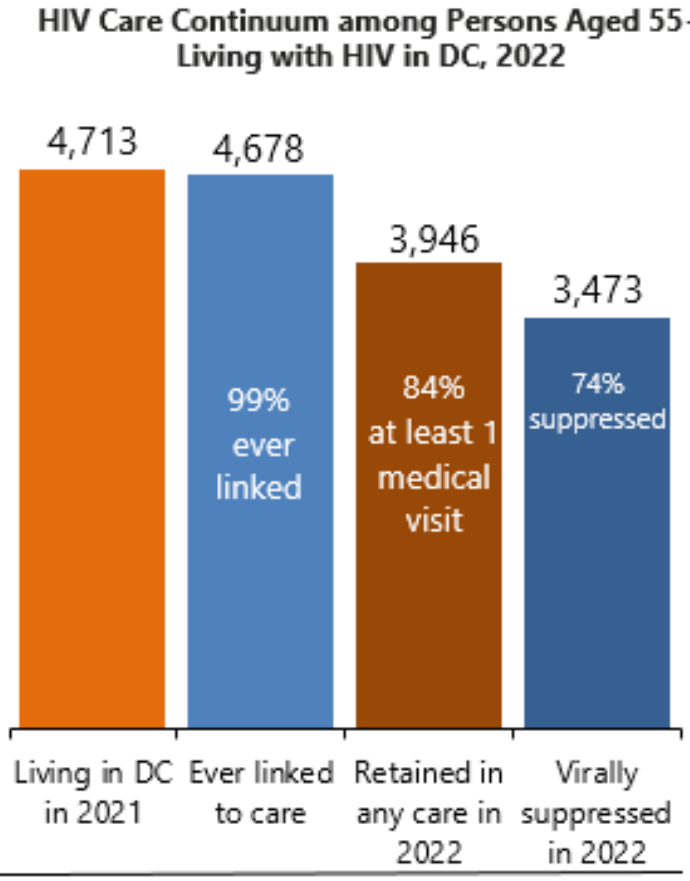
Older Adults (Aged 55 and Older)

5,000 Individuals aged 55+ living with HIV in DC in 2022

46% Percent of newly reported HCV cases in 2022 among those 55+

Of those newly diagnosed with HIV in DC in 2018-2022...

- **4 in 5** were Black
- **1 in 4** were Men who have sex with men
- **2 in 5** were Women



Among Individuals 55 years and older the following were observed...

60% **Decrease in newly reported HCV cases from 2018 to 2022**

70% **Decrease in newly reported HIV cases from 2018 to 2022**

8x **The number of chlamydia and gonorrhea compared to HIV**

Latinos

1,006 **Latinos living with HIV in DC in 2022**

1.2% **Percent of Latinos in DC known to be living with HIV**

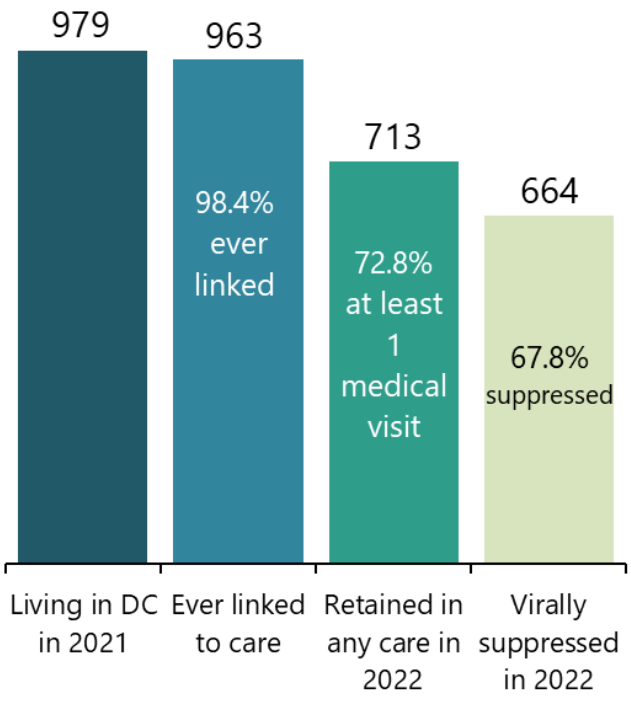
13.8% **% of Syphilis* among Latinos in 2022**

Of those newly diagnosed with HIV in DC in 2018-2022...

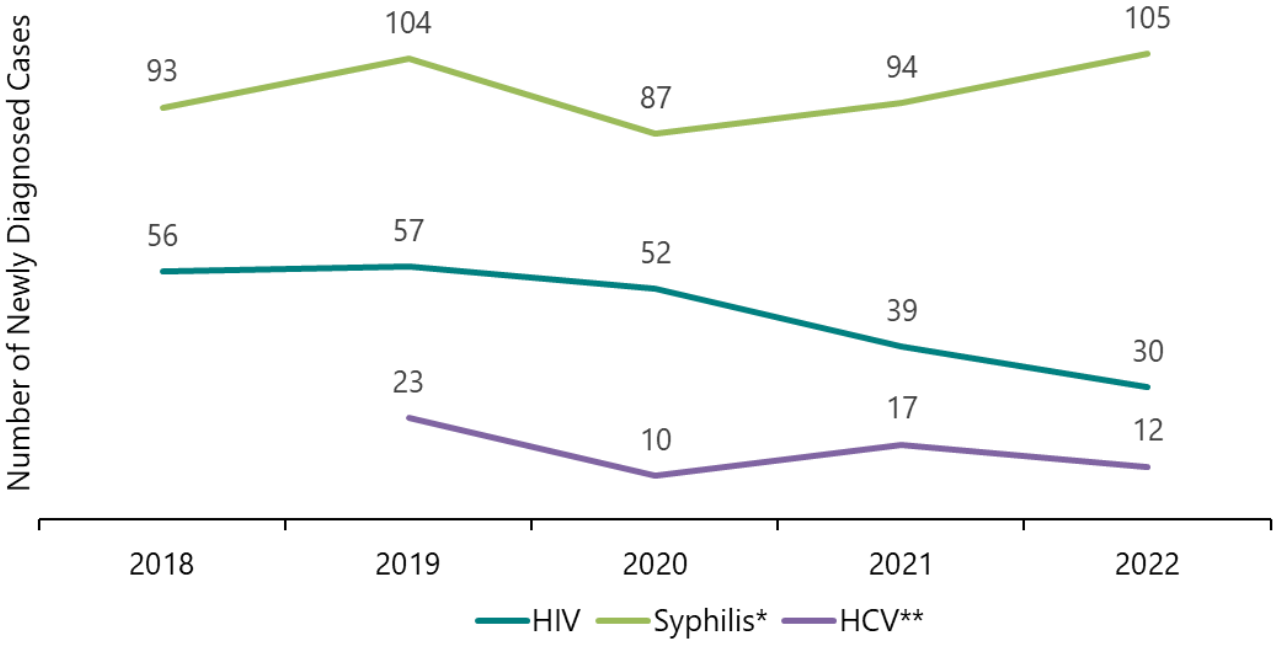
8 in 10 were Men who have sex with men

1 in 2 were aged 30-39

HIV Care Continuum among Latinos Living with HIV in DC, 2022



Number of Newly Diagnosed HIV, Syphilis*, and HCV among Latinos, by Year, District of Columbia, 2018-2022**



*Primary, Secondary and Early Non-Primary Non-Secondary Syphilis
**This may be an underrepresentation due to missing Race/Ethnicity

Youth (Ages 13-24)

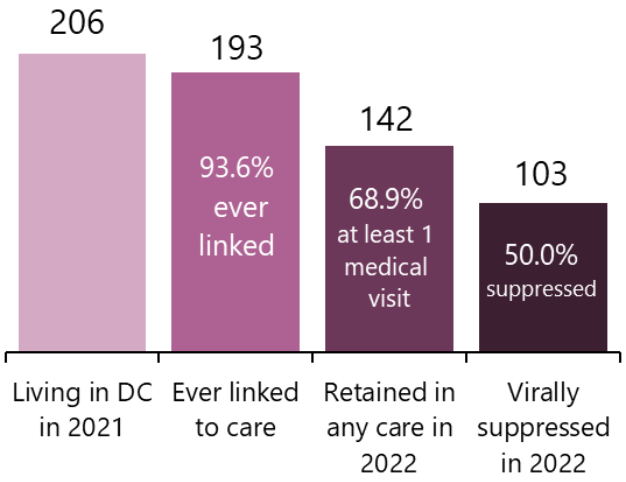
191 Youth living with HIV in DC in 2022

19% Proportion of newly diagnosed HIV among youth in DC in 2022

3.6% Incidence of Chlamydia among youth in 2022

1.3% Incidence of Gonorrhea among youth in 2022

HIV Care Continuum among Youth Aged 13-24 Living with HIV in DC, 2022



Of those newly diagnosed with HIV in DC in 2022...

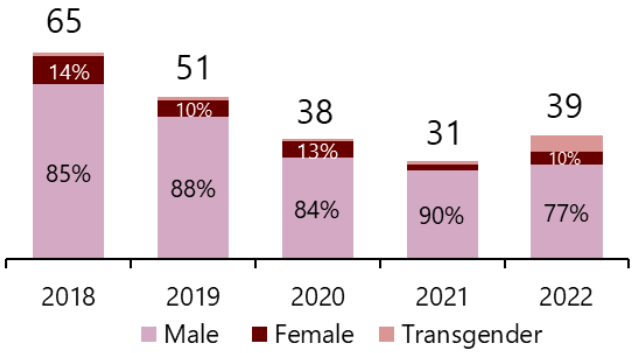
3 in 4 were Black

7 in 10 were Men who have sex with men

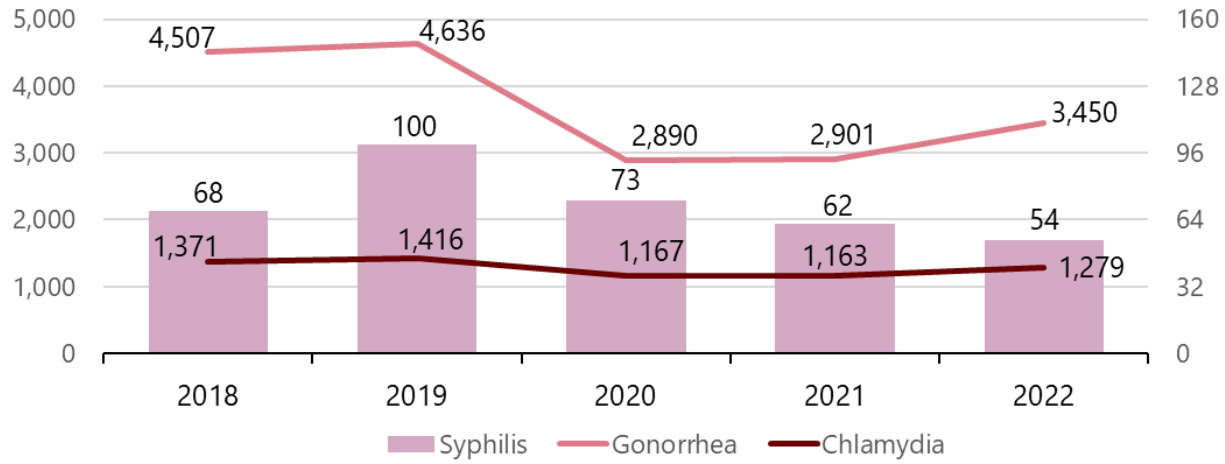
3 in 10 were aged 17-19

1 in 47 were Transgender

Number of Newly Diagnosed HIV Cases among Youth 13-24, by Year and Gender Identity, DC, 2018-2022



Number of Newly Reported Gonorrhea, Chlamydia, and Syphilis* Cases among Youth 13-24



*Primary, Secondary and Early Non-Primary Non-Secondary Syphilis

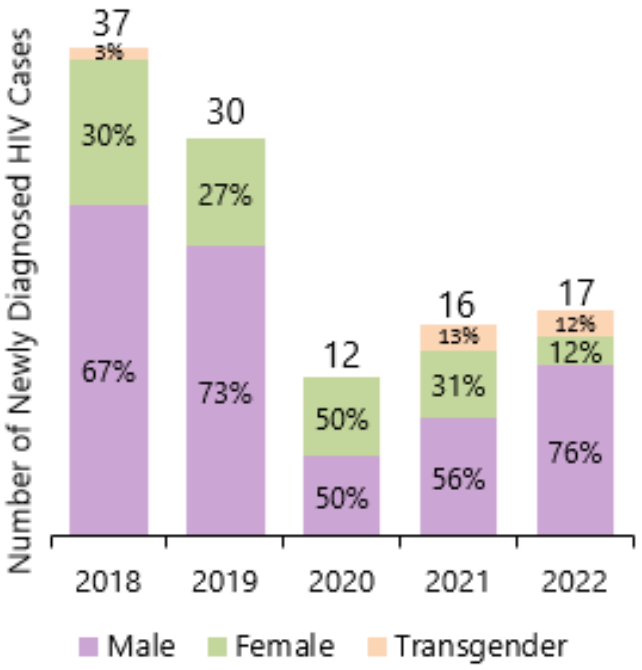
Foreign-Born

972	Number of Foreign-Born people living with HIV in DC in 2022
125	Number of Foreign-Born people newly diagnosed with HIV 2018-2022
77%	Percent of TB cases among Foreign-Born people 2018-2022

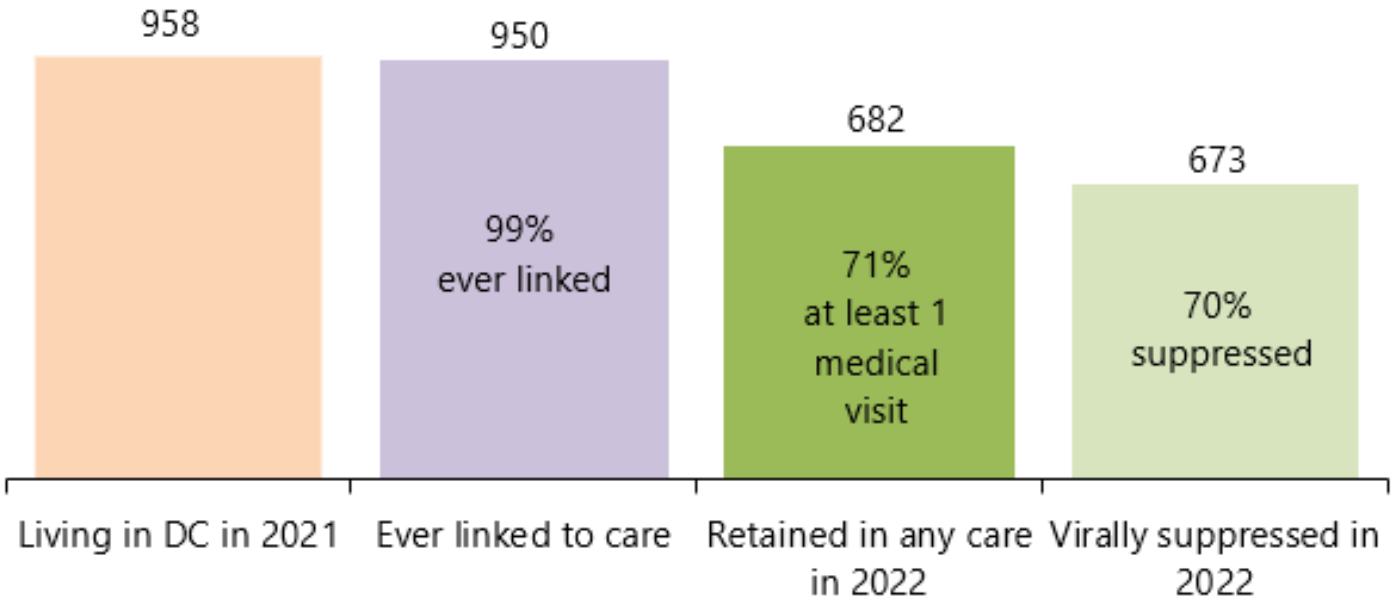
Of all Foreign-Born persons diagnosed in DC in 2022...

- **7 in 10** were Latino
- **9 in 10** were <40
- **3 in 4** were Men

Number of New HIV Diagnoses among Foreign-Born People, by Year, DC, 2018-2022



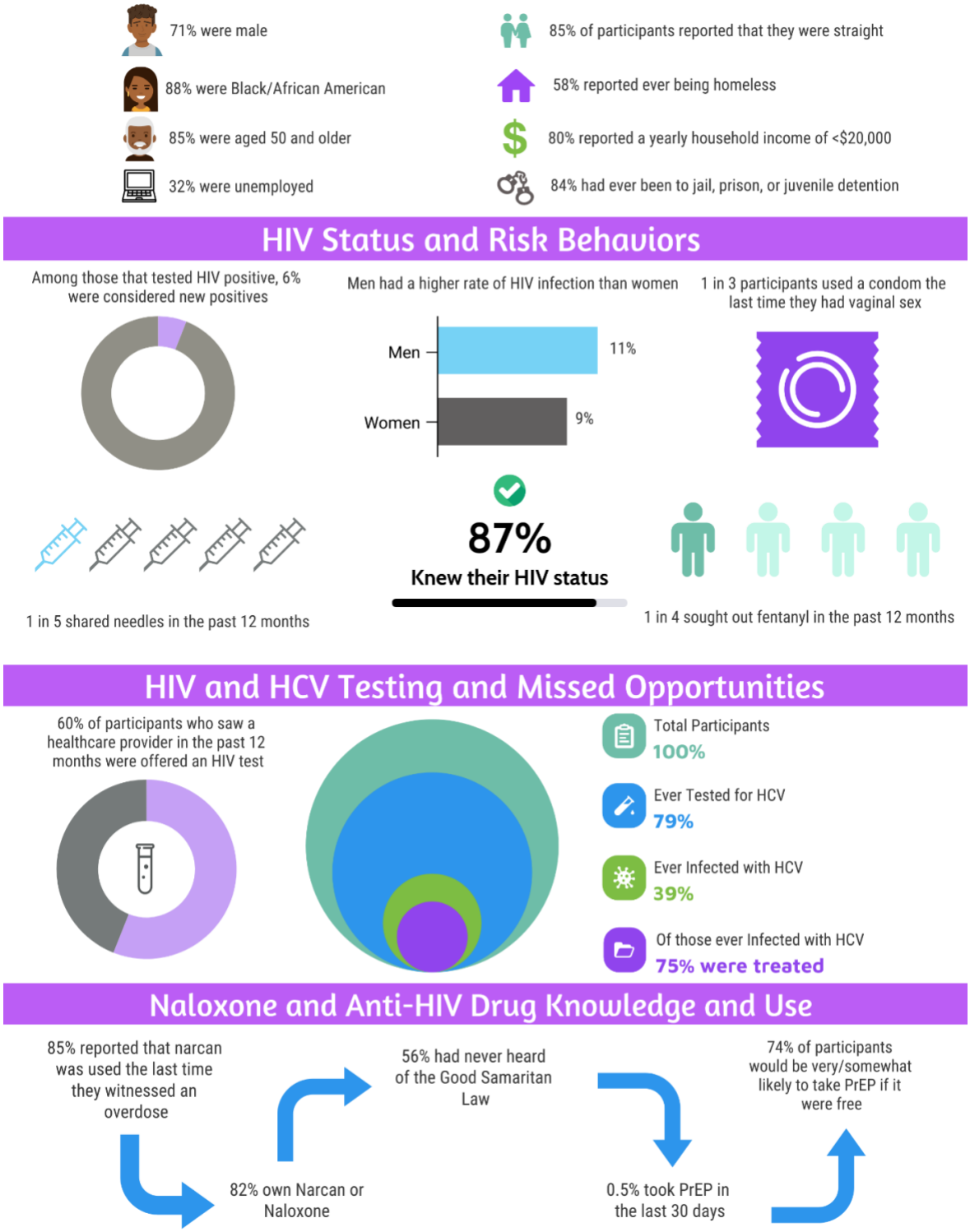
HIV Care Continuum among Foreign-Born People Living with HIV in DC, 2022



National HIV Behavioral Surveillance (NHBS)

People that use injection drugs

The National HIV Behavioral Surveillance (NHBS) is a CDC-funded initiative to learn more about what puts people at risk for HIV. The purpose of NHBS is to assess prevalence of HIV and trends in sexual and drug-use behaviors among populations most at risk for HIV. In 2022, PWID were recruited throughout the DC Metropolitan Statistical Area (MSA) and were surveyed.



Government of the District of Columbia

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DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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MURIEL BOWSER, MAYOR