



HIV in Manitoba 2024

ANNUAL SURVEILLANCE UPDATE

Epidemiology & Surveillance

*Provincial Information Management and Analytics
Health Policy and Planning Division
Department of Health, Seniors and Long-Term Care
Government of Manitoba*

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Land Acknowledgement

We acknowledge that we are located on Treaty 1 Territory and that Manitoba is located on the Treaty Territories and ancestral lands of the Anishinaabeg, Anishinewuk, Dakota Oyate, Denesuline and Nehethowuk Nations.

We acknowledge that Manitoba is located on the Homeland of the Red River Métis.

We acknowledge that northern Manitoba includes lands that were and are the ancestral lands of the Inuit.

We respect the spirit and intent of Treaties and Treaty Making and remain committed to working in partnership with First Nations, Inuit and Métis people in the spirit of truth, reconciliation and collaboration.

Acknowledgements

We acknowledge the important contribution and dedicated work of public health and health-care practitioners across the province who are involved in the diagnosis, reporting, treatment, and respectful care of persons living with HIV.

We acknowledge all people in Manitoba who are living with HIV, with special recognition of those whose data and experiences inform this report. They are valued and respected members of our community.

Executive Summary

HIV in Manitoba 2024: Annual Surveillance Update describes epidemiological trends of human immunodeficiency virus (HIV) in Manitoba by sex, age at diagnosis, health region, risk factors, and first absolute CD4+ T-cell count. The report covers a six-year period from Jan. 1, 2019 to Dec. 31, 2024, with a focus on 2024.

Key highlights include:

- In 2024, 99,849 people were tested for HIV in Manitoba, which is similar to 2023 (100,463 people tested). Test positivity increased from 0.62 per cent in 2023 to 0.70 per cent in 2024.
- In Manitoba, there were 291 newly diagnosed HIV cases (138 males, 153 females) reported in 2024, compared to 283 cases in 2023. This represents a 2.83 per cent increase in the number of new HIV diagnoses.
- The age-standardized rate of newly diagnosed HIV cases increased dramatically from 2019 (6.3 cases per 100,000) to 2023 (19.1 cases per 100,000) and remained elevated in 2024 (18.8 cases per 100,000).
- Individuals aged 30-39 years had the highest age-specific rate of newly diagnosed HIV cases in 2024 (50.6 cases per 100,000), consistent with previous years.
- In 2024, the highest age-standardized rate was reported among the residents of Prairie Mountain Health Region (26.4 cases per 100,000), followed by the Northern Health Region residents (25.3 cases per 100,000).
- Injection drug use was the most frequently reported acquisition risk factor for both females and males in 2024.
- There was one perinatal case in 2024, compared to none in 2023, 2022, and 2020, one in 2021 and two in 2019.
- Most cases with CD4 data had a first CD4 count of 500 cells/mm³ or higher. However, males had more cases with counts below 200 cells/mm³ than females, suggesting later diagnoses among males. A first CD4 count below 200 cells/mm³ indicates advanced HIV, representing a very late diagnosis and a high risk of serious illnesses.

Introduction

Human immunodeficiency virus (HIV) remains a significant public health issue in Manitoba. The rate of newly diagnosed HIV infections in Manitoba tripled from 2019 to 2024, with disadvantaged populations disproportionately affected.¹ In 2024, Manitoba reported the highest rate of newly diagnosed HIV cases in Canada – over three times the national average (excluding Quebec).²

The objective of this report is to describe the epidemiology of newly diagnosed HIV cases among Manitoba residents over a six-year period, Jan. 1, 2019 to Dec. 31, 2024, with an emphasis on 2024. Surveillance data are presented by year of diagnosis, sex, age at diagnosis, health region of residence, risk factors and first CD4 counts.

Methods

Data Sources

Public Health Information Management System (PHIMS)

In Manitoba, HIV is a notifiable infection under [The Public Health Act](#). Reporting requirements, case definitions and guidelines for case and contact management are outlined in the [provincial HIV protocol](#). Positive laboratory and clinical case reports are submitted to the Manitoba Health Surveillance Unit (MHSU) by laboratories and health-care providers (HCPs). These reports are subsequently referred to Service Delivery Organizations, including First Nations and Inuit Health Branch (Indigenous Services Canada), for public health follow-up.

Upon referral, public health nurses collect [standardized information](#) through client interviews and by reviewing hospital and laboratory records and other relevant sources (e.g., eChart Manitoba). Information collected includes socio-demographic details (such as date of birth, sex, and address of residence), and clinical information (such as date of diagnosis, structural and behavioural risk factors, and CD4 count at diagnosis).

¹ [Manitoba HIV Program Report 2018-2021](#). Manitoba HIV Program. Winnipeg, Manitoba. December 1, 2022.

² [HIV in Canada: 2024 Surveillance Highlights](#). Public Health Agency of Canada. December 1, 2025.

All data are entered into and maintained in PHIMS, a web-based application that facilitates recording and tracking of information on clients with notifiable communicable diseases. PHIMS was deployed in Manitoba in 2018 for all sexually transmitted and blood-borne infections (STBBIs). Data for this report were extracted from PHIMS on Oct. 29, 2025.

Cadham Provincial Laboratory (CPL)

HIV testing data described in this report are maintained by the Laboratory Information Management System (LIMS) at CPL and were extracted on Sept. 16, 2025.

Manitoba Health Insurance Registry

The Manitoba Health Insurance Registry contains records of all individuals registered to receive health care through Manitoba Health since 1970. Population data presented in this report are based on records of residents registered with Manitoba Health as of June 1 of each year. When the most recent year's population data are unavailable, the previous year is used.

Population reports are available at: <https://www.gov.mb.ca/health/population/>.

Inclusion/Exclusion Criteria

All newly diagnosed laboratory-confirmed HIV cases, including perinatal cases, with an index date between Jan. 1, 2019 to Dec. 31, 2024, among residents of Manitoba, were included in this report. Cases were excluded if: a) the individual was a resident of Correctional Services Canada (CSC) facilities in Manitoba at the time of diagnosis, or b) the individual was an out-of-province resident at the time of diagnosis.

HIV Case Definitions

A laboratory-confirmed HIV case is defined as an individual with:

- serological detection of HIV-1 and/or HIV-2 antibodies (IgM, IgA, IgG), and/or HIV p24 antigen, AND a reactive immunochromatographic confirmatory test, OR
- detection of HIV nucleic acid by polymerase chain reaction, OR
- isolation of HIV in culture

Perinatal cases are defined as newly laboratory-confirmed cases in children whose suspected mode of acquisition is from a mother/birth parent with HIV infection. Acquisition may have occurred during pregnancy, childbirth, or from breastfeeding. Confirmation of the exact mode of acquisition is not required.

Point-of Care (POC) HIV testing is available in Manitoba, but these results are not considered confirmatory. All reactive POC results should undergo confirmatory testing using standard HIV laboratory testing methods. Reactive POC results are reportable to MHSU by HCPs and are classified as **probable HIV infection** when confirmatory testing is not performed by CPL.

Probable cases (with only positive POC results) are not included in this report.

Negative POC tests performed by HCPs are documented in the client's health record, but are not recorded in any laboratory information system.

HIV self-tests are available for personal use, and the results are not reportable to Manitoba Health. Individuals who receive a positive self-test result are encouraged to inform their HCP and undergo confirmatory testing.

HIV cases previously diagnosed elsewhere, but newly reported to Manitoba, are classified as "**Introduced cases**" (see Appendix A).

Other Definitions

- **Index Date:** It is defined as the earliest date of specimen collection date, result date, public health received date, and classification date.
- **Health region:** Cases are assigned to a health region based on the postal code at time of initial investigation. This includes First Nations people living on reserve.
- **Age at diagnosis:** It is calculated as the client's date of birth subtracted from the index date of HIV infection.
- **Sex:** It is identified based on the individual's self-reported gender at the time of registration for health services in Manitoba.
- **Risk factors:** Risk factor information was collected during client interviews using standardized questions included in the [case form](#). For each question, investigators could report one of the following response options: *Yes, No, Unknown, Declined to Respond, or Not Asked*.
 - A client was considered **assessed for risk factors** if there was a response to at least one risk factor question.
 - A risk factor was considered **reported by a client** if the response was *Yes*.
 - Risk factors are **not mutually exclusive** as a client may report multiple risk factors.

The risk factors considered in this report were categorized into two groups:

Acquisition risk factors

- blood/tissue recipient
- injection drug use (IDU)
- shared injection equipment
- men who had sex with men (MSM)
- MSM and IDU
- occupational exposure
- probable acquisition in another country
- perinatal
- contact to a known case
- other acquisition risk factors (i.e., invasive medical/surgical/dental procedure, body piercing/tattooing/scarification/acupuncture)
- **no identifiable acquisition risk factor** – cases where responses to all the acquisition risk factors were *No*, or where the response to the question “No identifiable risk factor” was *Yes*)

Associated risk factors:

- history of STBBI
 - unstable housing
 - substance use – non-injection
 - history of incarceration
 - underlying mental health issue
 - transactional sex (i.e., has given or received goods in exchange for sex)
 - pregnancy at time of diagnosis
 - **no identifiable risk factor** – cases where responses to all the risk factor questions, including both acquisition and associated risk factors, were *No*, or where the response to the question “No identifiable risk factor” was *Yes*
- First absolute CD4+ T-cell count (also referred to as first CD4 count): It is defined as the absolute number of CD4+ T lymphocytes (cells/mm³) measured at the time of HIV diagnosis. This measure provides an indication of immune system health and disease progression at diagnosis.
 - Higher first CD4 counts suggest a stronger immune system and an earlier stage of HIV infection at diagnosis
 - Lower first CD4 counts indicate advanced HIV infection and a later stage of infection at diagnosis.

Statistical Methods

Crude and age-specific rates were calculated using the population data from the Manitoba Health registry as of June 1 of each year. Age-standardized rates were derived through direct standardization, based on the age distribution of the 2021 Canadian standard population (five-year age groups) from Statistics Canada. Age-standardized rates allow fair comparison of rates across populations with different age structures over time or geography.

Data were validated, cleaned, and analyzed in R version 4.4.1 (R Core Team, 2024).

Limitations

There are several limitations to consider when interpreting the findings from this report.

- Public health surveillance data are routinely updated within the Public Health Information Management System (PHIMS). Client files may be updated after a report is published (e.g., confirmation of infection stage), which can result in differences from previous reports.
- HIV remains a stigmatizing infection and may be asymptomatic in its early stages. Individuals may delay seeking medical care or testing, leading to delayed diagnosis and reporting, and potential underestimation of cases in the province.
- Point-of-care (POC) or self-care test results may not be reported to Manitoba Health when individuals with positive results do not undergo confirmatory laboratory testing. This can lead to an underestimation of both the number of people tested for HIV and the true number of HIV cases. Negative POC and self-test results are not captured in laboratory information systems and are, therefore, not included in HIV testing data. The availability and uptake of approved POC tests and self-testing kits are evolving and may influence overall trends in confirmatory HIV antigen/antibody screen tests performed.
- This report does not separate sex from gender. As a result, sex-based findings may not fully reflect the experiences of gender diverse individuals, which affects how these results should be interpreted.

- Between 2018 and 2023, heterosexual contact was routinely included as a reported risk factor in the HIV annual surveillance updates. In 2024, collection of this information changed to be documented as part of assessing exposures to other people (contacts) and was not readily available for analysis at the time of publication. A standardized method to accurately extract and define heterosexual contact from exposure data is currently under development. Therefore, this risk factor is not included in the 2024 report. Caution is advised when interpreting acquisition risk factor results, particularly regarding heterosexual contact, which remains an important factor in HIV transmission in Manitoba. This risk factor is expected to be incorporated in future reports once the methodology is finalized.
- The risk factors may be impacted by self-reporting bias due to limited disclosure or misattribution of risks. Additionally, the reason for seeking HIV testing and/or receptiveness to being tested may also affect accuracy and completeness of the reported risk factors.
- Analyses exploring other variables such as self-reported race, ethnicity and Indigenous status as well as education, income, or social risk factors could not be readily undertaken.
- Due to different standardization methods and the choice of standard populations, age-standardized rates may differ from other published reports.

Results

HIV Testing

In Manitoba in 2024, 145,698 HIV antigen/antibody screen tests were performed and 99,849 people tested for HIV ([Figure 1](#); [Table 1](#)). This is similar to 2023, when 100,463 people were tested (0.6 per cent decrease). The percentage of people who tested positive for HIV has increased since 2019, reaching a test positivity rate of 0.70 per cent in 2024. HIV test positivity is an important measure and should be considered alongside the number of tests performed. The test positivity may increase for two main reasons: 1) an increase in the incidence of the infection, or 2) screening programs are becoming more targeted to groups at increased risk of HIV infection and therefore, more cases are diagnosed with fewer tests.

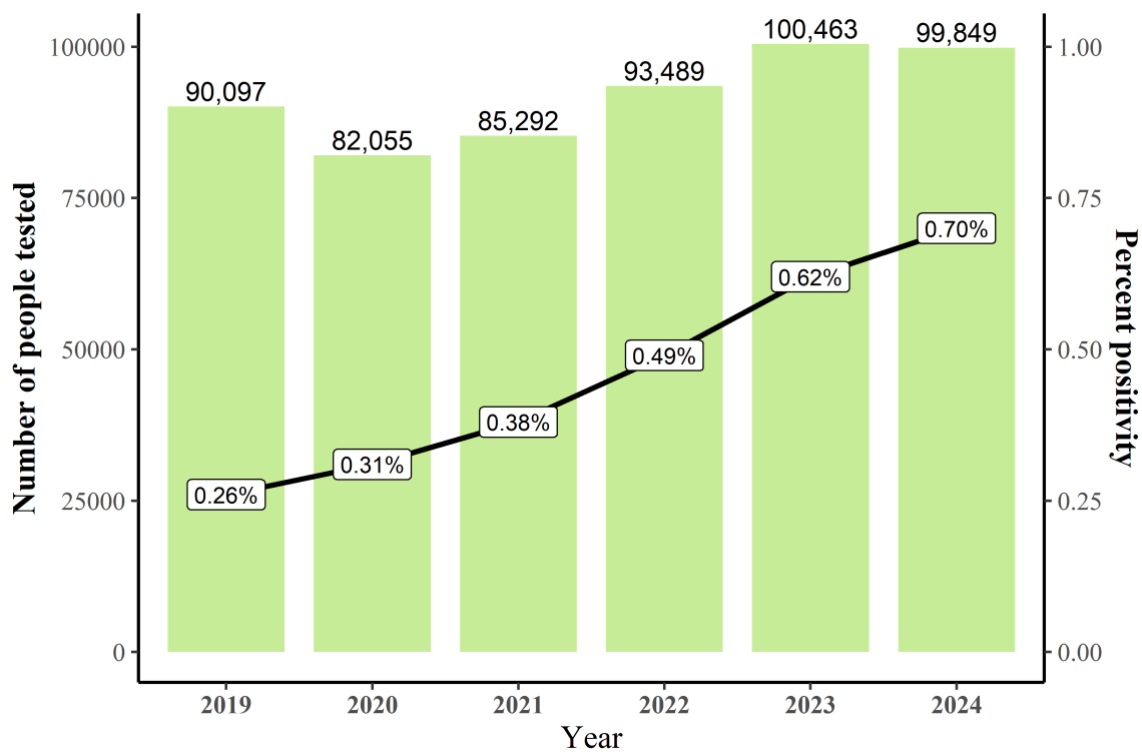


Figure 1. HIV testing in Manitoba: number of people tested and test positivity (percentage), tests completed by Cadham Provincial Laboratory, 2019 – 2024

In recent years, females had nearly twice as many HIV screen tests performed compared to males (Figure 2). This trend may be explained in part, by routine screening among women/birthing parents during pregnancy, regardless of risk status. There were 63,581 (63.7 per cent) females tested in 2024 compared to 36,268 (36.3 per cent) males. Among both males and females, the 30-39 years age group had the highest number of people tested for HIV (n=33,724; 33.8 per cent), followed by those 20-29 years of age (n=29,857; 29.9per cent).

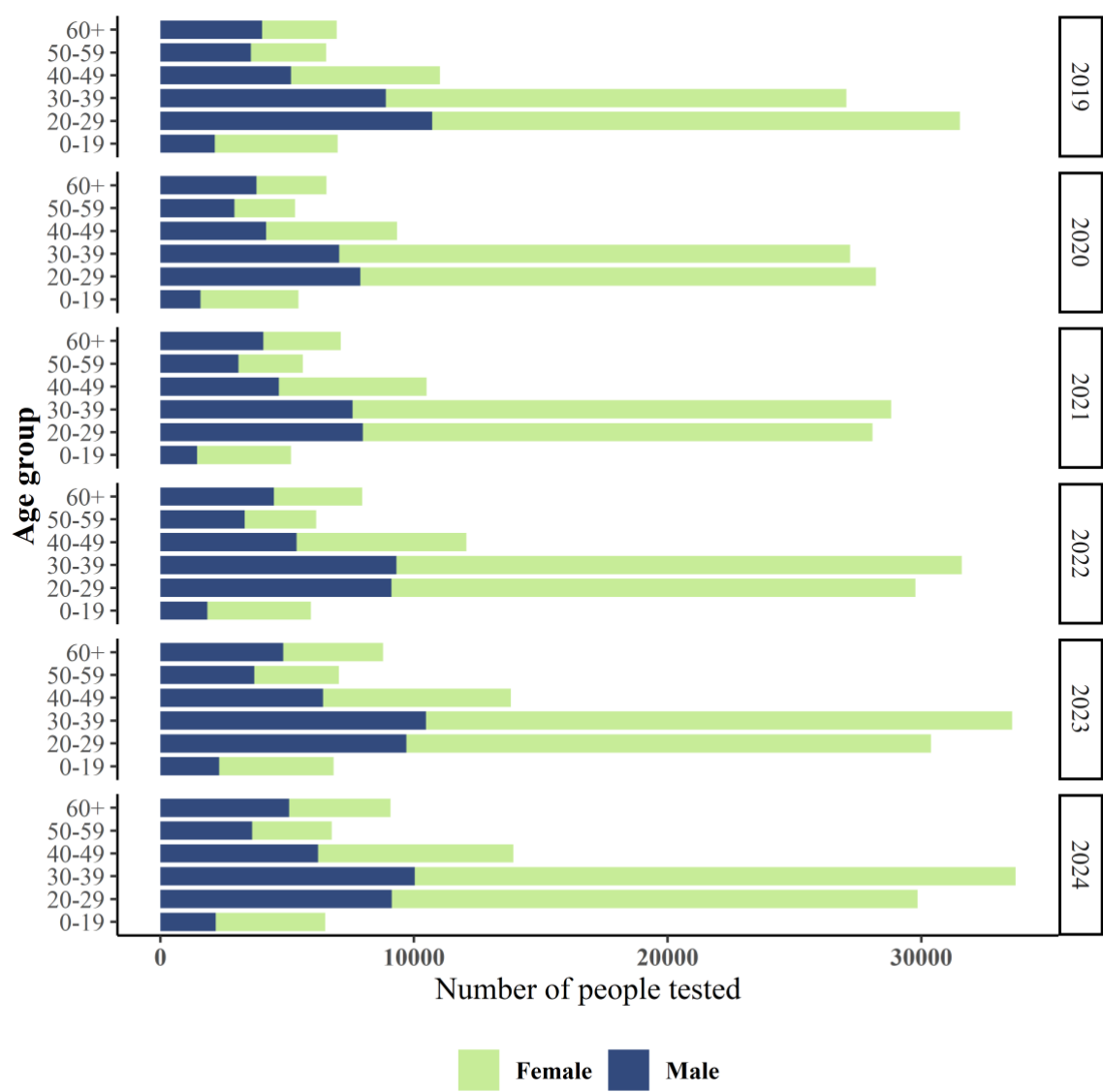


Figure 2. Number of people tested for HIV by sex and age group, tests completed by Cadham Provincial Laboratory, Manitoba, 2019 – 2024

Surveillance

New HIV Diagnoses

In Manitoba, there were 291 newly diagnosed laboratory-confirmed HIV cases (138 males and 153 females) reported in 2024 compared to 283 cases in 2023 ([Figure 3](#); [Table 2](#) and [Table 3](#)). The age-standardized new HIV diagnosis rate increased steadily from 2019 to 2023, rising from 6.3 per 100,000 in 2019 to 19.1 per 100,000 in 2023. The rate remained elevated in 2024 at 18.8 per 100,000.

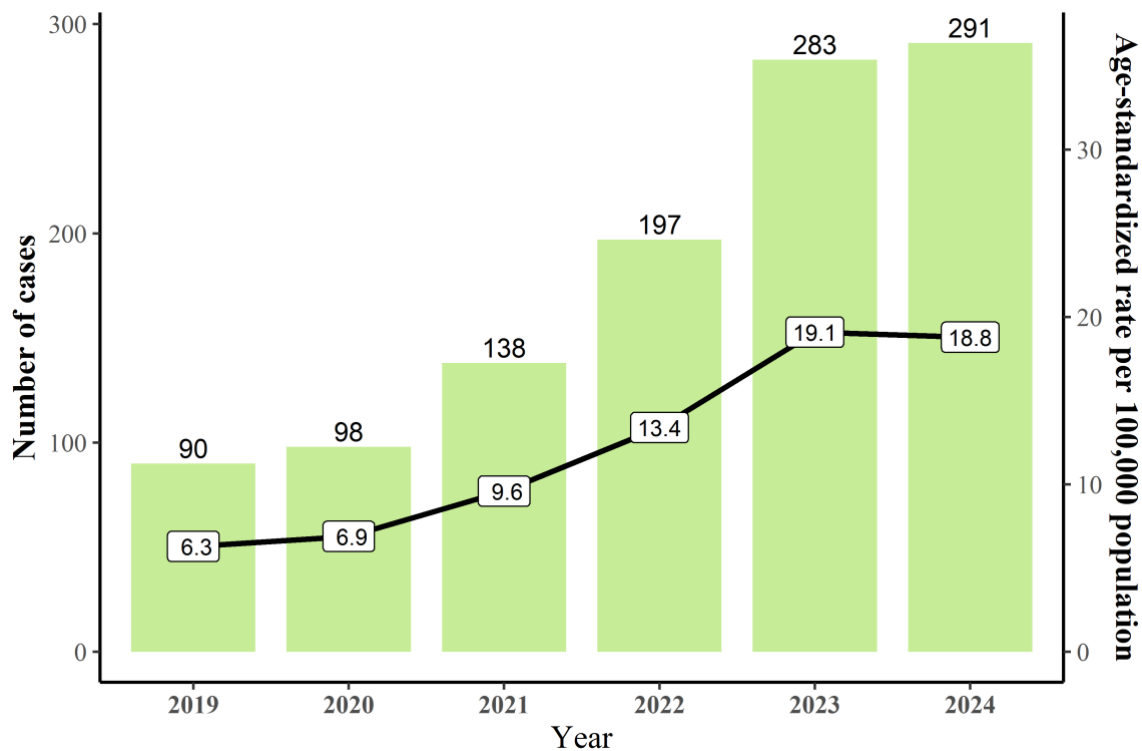


Figure 3. Number and age-standardized rate (per 100,000 population) of newly diagnosed laboratory-confirmed HIV cases, Manitoba, 2019 – 2024

New Diagnoses by Age and Sex

The age-standardized rate of newly diagnosed laboratory-confirmed HIV cases among males and females has steadily increased from 2019 to 2023. In 2024, however, the rate declined from 19.0 to 18.2 per 100,000 among males while it increased from 19.1 to 19.5 per 100,000 among females. Over the reporting period, females had a higher rate of HIV infection than males since 2021 ([Figure 4](#); [Table 3](#)). This trend differs from national HIV surveillance data, where males had a higher rate than females^{3,4,5,6}.

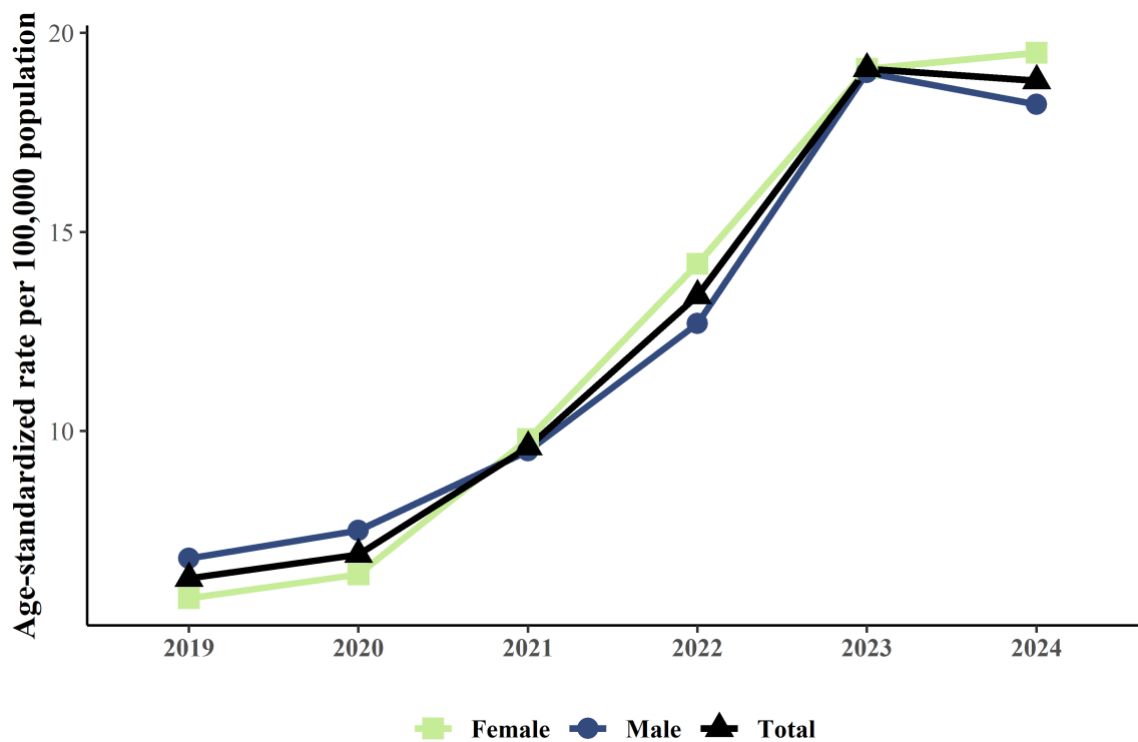


Figure 4. Age-standardized rate (per 100,000 population) of newly diagnosed laboratory – confirmed HIV cases by sex, Manitoba, 2019 – 2024

³ [HIV in Canada: 2024 Surveillance Highlights](#). Public Health Agency of Canada. December 1, 2025.

⁴ [HIV in Canada: 2023 Surveillance Highlights](#). Public Health Agency of Canada. November 29, 2024.

⁵ [HIV in Canada: 2022 Surveillance Highlights](#). Public Health Agency of Canada. December 01, 2023.

⁶ [HIV in Canada: 2021 Surveillance Highlights](#). Public Health Agency of Canada. January 01, 2024.

The number of newly diagnosed laboratory-confirmed cases by age group in 2024 differed by sex (Figure 5). There were more female cases in younger age groups (≤ 29 years old) and the 40-49 age group. However, there were more male cases reported in older age groups (≥ 50 years old). In 2024, the median age of cases was 36 years for males and 33 years for females.

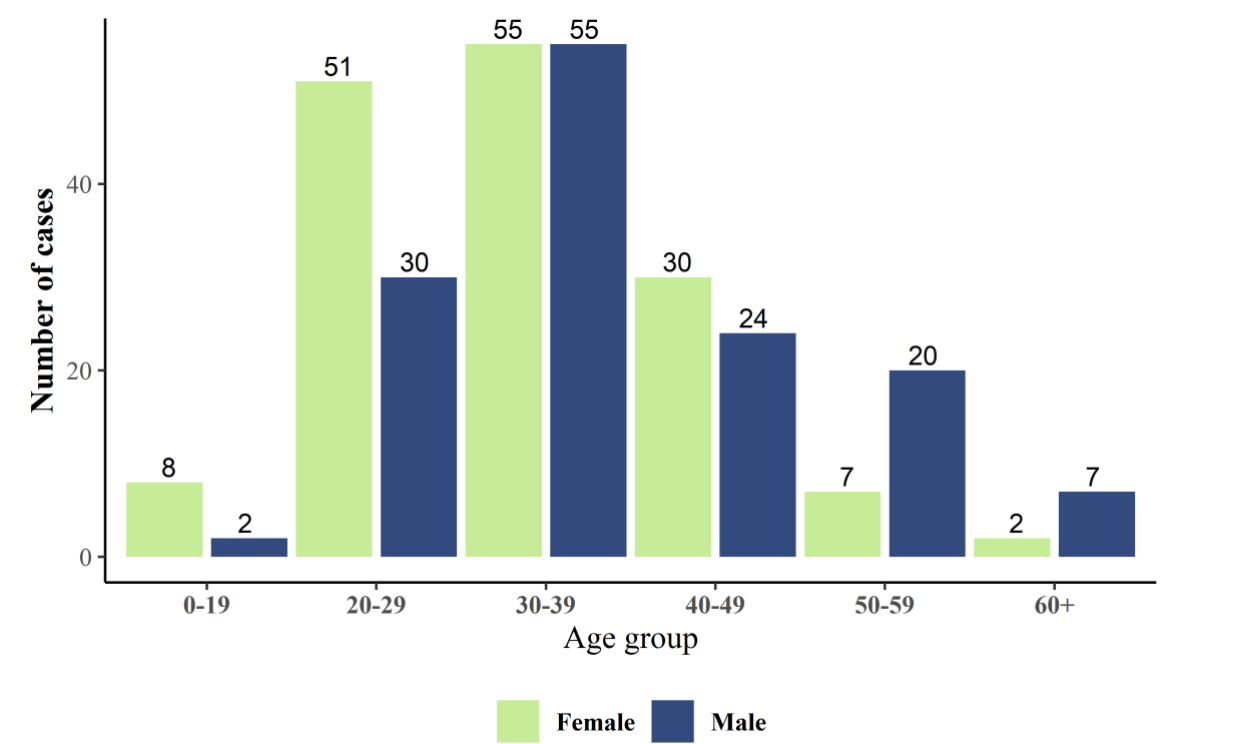


Figure 5. Number of newly diagnosed laboratory-confirmed HIV cases by sex and age group, Manitoba, 2024

Figure 6 (Table 4) illustrates that rates of HIV infection increased across most age groups from 2019 to 2024, with the largest rise in adults aged 30 to 39, increasing from 14.7 to 50.6 per 100,000. Adults aged 20 to 29 also showed a marked increase from 20.8 to 40.1 per 100,000. Rates in the 40 to 49 group rose from 5.2 to 40.7 by 2023, then declined to 28.2 in 2024. Adults aged 50 to 59 experienced a steady increase from 5.1 to 16.1 per 100,000. Rates remained low in younger populations, with those aged 0 to 19 increasing from 0.9 to 2.8 per 100,000. Individuals aged 60 and older continued to have low rates, rising from 0.7 to 2.6 per 100,000.

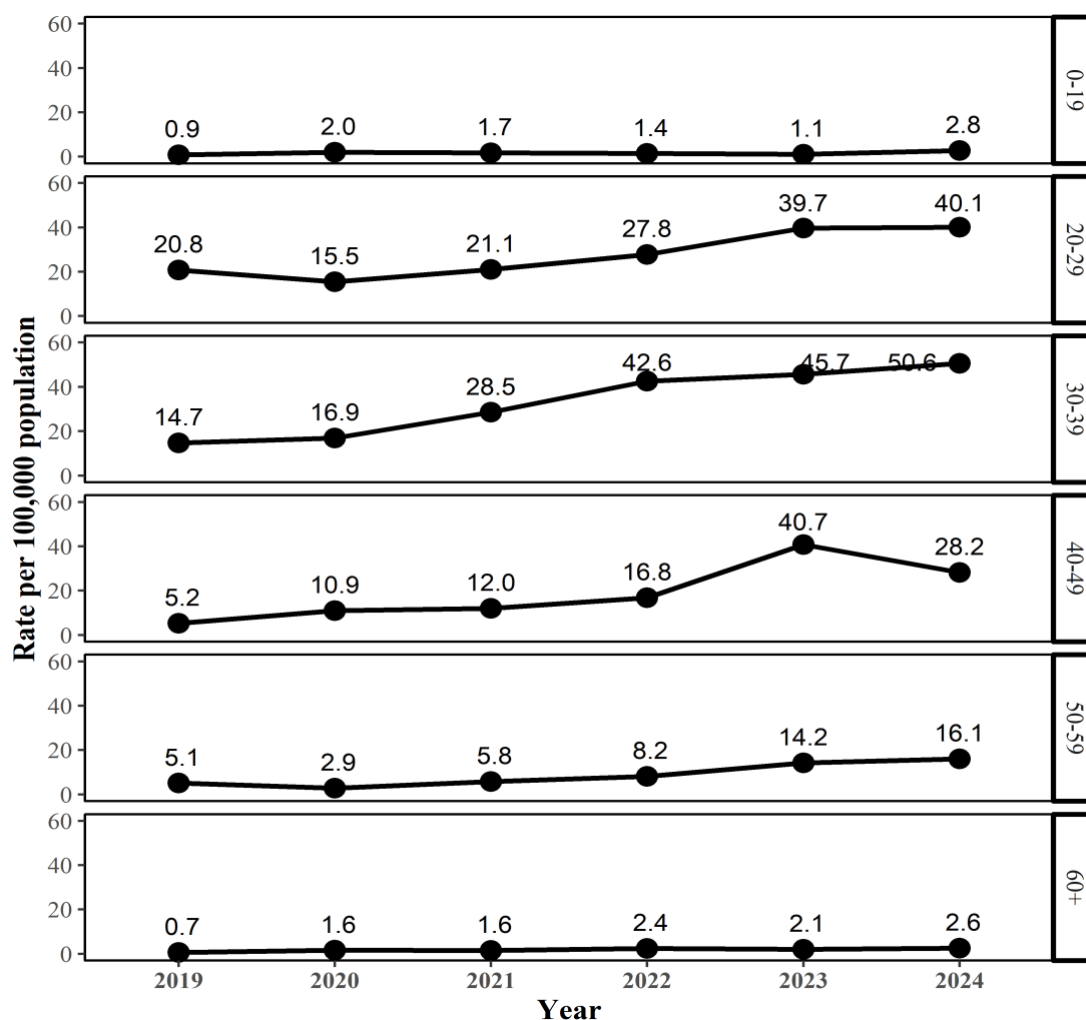


Figure 6. Age-specific rate of newly diagnosed laboratory-confirmed HIV cases, Manitoba, 2019 – 2024

New Diagnoses by Health Region

The highest proportion of newly diagnosed HIV cases in 2024 were reported among residents of the Winnipeg Health Region (n=186, 63.9 per cent), followed by the Prairie Mountain Health Region (n=45, 15.5%) (Figure 7, Table 5). In 2024, the number of new HIV cases ranged between 13 and 24 in other health regions in Manitoba. Cases among First Nations peoples living on reserve are assigned to the health region in which the community is located. There were two cases with an unknown health region.

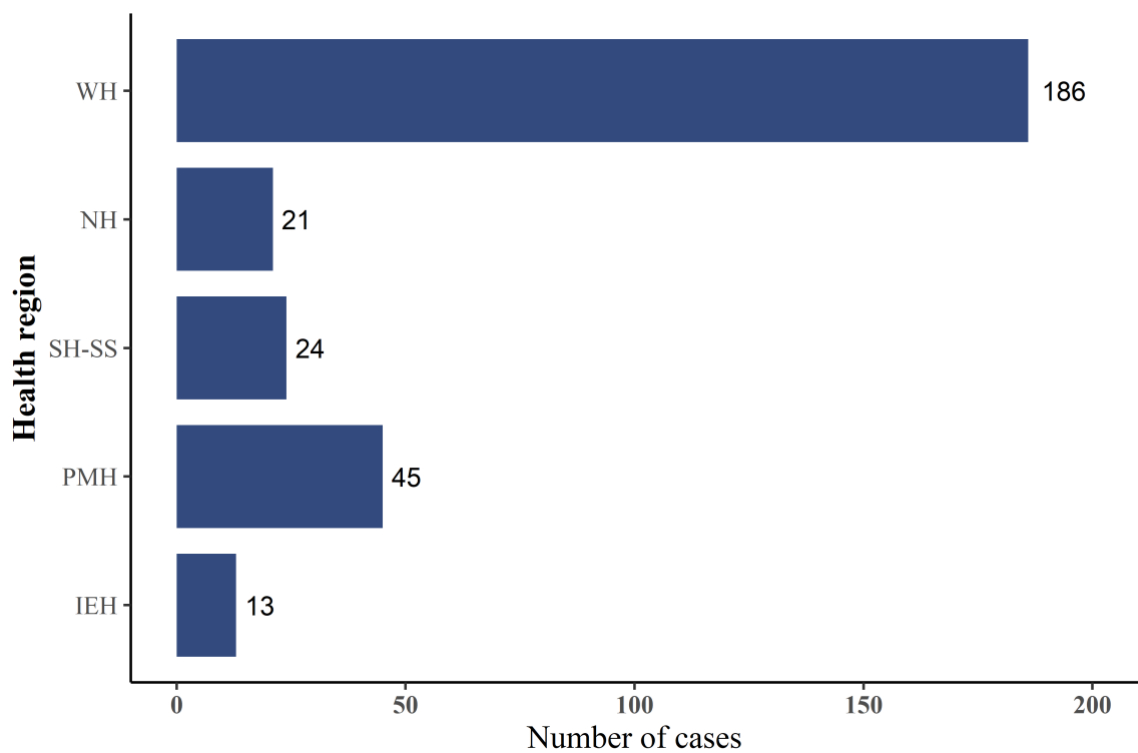


Figure 7. Number of newly diagnosed laboratory-confirmed HIV cases by health region, Manitoba, 2024

Abbreviations: IEH (Interlake-Eastern Health), NH (Northern Health), PMH (Prairie Mountain Health), SH-SS (Southern Health – Santé Sud), WH (Winnipeg Health)

Notes:

- Two cases with an unknown health region are not included in this plot.

As presented in [Figure 8 \(Table 5\)](#), in 2024, Prairie Mountain Health Region had the highest age-standardized rate of new HIV cases (26.4 cases per 100,000) in Manitoba, followed by the Northern Health Region (25.3 cases per 100,000) and Winnipeg Health Region (20.0 cases per 100,000). The age-standardized rate of newly diagnosed HIV cases increased from 2023 to 2024 in Prairie Mountain and Interlake Eastern Health Regions while decreased in other health regions of Manitoba.

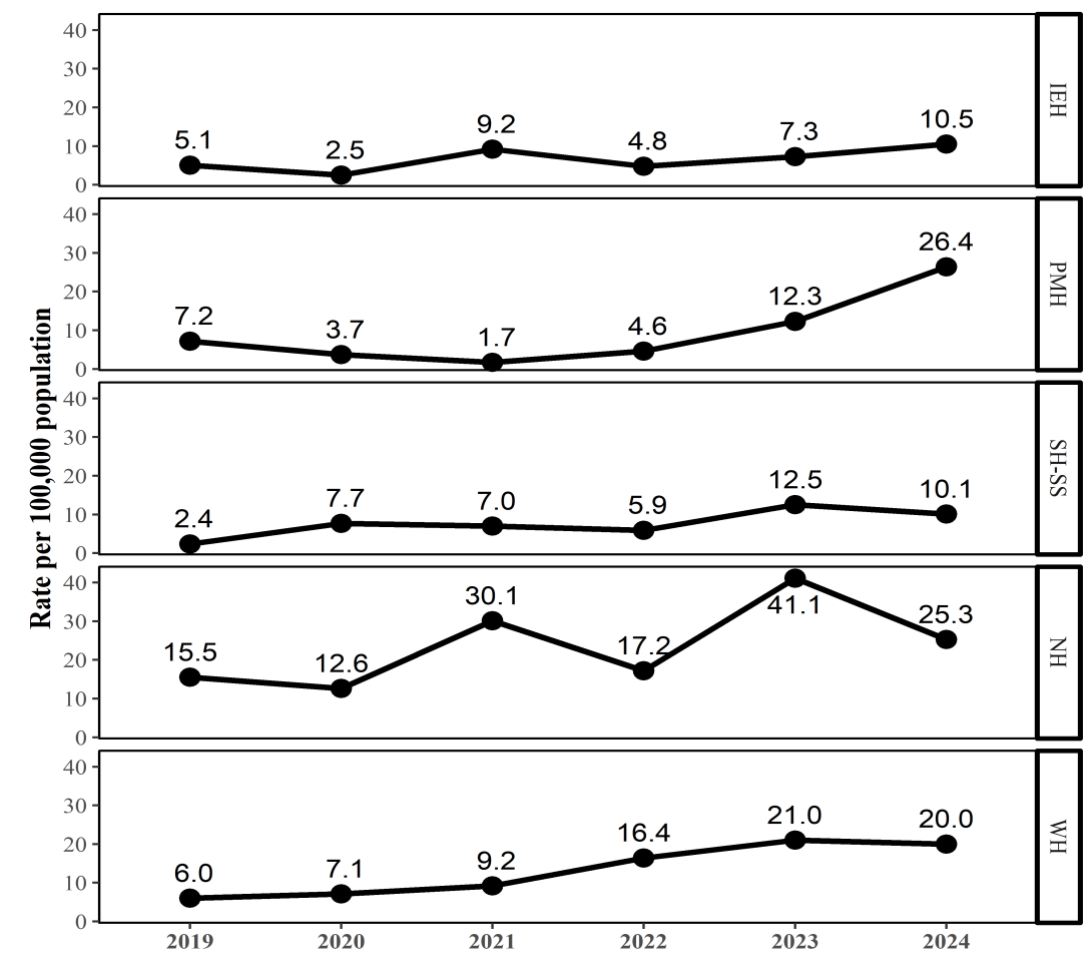


Figure 8. Age-standardized rate of newly diagnosed laboratory-confirmed HIV cases by health region, Manitoba, 2019 – 2024

Abbreviations: IEH (Interlake-Eastern Health), NH (Northern Health), PMH (Prairie Mountain Health), SH-SS (Southern Health – Santé Sud), WH (Winnipeg Health)

Notes:

- Two cases with an unknown health region are not included in this plot.

New Diagnoses by Risk Factor

In 2024, 273 of 291 newly diagnosed laboratory-confirmed HIV cases (93.8 per cent) were assessed for risk factors, including 143 of 153 females (93.5 per cent) and 130 of 138 males (94.2 per cent). Of the 273 cases assessed, 262 (96.0 per cent) reported at least one risk factor, including 138 females (96.5 per cent) and 124 males (96.1 per cent). Because individuals may report more than one risk factor, risk factors are not mutually exclusive.

[Figure 9](#) shows the number and percentage of reported acquisition risk factors among newly diagnosed laboratory-confirmed HIV cases, by sex, in Manitoba in 2024. Among both females and males assessed, injection drug use (IDU) was the most frequently reported acquisition risk factor (n=97; 67.8 per cent for females and n=60; 46.2 per cent for males).

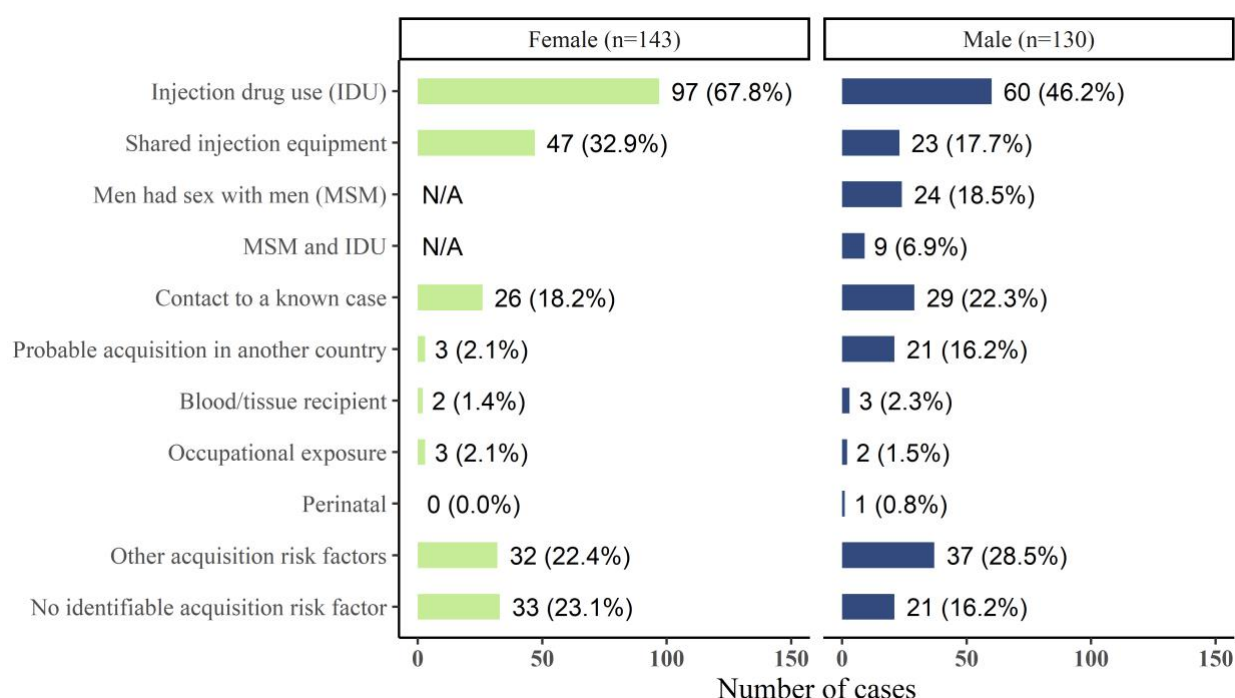


Figure 9. Reported acquisition risk factors among newly diagnosed laboratory-confirmed HIV cases by sex, Manitoba, 2024

Notes:

- “Other acquisition risk factors” category includes invasive medical/surgical/dental procedure and body piercing, scarification, tattoo application.
- The “MSM” and MSM and IDU” categories are not applicable (N/A) to female cases.

- Risk factors are not mutually exclusive as a client may report multiple risk factors.
- No identifiable acquisition risk factor was defined as cases where responses to all the acquisition risk factors were *No*, or where the response to the question “No identifiable risk factor” was *Yes*.

Since 2019, IDU has consistently been one of the most frequently reported acquisition risk factors in MB, surpassing men who have sex with men (MSM). This pattern differs from national HIV surveillance data, where a large proportion of HIV diagnoses in 2024 were attributed to male-to-male sexual contact.⁷

A reported acquisition risk factor does not necessarily indicate the mode of transmission. In 2024, information about heterosexual contact was not readily available for analysis, so it is not included in this report. Caution is advised when interpreting acquisition risk factor results, particularly regarding heterosexual contact, which remains an important factor in HIV transmission in Manitoba. For more details, see the Limitations section.

⁷ [HIV in Canada: 2024 Surveillance Highlights](#). Public Health Agency of Canada. December 1, 2025.

Figure 10 illustrates the number and percentage of associated risk factors among newly diagnosed laboratory-confirmed HIV cases, by sex, in Manitoba in 2024. Among both females and males, the most reported were history of STBBI (68.5 per cent in females and 48.5 per cent in males) and unstable housing (60.8 per cent in females and 39.2 per cent in males), followed by non-injection substance use (32.2 per cent) among females and history of incarceration among males (37.7 per cent).

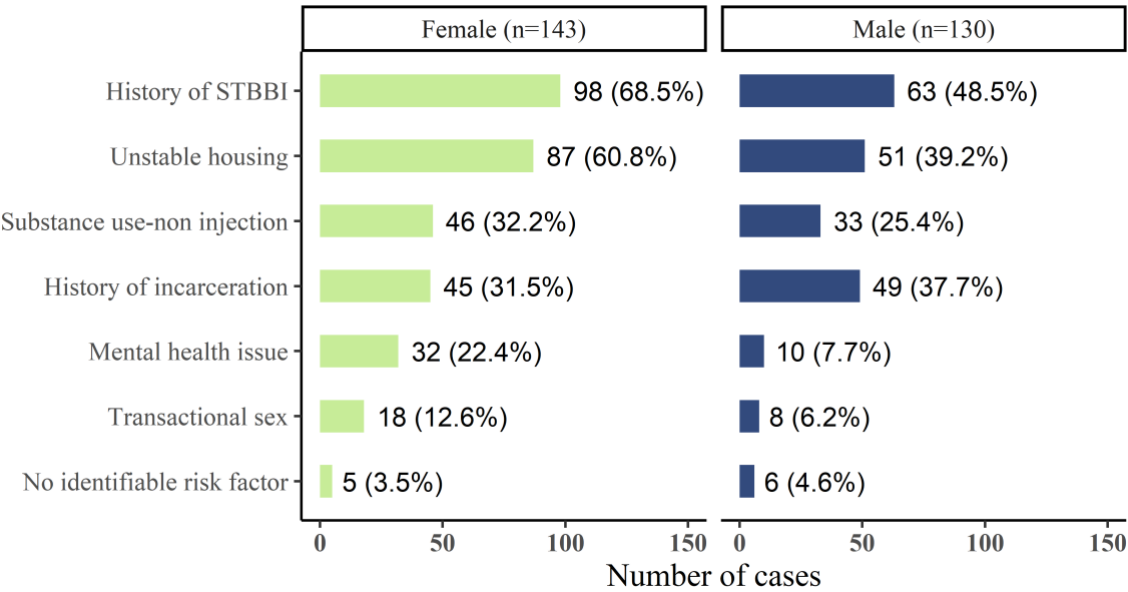


Figure 10. Reported associated risk factors among newly diagnosed laboratory-confirmed HIV cases by sex, Manitoba, 2024

Notes:

- “Transactional sex” includes risk factors “Has given goods in exchange for sex” and “Has received goods in exchange for sex.”
- Risk factors are not mutually exclusive as a client may report multiple risk factors.
- No identifiable risk factor was defined as cases where responses to all the risk factor questions, including both acquisition and associated risk factors, were *No*, or where the response to the question “No identifiable risk factor” was *Yes*.

Immune System Health at Diagnosis (first CD4 Count)

HIV weakens the immune system by reducing CD4 cells, which are a type of white blood cell essential for immune defense. If an individual has HIV and is not on treatment, CD4 counts will fall over time. The lower the CD4 cell count, the greater the damage to the immune system and the greater risk of illness. When an individual living with HIV takes treatment, CD4 counts should gradually increase. Higher CD4 counts at diagnosis suggest that the individual was diagnosed at an earlier stage of infection, while lower first CD4 counts indicate a later stage of infection at diagnosis. While CD4 counts can vary day to day in individuals, tracking this measure overall supports monitoring of late diagnoses and informs strategies for more timely testing and treatment to reduce further transmission of HIV.

[Figure 11](#) shows the breakdown of first CD4 count categories among newly diagnosed laboratory-confirmed HIV cases in Manitoba in 2024. Of 291 newly diagnosed cases, 212 (72.9 per cent) had a first CD4 count reported. Among these, the largest number of cases had a first CD4 count of 500 cells/mm³ or higher at diagnosis (n=90, 42.5 per cent), which is considered within the normal range. Smaller numbers of cases had lower first CD4 counts, with 51 (24.1 per cent) cases in the 350 to 499 range and 49 (23.1 per cent) cases in the 200 to 349 range. Twenty-two cases had first CD4 counts below 200 cells/mm³ (10.4 per cent), indicating advanced HIV at diagnosis.

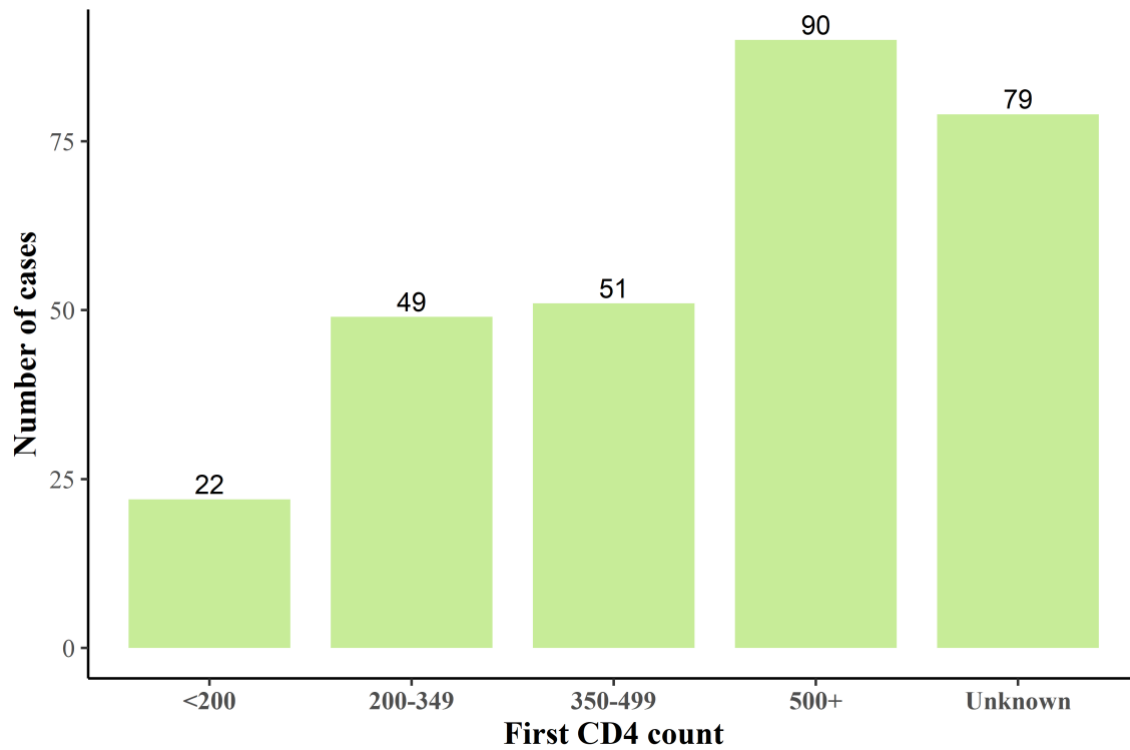


Figure 11. Number of newly diagnosed laboratory-confirmed HIV cases by first CD4 count category, Manitoba, 2024

As shown in [Figure 12](#), most HIV cases in both sexes had a first CD4 count of 500 cells/mm³ or higher at diagnosis, with 45 females and 45 males in this category. Females had more cases in the 200 to 349 and 350 to 499 ranges (28 and 26 cases) compared to males (21 and 25 cases). Males had more cases with a first CD4 count below 200 cells/mm³ (13 males vs. eight females), suggesting a higher proportional of late diagnoses among males. A substantial number of cases had unknown CD4 counts (45 females and 34 males), which may indicate challenges in maintaining engagement in care, particularly among people living with HIV who experience intersecting social and economic barriers, such as discrimination in the health-care system and housing instability.

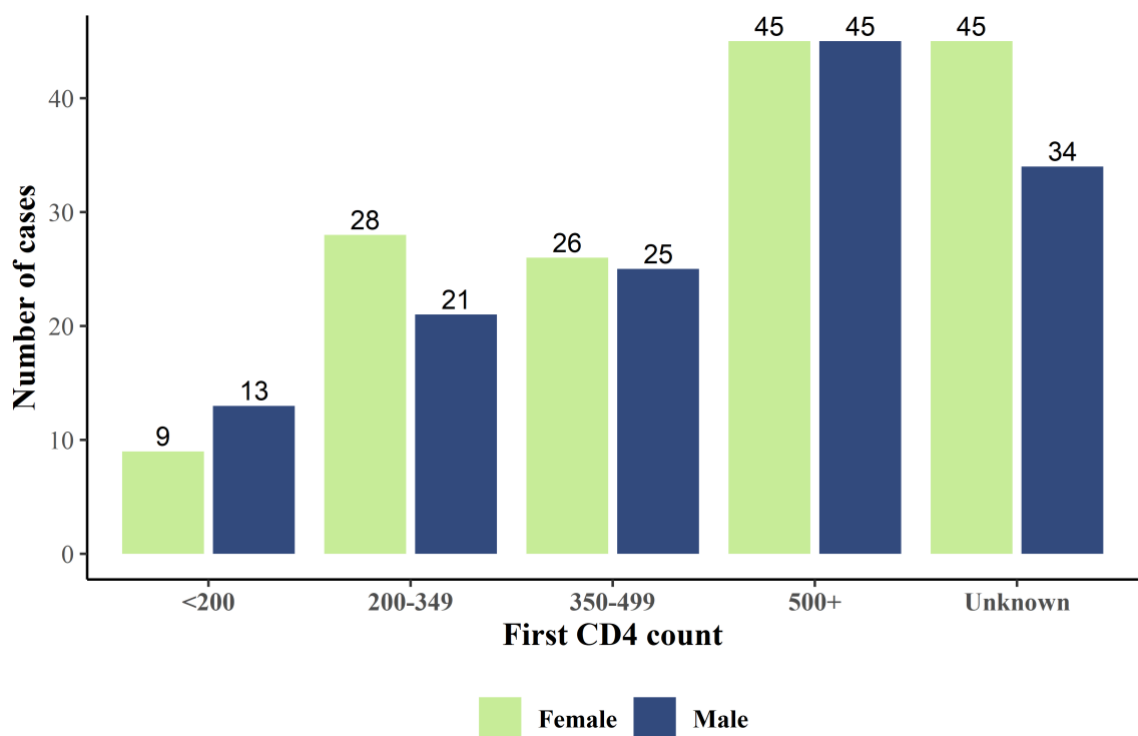


Figure 12. Number of newly diagnosed laboratory-confirmed HIV cases by first CD4 count category and sex, Manitoba, 2024

Conclusions

This report describes HIV testing trends and the epidemiology of newly diagnosed laboratory-confirmed HIV cases in Manitoba from 2019 to 2024. The number of people tested for HIV in 2024 (99,849 people) is similar to 2023 (100,463 people). HIV test positivity has increased over the past six years, rising from 0.26 per cent in 2019 to 0.70 per cent in 2024, which may reflect increased transmission and/or more targeted screening. There were 291 new HIV cases in 2024, slightly higher than 2023 (283 new cases). The age-standardized rate remained stable at 18.8 per 100,000 after several years of increase. In 2024, the rate declined slightly in males and increased in females, with females having a higher rate overall. Females were more commonly diagnosed in younger age groups and males were more commonly diagnosed in older age groups. Adults aged 30-39 years had the highest rates, with marked increases since 2019. In 2024, the Winnipeg Health Region accounted for most cases (n=186, 63.9 per cent), but Prairie Mountain Health Region reported the highest rate (26.4 per 100,000). Injection drug use was the most frequently reported acquisition risk factor for both females and males in 2024. Analyses of heterosexual contact, another important acquisition risk factor in Manitoba, could not be readily undertaken in 2024. Among both females and males, the most frequently reported associated risk factors were history of STBBI and unstable housing. Most cases with available data had a CD4 count of 500 or higher cells/mm³ at diagnosis. However, males had more cases with a first CD4 count below 200 cells/mm³ than females, suggesting later diagnoses among males.

Data Tables

The following data tables provide information that accompany the figures and results presented in this report.

Table 1. Number of HIV antigen/antibody screen tests and test positivity (percentage), tests completed by Cadham Provincial Laboratory, Manitoba, 2019 – 2024

Year	Number of screen tests	Number of people tested	Percent positivity
2019	124,833	90,097	0.26%
2020	117,885	82,055	0.31%
2021	123,220	85,292	0.38%
2022	133,905	93,489	0.49%
2023	144,771	100,463	0.62%
2024	145,698	99,849	0.70%

Table 2. Number, crude and age-standardized rates (per 100,000) of newly diagnosed laboratory-confirmed HIV cases, Manitoba, 2019 – 2024

Year	Cases	Crude Rate	Age-Standardized Rate	95% CI
2019	90	6.6	6.3	5.1 – 7.8
2020	98	7.1	6.9	5.6 – 8.4
2021	138	9.9	9.6	8.1 – 11.4
2022	197	13.8	13.4	11.6 – 15.4
2023	283	19.5	19.1	16.9 – 21.4
2024	291	19.6	18.8	16.7 – 21.2

Table 3. Number, crude and age-standardized rates (per 100,000) of newly diagnosed laboratory-confirmed HIV cases by sex, Manitoba, 2019 – 2024

Sex	Year	Cases	Crude Rate	Age-Standardized Rate	95% CI
Female	2019	42	6.1	5.8	4.2 – 7.9
	2020	46	6.6	6.4	4.7 – 8.5
	2021	71	10.1	9.8	7.7 – 12.4
	2022	105	14.6	14.2	11.6 – 17.2
	2023	142	19.5	19.1	16.1 – 22.5
	2024	153	20.5	19.6	16.6 – 23
Male	2019	48	7.0	6.8	5 – 9.1
	2020	52	7.5	7.5	5.6 – 9.8
	2021	67	9.6	9.5	7.4 – 12.1
	2022	92	13.0	12.7	10.2 – 15.6
	2023	140	19.4	19.0	16 – 22.5
	2024	138	18.7	18.2	15.3 – 21.5

Table 4. Number and age-specific rates (per 100,000) of newly diagnosed laboratory-confirmed HIV cases, Manitoba, 2019 – 2024

Year	Age Group (years)											
	0-19		20-29		30-39		40-49		50-59		60+	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
2019	3	0.87	39	20.79	28	14.66	9	5.24	9	5.09	2	0.66
2020	7	2.03	29	15.50	33	16.94	19	10.94	5	2.86	5	1.61
2021	6	1.74	40	21.09	56	28.51	21	12.02	10	5.79	5	1.56
2022	5	1.43	54	27.79	86	42.57	30	16.76	14	8.17	8	2.41
2023	4	1.13	78	39.69	95	45.70	75	40.75	24	14.21	7	2.07
2024	10	2.76	81	40.10	110	50.62	54	28.16	27	16.07	9	2.61

Table 5. Number, crude and age-standardized rates (per 100,000) of newly diagnosed laboratory-confirmed HIV cases by Health Region, Manitoba, 2019 – 2024

Health region	Year	Cases	Crude Rate	Age-Standardized Rate	95% Confidence Interval
WH	2019	50	6.4	6.0	4.4 – 7.9
	2020	59	7.5	7.1	5.4 – 9.2
	2021	77	9.7	9.2	7.2 – 11.5
	2022	143	17.6	16.4	13.8 – 19.3
	2023	188	22.6	21.0	18.1 – 24.2
	2024	186	21.7	20.0	17.2 – 23.1
NH	2019	13	16.9	15.5	8.2 – 26.7
	2020	10	12.9	12.6	6 – 23.3
	2021	24	31.1	30.1	19.2 – 45.1
	2022	15	19.3	17.2	9.6 – 28.5
	2023	31	40.1	41.1	27.8 – 58.7
	2024	21	27.2	25.3	15.6 – 38.9
SH-SS	2019	5	2.4	2.4	0.8 – 5.6
	2020	16	7.6	7.7	4.4 – 12.5
	2021	15	6.9	7.0	3.9 – 11.5
	2022	13	5.8	5.9	3.2 – 10.2
	2023	27	11.9	12.5	8.2 – 18.2
	2024	24	10.3	10.1	6.5 – 15.1
IEH	2019	6	4.5	5.1	1.9 – 11.1
	2020	3	2.2	2.5	0.5 – 7.3
	2021	11	8.1	9.2	4.6 – 16.6
	2022	6	4.4	4.8	1.8 – 10.5
	2023	9	6.5	7.3	3.3 – 13.8
	2024	13	9.4	10.5	5.6 – 18
PMH	2019	12	7.0	7.2	3.7 – 12.5
	2020	6	3.5	3.7	1.4 – 8.1
	2021	3	1.7	1.7	0.4 – 5.1
	2022	8	4.5	4.6	2 – 9.2
	2023	21	11.9	12.3	7.6 – 18.8
	2024	45	25.2	26.4	19.3 – 35.4

Appendix A - Introduced HIV Cases

In Manitoba, in 2024, there were 85 HIV cases introduced into the province. Although introduced cases are not incident cases and do not reflect local transmission in Manitoba, they are important to monitor, as each case requires ongoing clinical care and antiretroviral therapy and may contribute to ongoing transmission.

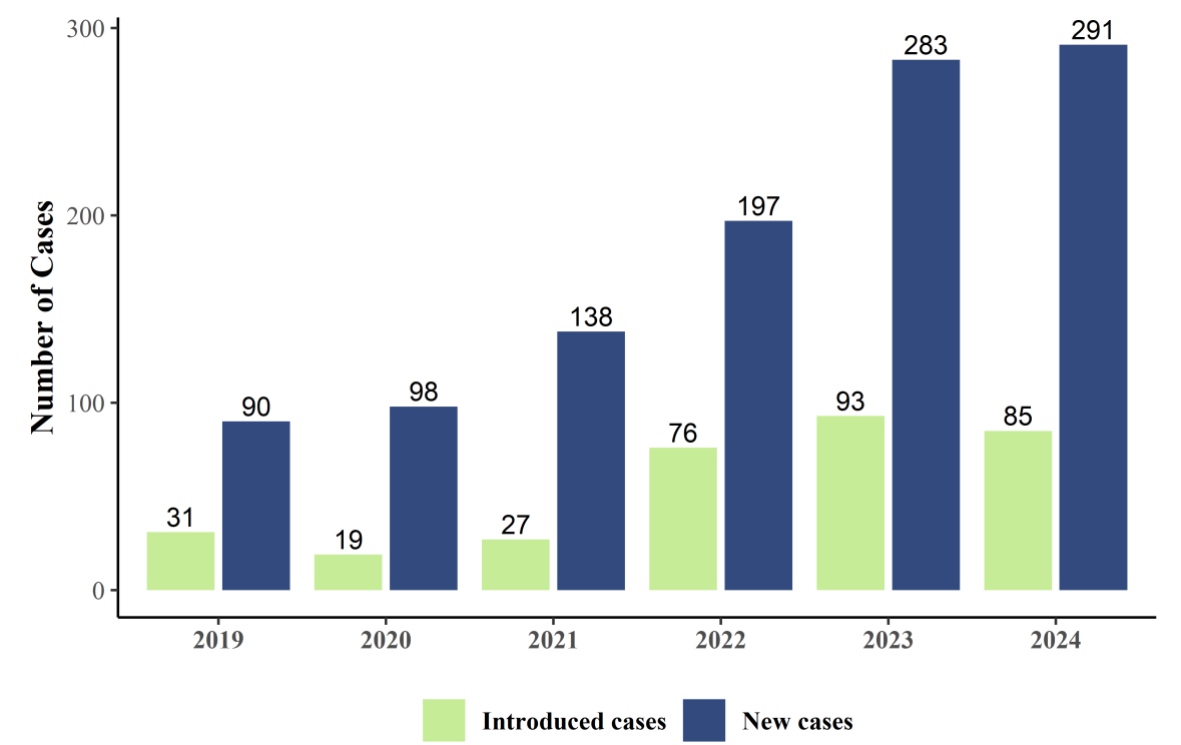


Figure A-1. Number of HIV cases by type of HIV cases, Manitoba, 2019-2024

Appendix B - Other HIV Reports

Provincial STBBI Surveillance Report

Variation in the number of cases reported within the [provincial Sexually Transmitted and Blood-Borne Infections \(STBBI\) surveillance report](#) and [provincial HIV surveillance reports](#) may be explained by differences in case definitions and the timing of data extraction from PHIMS. Specifically, the CSC cases are excluded from the annual HIV surveillance update report, but are included in the STBBI surveillance report. In addition, information on cases is continuously updated in PHIMS, which may result in differences between the STBBI and HIV surveillance reports.

Manitoba HIV Program Updates

Variation in the number of cases reported within [Manitoba HIV Program Updates](#) and [provincial surveillance reports](#) may be explained by differences in case definitions, geographical boundaries, and the timing of data extraction. Specifically, the Manitoba HIV Program uses a case definition that requires presentation to a clinic for HIV care, whereas the annual surveillance report counts newly diagnosed cases of HIV based on laboratory confirmation. In addition, the Manitoba HIV Program provides care to HIV-positive individuals who live near and outside the provincial border. These people are included in the Manitoba HIV Program Updates. In surveillance updates, non-residents of Manitoba are excluded.

National HIV Surveillance Reports

Manitoba provides non-nominal HIV surveillance data to the Centre for Communicable Diseases and Infection Control at the Public Health Agency of Canada (PHAC) on an annual basis for inclusion in [national surveillance reports](#). If/where there are variations in case numbers reported in provincial and national reports, this is explained by the use of slightly different case definitions and continuous updating of information within the provincial public health system, PHIMS. Specifically, CSC cases are included in the data submission to PHAC.