

2023 Massachusetts Integrated HIV, STI, and Viral Hepatitis Surveillance Report



Massachusetts Department of Public Health
Bureau of Infectious Disease and
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Slide set for 2023 Integrated Report

<https://www.mass.gov/lists/std-data-and-reports>

For additional contact information see [HIV, STI, and Viral Hepatitis Program Staff Contact Information](#)

Acknowledgments

We are grateful to healthcare providers and laboratories across the Commonwealth who report HIV, STI, and viral hepatitis diagnoses and corresponding clinical information to the Massachusetts Department of Health (DPH), Bureau of Infectious Disease and Laboratory Sciences (BIDLS). These reports are essential to perform timely epidemiologic investigations and to inform an effective public health response. We also wish to acknowledge the contributions of the many program staff within BIDLS who collect, manage, maintain, and analyze this information and who reviewed draft sections relevant to their areas of expertise.

ⁱ Providers may use this number to report individuals newly diagnosed with a notifiable sexually transmitted infection, including HIV, or request partner services. Partner services is a free and confidential service for individuals recently diagnosed with a priority infection. The client-centered program offers counseling, linkage to other health and social services, anonymous notification of partners who were exposed and assistance with getting testing and treatment. For more information, see: <https://www.mass.gov/service-details/partner-services-program-information-for-healthcare-providers>

TABLE OF CONTENTS

DESCRIPTION	PAGE
<u>List of Commonly Used Acronyms</u>	iii
<u>Key Highlights</u>	1
<u>Chlamydia</u>	4
<u>Gonorrhea</u>	11
<u>Syphilis</u>	16
<u>HIV</u>	21
<u>Viral Hepatitis – Hepatitis A</u>	30
<u>Viral Hepatitis – Hepatitis B</u>	31
<u>Viral Hepatitis – HCV</u>	35
<u>Co-infections</u>	39
<u>Specific Populations – Adolescents and Young Adults</u>	45
<u>Specific Populations – Men Who Have Sex with Men</u>	51
<u>Specific Populations – Persons Who Inject Drugs</u>	58
<u>Specific Populations – Racial/Ethnic Minorities</u>	61
<u>Specific Populations – Women and Infants</u>	65
<u>Specific Populations – Older Individuals</u>	67
<u>Technical Notes</u>	
• <u>Strengths and Limitations of Data</u>	76
• <u>Interpreting HIV, STI, and Viral Hepatitis Data</u>	77
• <u>HIV, STI, and Viral Hepatitis Case Classifications</u>	80
<u>HIV, STI, and Viral Hepatitis Program Staff Contact Information</u>	98
<u>HIV, STI, and Viral Hepatitis Resources</u>	99

LIST OF COMMONLY USED ACRONYMS

AFAB	Assigned Female at Birth
AI/AN	American Indian/Alaska Native
AIDS	Acquired Immunodeficiency Syndrome
AMAB	Assigned Male at Birth
API	Asian/Pacific Islander
BIDLS	Bureau of Infectious Disease and Laboratory Sciences
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CI	Confidence Interval
COVID-19	Coronavirus Disease 2019
DOE	Department of Education
DPH	(Massachusetts) Department of Public Health
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSR	Health Service Region
HTSX	Heterosexual Sex
IDU	Injection Drug Use
MSM	Male-to-Male Sex or Men Who Have Sex with Men
N	Number
NH	Non-Hispanic
NIR	No Identified Risk
PLWH	Persons Living with HIV Infection
Pres. HTSX	Presumed Heterosexual Sex
PR/USD	Puerto Rico/United States Dependency
PWID	Persons Who Inject Drugs
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection

KEY HIGHLIGHTS

The 2023 Integrated HIV, STI, and Viral Hepatitis Surveillance Report provides data on infections reported to the Massachusetts Department of Public Health (DPH), Bureau of Infectious Disease and Laboratory Sciences (BIDLS) by healthcare providers and laboratories per regulation (105 CMR 300.000). This report focuses on a subset of these diseases:

- Chlamydia
- Gonorrhea
- Syphilis
- HIV
- Hepatitis A, B and C

The intended audience for this annual surveillance report includes the clinicians and laboratory professionals who report cases, community organizations, local public health departments, advocates, policymakers, and researchers who are interested in the health of Massachusetts residents.

Key highlights in 2023

Chlamydia, Gonorrhea, and Syphilis:

- Chlamydia continues to be the most frequently reported STI, with nearly 29,000 cases reported in 2023.¹
- The total number of confirmed chlamydia cases increased by 31% from 24,143 in 2014 to 31,633 in 2019, decreased to 24,701 in 2020, and then increased to 28,910 in 2023. However, with 28,910 cases reported in 2023, confirmed chlamydia incidence has not yet returned to pre-COVID levels.
- The overall average age of confirmed chlamydia cases in Massachusetts increased from 24.6 years in 2014 to 26.4 years in 2023.
- After a sharp 57% increase from 2016 (N=4,638) to 2017 (N=7,293), confirmed gonorrhea incidence remained relatively stable through 2020 (N=7,303), and then increased by 34% to 9,779 in 2023.
- The number of confirmed gonorrhea cases reported among males is approximately twice that reported among females. In 2023, 6,662 confirmed gonorrhea cases were reported among males, compared to 3,038 among females, and 71 among individuals of transgender experience and/or nonbinary individuals.²
- The number of confirmed and probable infectious syphilis cases (primary, secondary, and early non-primary non-secondary syphilis diagnosed within the first year of infection) increased to a ten-year high of 1,579 in 2022 and subsequently decreased to 1,449 in 2023. Although the number of cases among females have risen over the past decade, infectious syphilis continues to disproportionately affect males, reflecting an ongoing epidemic among men who have sex with men (MSM).
- After remaining between zero and four from 2011 to 2018, the annual number of reportable cases of congenital syphilis diagnosed in Massachusetts increased significantly, ranging from nine to fourteen between 2019 to 2023. The proportion of congenital syphilis cases averted also increased during this time period from 80% in 2019 (N=35 all stage syphilis cases among pregnant persons who did not have a confirmed or probable congenital syphilis case/44 total all stage syphilis cases among all pregnant persons) to 87% in 2023 (N=91/105).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates, for more information see Interpreting HIV, STI, and Viral Hepatitis Data.

KEY HIGHLIGHTS

- According to CDC, among the 50 states in 2022, Massachusetts ranked 36th in chlamydia incidence rate (at 406.4 per 100,000), 38th in gonorrhea incidence rate (at 131.9 per 100,000), and 34th in primary and secondary syphilis incidence rate (at 11.8 per 100,000).¹

HIV:

- The number of persons living with HIV infection (PLWH) in Massachusetts increased by 11% from 21,785 at the end of 2014 to 24,119 at the end of 2023.^{2,3}
- After averaging approximately 640 diagnoses per year from 2014 to 2018 (five-year average of 636), the number of new HIV infection diagnoses declined to 532 in 2019. In 2020, the number of new HIV infection diagnoses further declined to 434 and then remained at this lower level in 2021 and 2022, when there were 449 and 446 diagnoses, respectively. In 2023, the number of new HIV infection diagnoses (N=540) returned to pre-pandemic levels, increasing by 21% compared to the prior year.
- The number of deaths due to any cause among individuals reported with HIV infection increased by 32% from 279 in 2014 to a peak of 367 in 2022 and then decreased by 16% to 307 in 2023.
- There were large disparities in age-adjusted HIV diagnosis rates by race/ethnicity: the average annual age-adjusted HIV diagnosis rates for 2021 to 2023 among Black (non-Hispanic) individuals (34.7 per 100,000) and Hispanic/Latinx individuals (15.5 per 100,000) were 11 and five times that of White (non-Hispanic) individuals (3.2 per 100,000), respectively.
- Male-to-male sex (MSM) remained the predominant exposure mode among individuals diagnosed with HIV infection, accounting for 39% of recent HIV infection diagnoses (from 2021 to 2023). Those reported with no identified risk (NIR) comprised the second largest exposure mode group, accounting for 28% of recent HIV infection diagnoses and consisting predominantly of individuals assigned male at birth (AMAB) (73%), individuals born outside the US (58%), Black (non-Hispanic) individuals (50%), and Hispanic/Latinx (26%) individuals.
- The total statewide number of reported cases with injection drug use (IDU) as the primary exposure mode increased from 59 in 2019 to 82 in 2021. The increase was primarily due to a cluster of HIV infection identified in early 2019 in Boston among people who inject drugs (PWID) who were experiencing or had experienced recent homelessness. Following a focused public health response, the number of HIV infection diagnoses attributed to IDU decreased by 54% to 38 cases in 2023.
- As of July 1, 2024, a total of 213 cases diagnosed since November 2018 have been investigated and identified as part of the Boston cluster. As it is an active cluster of concern among PWID, additional cases will continue to be investigated and added. Continuing trends among those newly diagnosed in the Boston cluster (N=15 cases diagnosed in 2023) include an increase in polysubstance and methamphetamine use.⁴

¹ Centers for Disease Control and Prevention. Sexually Transmitted Infections Surveillance 2022 Atlanta: U.S. Department of Health and Human Services; 2024. Please note, 2022 state rankings and rates are presented because 2023 rankings were not yet available at the time of this publication. 2022 rates presented here are from CDC and may differ from 2022 rates reported in the Massachusetts Integrated HIV, STI, and Viral Hepatitis Reports.

² 2023 HIV prevalence data are preliminary and subject to change.

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

⁴ For more information, see: Joint MDPH and BPHC Clinical Advisory: Increase in newly diagnosed HIV infections among persons who inject drugs in Boston, March 15, 2021, available at: <https://www.mass.gov/doc/joint-mdph-and-bphc-clinical-advisory-hiv-transmission-through-injection-drug-use-in-boston-march-15-2021/download>

KEY HIGHLIGHTS

Hepatitis A, B, and C:

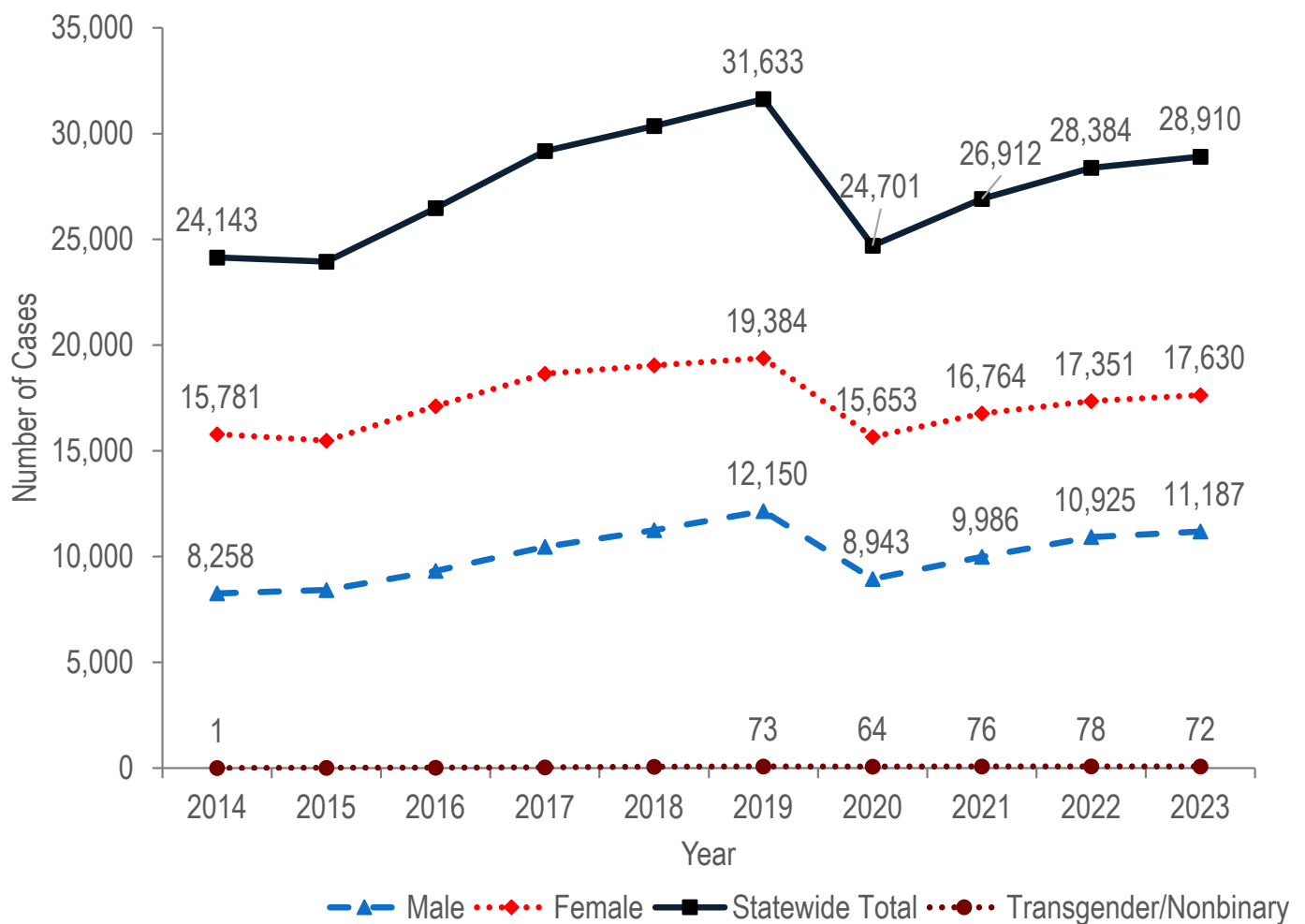
- Between 2018 and 2020,¹ DPH and local health departments investigated an outbreak of hepatitis A. The populations most affected by the outbreak were those with recent homelessness or unstable housing, and/or substance use disorder. The outbreak was declared over in spring of 2020 and case counts among the affected populations remained low through 2022. However, a small outbreak affecting these same populations was detected in the fall of 2023, prompting additional vaccination efforts.
- From 2014 to 2023, an average of 1,733 cases of confirmed and probable chronic hepatitis B virus (HBV) infection were reported each year (with a low of 1,172 in 2020 and a high of 1,994 in 2017). Changes in testing behaviors and travel due to the COVID-19 pandemic likely influenced the number of reported cases and may have contributed to the decrease in 2020, followed by the rebound from 2021 to 2023.
- The total number of confirmed acute HBV cases reported decreased from 53 cases in 2017 to 14 cases in 2021 and subsequently increased to 36 cases in 2023.
- In 2023, 2,580 confirmed and probable cases of hepatitis C (HCV) were reported. Most reported cases are chronically infected and DPH currently estimates that there are over 250,000 persons living with HCV infection in Massachusetts.
- The majority of HCV cases reported in 2023 were among young adults (age 20–39 years), reflecting ongoing transmission among young people who inject drugs.

¹Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

CHLAMYDIA BY GENDER

Chlamydia is the most frequently reported sexually transmitted infection (STI) in Massachusetts and nationally. Chlamydia is a sexually transmitted bacterial infection that can be spread through vaginal, anal, or oral sexual contact with an infected partner, and from a pregnant person to child during birth. While most people with chlamydia usually have no signs or symptoms, some may experience dysuria; vaginal, penile, or anal discharge; or irregular bleeding. Chlamydia is easily treated, but repeated infections are common. Women are at great risk of complications of repeated infections. For more information, see <https://www.cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm>.

Figure 1. Number of confirmed chlamydia cases reported by gender, Massachusetts 2014–2023



Note: Cases with no gender reported (2014–2023: N=423) are included in the statewide total but are not depicted in Figure 1 separately due to small numbers. Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change.

CHLAMYDIA BY GENDER

- The total number of confirmed chlamydia cases increased by 31% from 24,143 in 2014 to 31,633 in 2019, decreased to 24,701 in 2020, and then increased to 28,910 in 2023.¹ A decrease in chlamydia cases in 2020, followed by an increase in 2021 was also observed nationally.²
- Each year from 2014 to 2023, approximately twice as many confirmed chlamydia cases were reported among females as among males. In 2023, the ratio of female-to-male chlamydia cases was 1.6 (1.6 = 17,630/11,187).
- In 2023, 72 confirmed chlamydia cases were reported among individuals of transgender experience and/or individuals who are nonbinary.³

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² CDC, Trends in Reported Cases and Rates of Reported Cases for Nationally Notifiable STDs, United States, 2017-2021*, available at

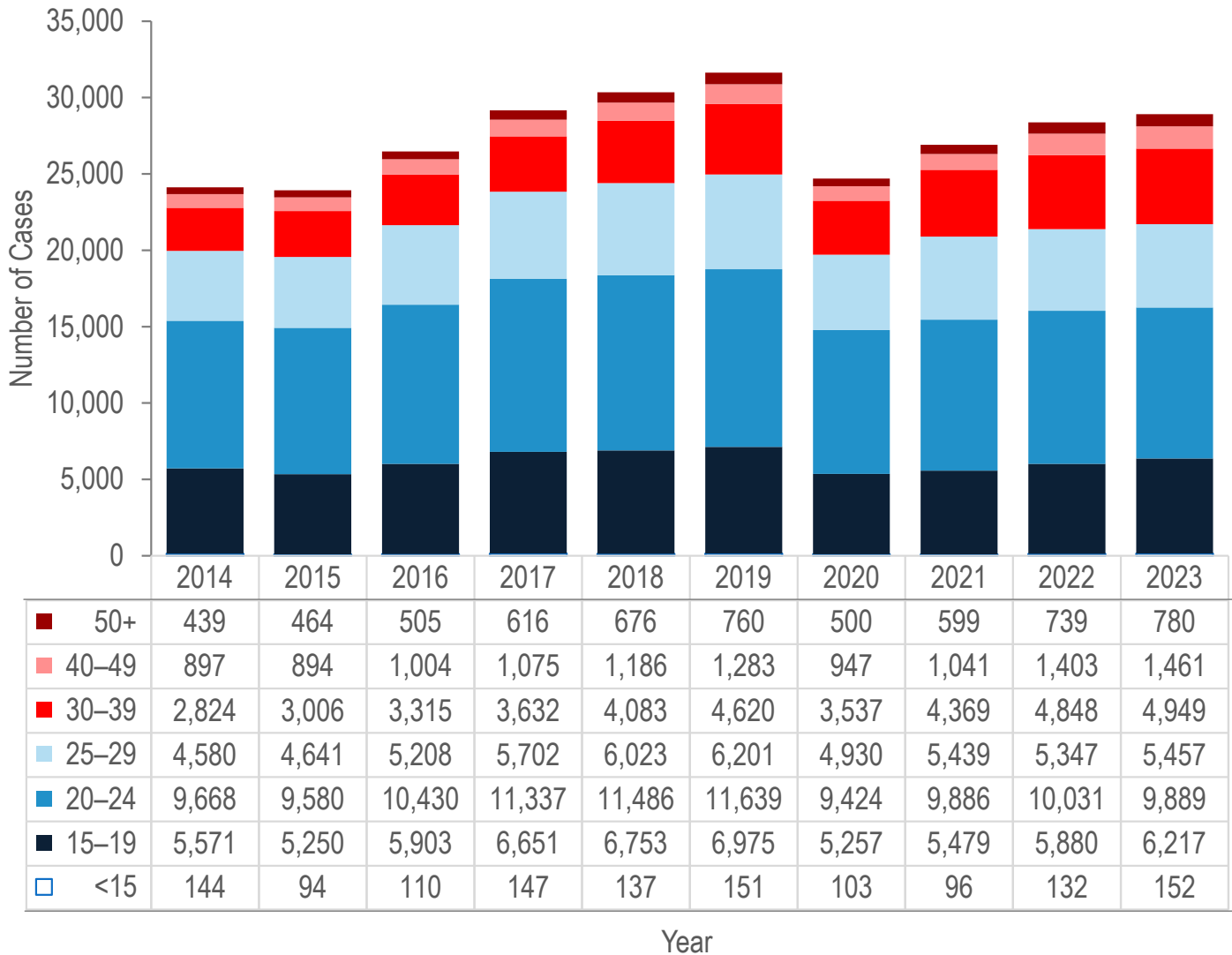
<https://www.cdc.gov/std/statistics/2021/default.htm>

Pagaoa, Melissa MPH; Grey, Jeremy PhD; Torrone, Elizabeth PhD; Kreisel, Kristen PhD; Stenger, Mark MA; Weinstock, Hillard MD Trends in Nationally Notifiable Sexually Transmitted Disease Case Reports During the US COVID-19 Pandemic, January to December 2020, Sexually Transmitted Diseases: October 2021 - Volume 48 - Issue 10 - p 798-804

³ Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates. For more information, see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

CHLAMYDIA BY AGE

Figure 2. Number of confirmed chlamydia cases reported by age group (years), Massachusetts 2014–2023



Note: Cases with no age reported (2014–2023: N=90) are not included in this figure
 Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change.

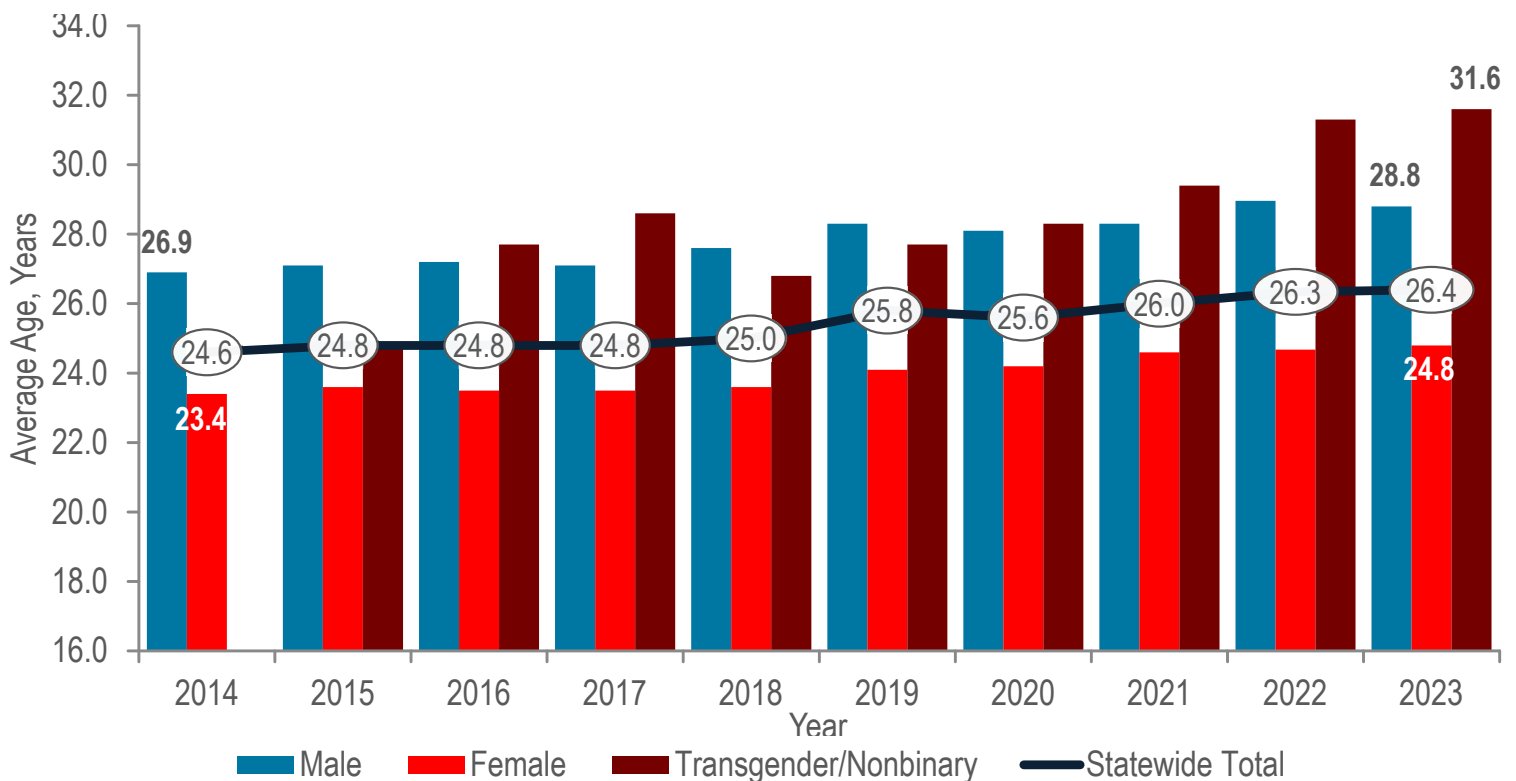
- Each year from 2014 to 2023, the greatest number of confirmed chlamydia cases was reported among 20–24 year-olds, followed by 15–19 year-olds. In each of these years over half (56% to 63%) of confirmed chlamydia cases were reported among individuals in these age groups.¹
- From 2014 to 2023, the largest increase in the number of confirmed chlamydia cases was among individuals aged 30–39 years (by 75% from 2,824 to 4,949).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

CHLAMYDIA BY AVERAGE AGE AND GENDER

In 2021, the United States Preventive Services Task Force and the CDC recommended screening for chlamydia in sexually active women under 25 years of age, and in older women at increased risk for infection.¹ Screening of sexually active young men is also recommended in higher prevalence clinical settings such as adolescent clinics, correctional facilities, and sexual and reproductive health clinics, and among men who have sex with men.²

Figure 3. Average age of confirmed chlamydia cases reported by gender, Massachusetts 2014–2023



Note: Cases with no age reported (2014–2023: N=90) are not included in this analysis and transgender/nonbinary cases are not presented for 2014 because collection of this gender began in 2015.

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- The overall average age of confirmed chlamydia cases in Massachusetts increased from 24.6 years in 2014 to 26.4 years in 2023.³ This marks the fifth year that the average age has exceeded the CDC recommended screening age range of under 25 years for sexually active women.
- The increase in average age appeared to be driven mostly by male chlamydia cases. From 2014 to 2023, the proportion of confirmed chlamydia cases among males increased from 34% to 39% (See Figure 1). Additionally, the increase in average age of confirmed chlamydia cases reported among males was greater than the increase among females. From 2014 to 2023, the average age of confirmed chlamydia cases reported among males increased by 1.9 years compared to an increase of 1.4 years among females.

¹ Source: *Final Recommendation Statement: Chlamydia and Gonorrhea: Screening*. U.S. Preventive Services Task Force. September 2021.

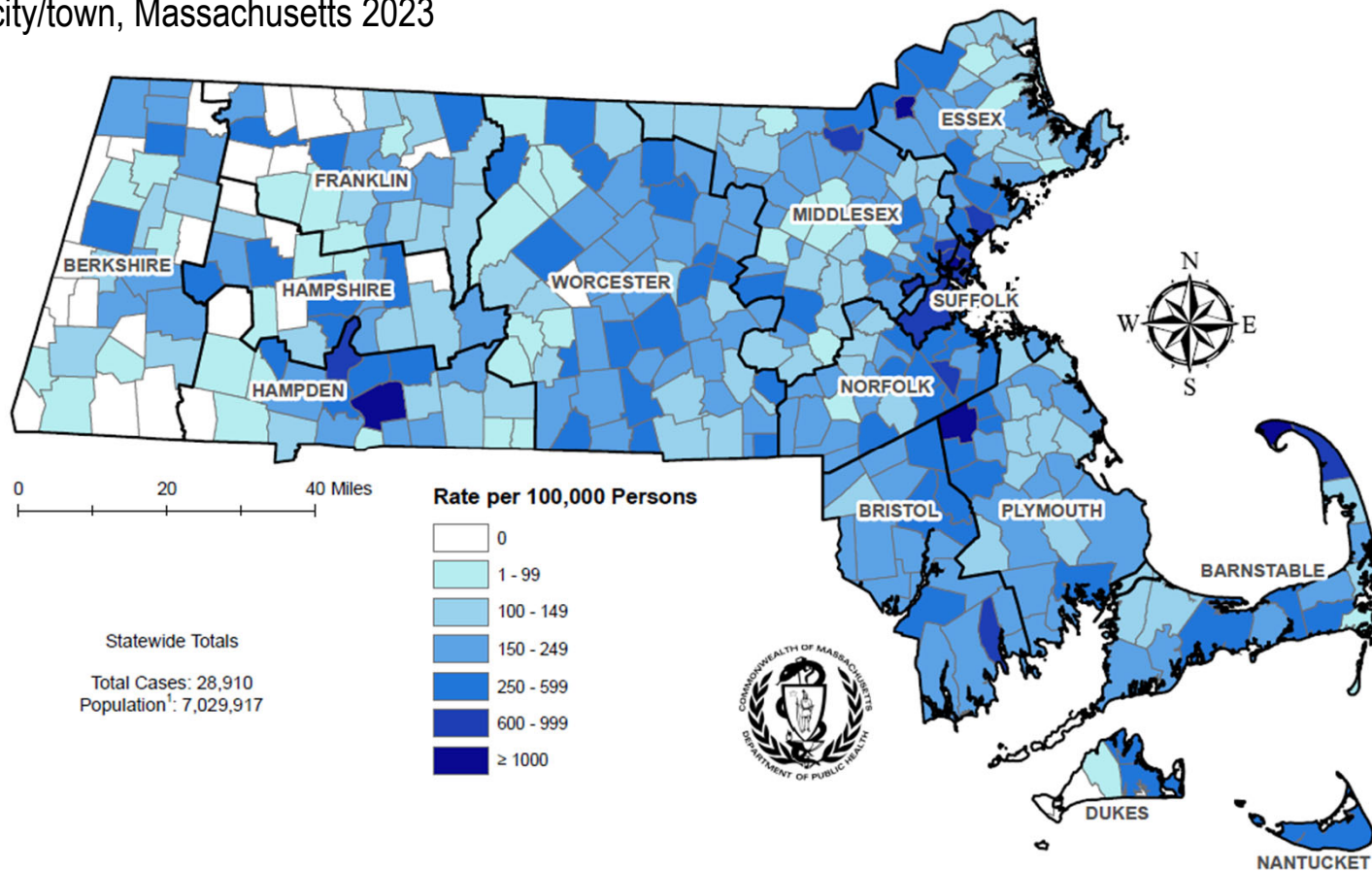
<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening#fullrecommendationstart>.

² For more information, see MDPH Chlamydia Screening Advisory (2022) <https://www.mass.gov/doc/chlamydia-screening-advisory-2022/download>

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

CHLAMYDIA BY CITY/TOWN

Figure 4. Incidence rate of confirmed chlamydia cases per 100,000 population¹ reported by city/town, Massachusetts 2023



Note: regional data include individuals tested in a correctional facility.

There are no city/towns with <10 cases of chlamydia that fall within the top two rate categories (≥600 cases per 100,000)

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- Confirmed chlamydia cases continue to be reported throughout Massachusetts, with concentrations in the most populated cities.
- The five cities² with the highest confirmed chlamydia incidence rates in 2023³ were Provincetown (2,156.1 per 100,000),⁴ Brockton (1,335.6 per 100,000), Springfield (1,040.9 per 100,000), Chelsea (1,012.6 per 100,000), and Lawrence (1,010.7 per 100,000).
- In 2023, the statewide confirmed chlamydia incidence rate of 411.2 per 100,000 population was lower than the 2022 national rate of 495.0 per 100,000.⁵
 - While Louisiana ranked first and Vermont ranked 50th, Massachusetts ranked 36th in chlamydia incidence rate among the 50 states in 2022, the last year for which these national data are publicly available.⁶

¹ Population based on University of Massachusetts Donahue Institute Estimates.

² Among cities that reported at least 12 confirmed chlamydia cases in 2023.

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

⁴ The chlamydia incidence rate for Provincetown is high because of small population size (2,583), as opposed to the number of cases (79).

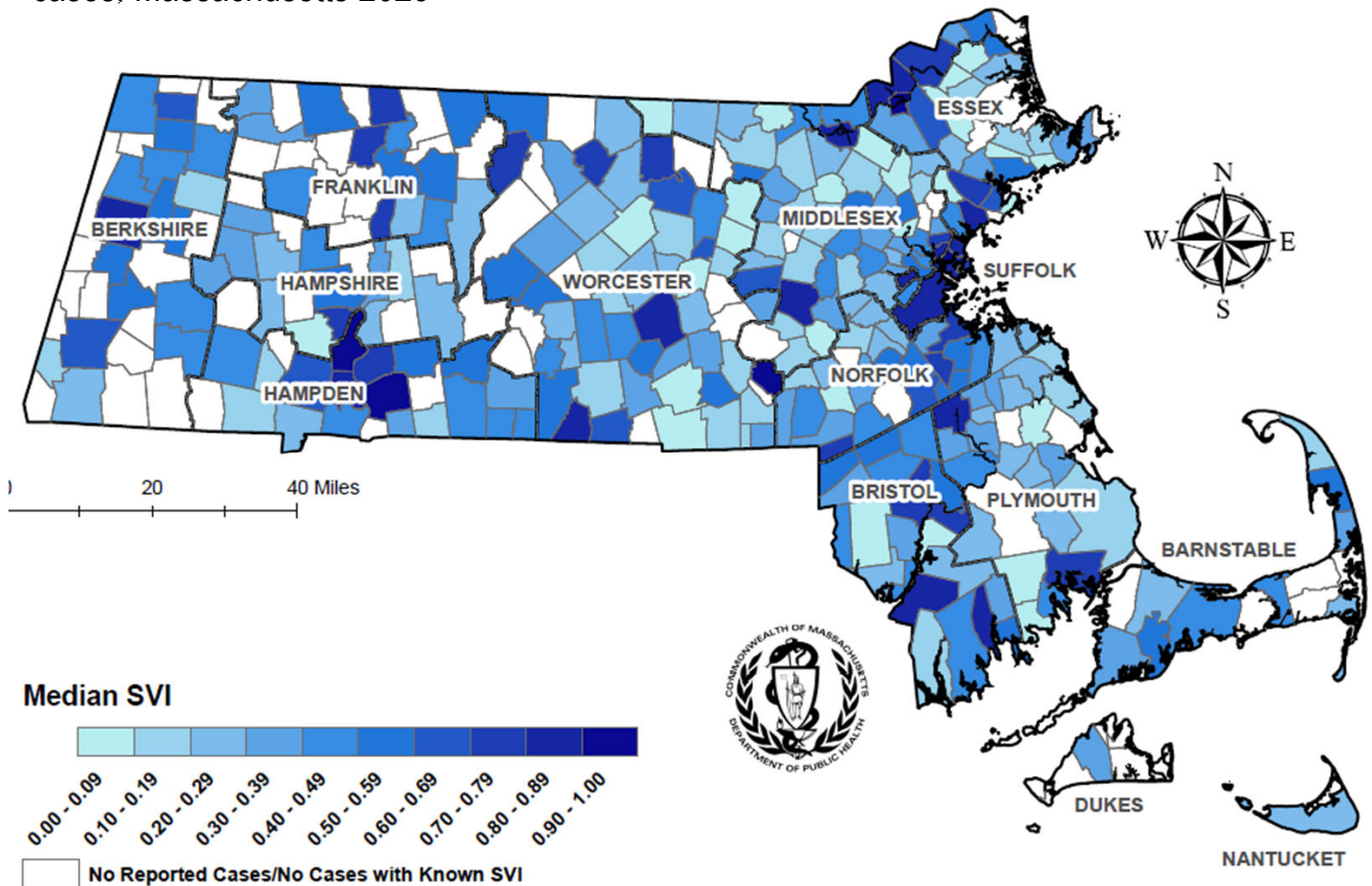
⁵ Centers for Disease Control and Prevention, Sexually Transmitted Infections Surveillance 2022, available at <https://www.cdc.gov/std/statistics/2021/default.htm>

⁶ Centers for Disease Control and Prevention. *Sexually Transmitted Infections Surveillance 2022* Atlanta: U.S. Department of Health and Human Services; 2024. Please note, 2022 state rankings are presented because 2023 rankings were not yet available at the time of this publication.

SVI AMONG CHLAMYDIA CASES BY CITY/TOWN

The social vulnerability index (SVI)¹ is a tool to identify socially vulnerable communities that was created by CDC and the Agency for Toxic Substances and Disease Registry (ATSDR). The CDC/ATSDR SVI uses U.S. Census data to determine the social vulnerability of every census tract. The SVI ranks each tract on 16 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation. Each census tract receives a separate ranking for each of the four themes, as well as an overall ranking. Originally developed to incorporate social determinants of health into emergency response and recovery efforts for environmental and natural disasters, more recently, higher SVI has been linked to higher HIV² and STI³ diagnosis rates, COVID-19 mortality, and lower COVID-19 vaccination coverage.⁴

Figure 5. Median overall Social Vulnerability Index (SVI) by city/town for confirmed chlamydia cases, Massachusetts 2023



Note: Census tract level overall SVI values for 2020 were obtained from the CDC/Agency for Toxic Substance and Disease Registry and assigned to all cases based on their street address at diagnosis, 1,084 cases were excluded from this analysis because address was unknown or the individuals were homeless. City/Town level median is calculated from the median SVI score for that city/town among gonorrhea cases. Values range from 0 to 1, with higher values implying greater social vulnerability. Map should be interpreted with caution as it displays median SVI scores for cities/towns with one or more cases. Data Sources: CDC/Agency for Toxic Substance and Disease, Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change.

¹ For more information, see: <https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>

² Gant, Z., Dailey, A., Hu, X. et al. A Census Tract-Level Examination of Diagnosed HIV Infection and Social Vulnerability among Black/African American, Hispanic/Latinx, and White Adults, 2018: United States. *J. Racial and Ethnic Health Disparities* (2022). <https://doi.org/10.1007/s40615-022-01456-7>

³ Copen CE, Haderkhanaj LT, Renfro KJ, Loosier PS. County-Level Chlamydia and Gonorrhea Rates by Social Vulnerability, United States, 2014-2018. *Sex Transm Dis.* 2022 Dec 1;49(12):822-825.

⁴ Dasgupta S, Bowen VB, Leidner A, et al. Association Between Social Vulnerability and a County's Risk for Becoming a COVID-19 Hotspot — United States, June 1–July 25, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1535–1541. DOI: <http://dx.doi.org/10.15585/mmwr.mm6942a3>

SVI AMONG CHLAMYDIA CASES BY CITY/TOWN

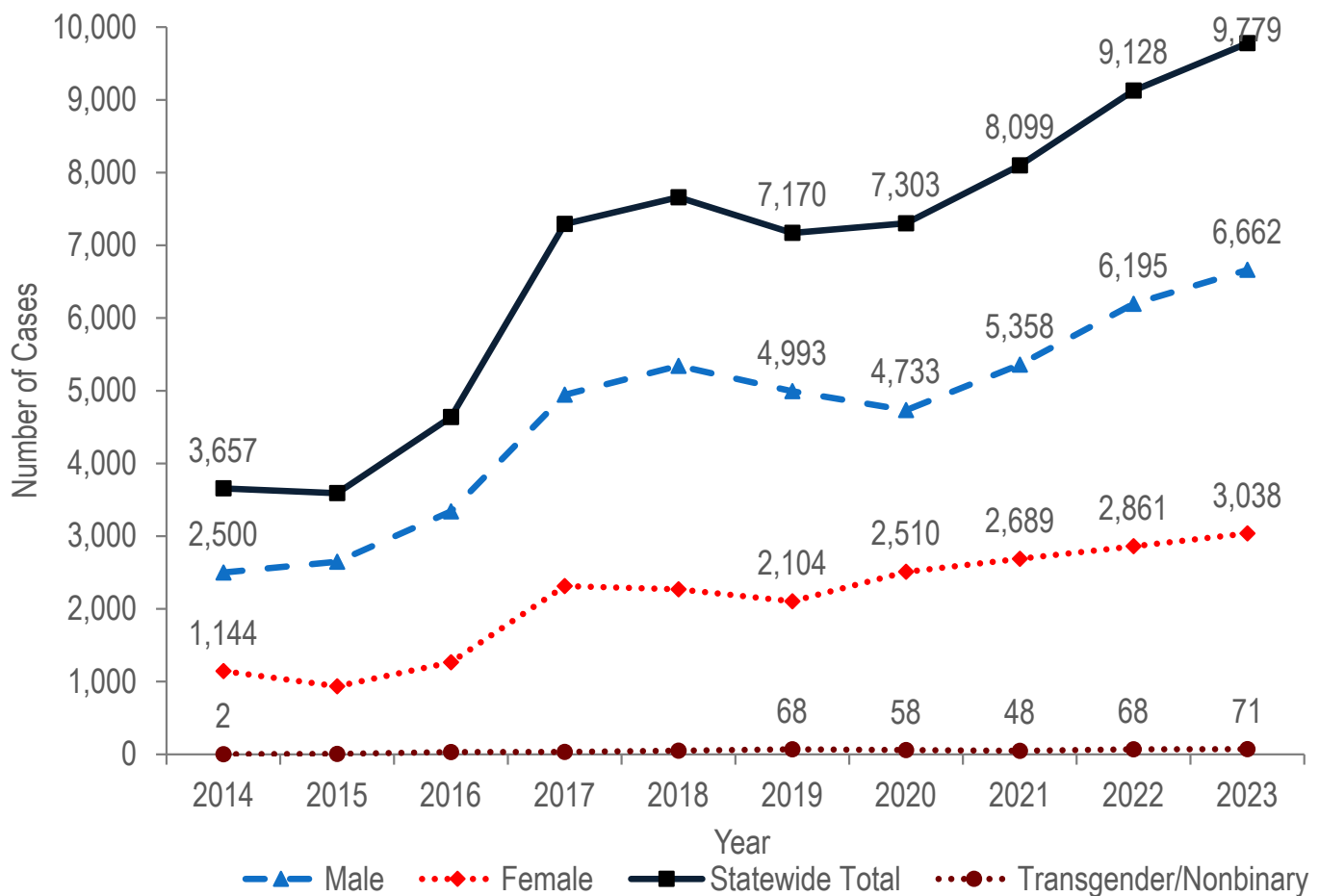
- In 2023,¹ the median SVI score among confirmed chlamydia cases in Massachusetts was 0.747, which would be categorized as highly vulnerable.
- The five cities with the highest SVI scores (i.e., the most highly vulnerable) among confirmed chlamydia cases in 2023 were Holyoke (0.938), Lawrence (0.934), Milford (0.911), Chelsea (0.910), and Springfield (0.894).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

GONORRHEA BY GENDER

Gonorrhea is a common bacterial STI. It can be spread through vaginal, anal, or oral sexual contact with an infected partner, or to an infant during birth. Symptoms of gonococcal infection can vary depending on the site of infection and may include dysuria; vaginal, penile, or anal discharge; irregular bleeding; abdominal or anal pain; and sore throat. Still, many infected individuals do not present with any symptoms of infection. Although gonorrhea infection is treatable, treatment has become more complex with increased antimicrobial non-susceptibility, including two cases of a novel strain of multidrug-non-susceptible gonorrhea that were detected in Massachusetts in 2022. For more information, see <https://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea-detailed.htm>. For more general information, see <https://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea-detailed.htm>.

Figure 6. Number of confirmed gonorrhea cases reported by gender, Massachusetts 2014–2023



Note: Cases with no gender reported (2014–2023: N=39) are included in the statewide total but are not depicted in Figure 6 separately due to small numbers. Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

GONORRHEA BY GENDER

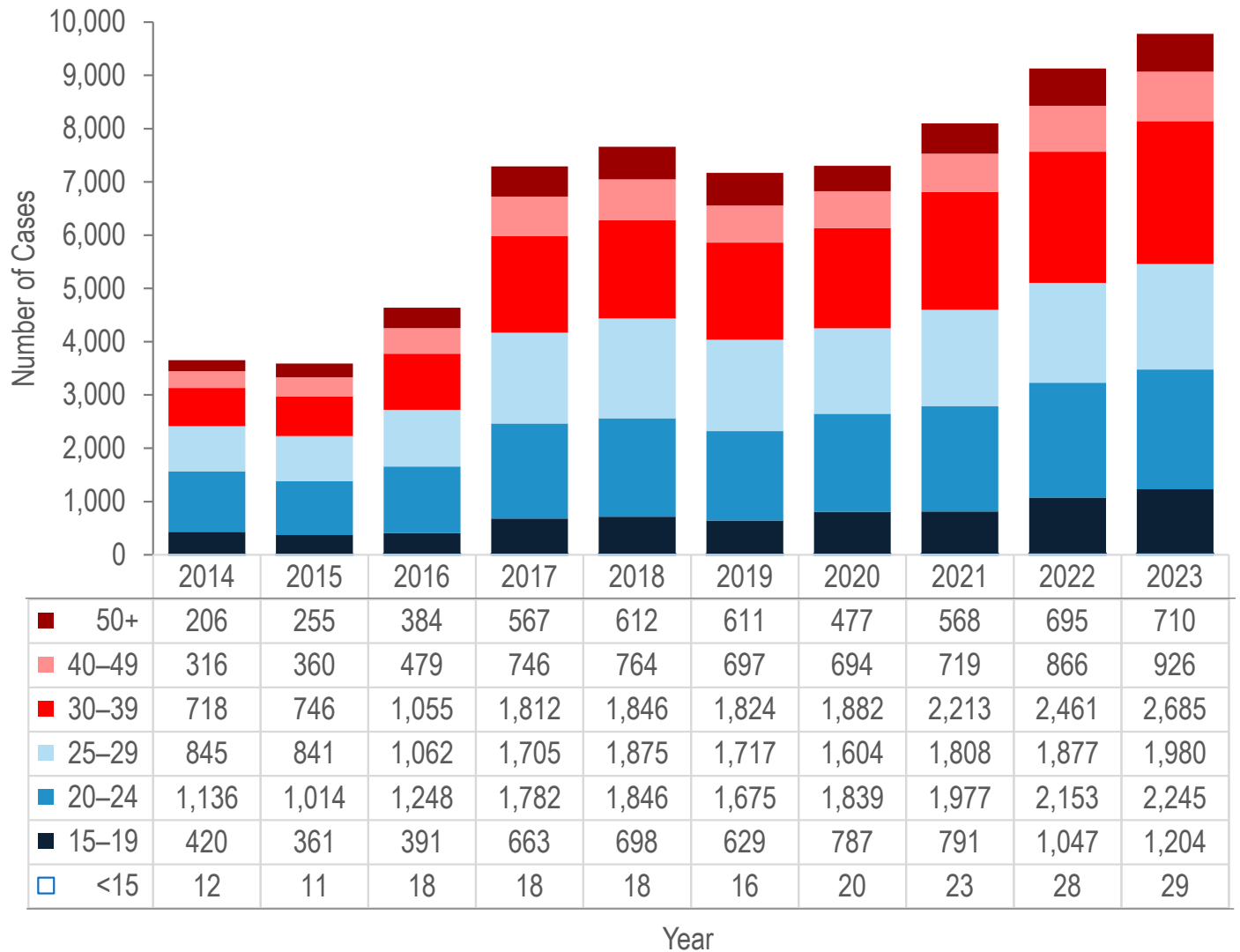
- After a sharp 57% increase from 2016 (N=4,638) to 2017 (N=7,293), the number of confirmed gonorrhea cases remained relatively stable through 2020 (N=7,303), and then increased by 34% to 9,779 in 2023.¹
- Between 2014 and 2023, the number of confirmed gonorrhea cases reported among males increased by 2.7 times (from 2,500 to 6,662, respectively). The number of confirmed gonorrhea cases among males in 2023 was more than double the number among females (3,038), resulting in a male-to-female ratio of 2.19 ($2.19 = 6,662/3,038$).
- The number of confirmed gonorrhea cases reported among females increased by 2.7 times from 1,144 in 2014 to 3,038 in 2023.
- In 2023, 71 confirmed gonorrhea cases were reported among individuals of transgender experience and/or nonbinary individuals.²

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates, for more information see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

GONORRHEA BY AGE

Figure 7. Number of confirmed gonorrhea cases reported by age group (years), Massachusetts 2014–2023



Note: Cases missing age (2014–2023: N=12) are not included in this figure

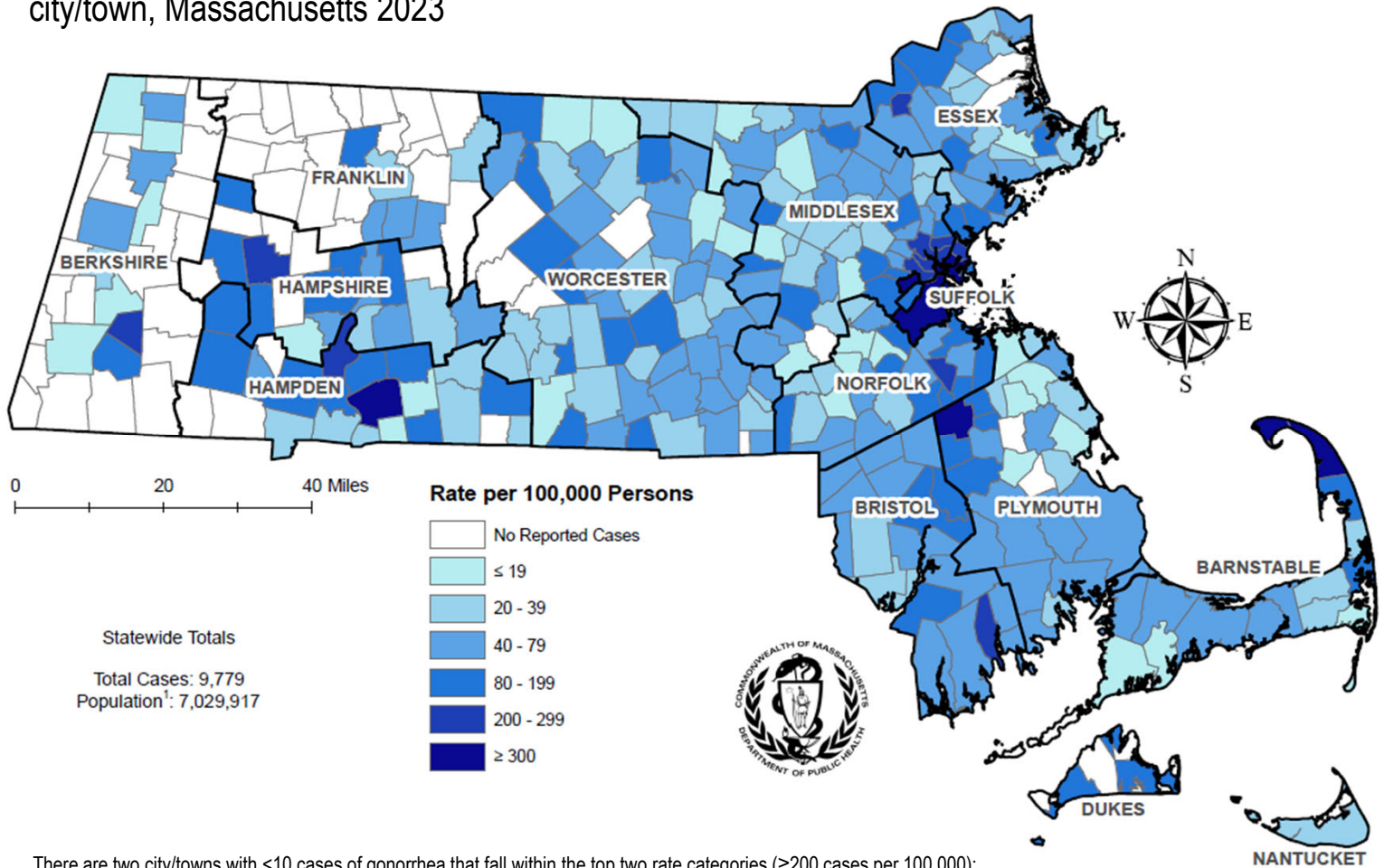
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- Each year from 2014 to 2023,¹ about half (43% to 54%) of confirmed gonorrhea cases were reported among individuals aged 20–24 or 25–29 years.
- From 2014 to 2023, the largest increase in the number of confirmed gonorrhea cases was among individuals aged 30–39 years (by 3.7 times from 718 to 2,685).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

GONORRHEA BY CITY/TOWN

Figure 8. Incidence rate of confirmed gonorrhea cases per 100,000 population¹ reported by city/town, Massachusetts 2023



There are two city/towns with <10 cases of gonorrhea that fall within the top two rate categories (≥200 cases per 100,000): Chesterfield, and Tyringham.

Note: regional data include individuals tested in a correctional facility.

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- Confirmed gonorrhea cases continued to be clustered in the most populated cities in Massachusetts in 2023.
- The five cities² with the highest incidence rates of confirmed gonorrhea in 2023 were Provincetown (2,865.7 per 100,000),³ Truro (489.0 per 100,000), Boston (412.8 per 100,000), Brockton (408.0 per 100,000), and Chelsea (328.5 per 100,000).
- In 2023,² the statewide incidence rate of confirmed gonorrhea of 139.1 per 100,000 population was lower than the 2022 national rate of 194.4 per 100,000.⁴
 - While Mississippi ranked first and Vermont ranked 50th, Massachusetts ranked 38th in gonorrhea incidence rate among the 50 states in 2022, the last year for which these national data are publicly available.⁵

¹ Population based on University of Massachusetts Donahue Institute Estimates

² Among cities that reported at least 12 confirmed gonorrhea cases in 2023.

³ The gonorrhea incidence rate for Provincetown is high because of small population size (2,583), as opposed to the number of cases (104).

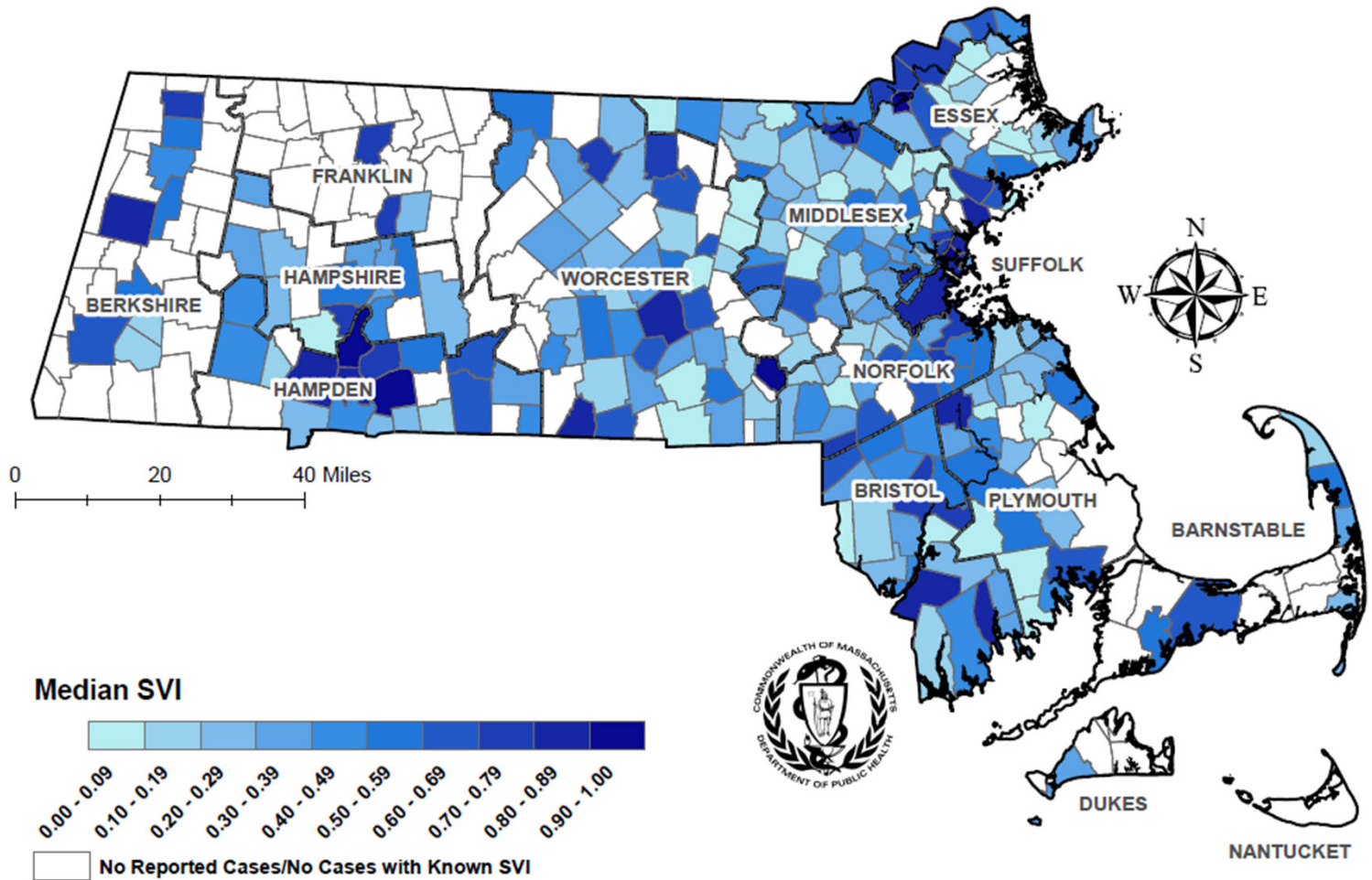
⁴ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

⁵ Centers for Disease Control and Prevention, Sexually Transmitted Infections Surveillance 2022, available at <https://www.cdc.gov/std/statistics/2021/default.htm>

⁶ Centers for Disease Control and Prevention. *Sexually Transmitted Infections Surveillance 2022* Atlanta: U.S. Department of Health and Human Services; 2024. Please note, 2022 state rankings are presented because 2023 rankings were not yet available at the time of this publication.

SVI AMONG GONORRHEA CASES BY CITY/TOWN

Figure 9. Median overall Social Vulnerability Index (SVI) by city/town for confirmed gonorrhea cases, Massachusetts 2023



Note: Census tract level overall SVI values for 2020 were obtained from the CDC/Agency for Toxic Substance and Disease Registry and assigned to all cases based on their street address at diagnosis, 338 cases were excluded from this analysis because address was unknown or the individuals were homeless. City/Town level median is calculated from the median SVI score for that city/town among gonorrhea cases. Values range from 0 to 1, with higher values implying greater social vulnerability. Map should be interpreted with caution as it displays median SVI scores for cities/towns with one or more cases.

Data Sources: CDC/Agency for Toxic Substance and Disease, Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change.

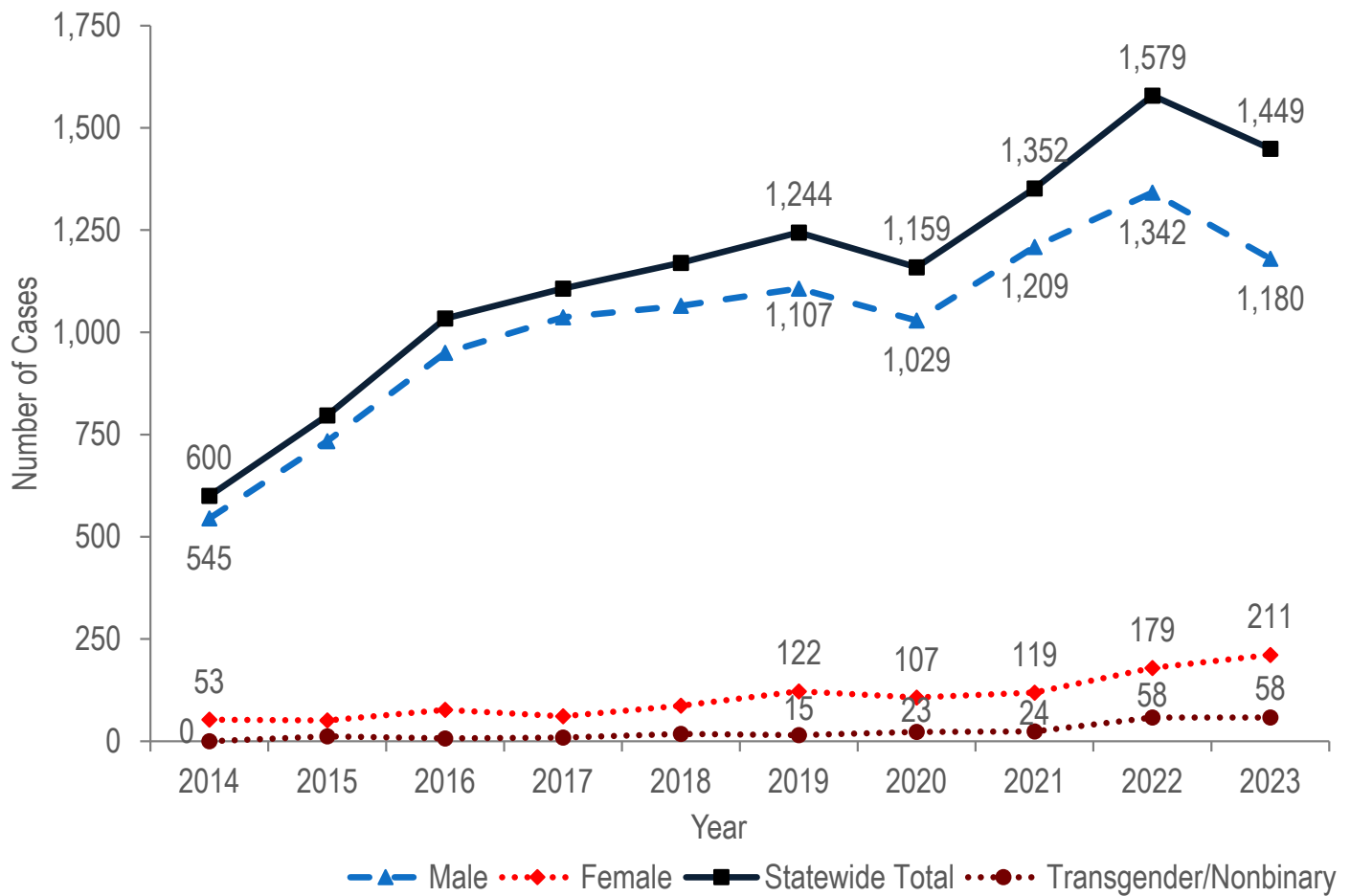
- In 2023,¹ the median SVI score among confirmed gonorrhea cases in Massachusetts was 0.739, which would be categorized as moderately highly vulnerable.
- The five cities with the highest SVI scores (i.e., the most highly vulnerable) among confirmed gonorrhea cases in 2023 were Lawrence (0.952), Holyoke (0.938), Milford (0.911), Chelsea (0.910), and Springfield (0.894).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

SYPHILIS BY GENDER

Syphilis is a sexually transmitted infection that can be spread through sexual contact with an infected person. The first symptom of syphilis infection is a sore or chancre at the site of inoculation that is usually firm, round, and painless. The most recognized symptom of the second stage of infection is a body rash which can be present on the palms of hands and soles of feet. As with primary syphilis symptoms, secondary symptoms also resolve with or without treatment. After the secondary stage of syphilis, untreated infected individuals enter a time of latent syphilis that can last for years. Individuals with syphilis are thought to be most infectious for the first year after acquisition. Syphilis infection can also be transmitted to an infant during pregnancy and birth. Syphilis transmission to an unborn baby is a serious complication of syphilis infection among pregnant individuals. From 2019 to 2023, the annual number of probable cases of congenital syphilis diagnosed in Massachusetts ranged from nine to fourteen after remaining between zero and four from 2011 to 2018. Syphilis is treatable and it is possible to be re-infected with repeated exposure. For more information, see <https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm>

Figure 10. Number of confirmed and probable infectious syphilis cases reported by gender, Massachusetts 2014–2023



Note: Cases with no gender reported (2014–2023: N=3) are included in the statewide total but are not depicted in Figure 10 separately due to small numbers. Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

SYPHILIS BY GENDER

- The total number of reported confirmed and probable infectious syphilis cases¹ increased to a ten-year high of 1,579 in 2022 and subsequently decreased to 1,449 in 2023.² A ten-year high was observed in 2022 among males (N=1,342) and in 2023 among females (N=211).
- The total number of confirmed and probable infectious syphilis cases increased by 2.4 times from 2014 (N=600) to 2023 (N=1,449). In the most recent five years from 2019 to 2023 the number of cases increased by 16% (from 1,244 to 1,449).
- Between 2014 and 2023, the proportion of confirmed and probable infectious syphilis cases among males remained between 81% and 94% each year. In 2023, there were 5.6 times as many syphilis cases reported among males (N=1,180) as among females (N=211).
- In 2023, 58 confirmed and probable infectious syphilis cases were reported among individuals of transgender experience and/or nonbinary individuals.³

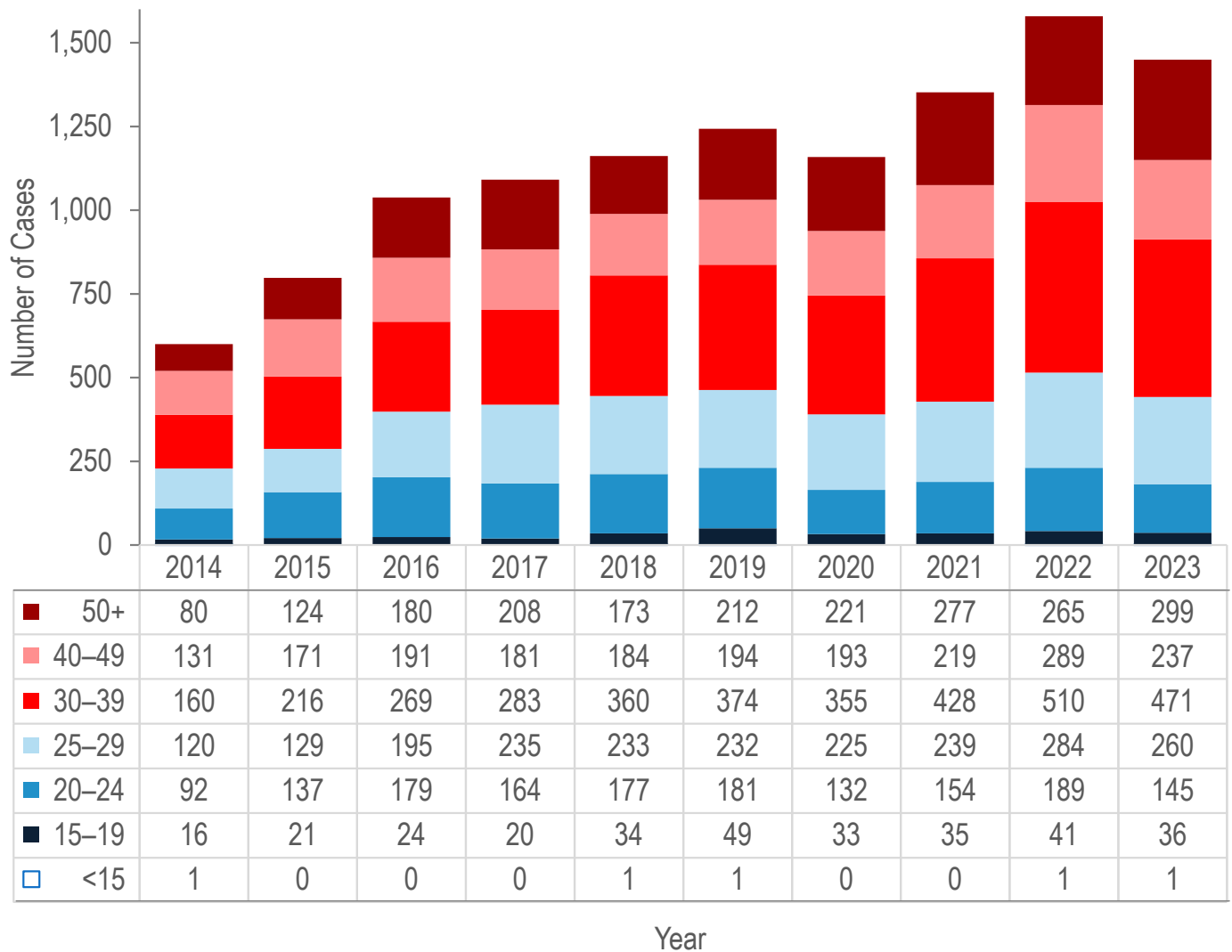
¹ Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

³ Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates, for more information see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

SYPHILIS BY AGE

Figure 11. Number of confirmed and probable infectious syphilis¹ cases reported by age group (years), Massachusetts 2014–2023



Note: All syphilis cases from 2014 to 2023 were reported with age, none were excluded from this figure
 Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

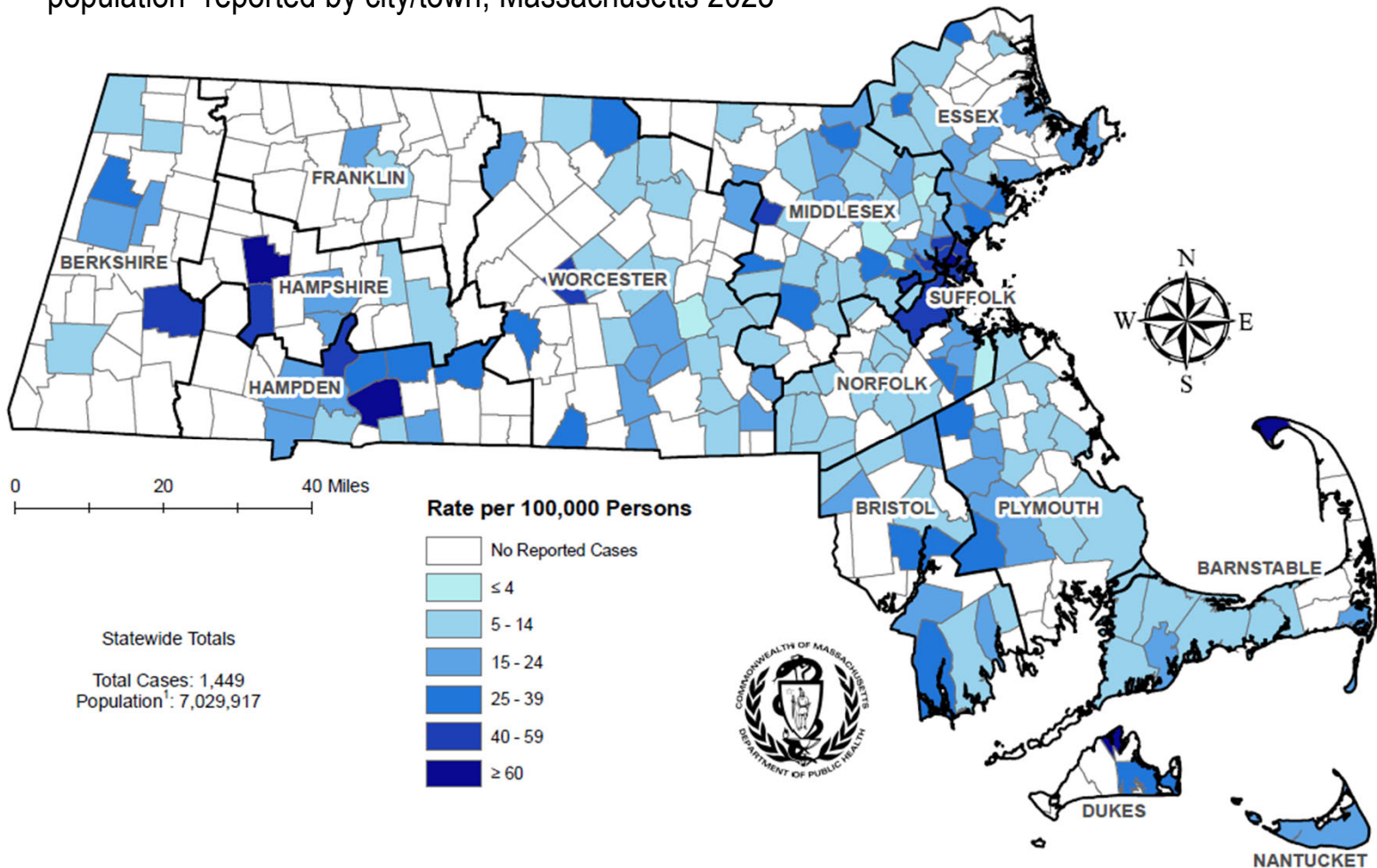
- From 2014 to 2023,² the largest increases in the number of reported confirmed and probable infectious syphilis cases were among individuals aged 50 years and above (by 3.7 times from 80 to 299) and 30–39 years (by 2.9 times from 160 to 471).
- The largest number of reported confirmed and probable infectious syphilis cases was among 30–39 year-olds for the past decade.

¹ Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

SYPHILIS BY CITY/TOWN

Figure 12. Incidence rate of confirmed and probable infectious syphilis cases per 100,000 population¹ reported by city/town, Massachusetts 2023



There are seven city/towns with <10 cases of syphilis that fall within the top two rate categories (≥40 cases per 100,00): Chesterfield, Tisbury, Boxborough, Oakham, Becket, Huntington, and Winthrop.

Note: regional data include individuals tested in a correctional facility.

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- The statewide confirmed and probable infectious syphilis² incidence rate decreased from a ten-year high of 22.7 in 2022 to 20.6 in 2023.³
- The five cities⁴ with the highest confirmed and probable infectious syphilis incidence rates were Provincetown (409.4 per 100,000),⁵ Chelsea (80.9 per 100,000), Springfield (72.5 per 100,000), Boston (53.9 per 100,000), and Holyoke (47.1 per 100,000).
- While South Dakota ranked first and Vermont ranked 50th, Massachusetts ranked 34th in primary and secondary syphilis incidence rate among the 50 states in 2022, the last year for which these national data are publicly available.⁶

¹ Population based on University of Massachusetts Donahue Institute Estimates.

² Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

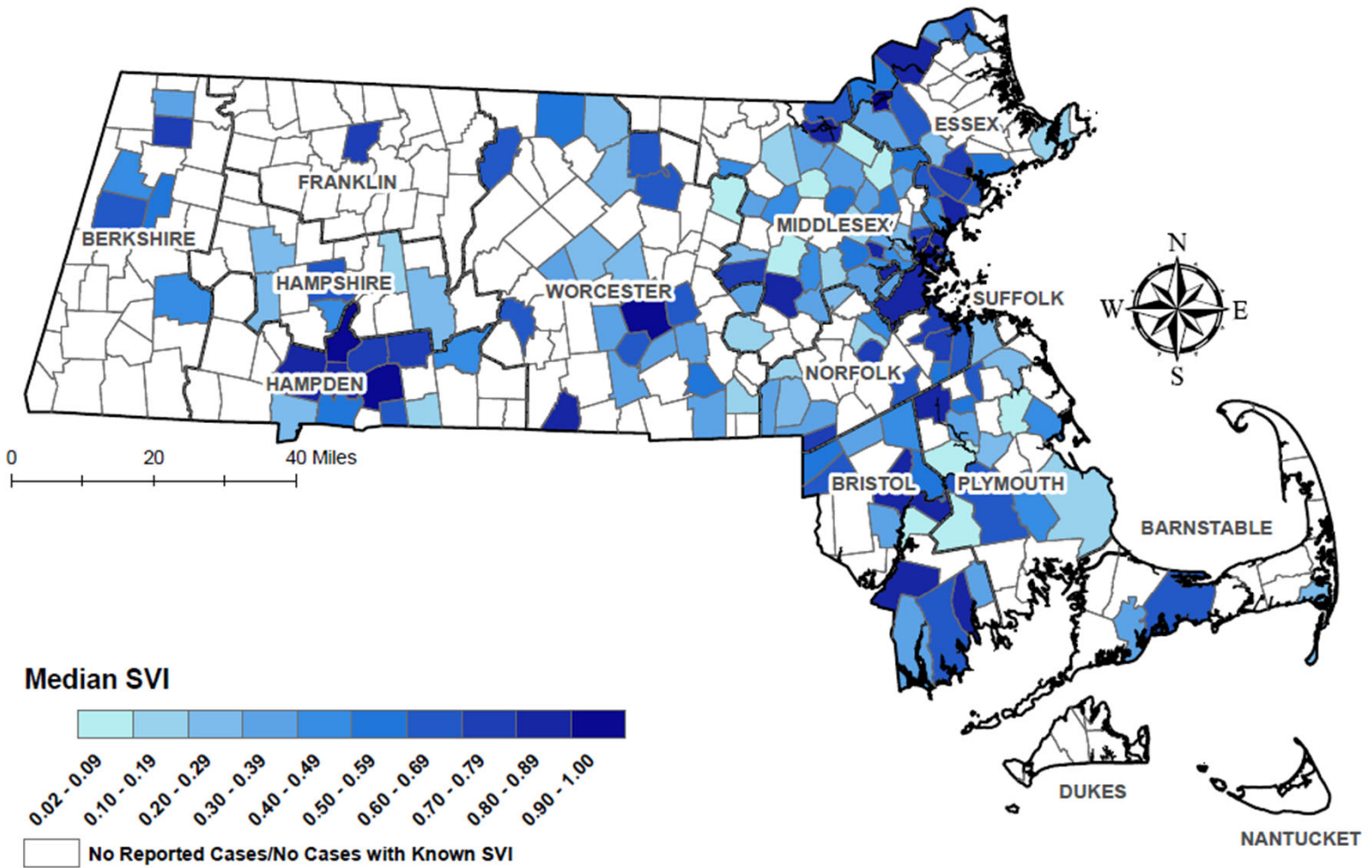
⁴ Among cities that reported at least 12 confirmed syphilis cases in 2023.

⁵ The syphilis incidence rate for Provincetown is high because of small population size (2,583), as opposed to the number of cases (15).

⁶ Centers for Disease Control and Prevention. *Sexually Transmitted Infections Surveillance 2022* Atlanta: U.S. Department of Health and Human Services; 2024. Please note, 2022 state rankings are presented because 2023 rankings were not yet available at the time of this publication.

SVI AMONG SYPHILIS CASES BY CITY/TOWN

Figure 13. Median overall Social Vulnerability Index (SVI) by city/town for confirmed and probable infectious syphilis cases,¹ Massachusetts 2023



Note: Census tract level overall SVI values for 2020 were obtained from the CDC/Agency for Toxic Substance and Disease Registry and assigned to all cases based on their street address at diagnosis, 58 cases were excluded from this analysis because address was unknown or the individuals were homeless. City/Town level median is calculated from the median SVI score for that city/town among infectious syphilis cases. Values range from 0 to 1, with higher values implying greater social vulnerability. Map should be interpreted with caution as it displays median SVI scores for cities/towns with one or more cases.

Data Sources: CDC/Agency for Toxic Substance and Disease, Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change.

- In 2023,² the median SVI score among confirmed and probable infectious syphilis cases in Massachusetts was 0.748, which is highly vulnerable.
- The five cities with the highest SVI scores (i.e., the most highly vulnerable) among confirmed and probable infectious syphilis cases in 2023 were Holyoke (0.975), Chelsea (0.944), Lawrence (0.928), Springfield (0.917), and Worcester (0.906).

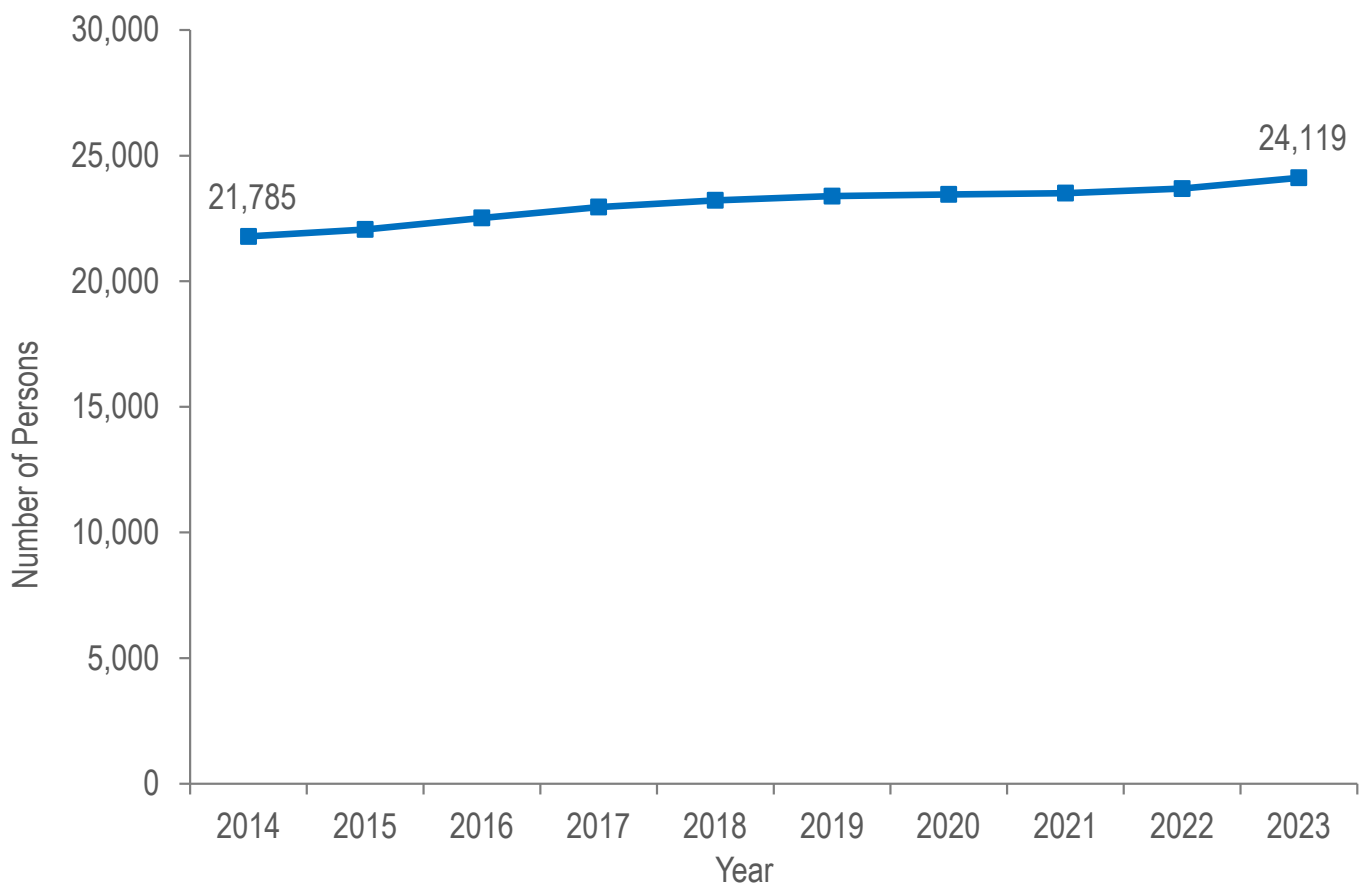
¹ Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

HIV PREVALENCE

Human immunodeficiency virus (HIV) is transmitted through exposure to blood, semen, vaginal secretions, or breast milk, most commonly through unprotected sex or through sharing drug injection equipment. HIV attacks the body's immune system, specifically the CD4 cells. Without treatment, HIV can destroy so many of these cells that the body can't fight off infections and can lead to acquired immunodeficiency syndrome (AIDS). But with proper medical care, HIV can be controlled. People with HIV who get effective HIV treatment can live long, healthy lives and protect their partners by reducing the risk for HIV transmission.¹

Figure 14. Number of persons living with HIV infection, Massachusetts 2014–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- The number of persons living with HIV infection (PLWH) in Massachusetts increased by 11% from 21,785 at the end of 2014 to 24,119 at the end of 2023.^{2,3}

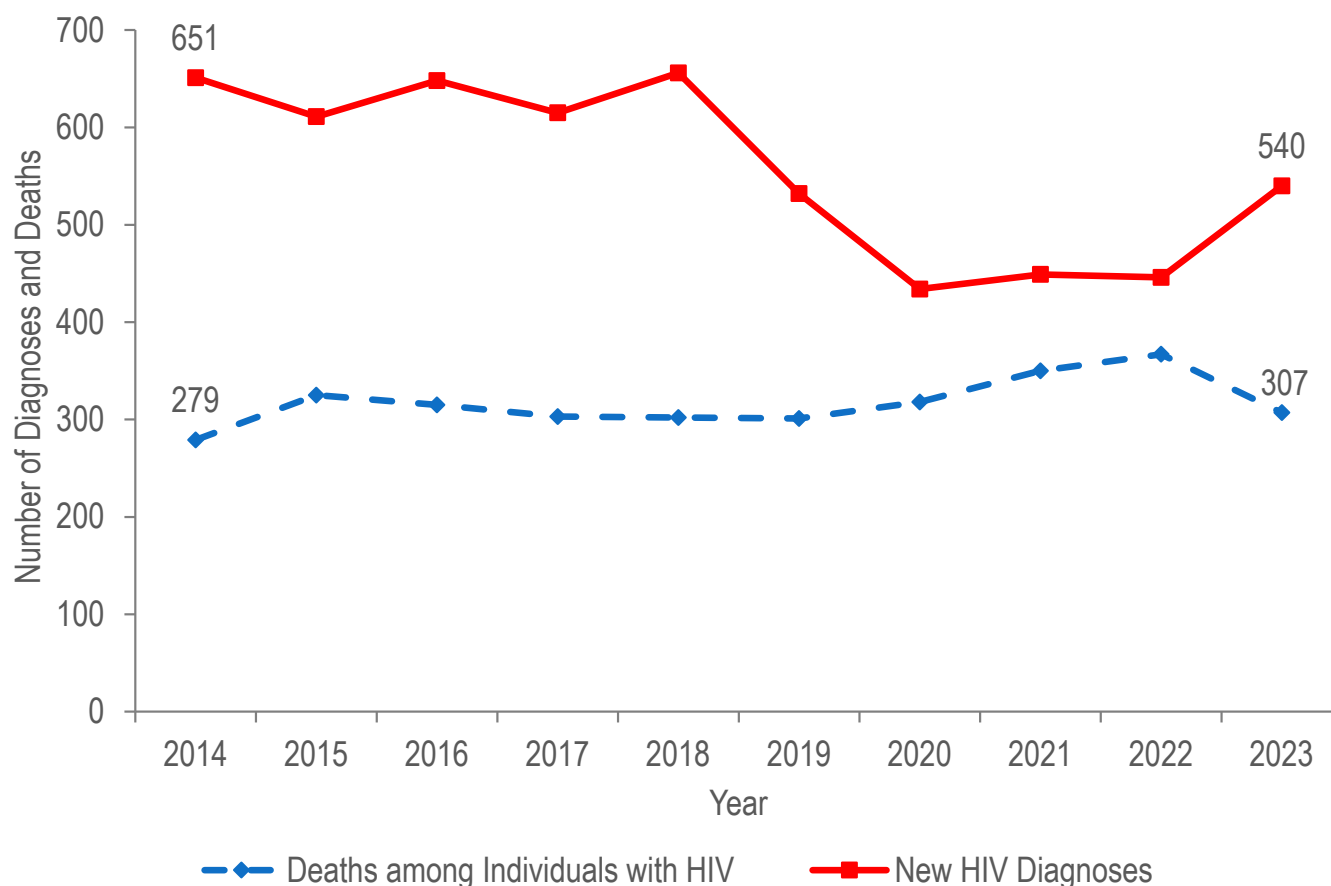
¹ For more information, see Centers for Disease Control and Prevention. *Diagnose and Treat to Save Lives: Decreasing Deaths Among People with HIV*. Atlanta: U.S. Department of Health and Human Services; 2020, available at: <https://www.cdc.gov/hiv/statistics/deaths/index.html>

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

³ 2023 HIV prevalence data are preliminary and subject to change.

DIAGNOSES AND DEATHS FROM ANY CAUSE AMONG PERSONS REPORTED WITH HIV

Figure 15. Number of HIV infection diagnoses and deaths from any cause among persons with HIV, Massachusetts 2014–2023



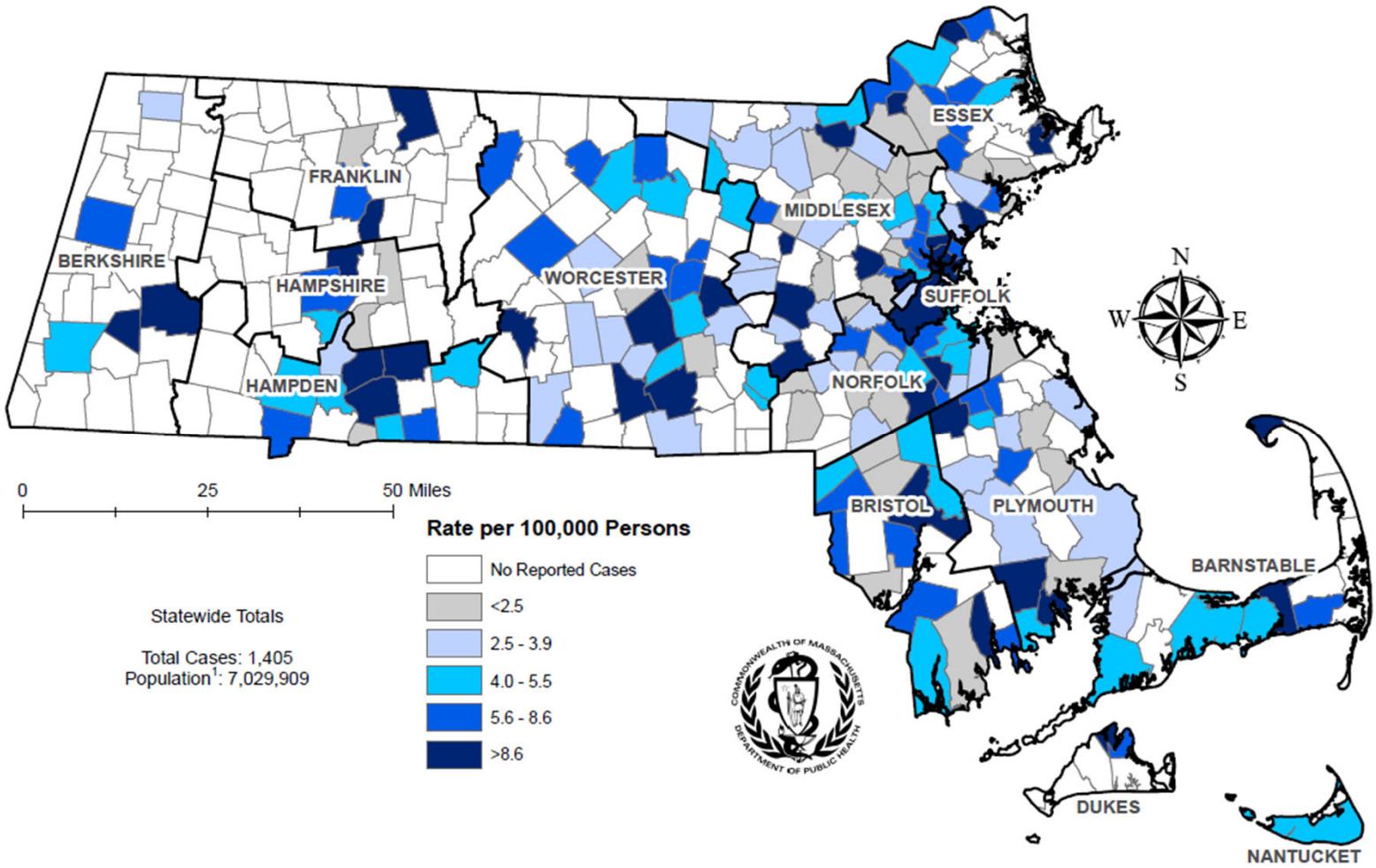
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- After averaging approximately 640 diagnoses per year from 2014 to 2018 (five-year average of 636), the number of new HIV infection diagnoses declined to 532 in 2019. In 2020, the number of new HIV infection diagnoses further declined to 434 and then remained at this lower level in 2021 and 2022, when there were 449 and 446 diagnoses, respectively. In 2023, the number of new HIV infection diagnoses (N=540) returned to pre-pandemic levels, increasing by 94 diagnoses, or 21%, compared to the prior year. By exposure mode, the largest increase in HIV diagnoses from 2022 to 2023 was among individuals with male-to-male sex (MSM) exposure mode (by 59 diagnoses, from 168 to 227), followed by presumed heterosexual (by 23 diagnoses, from 59 to 82), and no identified risk (NIR) (by 17 diagnoses, from 134 to 151) exposure modes.¹
- The number of deaths due to any cause among individuals reported with HIV infection increased by 32% from 279 in 2014 to a peak of 367 in 2022, and then decreased by 16% to 307 in 2023.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

HIV DIAGNOSES BY CITY/TOWN

Figure 16. Average annual rate of HIV diagnosis per 100,000 population¹ by city/town, Massachusetts 2021–2023



Note: regional HIV data exclude individuals diagnosed in a correctional facility.

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- The cities and towns² with the highest average annual rate of HIV infection diagnosis during 2021 to 2023³ included Brockton (23.7 per 100,000), Boston (17.3), Chelsea (17.2), Malden (14.6), and Lynn (14.5).
- Boston had the highest number of new HIV infection diagnoses from 2021–2023 (N=351), followed by Brockton (N=75), and Worcester (N=70).

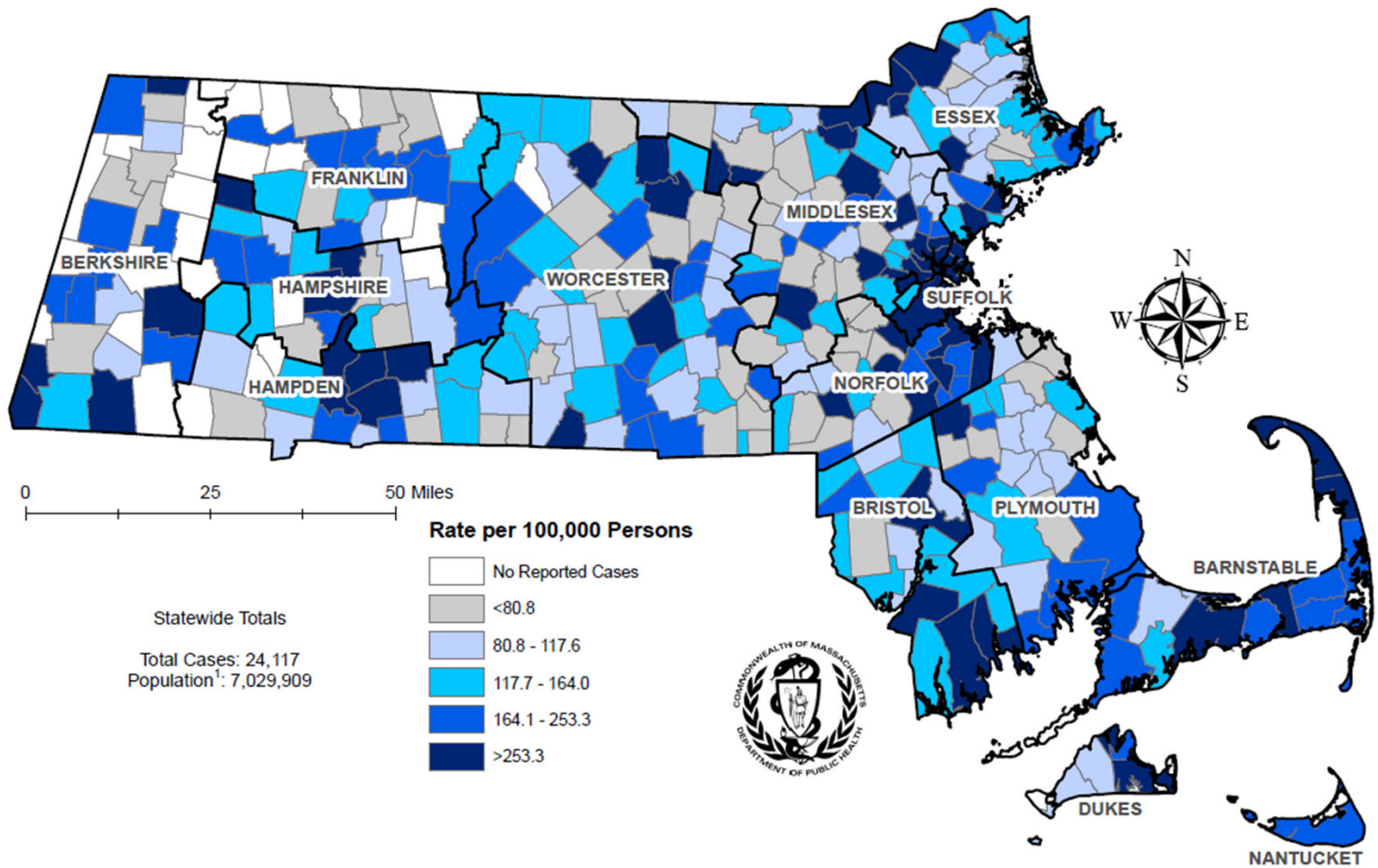
¹ Population based on University of Massachusetts Donahue Institute Estimates.

² Among cities that reported at least 12 HIV infections during 2021-2023. City/town is based on residence at HIV infection diagnosis and excludes individuals diagnosed in a correctional facility.

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

HIV PREVALENCE BY CITY/TOWN

Figure 17. Prevalence rate of persons living with HIV infection (PLWH) per 100,000 population¹ by city/town, Massachusetts 2023



Note: regional HIV data may include PLWH who may have been incarcerated in 2023.

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- The cities and towns² with the highest prevalence rate of PLWH in 2023³ included Provincetown (12,259.0 per 100,000), Shirley (847.8), Springfield (845.9), Boston (836.4), and Ayer (790.2).⁴
- Boston and Springfield had the highest numbers of PLWH in 2023, at 5,651 and 1,319, respectively.

¹ Population based on University of Massachusetts Donahue Institute Estimates.

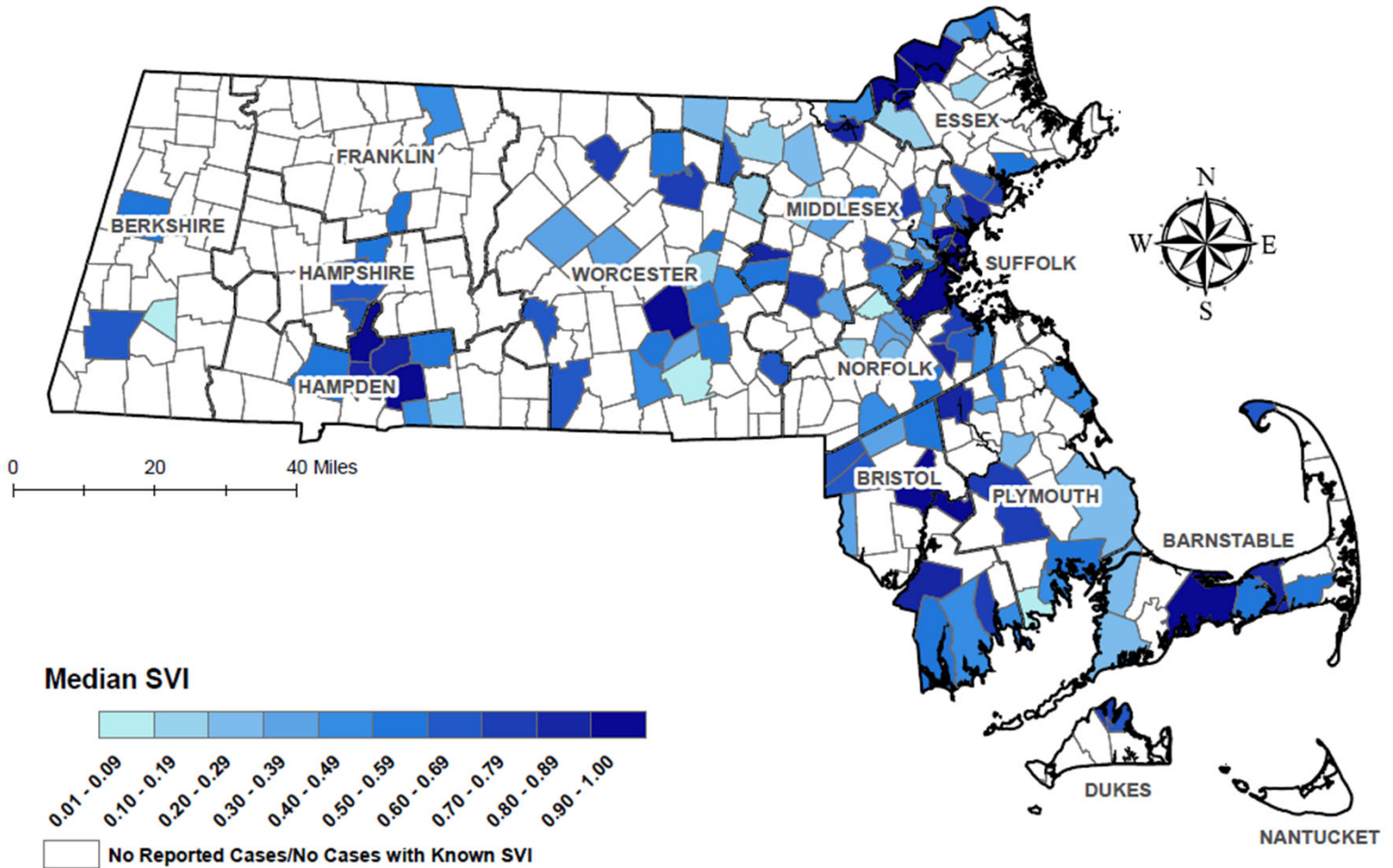
² Among cities that reported at least 50 PLWH in 2023. City/town is based on residence at HIV infection diagnosis and may include PLWH who may have been incarcerated in 2023.

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

⁴ The rates of HIV prevalence for Provincetown, Shirley, and Ayer are high because of small population sizes (3,663, 7,431, and 8,479, respectively), as opposed to the number of cases (449, 63, and 67, respectively). The rates of HIV prevalence in Shirley and Ayer are also high due to the inclusion of incarcerated individuals housed at Massachusetts Correctional Institute (MCI) Shirley and Federal Medical Center (FMC) Devens, respectively.

SVI AMONG HIV DIAGNOSES BY CITY/TOWN

Figure 18. Median overall Social Vulnerability Index (SVI) by city/town for HIV infection diagnoses, Massachusetts 2023



Note: Census tract level overall SVI values for 2020 were obtained from the CDC/Agency for Toxic Substance and Disease Registry and assigned to all cases based on their street address at diagnosis, 49 cases were excluded from this analysis because address was unknown or the individuals were homeless. City/Town level median is calculated from the median SVI score for that city/town among HIV infection diagnoses. Values range from 0 to 1, with higher values implying greater social vulnerability. Map should be interpreted with caution as it displays median SVI scores for cities/towns with one or more cases.

Data Sources: CDC/Agency for Toxic Substance and Disease, Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change.

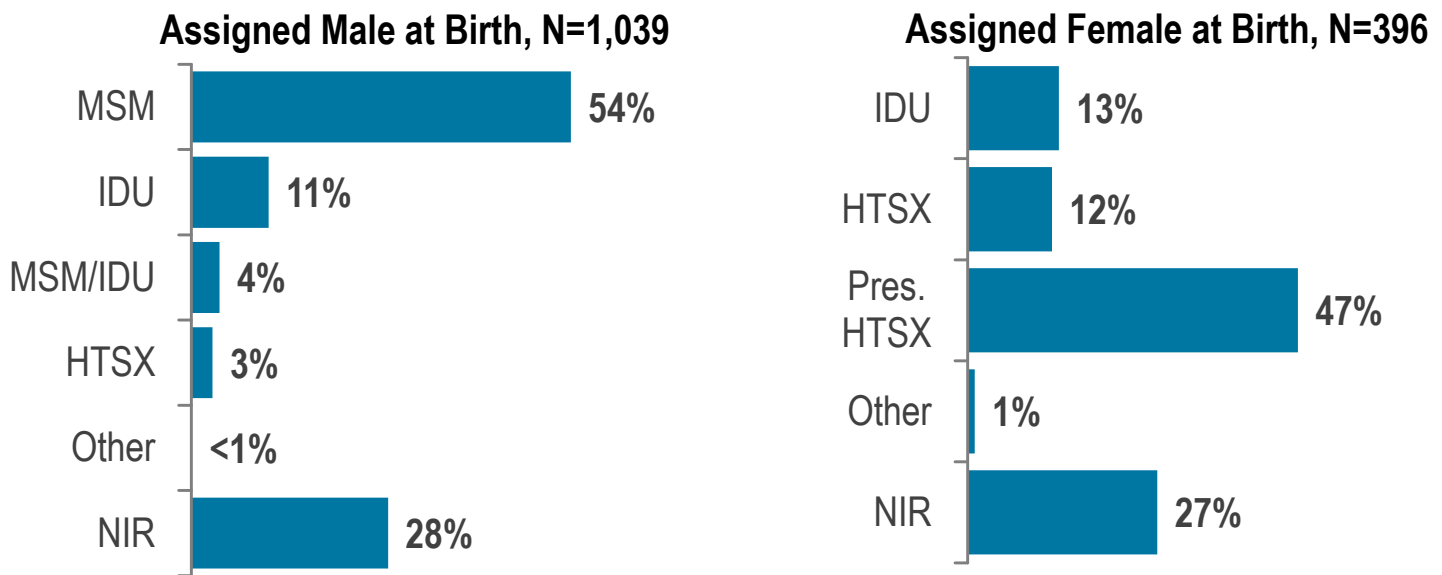
- In 2023,¹ the median SVI score among HIV infection diagnoses in Massachusetts was 0.797, which equates to highly vulnerable.²
- The five cities with the highest SVI scores (i.e., the most highly vulnerable) among HIV infection diagnoses in 2023 were Haverhill (0.983), Lawrence (0.936), Taunton (0.934), Malden (0.929), and Holyoke (0.926).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² SVI rankings were grouped into quartiles (low, <0.25; mid low, 0.25 - <0.5; mid high, 0.5 - <0.75; high >0.75).

HIV BY EXPOSURE MODE AND SEX ASSIGNED AT BIRTH¹

Figure 19. Percentage of HIV infection diagnoses by sex assigned at birth and exposure mode, Massachusetts 2021–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

MSM=male-to-male sex; IDU=injection drug use; HTSX=heterosexual sex; Pres. HTSX=presumed heterosexual exposure, includes individuals assigned female at birth with a negative history of injection drug use who report having sex with an individual that identifies as male of unknown HIV status and risk; NIR=no identified risk. For detailed definitions of primary exposure mode categories see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

- From 2021 to 2023,² of the 1,435 HIV infections newly diagnosed in Massachusetts, 1,039 (72%) were among individuals assigned male at birth (AMAB) and 396 (28%) were among individuals assigned female at birth (AFAB). Among the 1,435 HIV infections, 18 (1%) were among individuals of transgender experience,³ and 1,417 (99%) were among cisgender individuals.⁴
- From 2021 to 2023, the most frequently reported known exposure mode among individuals AMAB was male-to-male sex (54%) and among individuals AFAB was presumed heterosexual sex⁵ (47%). A substantial proportion of diagnoses among both individuals AMAB and AFAB were reported with no identified risk (28% and 27%, respectively).
- Among individuals AMAB, the proportion of HIV infection diagnoses with injection drug use (IDU) exposure mode increased from a low of 4% (N=19/486) in 2014 to 17% (N=76/456) in 2017, decreased to 9% (N=34/392) in 2019, increased to 18% in 2021 (N=55/314), and then decreased again to 6% (N=25/397) in 2023.
- Among individuals AFAB, the proportion of HIV infection diagnoses with IDU exposure mode increased from a low of 7% (N=12/165) in 2014 to 25% (N=40/159) in 2017, decreased to 18% (N=25/140) in 2019, increased to 22% in 2020 (N=27/121), and then decreased again to 9% (N=13/143) in 2023.

¹ Data reflect sex assigned at birth and therefore not gender identity or gender expression of transgender individuals.

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

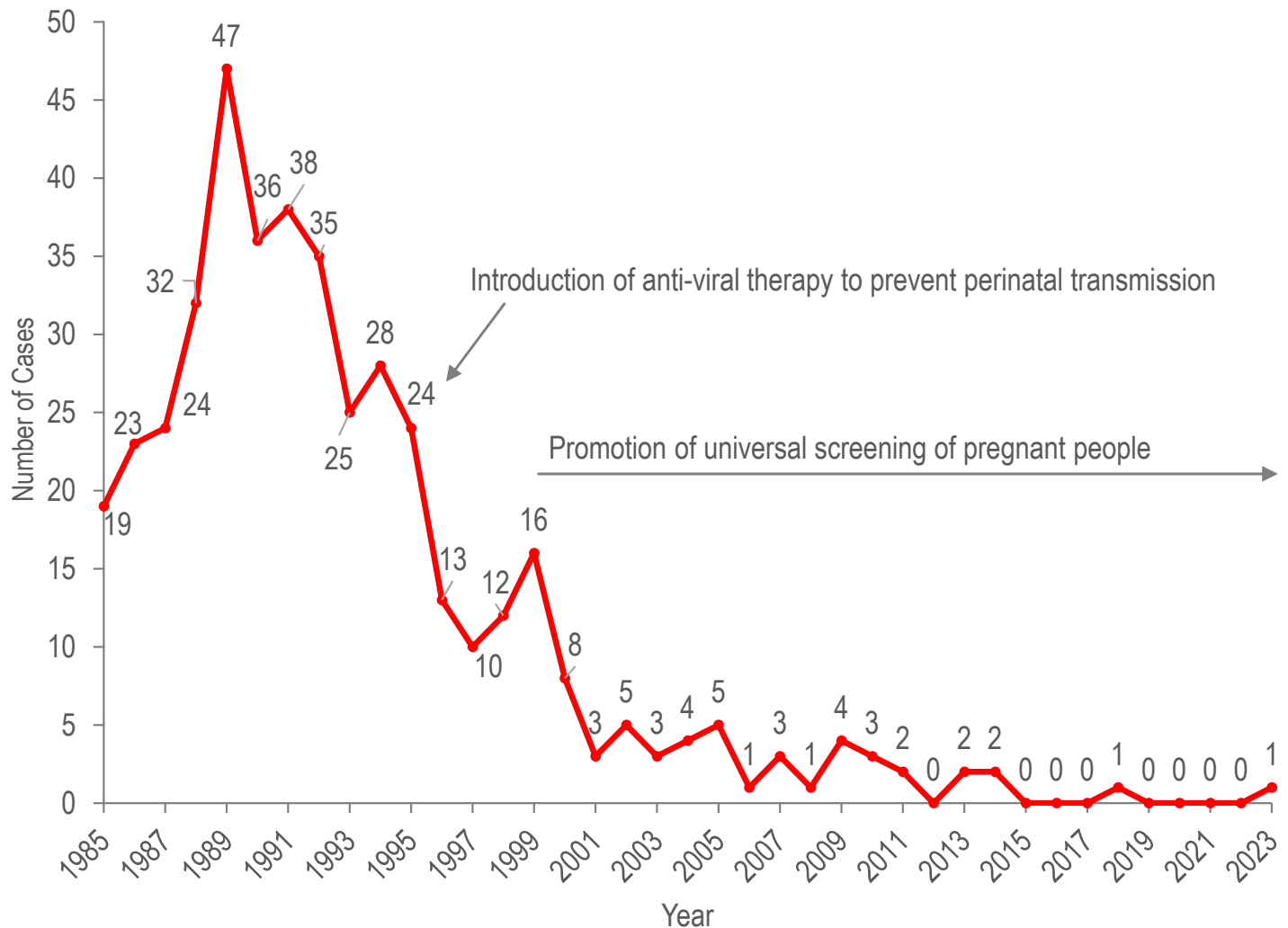
³ Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates, for more information see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

⁴ Persons whose current gender identity corresponds with their sex assigned at birth.

⁵ Presumed heterosexual exposure includes individuals assigned female at birth with a negative history of injection drug use who report having sex with an individual that identifies as male of unknown HIV status and risk.

PERINATAL TRANSMISSION OF HIV

Figure 20. Number of reported cases of perinatal transmission of HIV infection, by year of birth, Massachusetts 1985–2023



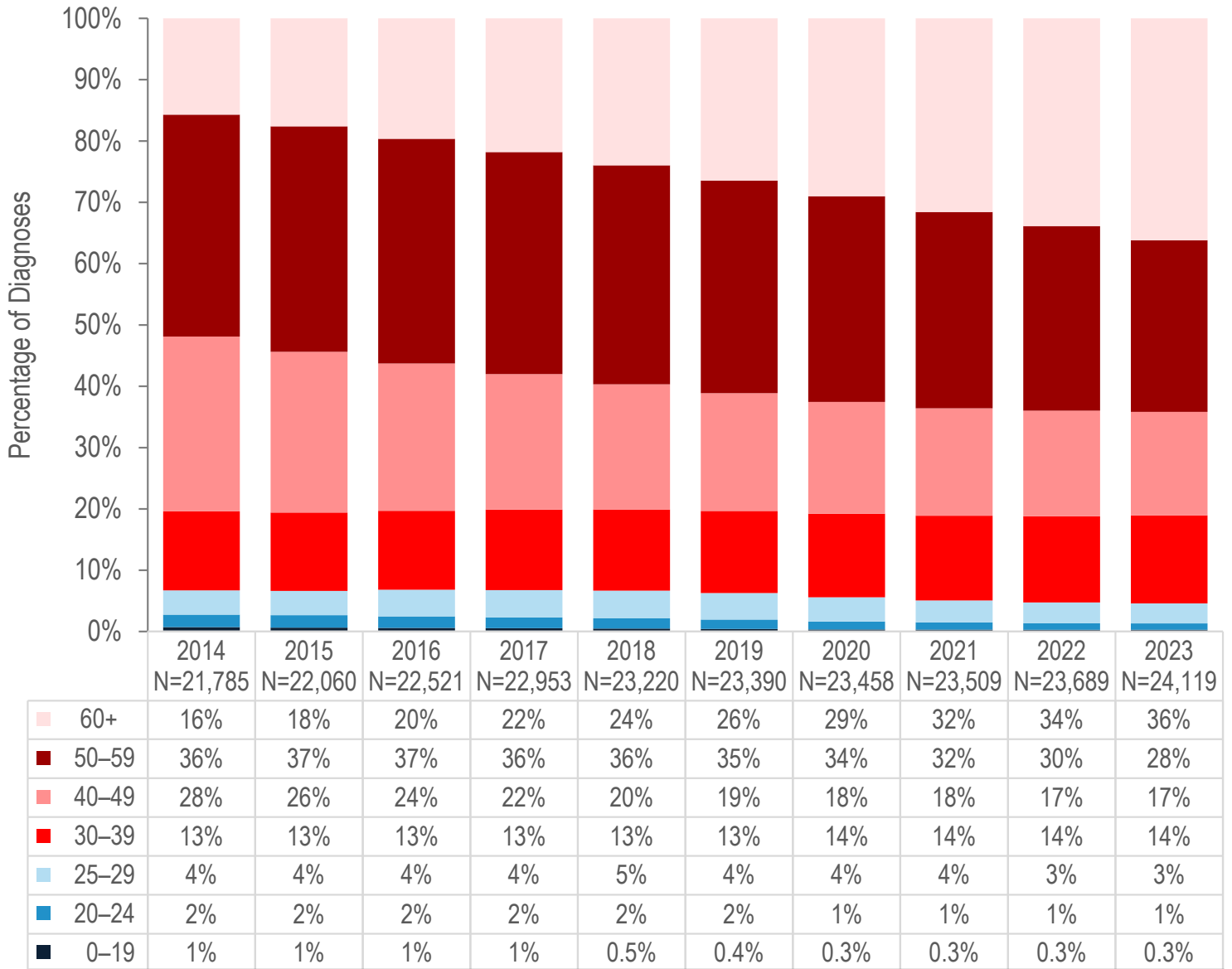
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- Since the mid-1990s, there has been a dramatic reduction in perinatal transmission of HIV infection related to high rates of antiretroviral treatment of HIV positive people and promotion of HIV screening during pregnancy.
- There were only two cases identified in the past nine years (one in 2018 and one in 2023).¹

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

AGE AMONG PERSONS LIVING WITH HIV INFECTION

Figure 21. Percentage distribution of individuals living with HIV infection by age on December 31, Massachusetts 2014–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

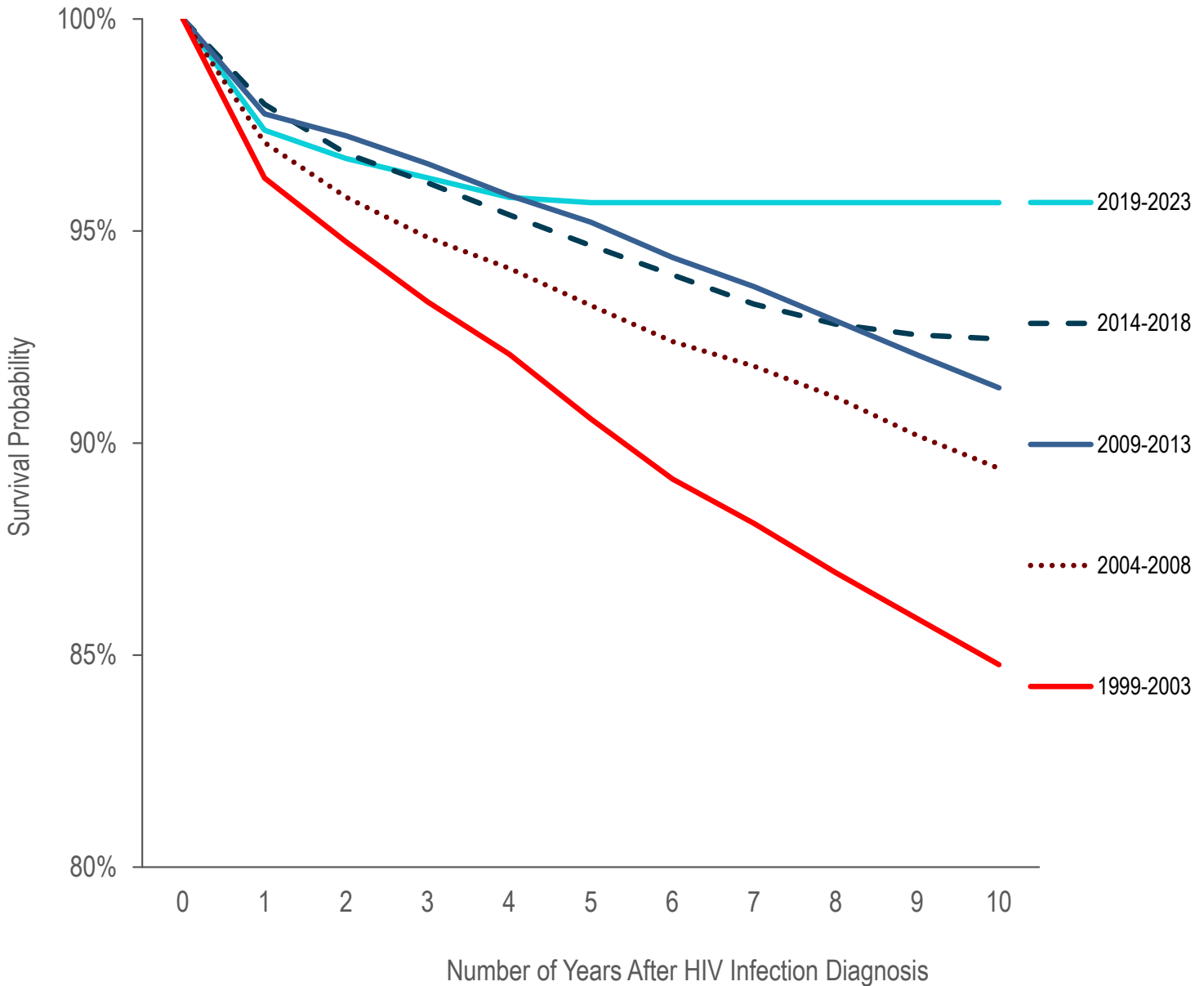
- Because of effective HIV treatment, people diagnosed with HIV infection are living longer, healthier lives. The proportion of people living with HIV infection who were aged 60 years or older increased from 16% on December 31, 2014 to 36% on December 31, 2023.^{1,2}

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² 2023 HIV prevalence data are preliminary and subject to change.

SURVIVAL AMONG INDIVIDUALS DIAGNOSED WITH HIV

Figure 22. Ten-year survival among individuals with HIV infection by year of diagnosis, Massachusetts 1999–2023 (Total number of HIV diagnoses from 1999–2023, N=18,618)



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

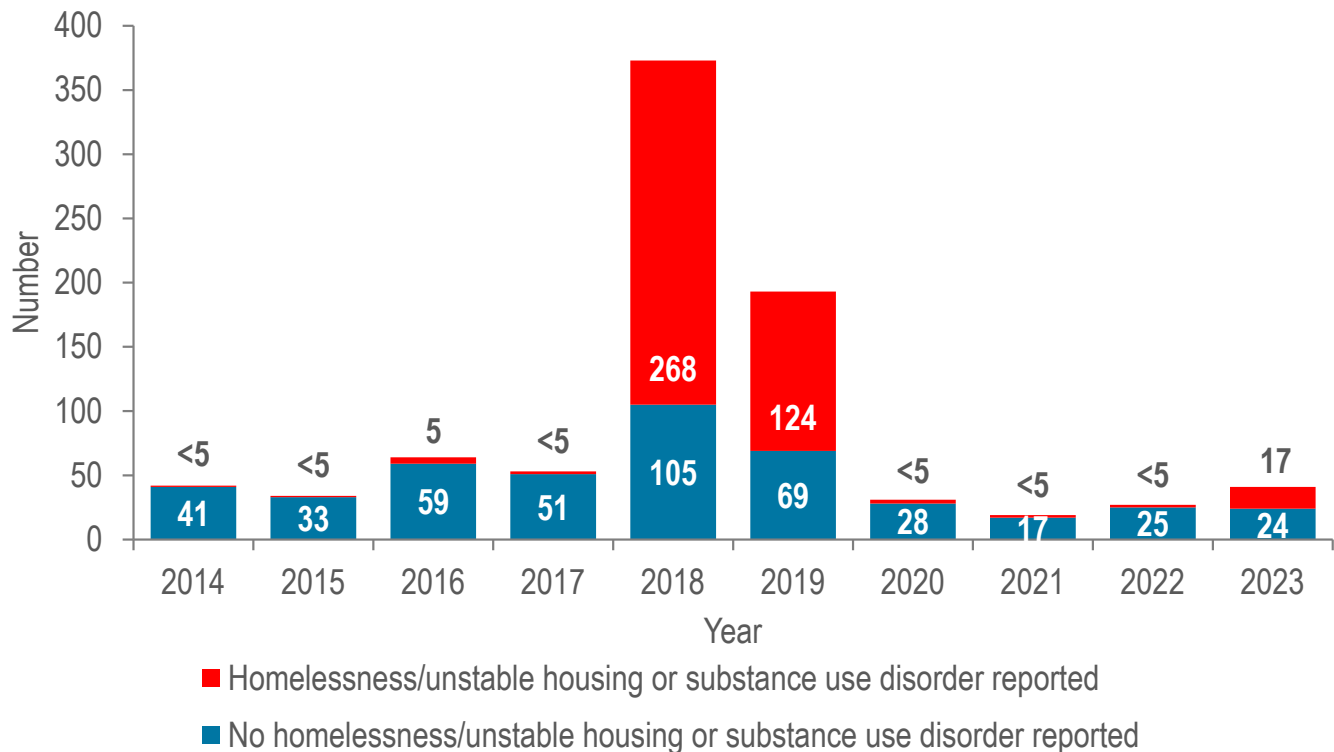
- Survival of individuals diagnosed with HIV infection has increased over time. In the earliest cohort of HIV infection diagnoses (1999–2003), estimated survival at ten years after HIV infection diagnosis was 85%, compared to 89% among individuals diagnosed from 2004–2008, 91% among individuals diagnosed from 2009–2013, and 93% among individuals diagnosed from 2014–2018, and 96% among individuals diagnosed from 2019–2023.¹

¹ Please note that actual ten-year survival is only available for individuals diagnosed in 2014 in the 2014–2018 cohort and not available for any individuals diagnosed in the most recent cohort (2019–2023).

VIRAL HEPATITIS - HEPATITIS A

Hepatitis A is a vaccine-preventable, viral liver disease that can cause mild to severe illness. It is usually transmitted person-to-person through the fecal-oral route or through consumption of contaminated food or water. Hepatitis A is a self-limited disease that does not result in chronic infection.

Figure 23. Number of hepatitis A cases reported by year, housing status, and presence of substance use disorder, Massachusetts 2014–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/17/2024 and subject to change

- Between 2018 and 2020, the Massachusetts Department of Public Health (DPH) and local health departments investigated an outbreak of hepatitis A. The populations most affected by the outbreak were those reported with recent homelessness or unstable housing, and/or substance use disorder, accounting for 72% (N=268/373) and 64% (N=124/193) of cases in 2018 and 2019, respectively. DPH partnered with clinical and community-based providers to implement a hepatitis A (HAV) vaccination response by deploying mobile vaccination providers to shelters, correctional facilities, harm reduction programs, and outreach venues. The outbreak was declared over in spring of 2020 and case counts among individuals with homelessness/unstable housing or substance use disorder remained low through 2022. A second, smaller outbreak affecting the same populations was detected in fall 2023, prompting additional vaccination efforts.¹ This outbreak ended in May of 2024 with a total of 24 cases. DPH encourages continued vaccination of populations at high risk of acquiring hepatitis A in accordance with recommendations from the Advisory Committee on Immunization Practices.²

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of 2020 to 2022 data.

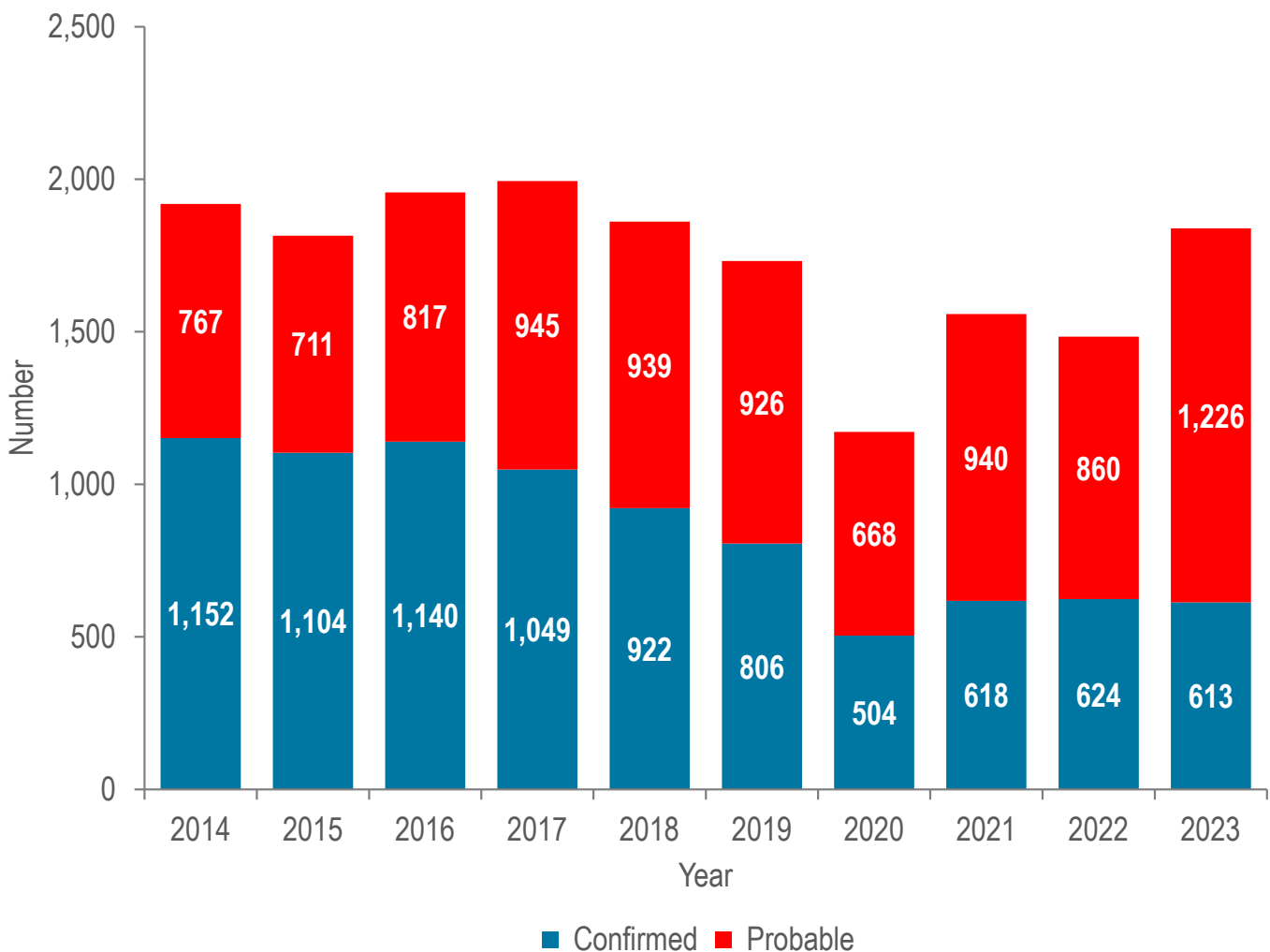
² Nelson NP, Weng MK, Hofmeister MG, et al. Prevention of Hepatitis A Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, 2020. MMWR Recomm Rep 2020;69(No. RR-5):1–38. DOI: <http://dx.doi.org/10.15585/mmwr.rr6905a1>

VIRAL HEPATITIS - HEPATITIS B

Hepatitis B is a liver infection caused by the hepatitis B virus. Transmission occurs via contact with blood or other body fluids, including from pregnant person to infant at birth, via sexual contact, and through sharing of drug injection equipment. Most people who get the disease recover from it and cannot be re-infected. However, about 10% of adults who get hepatitis B will go on to have chronic (long-term) infection and can pass it on to others. When it is chronic, it can be a serious disease that can lead to cirrhosis (scarring of the liver) and/or liver cancer. The younger a person is when infected, the more likely they are to go on to have chronic infection and to develop serious liver disease. There is a vaccine to prevent hepatitis B infection.

The impact of chronic hepatitis B in the US is greater among people born in regions of the world with high or moderate prevalence of chronic hepatitis B, including much of Asia and the Pacific Islands.

Figure 24. Number of confirmed and probable chronic hepatitis B cases reported by year, Massachusetts 2014–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/17/2024 and subject to change

VIRAL HEPATITIS - HEPATITIS B

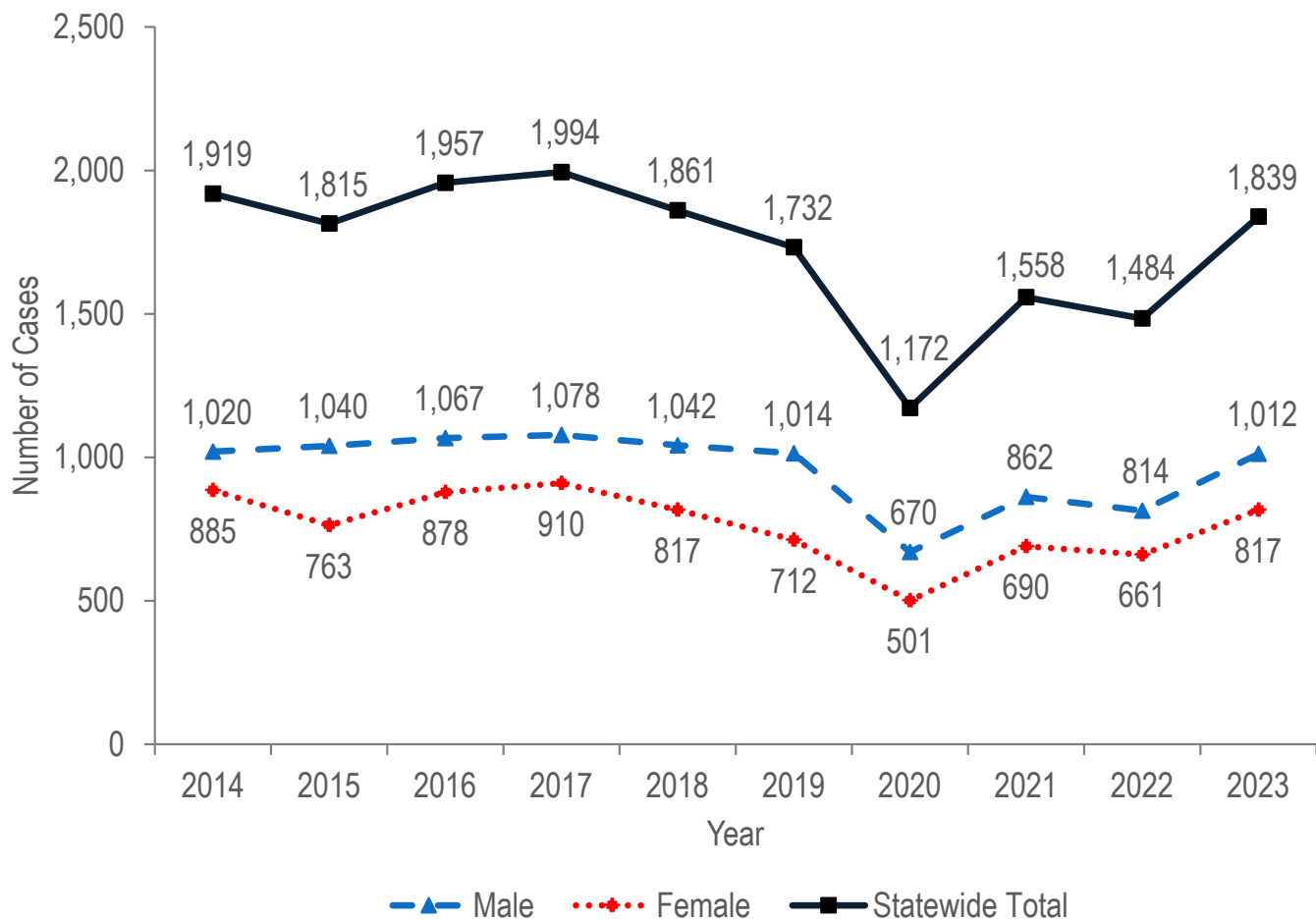
- From 2014 to 2023,¹ an average of 1,733 cases of confirmed and probable chronic hepatitis B virus (HBV) infection were reported each year (with a low of 1,172 in 2020 and a high of 1,994 in 2017). Changes in testing behaviors and travel due to the COVID-19 pandemic likely influenced the number of reported cases and may contribute to the decrease in 2020, followed by the rebound from 2021 to 2023.
- The surveillance case definition for chronic HBV requires two positive tests; for certain test types, these two tests must be taken at least six months apart. Reported cases are classified as "probable" following the initial test result and are re-classified as "confirmed" if additional test results are received. During the most recent year of data, 2023, some cases currently reported as probable may be eventually confirmed in future reports as additional information is obtained.²

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² For more information, see [HIV, STI, and Viral Hepatitis Case Classifications](#).

HEPATITIS B BY GENDER

Figure 25. Number of confirmed and probable chronic hepatitis B cases reported by female and male gender, Massachusetts 2014–2023



Note: Cases reported as transgender or missing gender (2014–2023: N=78) are included in the statewide total but are not depicted in Figure 25 separately due to small numbers.

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/17/2024 and subject to change.

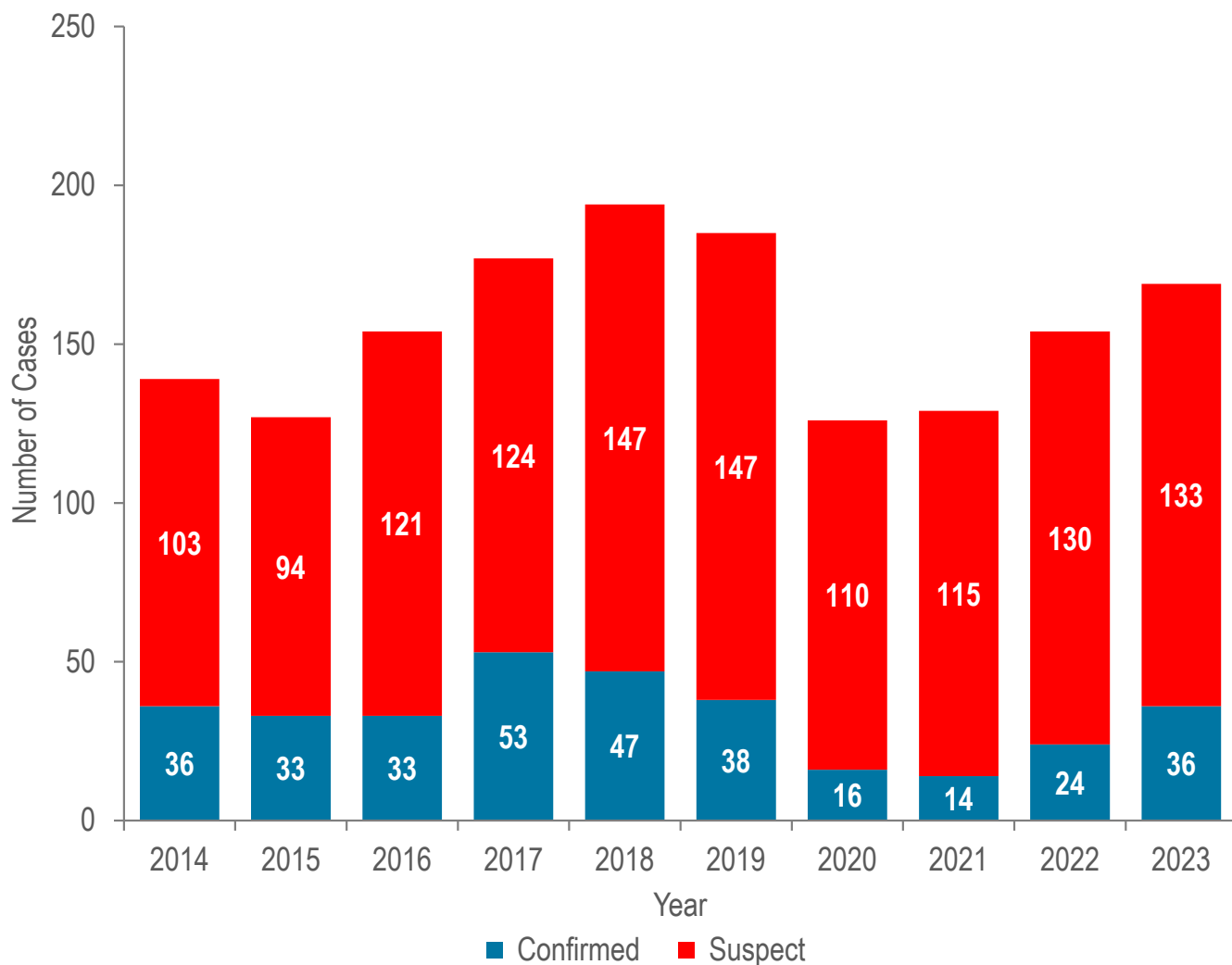
- In 2023,¹ 1,012 (55%) cases of confirmed and probable chronic HBV infection were newly reported among males, 817 (45%) were reported among females, and fewer than five were reported among individuals of transgender experience.²
- Hepatitis B in people of childbearing age is of particular concern due to the risk of transmission from pregnant person to infant at birth. Perinatal HBV transmission can be prevented by identifying HBV-positive pregnant people and providing post-exposure prophylaxis (PEP) to their infants within 12 hours of birth. The DPH Perinatal Hepatitis B Prevention Program provides case management to pregnant people who are HBV-positive and their infants to ensure appropriate PEP, vaccination, and post-vaccination serologic testing.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates, for more information see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

ACUTE HEPATITIS B

Figure 26. Number of confirmed and suspect acute hepatitis B cases reported by year, Massachusetts 2014–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/17/2024 and subject to change

- In 2023,¹ there were 36 confirmed acute and 133 suspect acute HBV cases for a total of 169 acute cases.²
- The total number of confirmed acute HBV cases reported decreased from 53 cases in 2017 to 14 cases in 2021 and subsequently increased to 36 cases in 2023.
- Injection drug use (IDU) is a significant, and increasingly important, risk factor for acquisition of acute HBV infection.

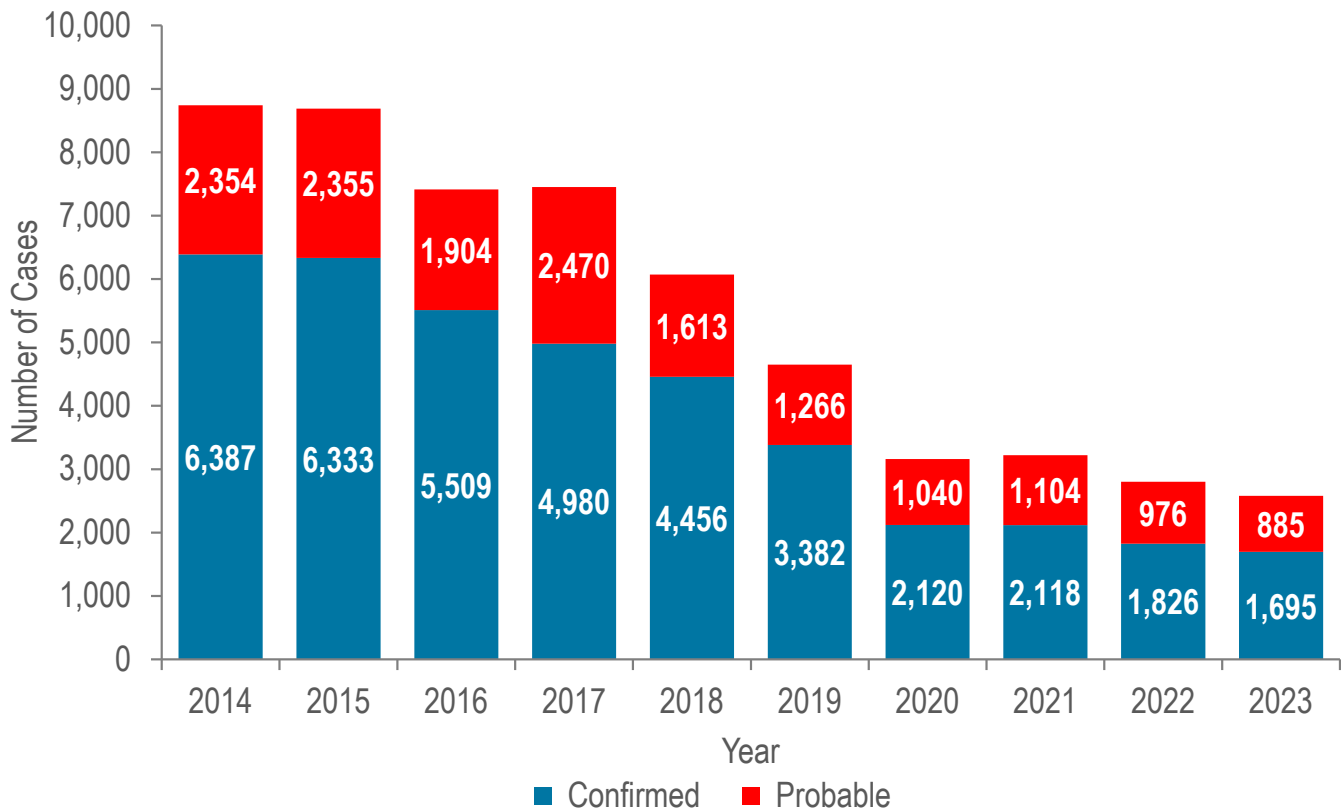
¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² For case definitions and classifications, see [HIV, STI, and Viral HCVase Classifications](#).

VIRAL HEPATITIS - Hepatitis C (HCV)

HCV is a liver infection caused by the hepatitis C virus. The majority of infected individuals are asymptomatic, but symptoms, when present, can include fatigue, loss of appetite, nausea, vomiting, abdominal pain, and jaundice. Over time, liver damage can result, and complications can include cirrhosis and liver cancer. HCV infection is spread by direct contact with the blood of an infected person. Transmission mechanisms can include: sharing equipment used to inject drugs, blood transfusions and organ transplants (primarily prior to 1992 when widespread screening of the blood supply began), from pregnant person to child at birth, sharing personal items such as toothbrushes or razors, tattoos and piercings in non-sterile environments, infection control breaches in healthcare settings, and, rarely, through sexual contact (more likely with HIV co-infection). Most people who get the infection will go on to have chronic infection. With the advent of direct-acting antivirals, HCV infection is curable with an 8-12 week course of treatment.

Figure 27. Number of confirmed and probable HCV cases reported by year, Massachusetts 2014–2023



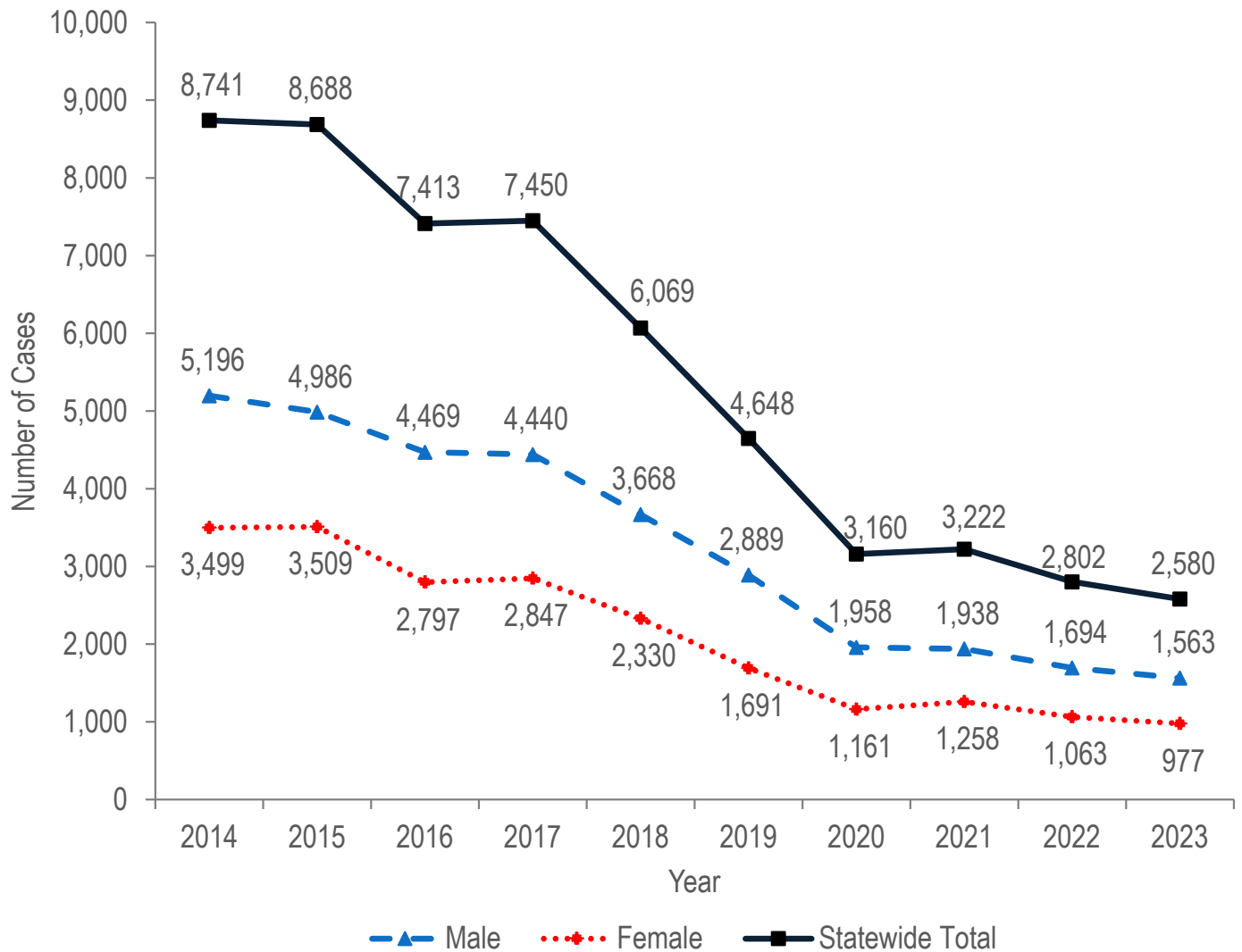
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/31/2024 and subject to change

- The total number of reported confirmed and probable HCV cases decreased from 8,741 in 2014 to 2,580 in 2023.¹
 - Most reported cases are chronically infected and DPH currently estimates that there are over 250,000 people living with HCV infection in Massachusetts.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023. Please note, in 2016, revised case definitions for acute and chronic HCV infection were implemented that contain significant changes from the case definitions for 2012 to 2015. For further information see <https://www.cdc.gov/nndss/conditions/>

HCV BY GENDER

Figure 28. Number of confirmed and probable HCV cases reported by female and male gender, Massachusetts 2013–2022



Note: Cases reported as transgender or missing gender (2014–2023: N=840) are included in the statewide total but are not depicted in Figure 28 separately due to small numbers.

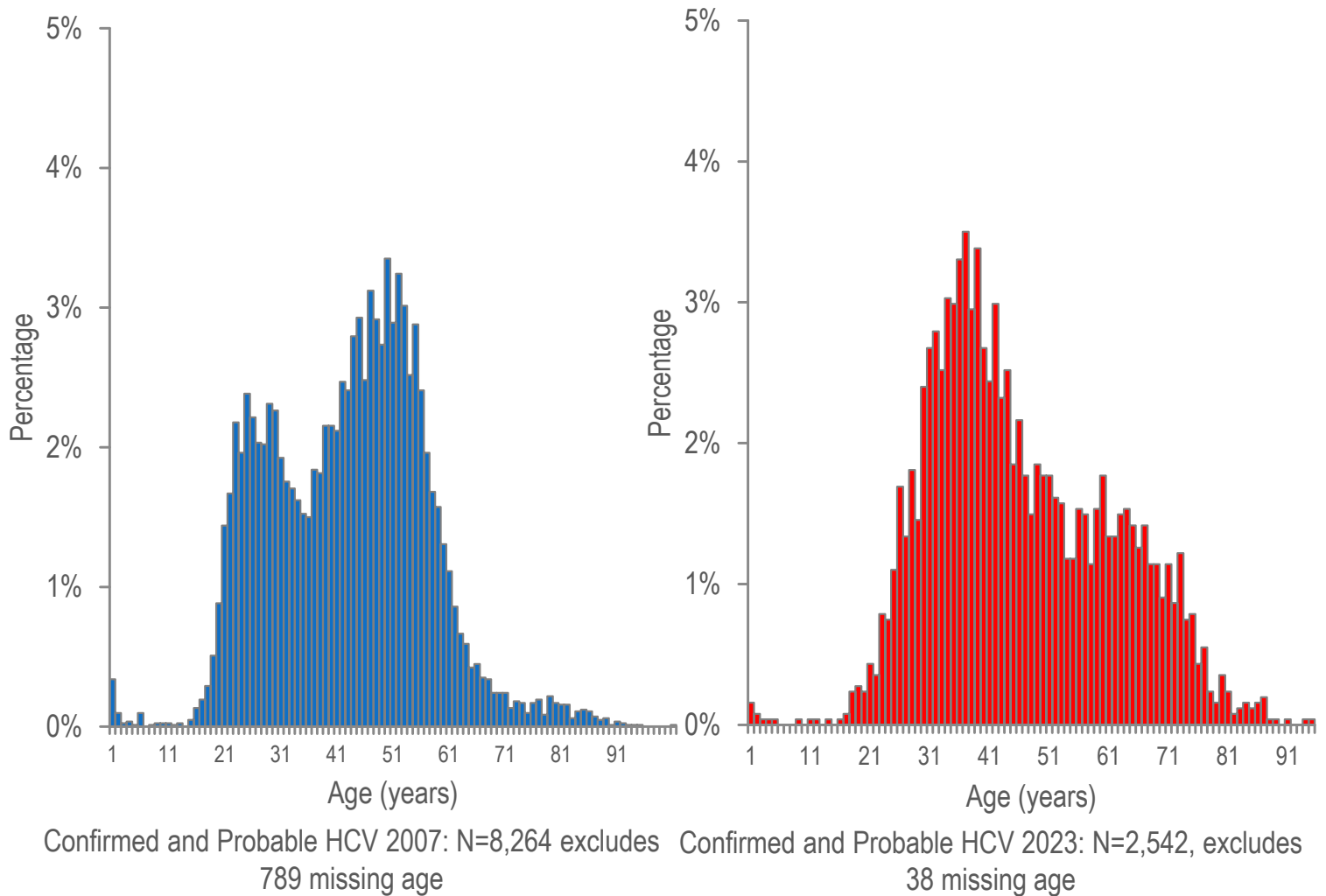
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/31/2024 and subject to change.

- In 2023,¹ 1,563 (61%) cases of confirmed and probable HCV infection were newly reported among males, 977 (38%) were reported among females, and 40 (1%) were reported among individuals with transgender experience or unknown gender.²

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates, for more information see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

Figure 29. Distribution of confirmed and probable HCV cases by age: 2007 versus 2023



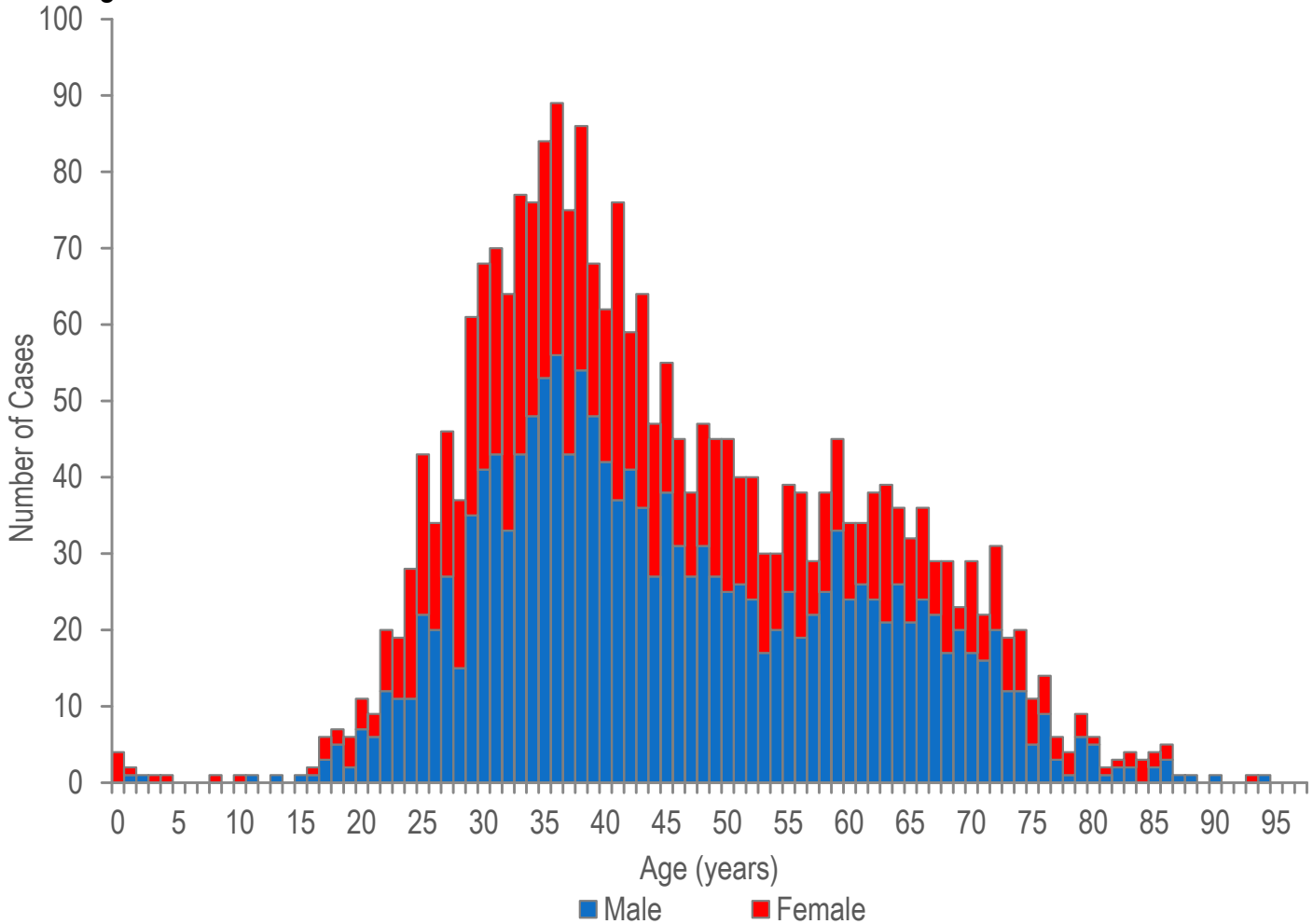
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/31/2024 and subject to change

- In 2007, reported cases of HCV were distributed in a curve with two age peaks, with the lower peak at age 24 years and the higher peak at age 49 years.
- In 2023,¹ the reported cases were again distributed in a bi-modal curve, but with the higher peak at age 36 years, and a lower, smaller peak at 59 years, reflecting a continuing shift in the age profile of newly reported cases.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

HCV BY AGE AND GENDER

Figure 30. Number of confirmed and probable HCV cases reported by age, and female and male gender, Massachusetts 2023



Note: Confirmed and Probable HCV 2023: N=2,542, excludes 38 missing age and/or gender. Cases reported as transgender are not depicted in Figure 30 separately due to small numbers. Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/31/2024 and subject to change.

- In 2023,¹ 1,563 (61%) confirmed and probable HCV cases were reported among males, 977 (38%) were reported among females, and fewer than five were reported among individuals of transgender experience.²
- Fifty-three percent (N=182/343) of confirmed and probable HCV infection cases in those less than 30 years of age were reported among males, 47% (N=161/343) were reported among females, and none were reported among individuals of transgender experience.
 - For newly reported HCV infections among persons less than 30 years of age with a known risk history, injection drug use was the most commonly reported risk factor for infection.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates, for more information see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

CO-INFECTIONS - HIV/SYPHILIS

Table 1. Percentage of 2023 confirmed and probable infectious syphilis¹ cases ever co-infected with HIV by gender, race/ethnicity, and age

	HIV/Syphilis Co-infections ²	Syphilis Cases	% of Syphilis Cases Co-infected with HIV
Total:	382	1,449	26%
Gender:			
Male	354	1,180	24%
Female	4	211	2%
Transgender/Nonbinary	24	58	41%
Race/Ethnicity:			
White NH	152	514	30%
Black NH	80	255	31%
Hispanic/Latinx	125	510	25%
Other NH	24	125	19%
Unreported	1	45	2%
Age:			
<15 years	0	1	0%
15–19 years	1	36	3%
20–24 years	14	145	10%
25–29 years	37	260	14%
30–39 years	126	471	27%
40–49 years	76	237	32%
50+ years	128	299	43%

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- In 2023,³ among 1,449 reported cases of confirmed and probable infectious syphilis, 26% (N=382/1,449) were co-infected with HIV.
- Among confirmed and probable infectious syphilis cases reported in 2023, proportions of HIV co-infection higher than the total proportion (26%) were observed in transgender individuals, Black (non-Hispanic) and White (non-Hispanic) individuals, and individuals aged 40 years and above.
- Seventy-two percent (N=850/1,180) of confirmed and probable infectious syphilis cases among males reported same sex contact. Of those who reported male-to-male sex, 35% (N=296/850) were co-infected with HIV, compared to 18% (N=58/330) of males with unknown risk.⁴

¹ Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

² HIV/syphilis co-infections include all infectious syphilis cases reported in 2023 that were ever diagnosed with HIV infection.

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

⁴ Case counts are based on current gender and include individuals of transgender experience who currently identify as male.

CO-INFECTIONS - HIV/GONORRHEA

Table 2. Percentage of 2023 confirmed gonorrhea cases ever co-infected with HIV by gender, race/ethnicity, and age

	HIV/Gonorrhea Co-infections ¹	Gonorrhea Cases	% of Gonorrhea Cases Co-infected with HIV
Total:	711	9,779	7%
Gender:			
Male	488	6,662	7%
Female	221	3,038	7%
Transgender/Nonbinary	2	71	3%
Unreported	0	8	0%
Race/Ethnicity:			
White NH	178	2,358	8%
Black NH	119	1,714	7%
Hispanic/Latinx	130	1,795	7%
Other NH	61	840	7%
Unreported	223	3,072	7%
Age:			
<15 years	2	29	7%
15–19 years	83	1,204	7%
20–24 years	155	2,245	7%
25–29 years	134	1,980	7%
30–39 years	209	2,685	8%
40–49 years	63	926	7%
50+ years	65	710	9%

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

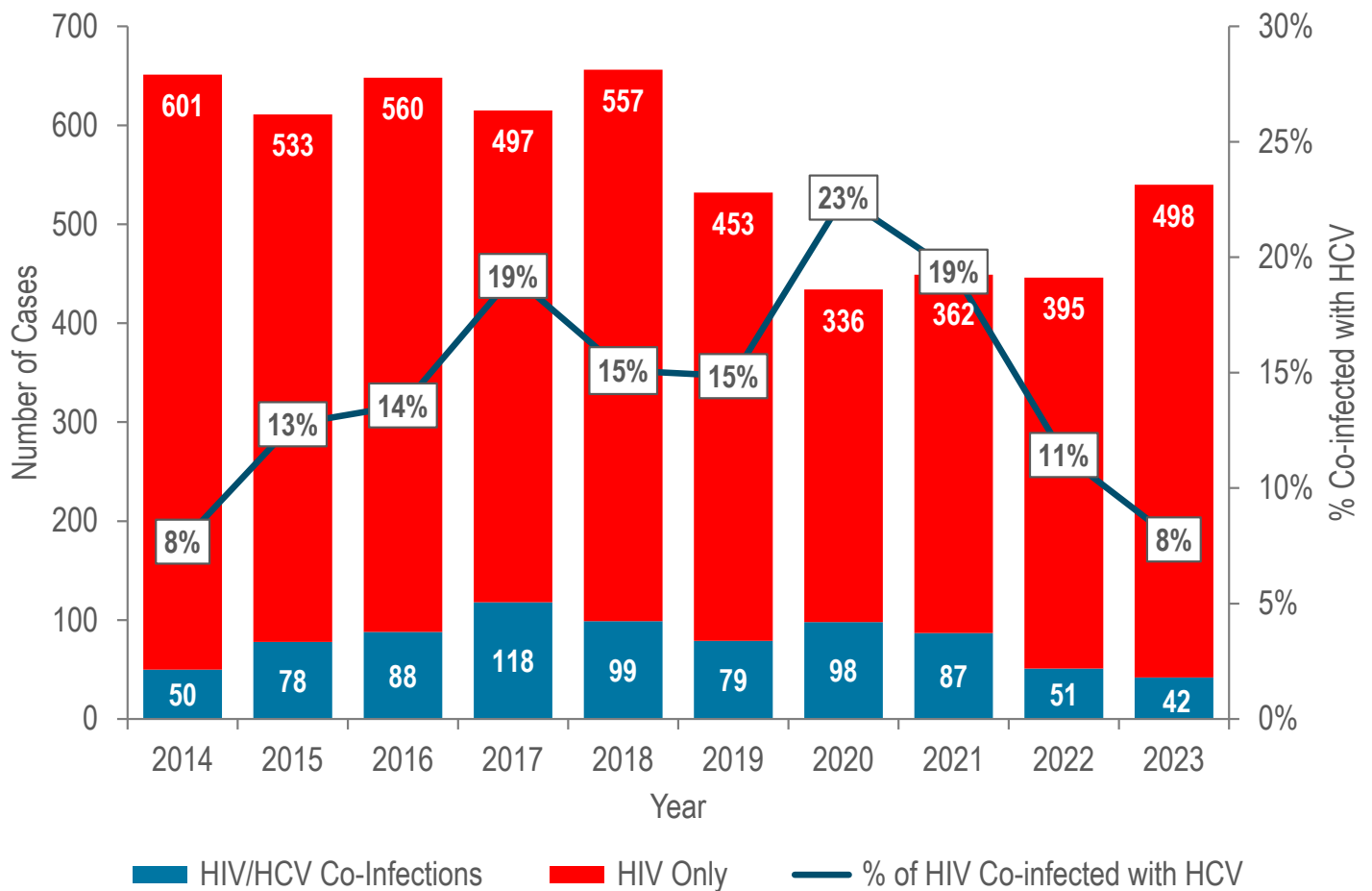
- In 2023,² among 9,779 confirmed cases of gonorrhea, 7% (N=711/9,779) were ever co-infected with HIV.
- Among confirmed gonorrhea cases reported in 2023, the proportion of individuals ever co-infected with HIV did not vary markedly by gender, race/ethnicity, or age.

¹ HIV/gonorrhea co-infections include all confirmed gonorrhea cases reported in 2023 that were ever diagnosed with HIV infection.

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

CO-INFECTIONS - HIV/HEPATITIS C (HCV)

Figure 31. Number of individuals diagnosed with HIV infection only, and ever co-infected with HCV by year of HIV infection diagnosis, Massachusetts 2014–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- The percentage of individuals diagnosed with HIV infection who were co-infected with HCV increased from 8% (N=50/651) in 2014 to 19% (N=118/615) in 2017, decreased to 15% in 2018 (N=99/656), increased again to a ten-year high of 23% (N=98/434) in 2020 and then decreased to 8% (N=42/540) in 2023.^{1,2} This trend mirrors that among HIV infection diagnoses with a primary exposure mode of injection drug use and is likely related to two outbreaks of HIV infection among persons who inject drugs. The first outbreak occurred from 2016 to 2018 in the northeastern part of the state and the second was identified in 2019 in the Boston area and is still ongoing (see Specific Populations – Persons Who Inject Drugs for more information).

¹ Total number of annual HIV diagnoses now excludes those first diagnosed in another state. Previously, all HIV diagnoses, including those first made in another state, were included in the co-infection analysis.

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

HIV/HCV CO-INFECTIONS BY DEMOGRAPHICS

Table 3. Individuals diagnosed with HIV infection ever co-infected with HCV by year of HIV infection diagnosis and selected demographics, 2018–2022

	2019		2020		2021		2022		2023	
	N	%	N	%	N	%	N	%	N	%
Assigned Sex at Birth:										
Assigned Male	53	67%	70	71%	60	69%	40	78%	32	76%
Assigned Female	26	33%	28	29%	27	31%	11	22%	10	24%
Race/Ethnicity:										
White NH	46	58%	72	73%	59	68%	33	65%	24	57%
Black NH	13	16%	10	10%	11	13%	2	4%	4	10%
Hispanic/Latinx	15	19%	15	15%	16	18%	14	27%	11	26%
Asian/Pacific Islander NH	1	1%	0	0%	0	0%	0	0%	1	2%
Other NH/Unknown	4	5%	1	1%	1	1%	2	4%	2	5%
Age:										
20–29 years	21	27%	19	19%	9	10%	9	18%	3	7%
30–39 years	33	42%	53	54%	43	49%	24	47%	19	45%
40–49 years	16	20%	15	15%	17	20%	8	16%	10	24%
50+ years	9	11%	11	11%	18	21%	10	20%	10	24%
HIV Exposure Mode:										
MSM	6	8%	10	10%	<5	N/A	<5	N/A	7	17%
IDU	51	65%	71	72%	75	86%	35	69%	30	71%
MSM/IDU	9	11%	12	12%	<5	N/A	8	16%	<5	N/A
HTSX	<5	N/A*	0	0%	<5	N/A	<5	N/A	<5	N/A
Pres. HTSX	<5	N/A	<5	N/A	<5	N/A	0	0%	0	0%
NIR	10	13%	<5	N/A	5	6%	<5	N/A	<5	N/A
Total:	79	100%	98	100%	87	100%	51	100%	42	100%

MSM=Male-to-Male Sex, IDU=Injection Drug Use, HTSX=Heterosexual Sex, Pres.=Presumed, NIR=No Identified Risk.

For more information, see HIV primary exposure mode definitions in Interpreting HIV, STI, and Viral Hepatitis Data.

*Values one through four are suppressed for denominator populations less than 50,000 or for unknown population sizes. Additional values of zero and greater than or equal to five may be suppressed to prevent back calculation.

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

HIV/HCV CO-INFECTIONS BY DEMOGRAPHICS

- From 2019 to 2023,^{1,2} the proportion of individuals co-infected with HIV/HCV who were assigned male at birth increased from 67% to 76%. During the same period, the proportion of individuals aged 50 years or older increased from 11% to 24%, while the proportion of 20-29 year-olds decreased from 27% to 7%. The proportion of individuals co-infected with HIV/HCV with IDU exposure mode likely reflected two separate HIV outbreaks among persons who inject drugs (PWID), increasing from 65% in 2019 to 86% in 2021 and then decreasing to 71% in 2023.
- The distribution of individuals co-infected with HIV/HCV infection by race/ethnicity remained relatively stable from 2018 to 2022, with White (non-Hispanic) individuals accounting for the majority of cases each year (57-73%).

¹ HIV/HCV co-infections now exclude those first diagnosed in another state. Previously, all HIV infection diagnoses that were ever diagnosed with HCV infection reported from 2019 – 2023 were included in the co-infection analysis, including those first made in another state.

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

HIV/HCV - PERCENTAGE CO-INFECTED

Table 4. Percentage of 2023 HIV infection diagnoses ever co-infected with HCV by gender, race/ethnicity, age, and HIV exposure mode

	HIV/HCV Co-infections ¹	HIV Diagnoses	% of HIV Diagnoses Co-infected with HCV
Total	42	540	8%
Assigned Sex at Birth:			
Assigned Male	32	397	8%
Assigned Female	10	143	7%
Race/Ethnicity:			
White NH	24	145	17%
Black NH	4	200	2%
Hispanic/Latinx	11	171	6%
Asian/Pacific Islander NH	1	14	7%
Other NH/Unknown	2	10	20%
Age:			
0–19 years	0	15	0%
20–29 years	3	133	2%
30–39 years	19	187	10%
40–49 years	10	100	10%
50+ years	10	105	10%
HIV Exposure Mode:			
MSM	7	227	3%
IDU	30	38	79%
MSM/IDU	<5	14	N/A*
HTSX	<5	25	N/A
Other	0	3	0%
Pres. HTSX	0	82	0%
NIR	<5	151	N/A

MSM=Male-to-Male Sex and Men Who Have Sex with Men, IDU=Injection Drug Use, HTSX=Heterosexual Sex, Pres.=Presumed, NIR=No Identified Risk * Values one through four are suppressed for denominator populations less than 50,000 or for unknown population sizes.

Additional values of zero and greater than or equal to five may be suppressed to prevent back calculation.

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

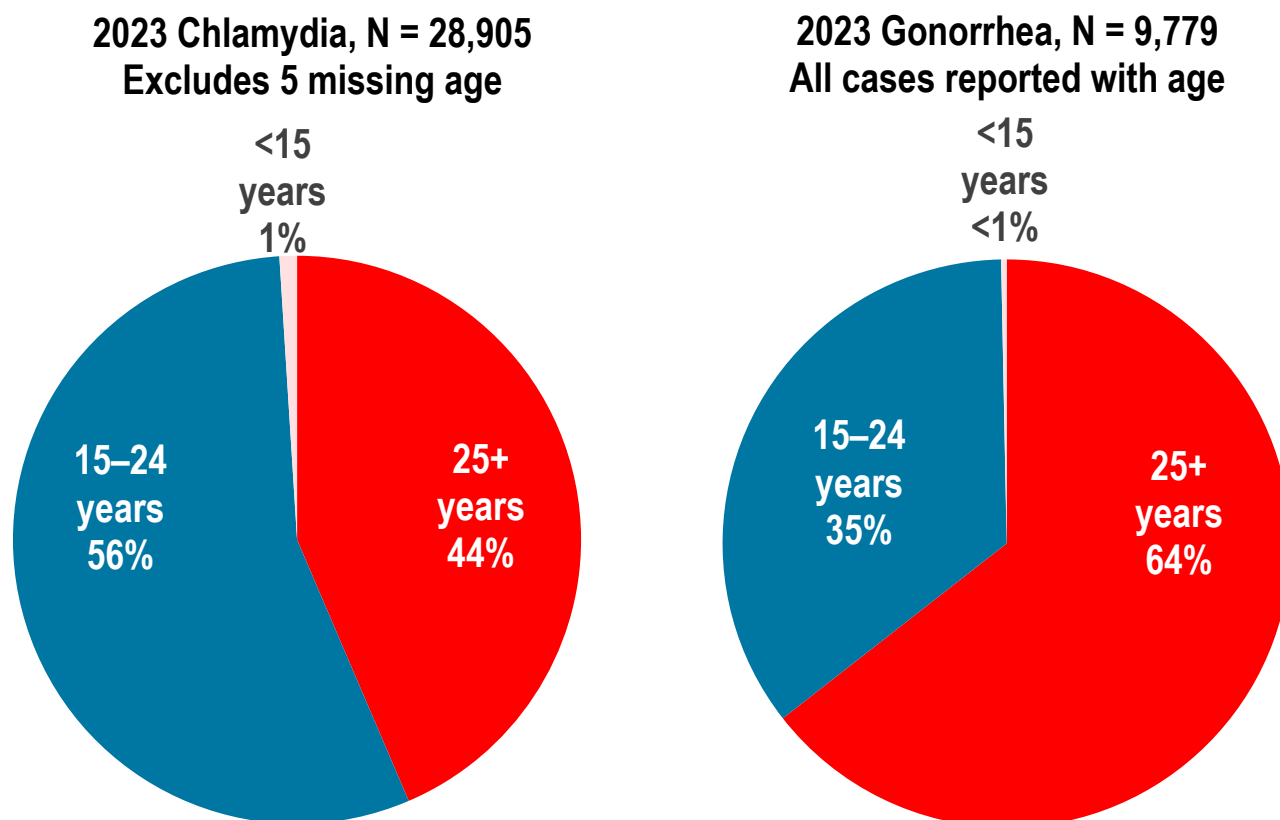
- In 2023,² among 540 individuals diagnosed with HIV infection, 8% (N=42/540) were ever co-infected with HCV.
- Among individuals diagnosed with HIV infection in 2023, higher rates of HCV co-infection were observed in White (non-Hispanic) individuals (17%), individuals of other or unknown race/ethnicity and individuals with IDU exposure mode (83%). Co-infection rates were similar for individuals assigned male at birth and individuals assigned female at birth.

¹ HIV/HCV co-infections include all HIV infection diagnoses reported in 2023 that were ever diagnosed with HCV infection. Total number of annual HIV diagnoses now excludes those first diagnosed in another state. Previously, all HIV diagnoses, including those first made in another state, were included in the co-infection analysis.

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

SPECIFIC POPULATIONS - ADOLESCENTS AND YOUNG ADULTS, STI DIAGNOSES BY AGE

Figure 32. Distribution of confirmed chlamydia and gonorrhea cases reported by age group (years), Massachusetts 2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

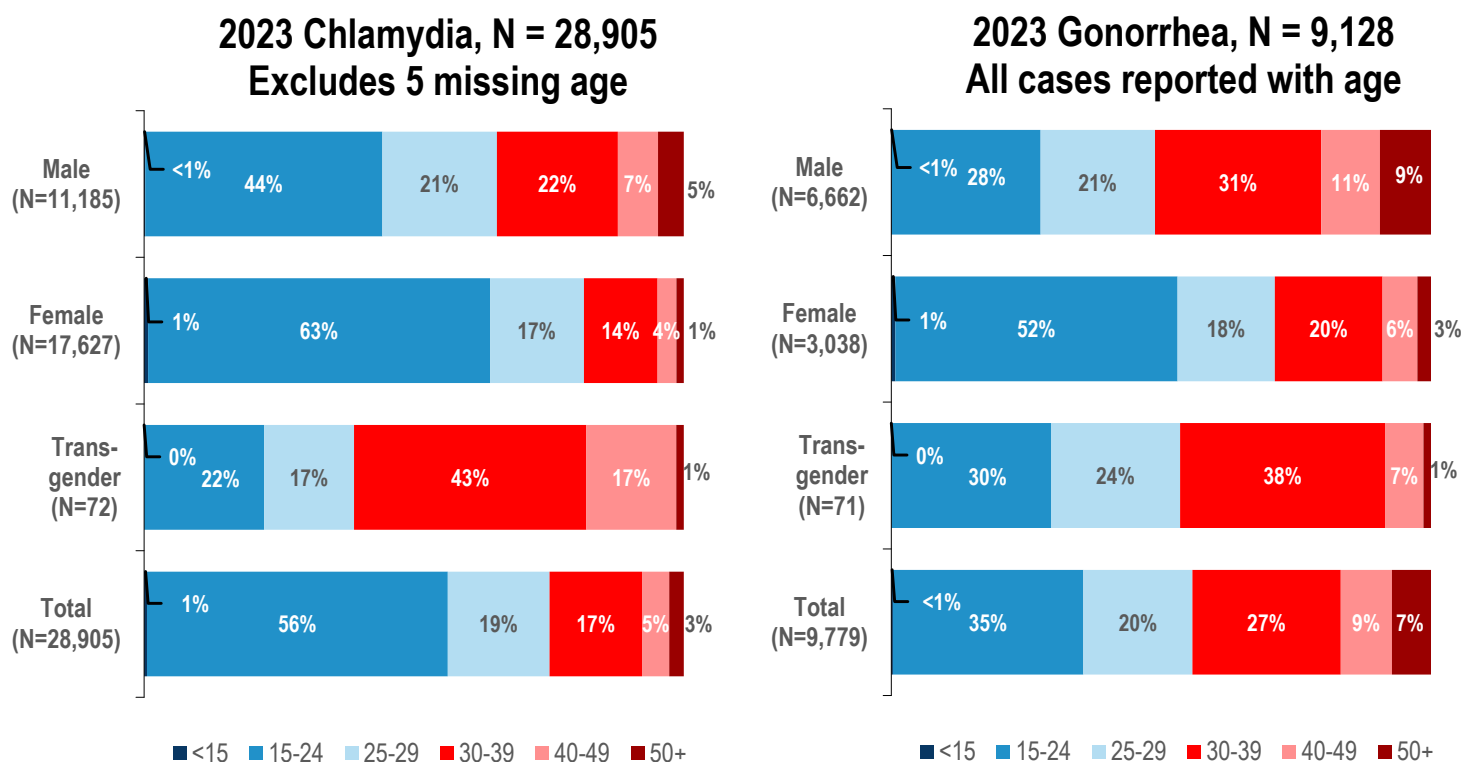
- In 2023,¹ in Massachusetts, 56% of confirmed chlamydia cases and 35% of confirmed gonorrhea cases were reported among adolescents and young adults aged 15–24 years.
 - Nationally, 58% of chlamydia cases and 40% of gonorrhea cases were reported among adolescents and young adults aged 15–24 years in 2022.²

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² Centers for Disease Control and Prevention. *Sexually Transmitted Infections Surveillance 2022*. Atlanta: U.S. Department of Health and Human Services; 2024. National percentages among 15-24 year-olds also exclude cases of unknown age for comparability with Massachusetts percentages. Please note, 2022 percentages are presented because 2023 percentages by age were not yet available at the time of this publication.

STI DIAGNOSES BY AGE AND GENDER

Figure 33. Distribution of confirmed chlamydia and gonorrhea cases reported by age group (years) and gender, Massachusetts 2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- In 2023,¹ in Massachusetts, 44% of confirmed chlamydia cases reported among males, 63% among females, 22% among individuals of transgender experience,² and 56% of total cases were reported among adolescents and young adults aged 15–24 years.
 - Nationally in 2022, 46% of chlamydia cases reported among males, 65% among females, and 58% of total cases were reported among adolescents and young adults aged 15–24 years.²
- In 2023, in Massachusetts, 28% of confirmed gonorrhea cases reported among males, 52% among females, 30% among individuals of transgender experience, and 35% of total cases were reported among adolescents and young adults aged 15–24 years.
 - Nationally in 2022, 32% of gonorrhea cases reported among males, 53% among females, and 40% of total cases were reported among adolescents and young adults aged 15–24 years.³

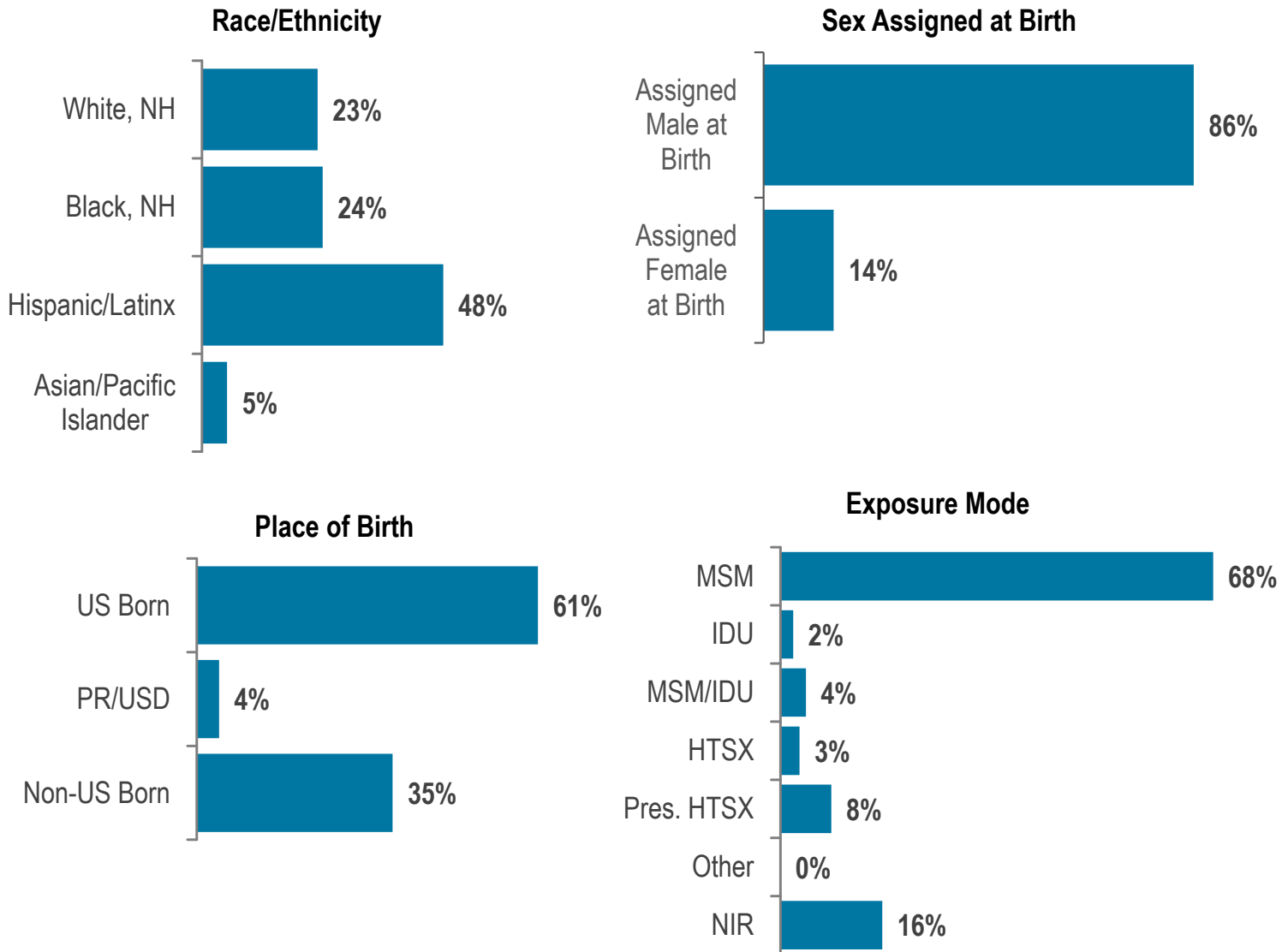
¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023

² Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates, for more information see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

³ Centers for Disease Control and Prevention. Sexually Transmitted Infections Surveillance 2022. Atlanta: U.S. Department of Health and Human Services; 2024. National percentages among 15-24 year-olds also exclude cases of unknown age for comparability with Massachusetts percentages. Please note, 2022 national data are presented because 2023 data by age and gender were not yet available at the time of this publication.

HIV DIAGNOSES BY RACE/ETHNICITY AND EXPOSURE MODE

Figure 34. Distribution of HIV infection diagnoses in adolescents and young adults (aged 15–24 years) by race/ethnicity, exposure mode, place of birth, and sex assigned at birth, Massachusetts 2021–2023, N=157



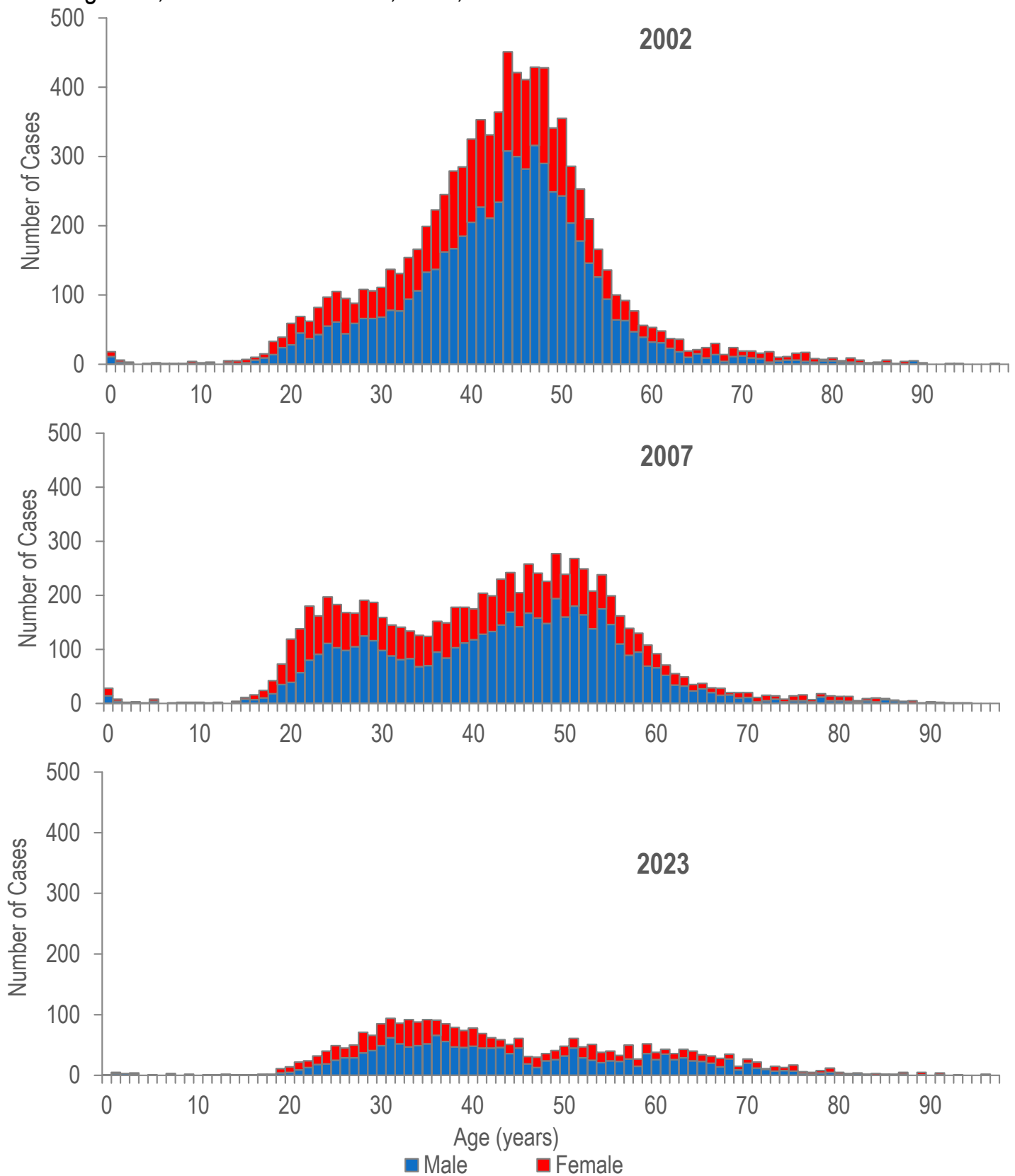
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- During 2021 to 2023,¹ 11% (N=157/1,435) of HIV infection diagnoses were reported among adolescents and young adults aged 15–24 years.
- Adolescent and young adults aged 15–24 years newly diagnosed with HIV infection in Massachusetts during 2021 to 2023 were predominantly Hispanic/Latinx (48%) or Black (non-Hispanic) (24%), assigned male at birth (86%), and US born (61%), with an exposure mode of male-to-male sex (68%).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

HEPATITIS C (HCV) BY AGE AND GENDER

Figure 35. Number of confirmed and probable HCV cases reported by age and female and male gender, Massachusetts 2002, 2007, 2023*



*Probable and Confirmed HCV 2002, N=9,046 (excludes 159 with missing age and/or gender), 2007 N=8,264 (excludes 789 with missing age and/or gender), 2023 N=2,542 (excludes 38 with missing age and/or gender). Cases reported as transgender are not depicted in Figure 35 separately due to small numbers. Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/31/2024 and subject to change.

HCV BY AGE AND GENDER

- The age distribution of HCV cases reported in Massachusetts changed between 2002 and 2023¹ with a significant increase in cases among young persons who inject drugs.
- In 2002, reported HCV cases were distributed in a curve with one age peak at 44 years.
- In 2007, reported cases of HCV were distributed in a curve with two age peaks, with the lower peak at age 24 years and the higher peak at age 49 years.
- In 2023, HCV cases among young adults who inject drugs outnumbered newly reported cases among the older (“baby boomer”) age cohort.
- The proportion of cases among young adults (aged 20-39 years) was higher in 2007 (38%, N=3,179/8,264) and 2023 (42%, N=1,066/2,542) compared to 2002 (31%, N=2,801/9,046).
- The primary risk for HCV infection in younger adults is injection drug use. While the primary exposure mode for HIV infection in younger adults is male-to-male sex, recent increases in the number of HIV infections attributed to injection drug use have been observed, particularly among young adults (aged 13-29 years).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

Table 5. Reported sexual behaviors among Massachusetts high school students, 2015 – 2023

	Percentage who reported:				
	2015	2017	2019	2021 ²	2023
	% (95% CI) n ¹	% (95% CI) n	% (95% CI) n	% (95% CI) n	% (95% CI) n
Ever having sexual intercourse	36.4% (32.4–40.6) 2,779	35.3% (31.8–39.1) 2,889	36.9% (32.8–41.3) 1,946	NA ³	NA
Having sexual intercourse before age 13	2.9% (2.2–3.8) 2,793	2.4% (1.6–3.4) 2,886	2.5% (1.7–3.4) 1,951	2.7% (2.1–3.3) 2,897	3.0% (2.2–3.8) 2,740
Having had sexual intercourse with 4+ partners during their life	7.9% (6.2–10.0) 2,781	6.7% (5.4–8.2) 2,886	7.8% (6.3–9.5) 1,938	4.3% (3.4–5.3) 2,883	5.3% (3.9–6.7) 2,732
Using a condom at last sexual intercourse⁴	62.5% (58.9–65.9) 766	57.8% (53.1–62.3) 719	51.4% (45.3–57.4) 427	58.0% (52.8–63.3) 468	51.6% (45.7–57.5) 568
Drinking alcohol or using drugs before last sexual intercourse⁴	21.8% (18.1–26.0) 782	18.2% (15.8–21.0) 631	23.4% (19.5–27.9) 434	20.7% (17.6–23.7) 432	19.1% (14.2–23.9) 572
Ever tested for HIV	9.9% (8.0–12.2) 3,010	10.5% (9.0–12.1) 3,125	12.6% (10.4–15.3) 2,085	NA	NA

¹ The number of respondents (unweighted) varied for each question because participants may not answer all questions.

² NA = Not asked. Some questions were removed from the YRBS in 2021 to allow for the addition questions related to COVID-19 and adverse childhood experiences.

³ Caution should be used in the interpretation of 2021 YRBS data due to the effect of the COVID-19 pandemic. COVID-19 precautions might have reduced school and student participation, although more schools were sampled in 2021 than in previous cycles. Additionally, COVID-19 may have also affected student behavior. For more information, see: Mpofu JJ, Underwood JM, Thornton JE, Brener ND, Rico A, Kilmer G, Harris WA, Leon-Nguyen M, Chyen D, Lim C, Mbaka CK, Smith-Grant J, Whittle L, Jones SE, Krause KH, Li J, Shanklin SL, McKinnon I, Arrey L, Queen BE, Roberts AM. Overview and Methods for the Youth Risk Behavior Surveillance System - United States, 2021. MMWR Suppl. 2023 Apr 28;72(1):1-12. doi: 10.15585/mmwr.su7201a1. PMID: 37104281; PMCID: PMC10156160.

⁴ Among youth reporting sexual intercourse in the past three months

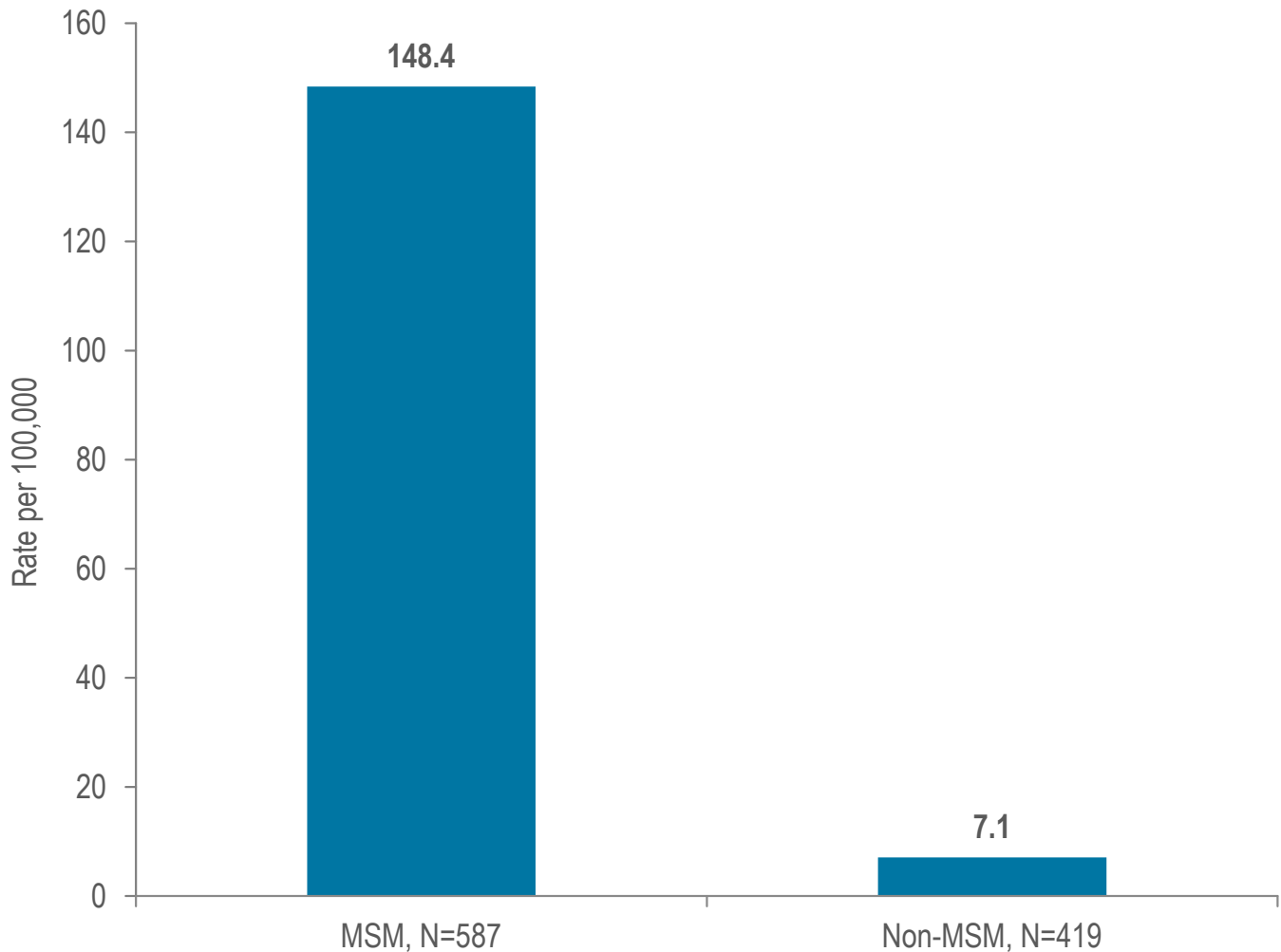
Data Source: Massachusetts Department of Elementary and Secondary Education and Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment

- The Massachusetts Youth Risk Behavior Survey (MYRBS) is performed biennially among a sample of ninth to twelfth grade students.
- The proportion of students reporting condom use at last sexual intercourse was lower in 2023 (51.6%, 95% CI: 45.7%–57.5%, n=568) compared to 2015 (62.5%, 95% CI: 58.9%–65.9%, n=766).

SPECIFIC POPULATIONS - MEN WHO HAVE SEX WITH MEN

HIV DIAGNOSIS RATE PER 100,000

Figure 36. Estimated¹ average annual HIV diagnosis rate per 100,000 population: MSM (men who have sex with men) compared to non-MSM (males) ages 18–64 years: Massachusetts 2021–2023



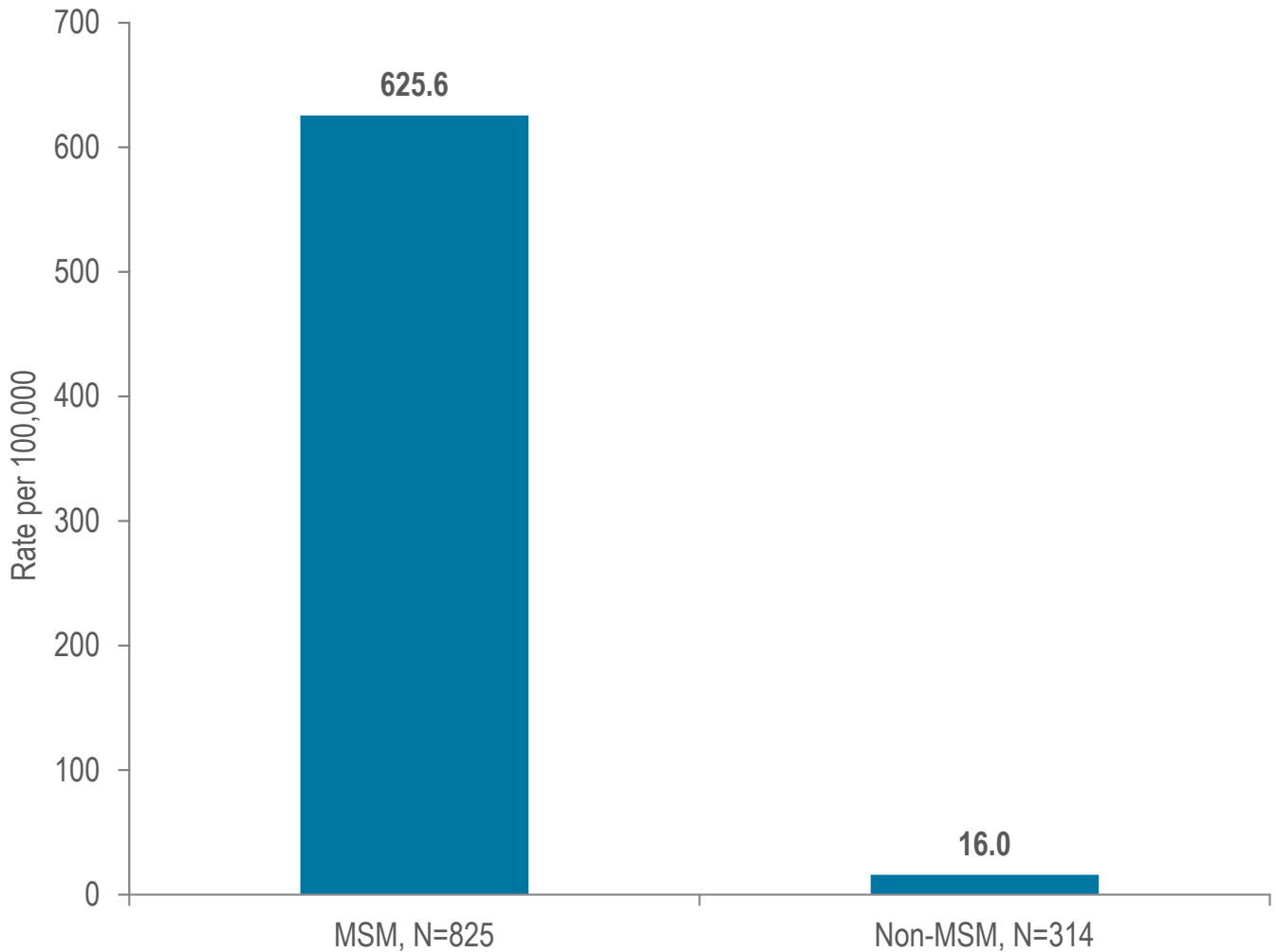
- At 148.4 per 100,000 population (95% confidence interval [CI]: 123.0–190.8 per 100,000), the estimated average rate of HIV diagnosis from 2021 to 2023² among MSM (ages 18–64 years) was 21 times the rate of infection in men who did not report sex with men (7.1 per 100,000 [95% CI: 7.0–7.2 per 100,000]).

¹ Multiple source estimation method for MSM rate (2020–2022 BRFSS, UMDI Interim 2020 Population Estimates by Age, Sex, Race, and Municipality, UMass Donahue Institute Population Estimates Program, March 1, 2022; and MDPH Bureau of Infectious Disease and Laboratory Sciences, data as of 7/1/2024)

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

MSM - SYPHILIS RATE PER 100,000

Figure 37. Estimated¹ confirmed and probable infectious syphilis² rate per 100,000 population: MSM compared to non-MSM (males) ages 18–64 years: Massachusetts 2023



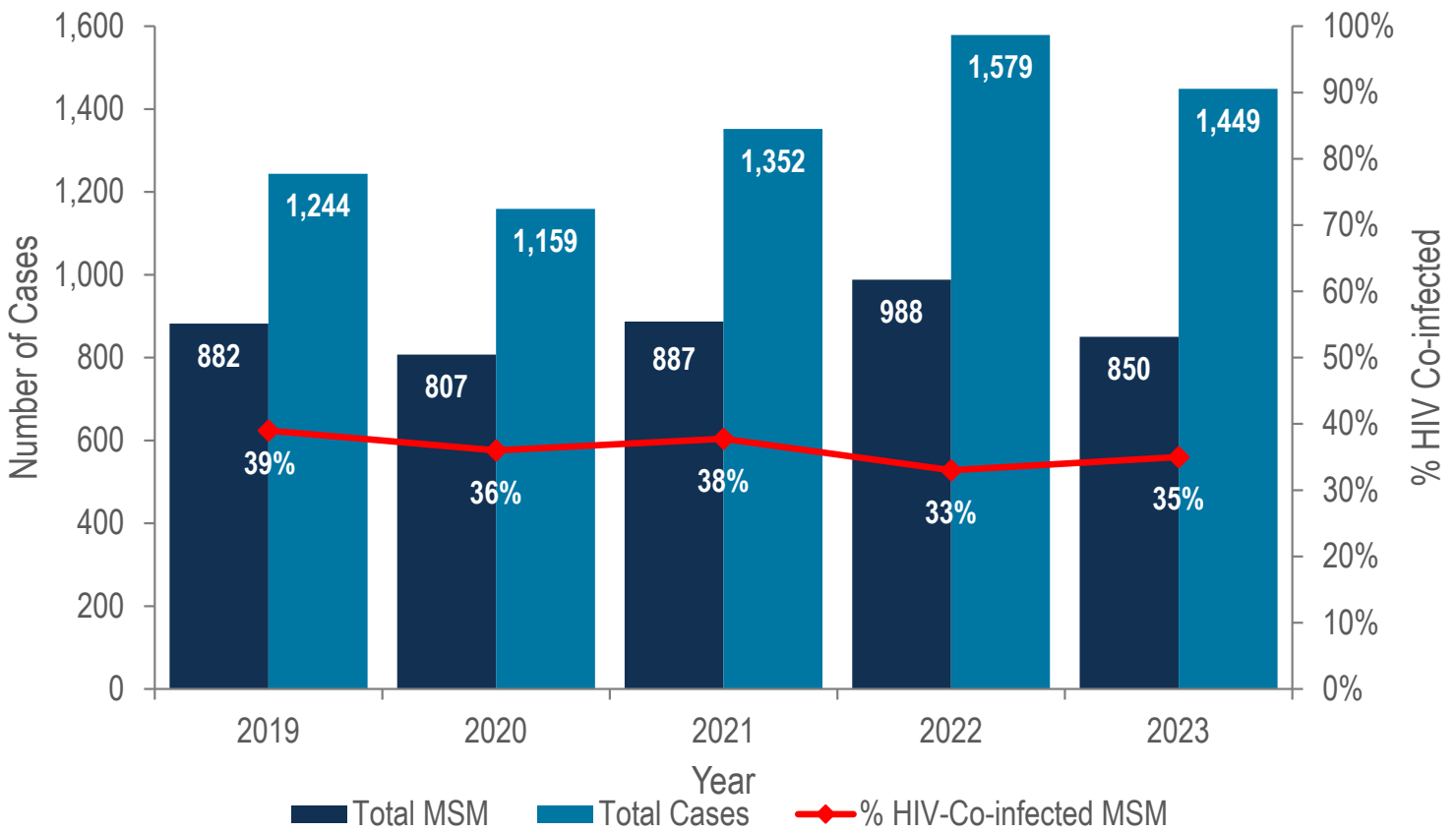
- At 625.6 per 100,000 population (95% confidence interval [CI]: 518.6–804.3 per 100,000), the estimated confirmed and probable infectious syphilis rate in 2023³ among MSM (ages 18–64) was 39 times the rate of infection in men who did not report sex with men (16.0 per 100,000 [95% CI: 15.8–16.2 per 100,000]).

¹ Multiple source estimation method for MSM rate (2020–2022 BRFSS, UMDI Interim 2020 Population Estimates by Age, Sex, Race, and Municipality, UMass Donahue Institute Population Estimates Program, March 1, 2022, and MDPH Bureau of Infectious Disease and Laboratory Sciences, data as of 7/22/2024)

² Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

Figure 38. Number of confirmed and probable infectious syphilis¹ cases among MSM and the percent of cases among MSM known to ever be co-infected with HIV, Massachusetts 2019–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- The incidence of confirmed and probable infectious syphilis in Massachusetts increased by 27% from 2019 to 2022 and subsequently decreased by 8% in 2023; MSM represented the majority of cases (59% in 2023).
- In 2023,² 35% (N=296/850) of confirmed and probable infectious syphilis cases among men reporting sex with men also self-reported co-infection with HIV.³

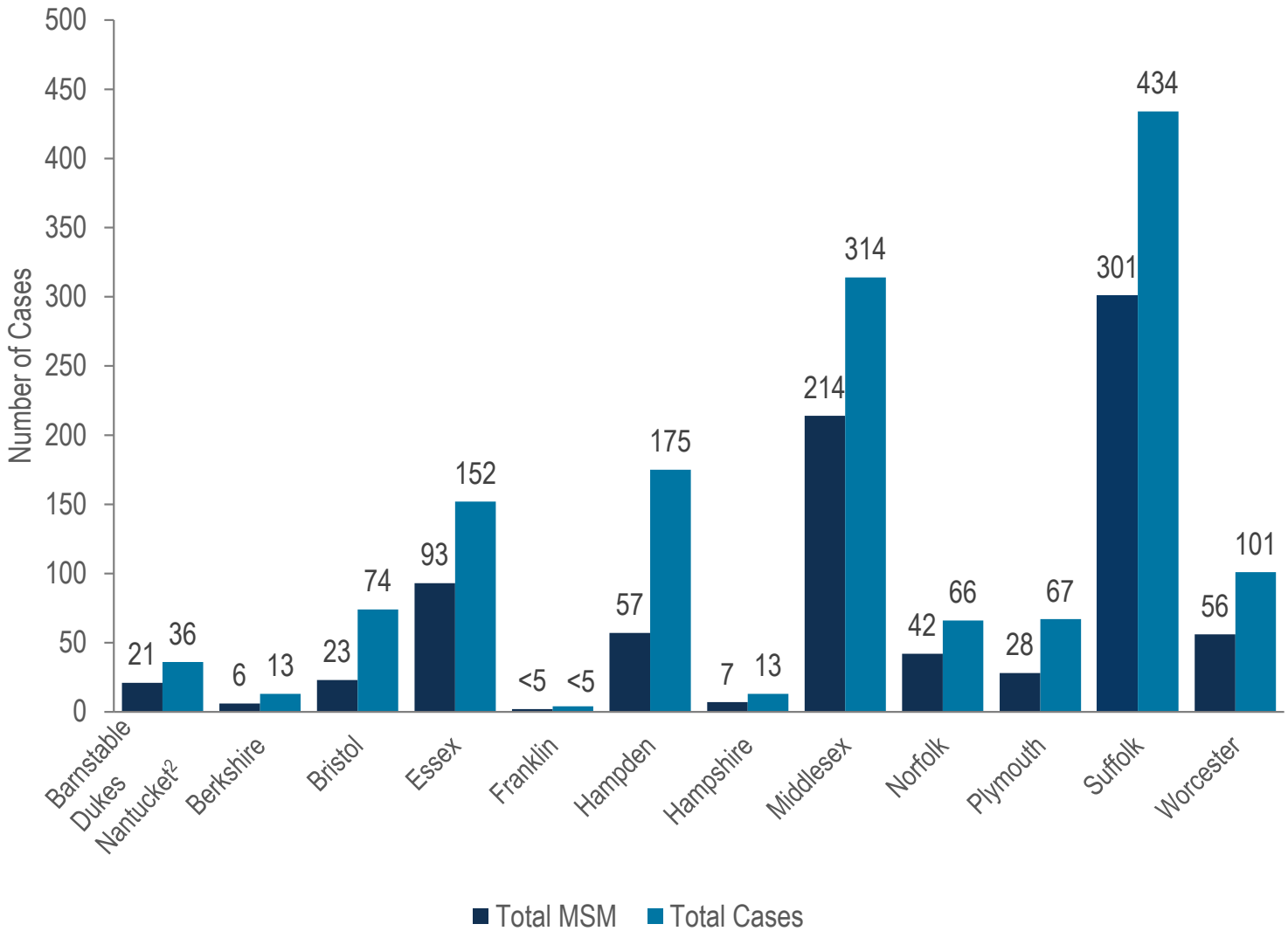
¹ Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

³ Please note that the syphilis/HIV co-infection rate among MSM is based on self-report, not database matching analyses, which were used to calculate HIV/syphilis co-infection rates elsewhere in this report.

MSM - SYPHILIS BY COUNTY

Figure 39. Total number of confirmed and probable infectious syphilis¹ cases and number among MSM by county, Massachusetts 2023



Note: MSM N=850, missing risk information N=142, total cases N=1,449

Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change.

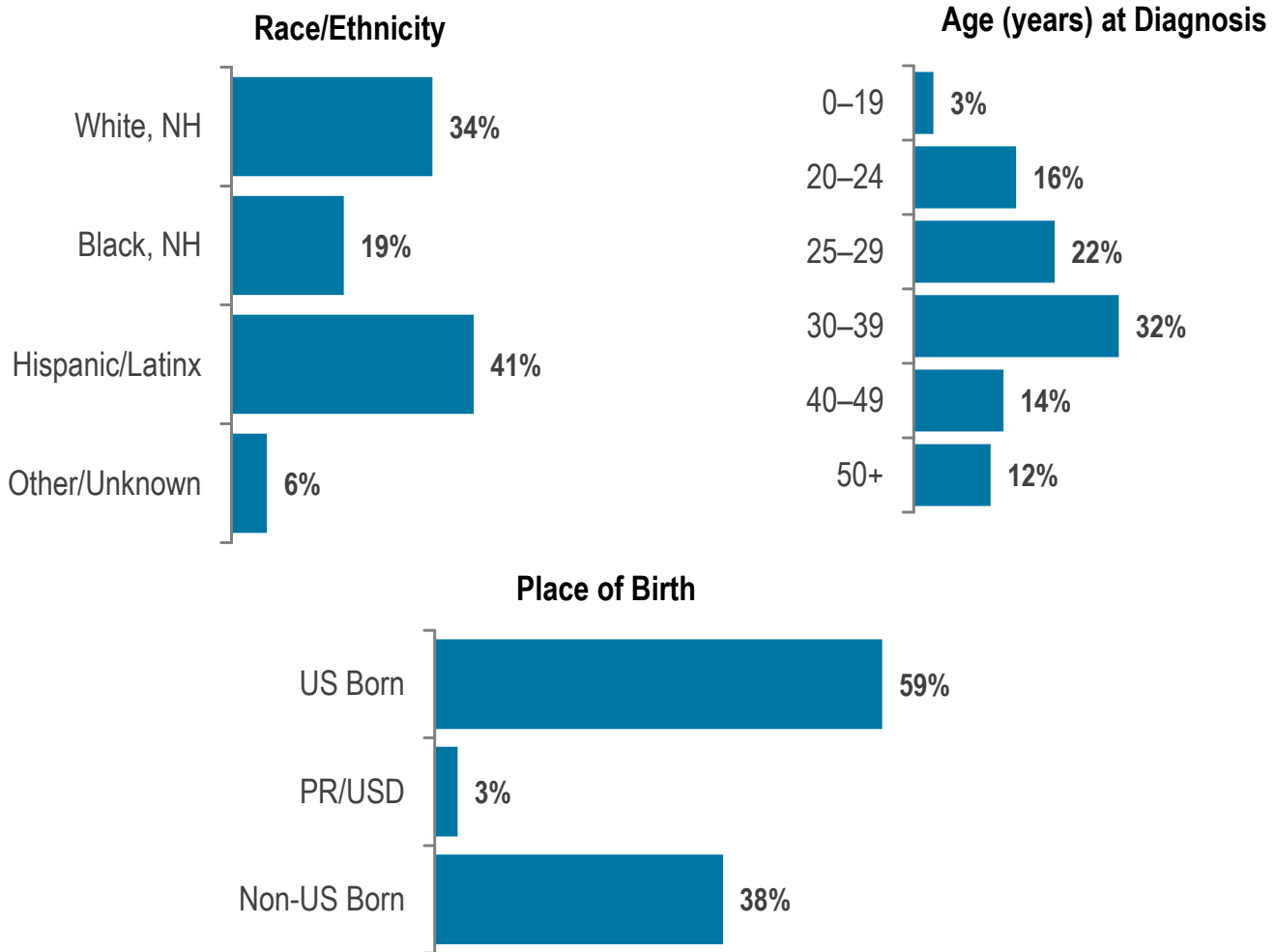
- In 2023,³ the largest proportions of MSM among confirmed and probable infectious syphilis cases were reported in Suffolk (69%, N=301/434) and Middlesex (68%, N=214/314) counties.

¹ Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

² Barnstable, Dukes and Nantucket Counties are combined because of small numbers.

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

Figure 40. HIV infection diagnoses among men reporting sex with men by race/ethnicity, age at diagnosis, and place of birth, Massachusetts 2021–2023 (N=559)

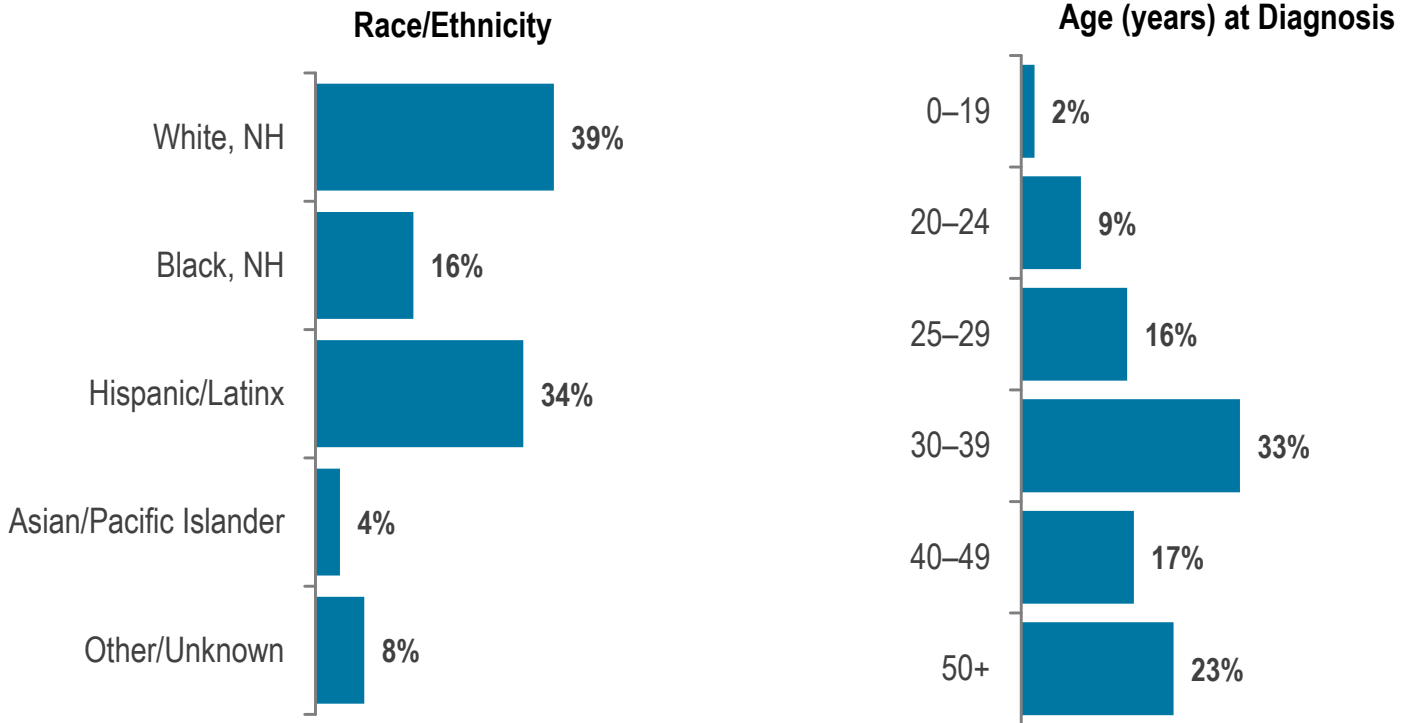


Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- Black (non-Hispanic) and Hispanic/Latinx individuals represented 7% and 13% of men in Massachusetts, compared to 19% and 41%, respectively, of men recently diagnosed with HIV infection with MSM exposure mode.
- Individuals with MSM exposure mode newly diagnosed with HIV infection in Massachusetts during 2021 to 2023¹ were predominantly in their twenties or thirties (38% 20–29 year-olds, 32% 30–39 year-olds), Hispanic/Latinx (41%) or White (non-Hispanic) (34%), and US born (59%).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

Figure 41. Confirmed and probable infectious syphilis¹ cases among men reporting sex with men, by race/ethnicity and age, Massachusetts 2023 (N=850)



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

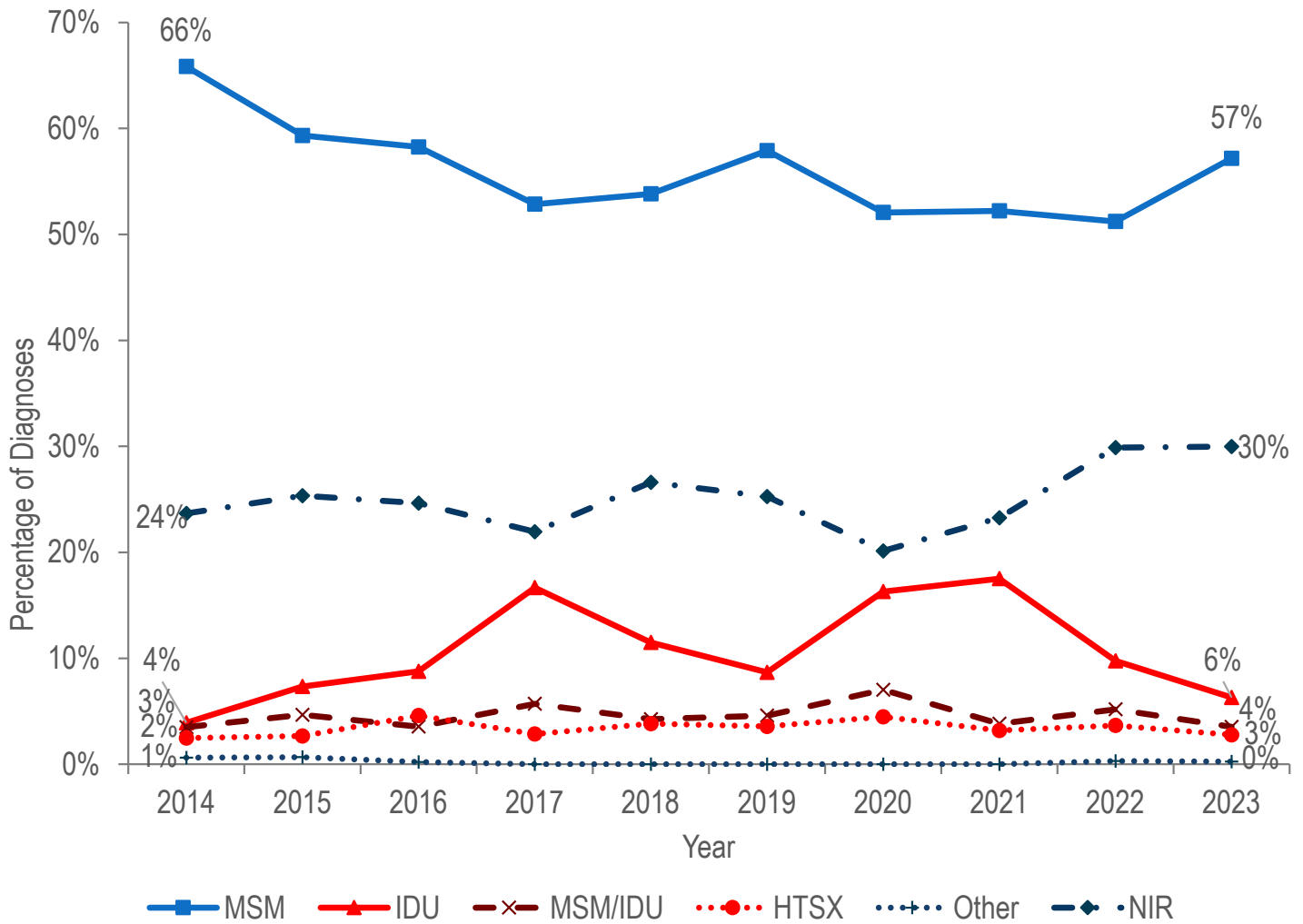
- Black (non-Hispanic) and Hispanic/Latinx individuals represented 7% and 13% of men in Massachusetts, compared to 16% and 34%, respectively, of confirmed and probable infectious syphilis cases among men reporting sex with men in 2023.
- In 2023,² confirmed and probable infectious syphilis cases among men reporting sex with men were predominantly White (non-Hispanic) (39%), and age 30 years and above (72% 30+ year-olds).

¹ Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

TRENDS IN HIV EXPOSURE MODE AMONG MALES

Figure 42. Percentage distribution of individuals assigned male at birth (AMAB) diagnosed with HIV infection by exposure mode, Massachusetts 2014–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- Among individuals AMAB, the proportion of HIV infection diagnoses with male-to-male sex as the reported mode of exposure decreased from 66% in 2014 to 51% in 2022 and subsequently increased to 57% in 2023.¹ During the same time period, the proportion reported with no identified risk remained between 20% and 30%.
- The proportion of cases among individuals AMAB attributed to injection drug use increased from 4% in 2014 to 17% in 2017 and then decreased to 9% in 2019. The increase in 2017 was primarily due to an outbreak among persons who inject drugs in the northeast part of the state between 2016 and 2018.² Following a focused public health response, the number of HIV infection diagnoses attributed to IDU in the northeast decreased. However, in early 2019, a new cluster of HIV infection was identified in Boston among PWID who were experiencing or had experienced recent homelessness, and the proportion of HIV infection diagnoses among individuals AMAB with IDU as the primary exposure increased to 18% in 2021. Following another focused public health response, the proportion decreased to 6% in 2023.³

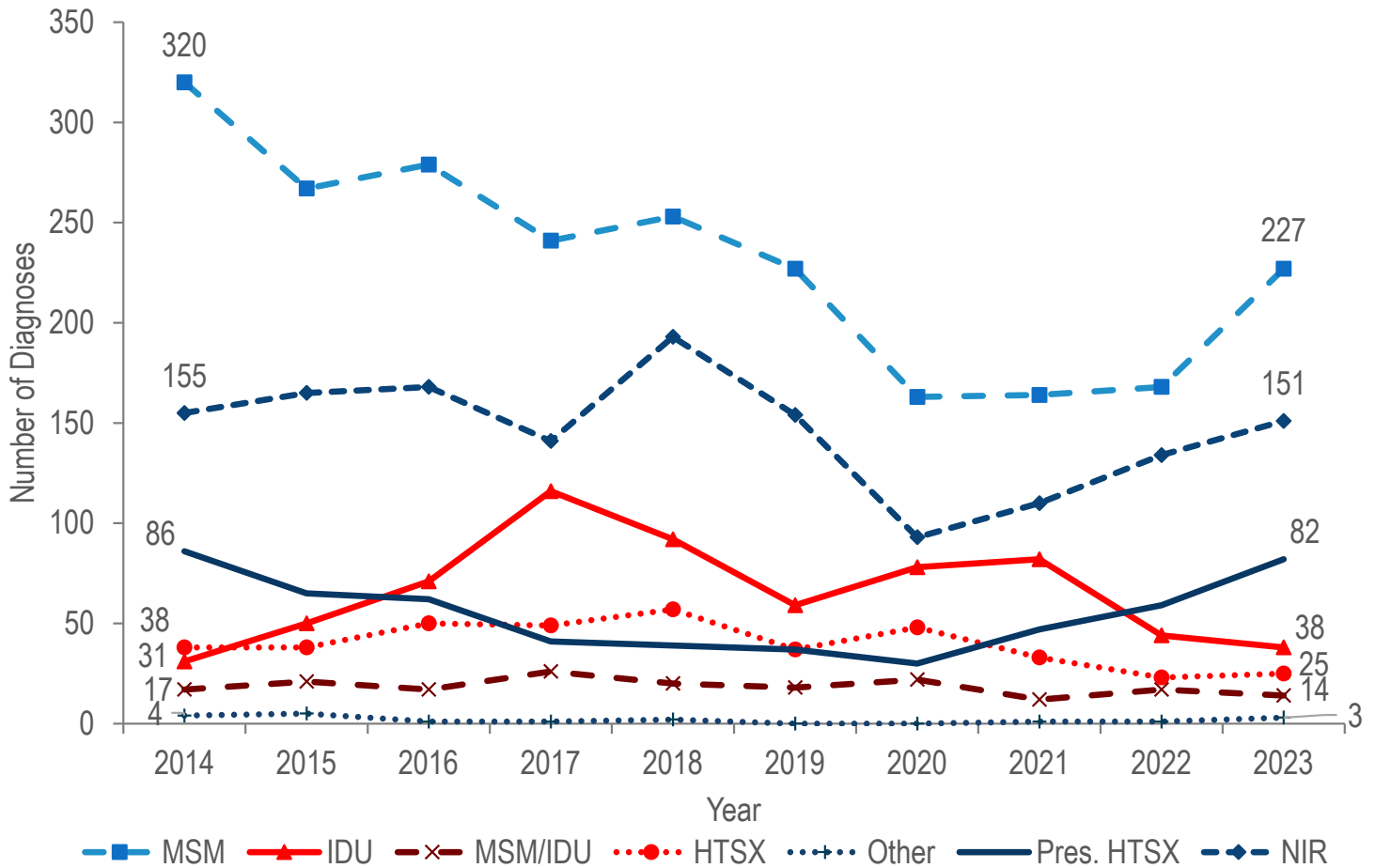
¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² For more information see: Charles Alpren et al. "Opioid Use Fueling HIV Transmission in an Urban Setting: An Outbreak of HIV Infection Among People Who Inject Drugs—Massachusetts, 2015–2018", *American Journal of Public Health* 110, no. 1 (January 1, 2020): pp. 37-44. <https://doi.org/10.2105/AJPH.2019.305366>

³ For more information, see: Joint MDPH and BPHC Clinical Advisory: Increase in newly diagnosed HIV infections among persons who inject drugs in Boston, March 15, 2021, available at: <https://www.mass.gov/doc/joint-mdph-and-bphc-clinical-advisory-hiv-transmission-through-injection-drug-use-in-boston-march-15-2021/download>

SPECIFIC POPULATIONS - PERSONS WHO INJECT DRUGS

Figure 43. Individuals diagnosed with HIV infection by exposure mode, Massachusetts 2014–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- The number of reported cases with injection drug use (IDU) as the primary exposure mode increased from a low of 31 in 2014 to a peak of 116 in 2017, and then decreased to 59 in 2019. The increase in 2017 was primarily due to an outbreak among persons who inject drugs (PWID) in the northeast part of the state between 2016 and 2018.¹ Following a focused public health response, the number of HIV infection diagnoses attributed to IDU in the northeast has decreased.
- However, in early 2019, a new cluster of HIV infection was identified in Boston among PWID who were experiencing or had experienced recent homelessness, and the total statewide number of reported cases with IDU as the primary exposure increased to 82 in 2021.² Following another focused public health response, the number of HIV infection diagnoses attributed to IDU decreased by 54% to 38 cases in 2023. As of July 1, 2024, a total of 213 cases diagnosed since November 2018 have been investigated and identified as part of the Boston cluster. As it is an active cluster of concern, additional cases will continue to be investigated and added. Continuing trends among those newly diagnosed in the Boston cluster (N=15 cases diagnosed in 2023) include an increase in polysubstance and methamphetamine use.³

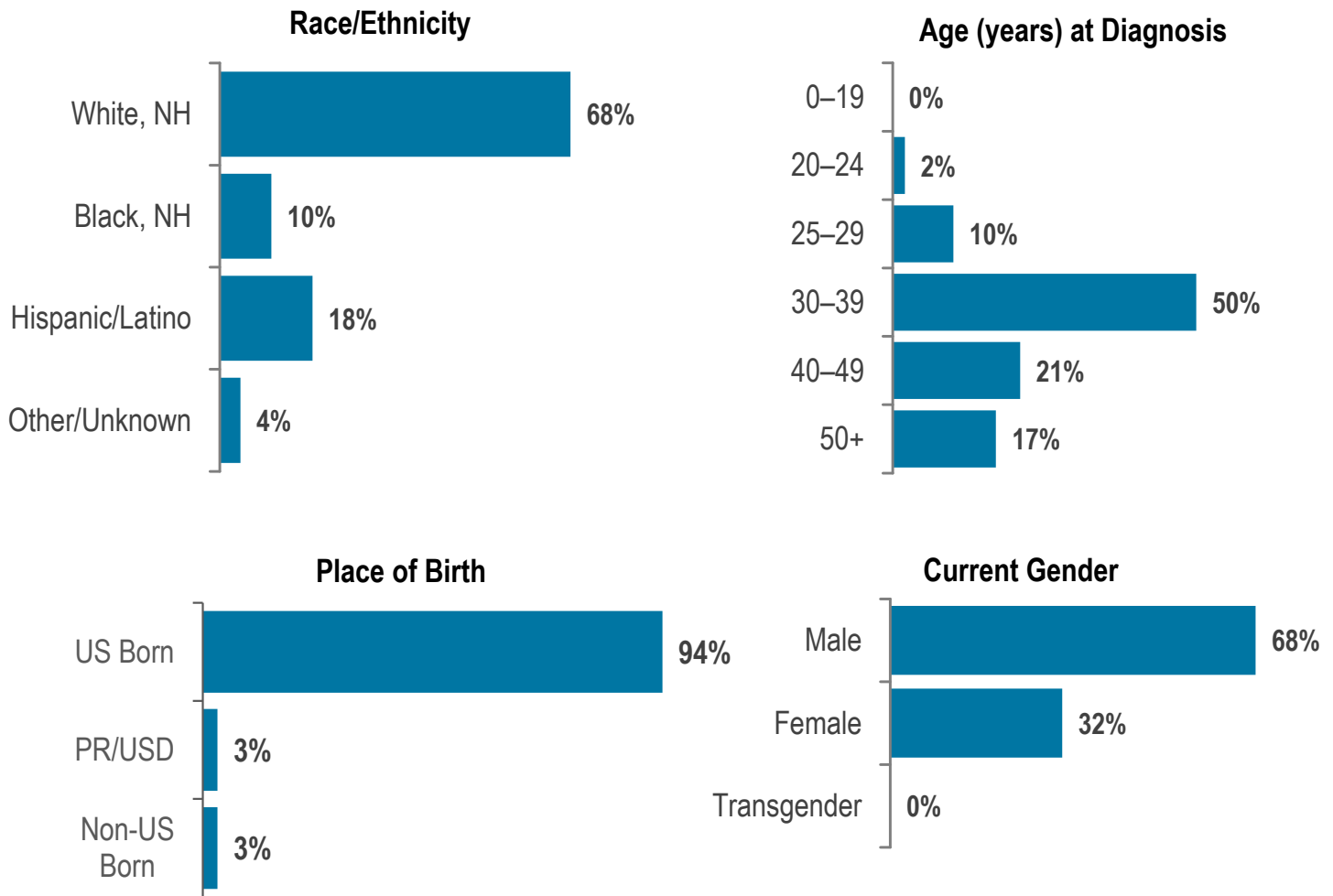
¹ For more information, see: Charles Alpren et al. "Opioid Use Fueling HIV Transmission in an Urban Setting: An Outbreak of HIV Infection Among People Who Inject Drugs—Massachusetts, 2015–2018", *American Journal of Public Health* 110, no. 1 (January 1, 2020): pp. 37-44. <https://doi.org/10.2105/AJPH.2019.305366>

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

³ For more information, see: Joint MDPH and BPHC Clinical Advisory: Increase in newly diagnosed HIV infections among persons who inject drugs in Boston, March 15, 2021, available at: <https://www.mass.gov/doc/joint-mdph-and-bphc-clinical-advisory-hiv-transmission-through-injection-drug-use-in-boston-march-15-2021/download>

PERSONS WHO INJECT DRUGS - RECENT HIV DIAGNOSES

Figure 44. Percentage of individuals with IDU exposure mode diagnosed with HIV infection by race/ethnicity, age, place of birth and current gender, Massachusetts 2021–2023 (N=164)



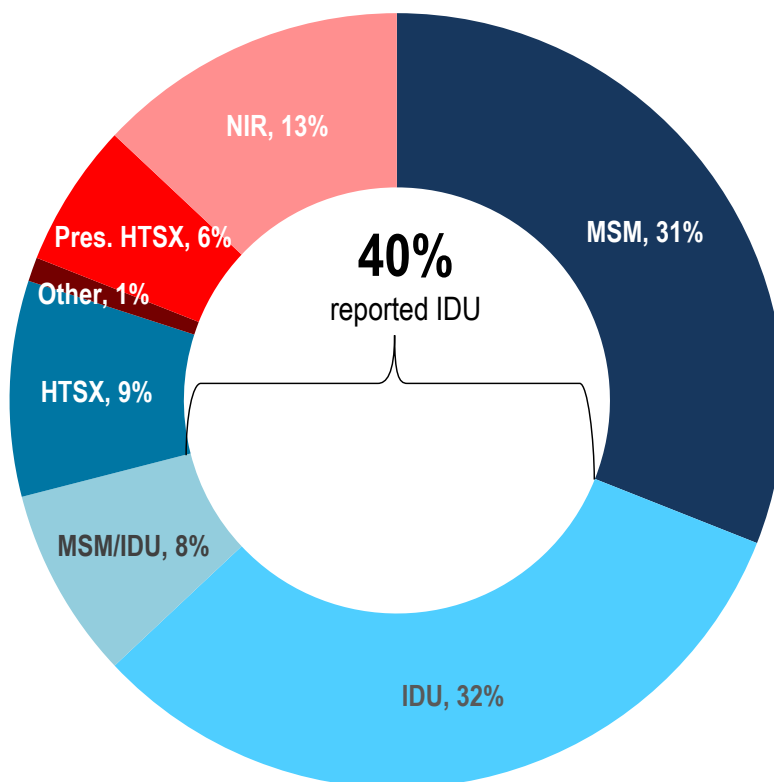
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- Individuals with IDU exposure mode newly diagnosed with HIV infection in Massachusetts during 2021 to 2023¹ were predominantly White (non-Hispanic) (68%), between 30 and 39 years of age (50%), US born (94%), and male (68%).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

DEATHS FROM ANY CAUSE AMONG INDIVIDUALS REPORTED WITH HIV BY EXPOSURE MODE

Figure 45. Deaths from any cause among individuals reported with HIV by exposure mode, Massachusetts 2023 (N=307)



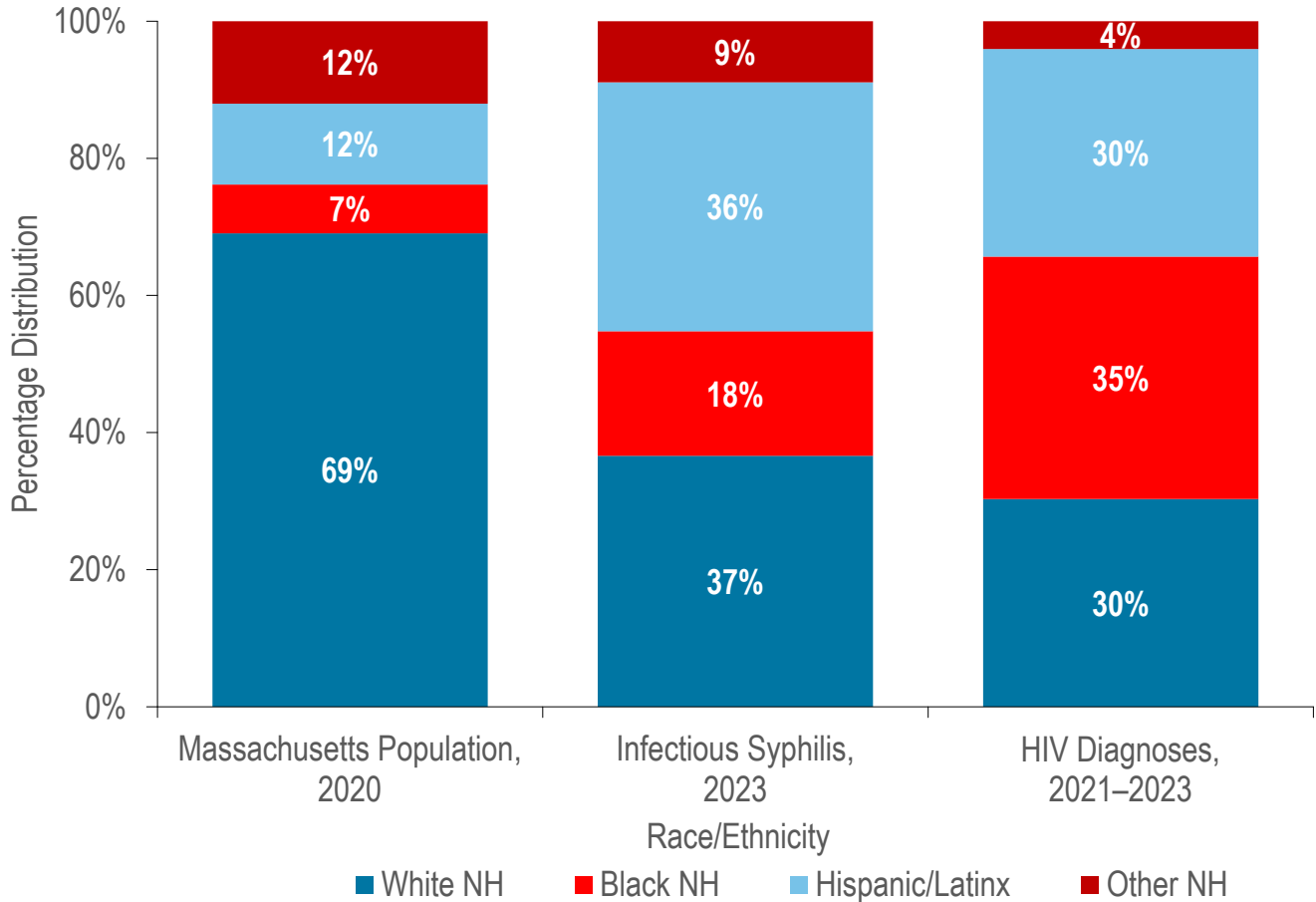
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- The proportion of deaths from any cause among individuals with HIV with IDU exposure mode decreased from 42% in 2014 to 32% in 2023.¹ At 32%, the proportion among IDU remained the largest among exposure modes in 2023, followed closely by MSM at 31%, with an additional 8% reported with an exposure mode of MSM/IDU. Comparatively, IDU and MSM accounted for 7% and 3%, respectively, of new HIV diagnoses in that year.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

SPECIFIC POPULATIONS - RACIAL AND ETHNIC GROUPS

Figure 46. Distribution of the general population¹ and of individuals diagnosed with confirmed and probable infectious syphilis² in 2023, and HIV infection during 2021–2023 by race/ethnicity, Massachusetts



Confirmed and Probable Infectious Syphilis 2023, N=1,404 and excludes 45 (3%) cases missing race/ethnicity; HIV Diagnoses 2021-2023, N=1,435
 Data Source: Bureau of Infectious Disease and Laboratory Sciences, HIV data are current as of 7/1/2024, STI data are current as of 7/22/2024 and subject to change

- In 2023,³ Black (non-Hispanic) and Hispanic/Latinx individuals represented 7% and 12% of the total Massachusetts population and 18% and 36% of confirmed and probable infectious syphilis cases (with known race/ethnicity), respectively.
- During 2021 to 2023, Black (non-Hispanic) and Hispanic/Latinx individuals represented 35% and 30% of individuals diagnosed with HIV infection in Massachusetts, respectively.

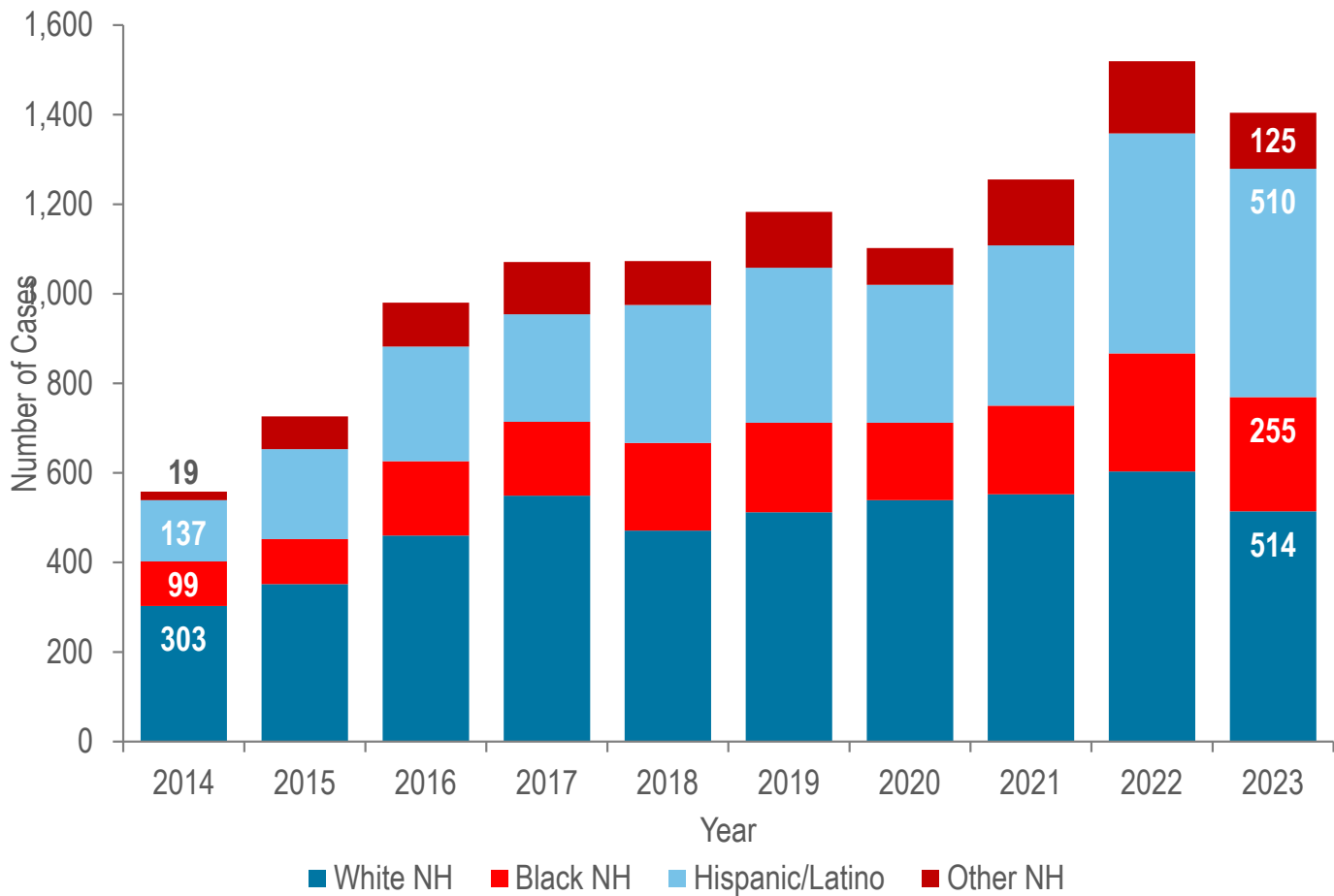
¹Population Data Source: UMDI Interim 2020 Population Estimates by Age, Sex, Race, and Municipality, UMass Donahue Institute Population Estimates Program, March 1, 2022

²Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

³Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

SYPHILIS BY RACE/ETHNICITY

Figure 47. Number of confirmed and probable infectious syphilis¹ cases reported by race/ethnicity, Massachusetts 2014–2023



Confirmed and Probable Syphilis 2014-2023 Total N=10,871; 600 (5%) cases missing race/ethnicity are not included in this figure
 Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

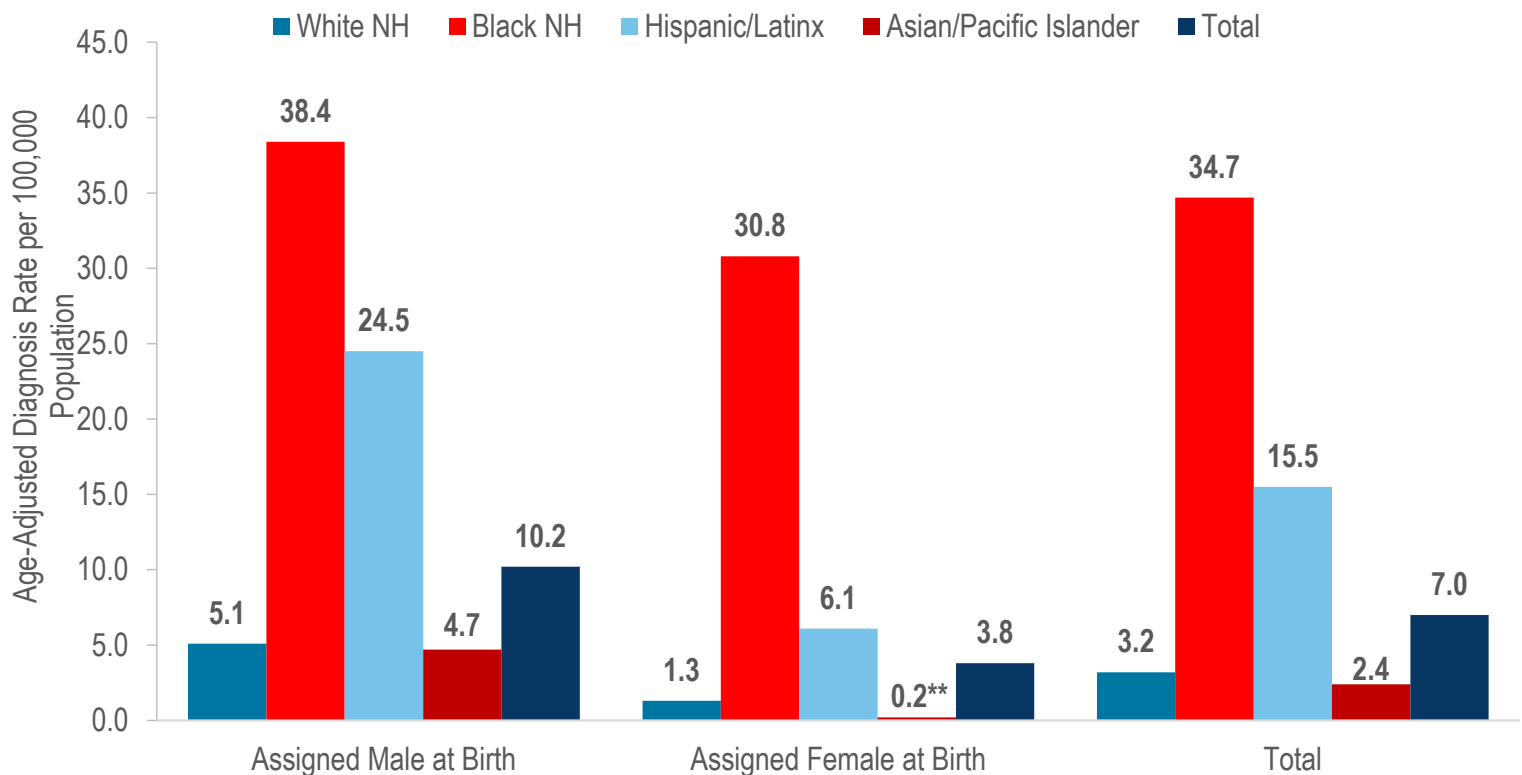
- The greatest number of confirmed and probable infectious syphilis cases was among White (non-Hispanic) individuals each year from 2014 to 2023.²
- From 2014 to 2023, the greatest proportionate increase in the number of confirmed and probable infectious syphilis cases was reported among Hispanic/Latinx individuals (more than tripled from 137 to 510), followed by Black (non-Hispanic) individuals (more than doubled from 99 to 255), and White (non-Hispanic) (increased by 70% from 303 to 514).
- From 2014 to 2023, the proportion of confirmed and probable infectious syphilis cases among White (non-Hispanic) individuals decreased from 54% to 37% while it increased from 25% to 36% among Hispanic/Latinx individuals.
- In 2023, the age-adjusted confirmed and probable infectious syphilis incidence rate among Black (non-Hispanic) individuals (46.5 per 100,000) and Hispanic/Latinx individuals (55.2 per 100,000) were four and five times that of White (non-Hispanic) individuals (10.4 per 100,000), respectively.

¹ Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

HIV BY RACE/ETHNICITY

Figure 48. Average annual age-adjusted HIV diagnosis rate per 100,000 population¹ by sex assigned at birth and race/ethnicity, Massachusetts 2021–2023 (N=1,435)



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

**Rates based on numerators <12 are marked with an asterisk (*) and should be interpreted with caution.

In 2021–2023,² the average annual age-adjusted HIV diagnosis rate per 100,000 population of individuals assigned male at birth (AMAB) was three times that of individuals assigned female at birth (AFAB). There were large disparities in average annual age-adjusted HIV diagnosis rates for 2021 to 2023 by race/ethnicity. Compared to the rate among White (non-Hispanic) individuals, the rate among:

- Black (non-Hispanic) individuals was 11 times greater, and
- Hispanic/Latinx individuals was five times greater.

With respect to differences based on race/ethnicity and sex assigned at birth, the average annual age-adjusted HIV diagnosis rate for 2021 to 2023 among:

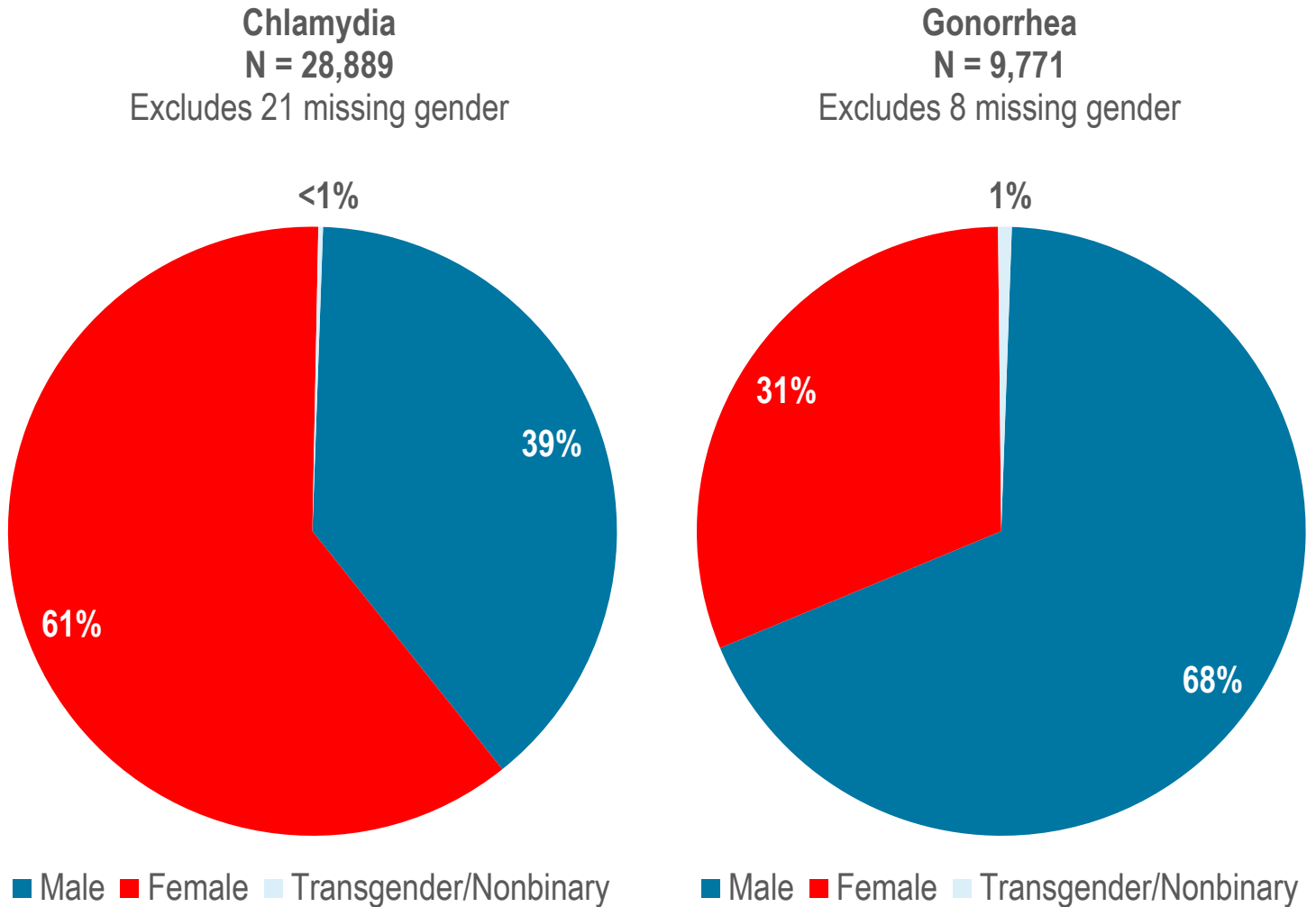
- Black (non-Hispanic) individuals assigned male at birth (AMAB), was seven times that of White (non-Hispanic) individuals AMAB,
- Hispanic/Latinx individuals AMAB was five times that of White (non-Hispanic) individuals AMAB,
- Black (non-Hispanic) individuals assigned female at birth (AFAB) was 24 times that of White (non-Hispanic) individuals AFAB, and
- Hispanic/Latinx individuals AFAB was five times that of White (non-Hispanic) individuals AFAB.

¹ As of 1/1/2020, BIDLS calculates rates per 100,000 population using denominators estimated by the University of Massachusetts Donahue Institute: UMDI Interim 2020 Population Estimates by Age, Sex, Race, and Municipality, UMass Donahue Institute Population Estimates Program, March 1, 2022; Note that rates and trends calculated using previous methods cannot be compared to these. All rates are age-adjusted using the 2000 US standard population.

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

SPECIFIC POPULATIONS - WOMEN AND INFANTS

Figure 49. Distribution of confirmed chlamydia and gonorrhea cases reported by gender, Massachusetts 2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- In 2023,¹ 61% of confirmed chlamydia cases were among females (N=17,630), 39% were among males (N=11,187), less than one percent (N=72) was among individuals of transgender experience, and no cases were reported among individuals who are nonbinary.²
- In 2023, 31% of confirmed gonorrhea cases were among females (N=3,038), 68% were among males (N=6,662), and one percent (N=71) was among individuals of transgender experience or individuals who are nonbinary.

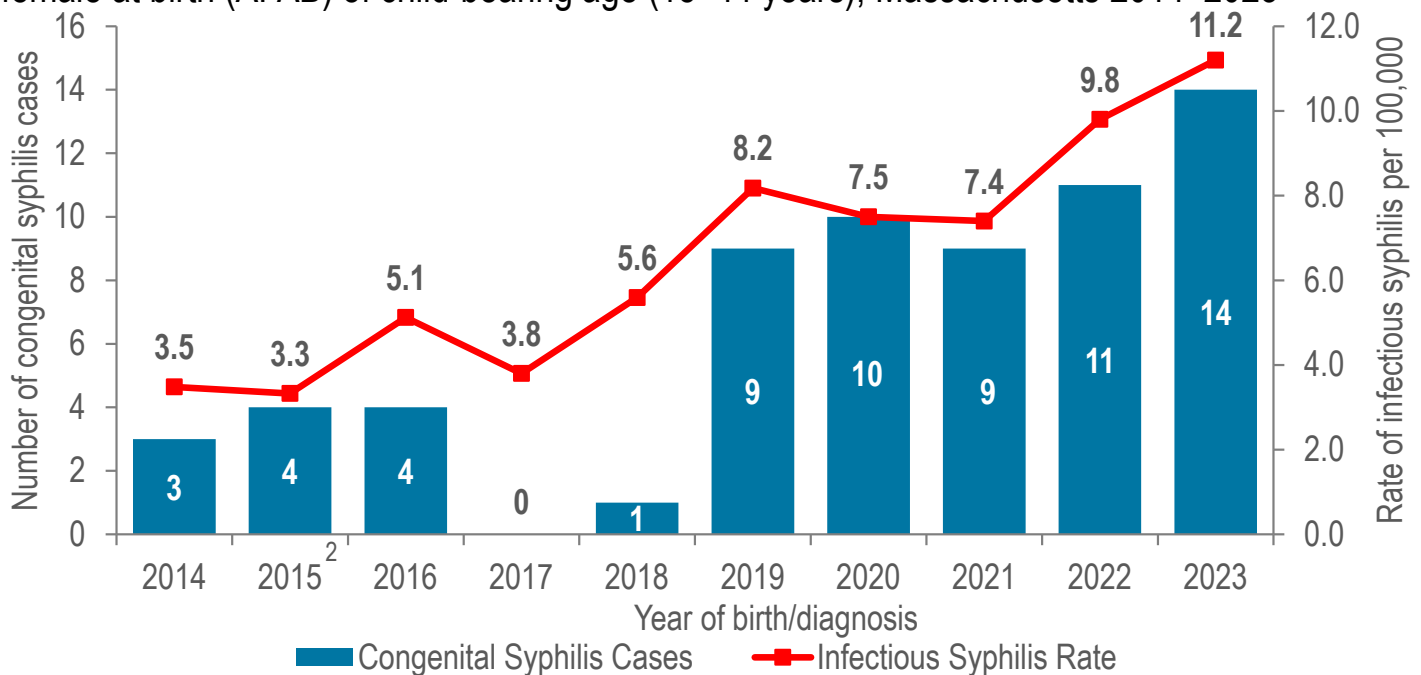
¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates, for more information see [Interpreting HIV, STI, and Viral Hepatitis Data](#).

WOMEN AND INFANTS - CONGENITAL SYPHILIS

Despite close follow-up of cases of syphilis in pregnant patients and their partners, breakthrough cases of congenital syphilis¹ have increased in Massachusetts. Three syphilitic stillbirths and eleven presumptive reportable cases were reported to DPH in 2023. In 2020, DPH released a recommendation for universal syphilis screening early in the 3rd trimester (around 27–28 weeks gestation), in addition to routine syphilis screening performed at the first prenatal visit. For more information see, Congenital Syphilis Clinical Alert, June 30, 2020, available at <https://www.mass.gov/doc/congenital-syphilis-clinical-alert-6-30-2020/download>

Figure 50. Number of confirmed and probable congenital syphilis cases reported by year of birth and rate of confirmed and probable infectious syphilis per 100,000 individuals assigned female at birth (AFAB) of child-bearing age (15–44 years), Massachusetts 2014–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- Trends in congenital syphilis typically mirror trends in infectious syphilis among individuals AFAB of child-bearing age.² In Massachusetts, as the rate of confirmed and probable infectious syphilis among individuals AFAB of child-bearing age increased to 11.2 per 100,000 in 2023,³ so too did the number of confirmed and probable cases of congenital syphilis (N=14).
- Nationally, the number of congenital syphilis cases reached 3,755 in 2022, with a rate of 102.5 cases per 100,000 live births, the highest rate reported since 1994. Massachusetts ranked 46th in congenital syphilis incidence rate among the 50 states in 2022.⁴

¹ A condition caused by infection in utero with *Treponema pallidum*. A wide spectrum of severity exists, from inapparent infection to severe cases that are clinically apparent at birth. For more information see <http://www.cdc.gov/std/stats/congenitalsyphilisdef-rev-jan-2015.pdf>

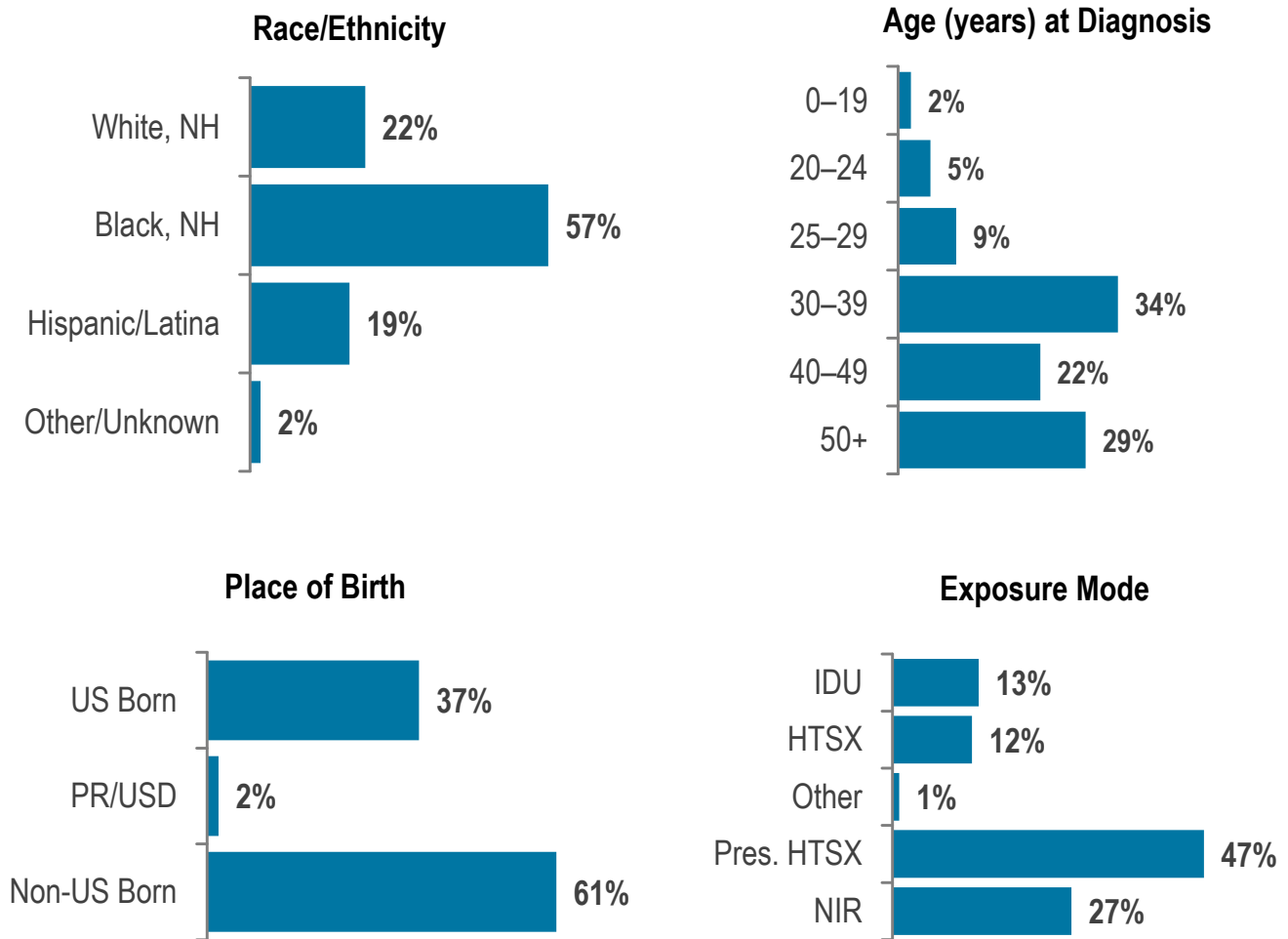
² On January 1, 2015, the congenital case definition was updated to better define treatment and laboratory parameters for classifying cases. From 2019 through 2022, one confirmed case of congenital syphilis and 9 syphilitic stillbirths were reported. All other reportable cases from 2015 to 2022 met the case definition of probable congenital syphilis which uses the birthing person's treatment adequacy and timing as the primary criteria for this classification status.

³ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

⁴ Centers for Disease Control and Prevention. Sexually Transmitted Infections Surveillance 2022 Atlanta: U.S. Department of Health and Human Services; 2024. Please note, 2022 state rankings are presented because 2023 rankings were not yet available at the time of this publication.

WOMEN¹ - RECENT HIV DIAGNOSES

Figure 51. Percentage of individuals assigned female at birth and diagnosed with HIV infection by race/ethnicity, age, place of birth, and exposure mode, Massachusetts 2021–2023 (N=396)



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

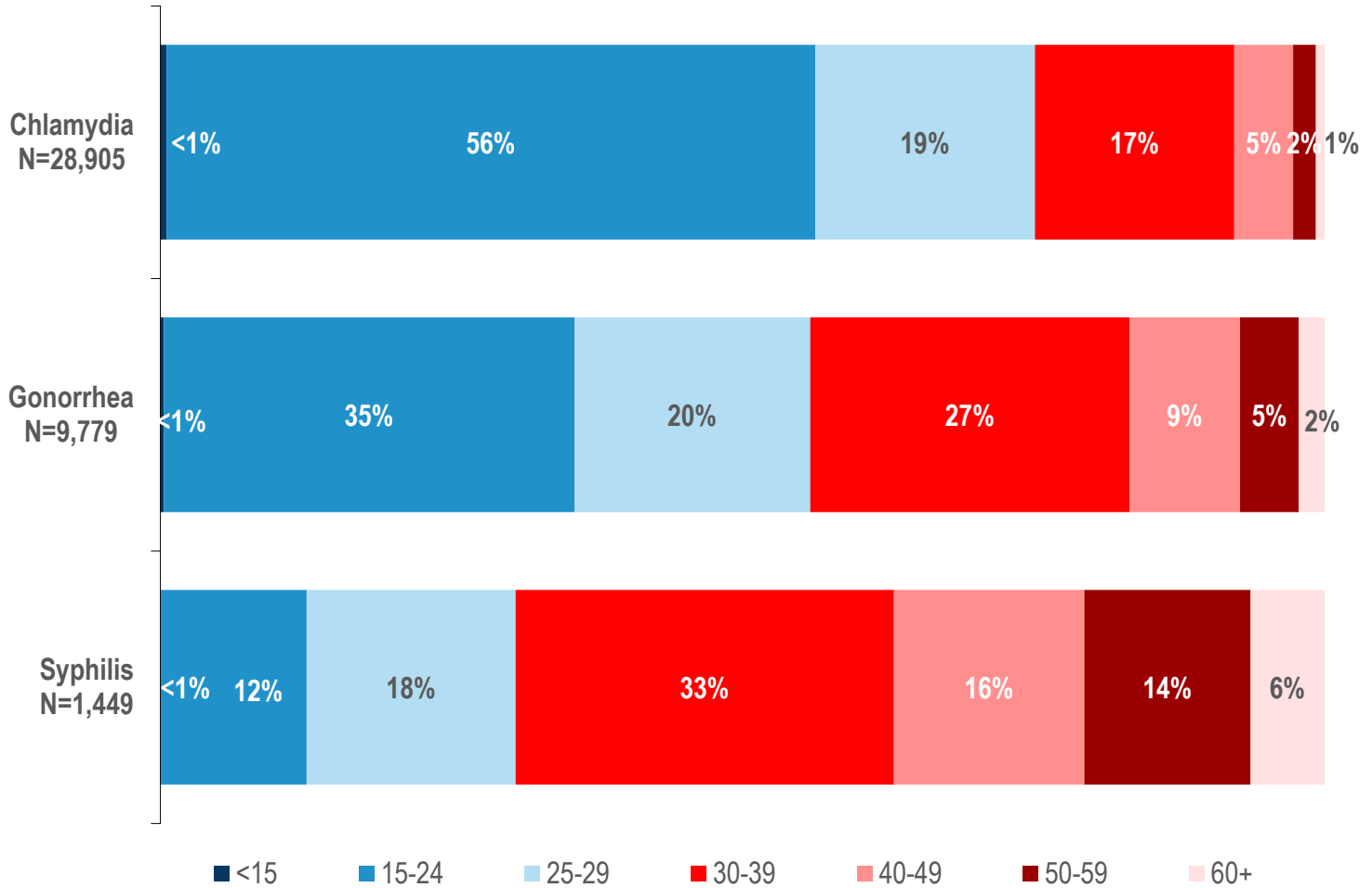
- Individuals assigned female at birth (AFAB) and newly diagnosed with HIV infection in Massachusetts during 2021–2023² were predominantly Black (non-Hispanic) (57%), 30 years of age or older (34% 30–39 year-olds, 22% 40–49 year-olds, 29% 50+ year-olds), with an exposure mode of presumed heterosexual sex (47%). While presumed heterosexual sex was the leading reported exposure mode, a large percentage of new HIV diagnoses were reported with no identified risk (NIR) (27%).
- Among individuals AFAB, the proportion of HIV infection diagnoses with IDU exposure mode increased from 7% (N=12/165) in 2014 to 25% (N=40/159) in 2017, remained between 18% (2019, N=25/140) and 22% (2020, N=27/121) from 2018 through 2021, and then decreased to 9% (N=13/143) in 2023.

¹ Recent HIV diagnoses among women include 396 individuals assigned female sex at birth. Data included reflect sex assigned at birth and therefore not gender identity or gender expression of individuals of transgender experience (N=18 individuals of transgender experience diagnosed with HIV infection from 2021 – 2023).

² Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

SPECIFIC POPULATIONS - OLDER INDIVIDUALS, STI DIAGNOSES BY AGE

Figure 52. Distribution of confirmed chlamydia, confirmed gonorrhea, and confirmed and probable infectious syphilis cases reported by age group (years), Massachusetts 2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

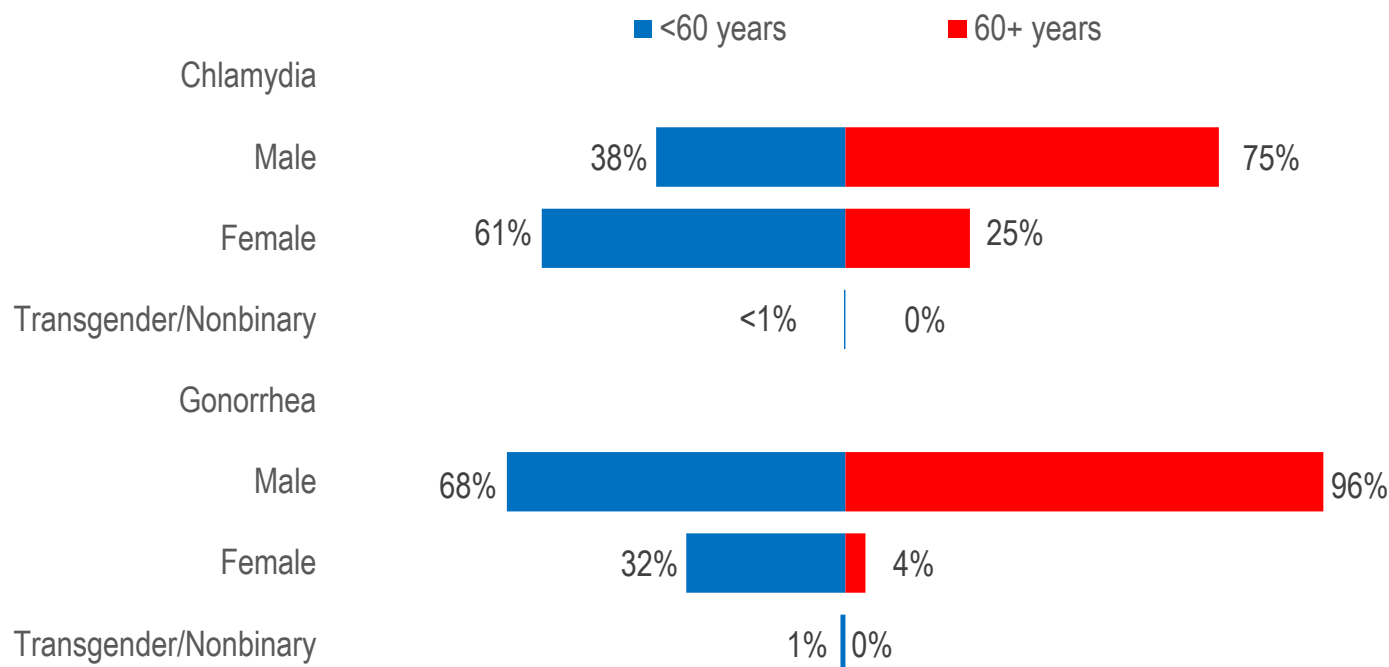
- In 2023,¹ in Massachusetts, 1% of confirmed chlamydia cases, 2% of confirmed gonorrhea cases, and 6% of confirmed and probable infectious syphilis² cases were reported among individuals aged 60+ years. An additional 2% of confirmed chlamydia cases, 5% of confirmed gonorrhea cases, and 14% of confirmed and probable infectious syphilis cases were reported among individuals aged 50–59 years.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

STI DIAGNOSES BY AGE AND GENDER

Figure 53. Percentage of confirmed chlamydia and gonorrhea cases by age at diagnosis (<60 years vs. 60+ years) and gender, Massachusetts 2023



Note: 2023 chlamydia N=28,884 (<60 N=28,669; 60+ N=215) and excludes cases missing gender and/or age (N=26). 2023 gonorrhea N=9,771 (<60 N=9,556; 60+ N=215) and excludes cases missing gender and/or age (N=7).

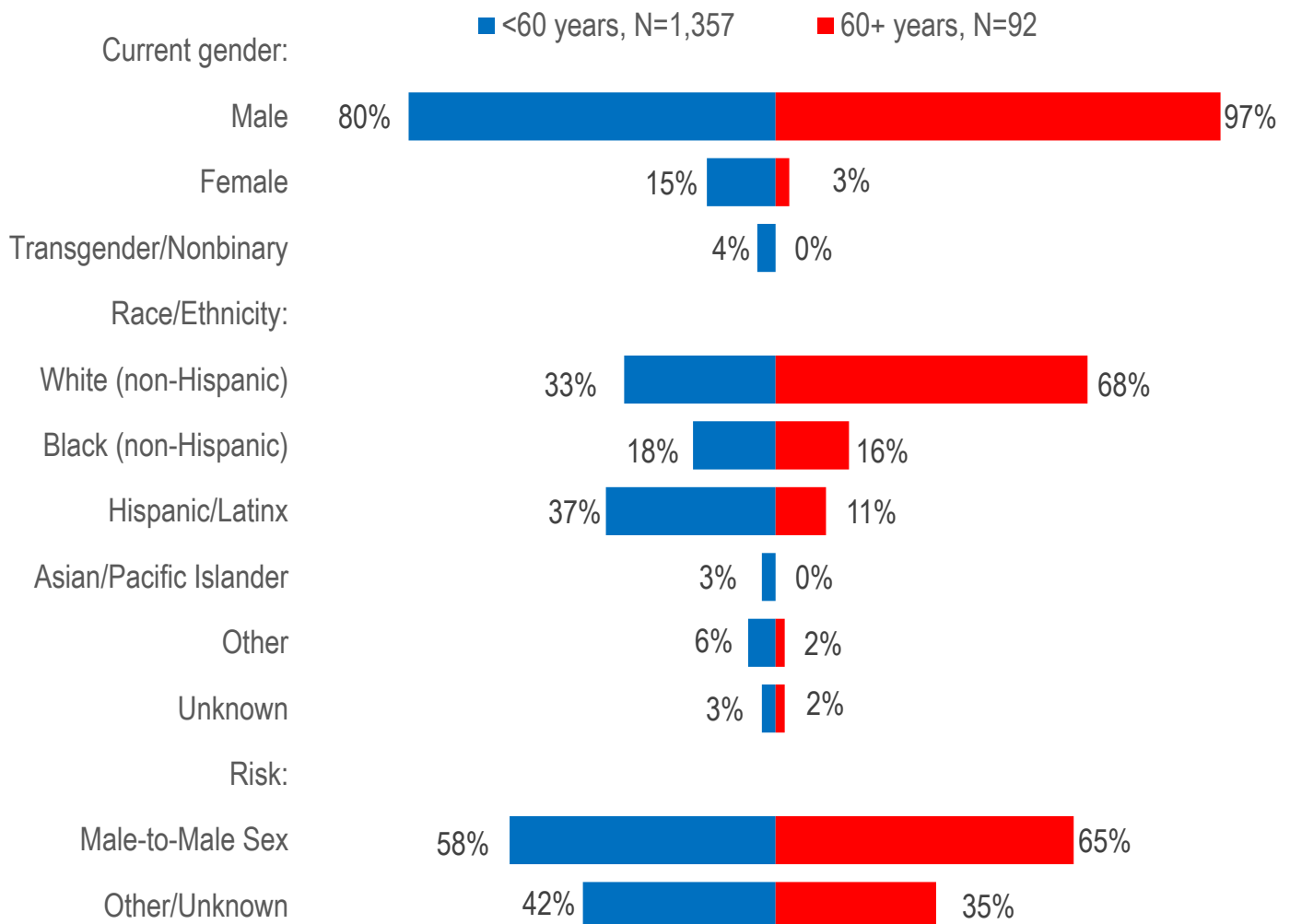
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change.

- In 2023,¹ a much larger proportion of confirmed chlamydia cases among individuals aged 60 years or older (75%) than aged less than 60 years (38%) was male.
- Similarly in 2023, a much larger proportion of confirmed gonorrhea cases among individuals aged 60 years or older (96%) than aged less than 60 years (68%) was male.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

SYPHILIS BY AGE, GENDER, RACE/ETHNICITY, AND RISK

Figure 54. Percentage of confirmed and probable infectious syphilis cases by age at diagnosis (<60 years vs. 60+ years), gender, race/ethnicity, and risk, Massachusetts 2023



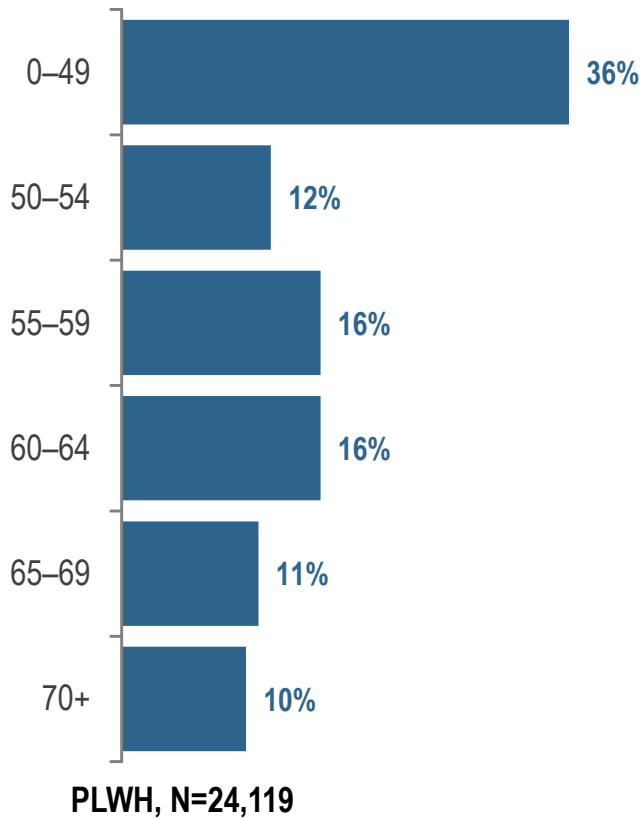
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/22/2024 and subject to change

- In 2023,¹ a larger proportion of confirmed and probable infectious syphilis cases among individuals aged 60 years or older (97%) than aged less than 60 years (80%) was male.
- A much larger proportion of confirmed and probable infectious syphilis cases among individuals aged 60 years or older (68%) than aged less than 60 years (33%) was White non-Hispanic.
- A slightly larger proportion of confirmed and probable infectious syphilis cases among individuals aged 60 years or older (65%) and aged less than 60 years (58%) reported male-to-male sex.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

² Infectious syphilis includes diagnoses made in the primary, secondary, and early non-primary non-secondary stages of infection (latent asymptomatic syphilis where infection occurred in the past 12 months).

Figure 55. Persons living with HIV infection by expanded age category, Massachusetts 2023 (N=24,119)

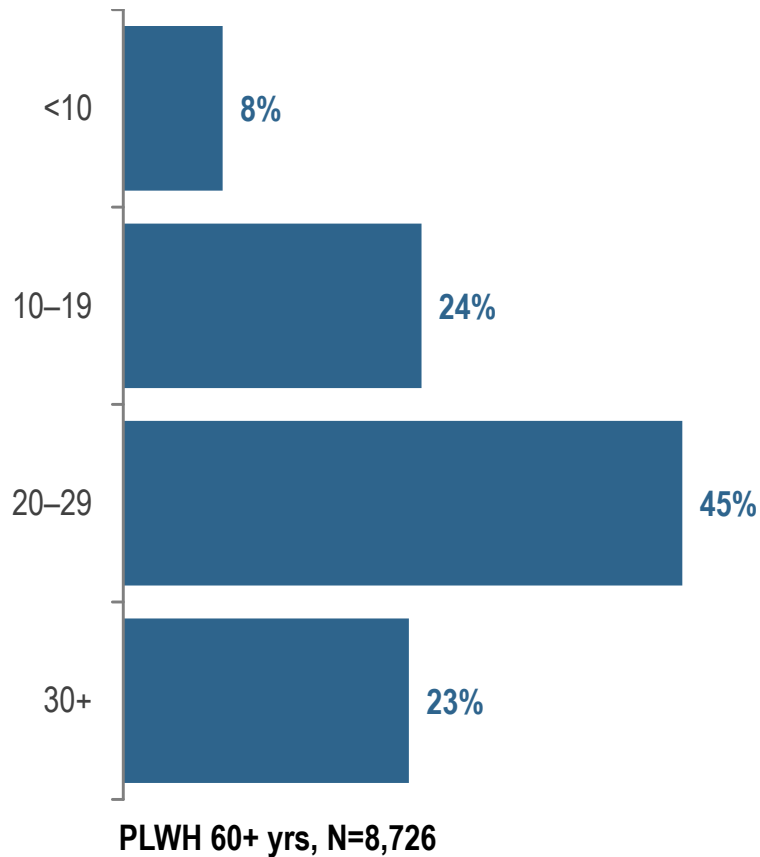


Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- In 2023¹, 20% (N=4,891) of PLWH were aged 65 years or older, the age of eligibility for Medicare for individuals without a disability.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

Figure 56. Number of years since HIV infection diagnosis among individuals aged 60 years and older living with HIV infection, Massachusetts 2023 (N=8,726)



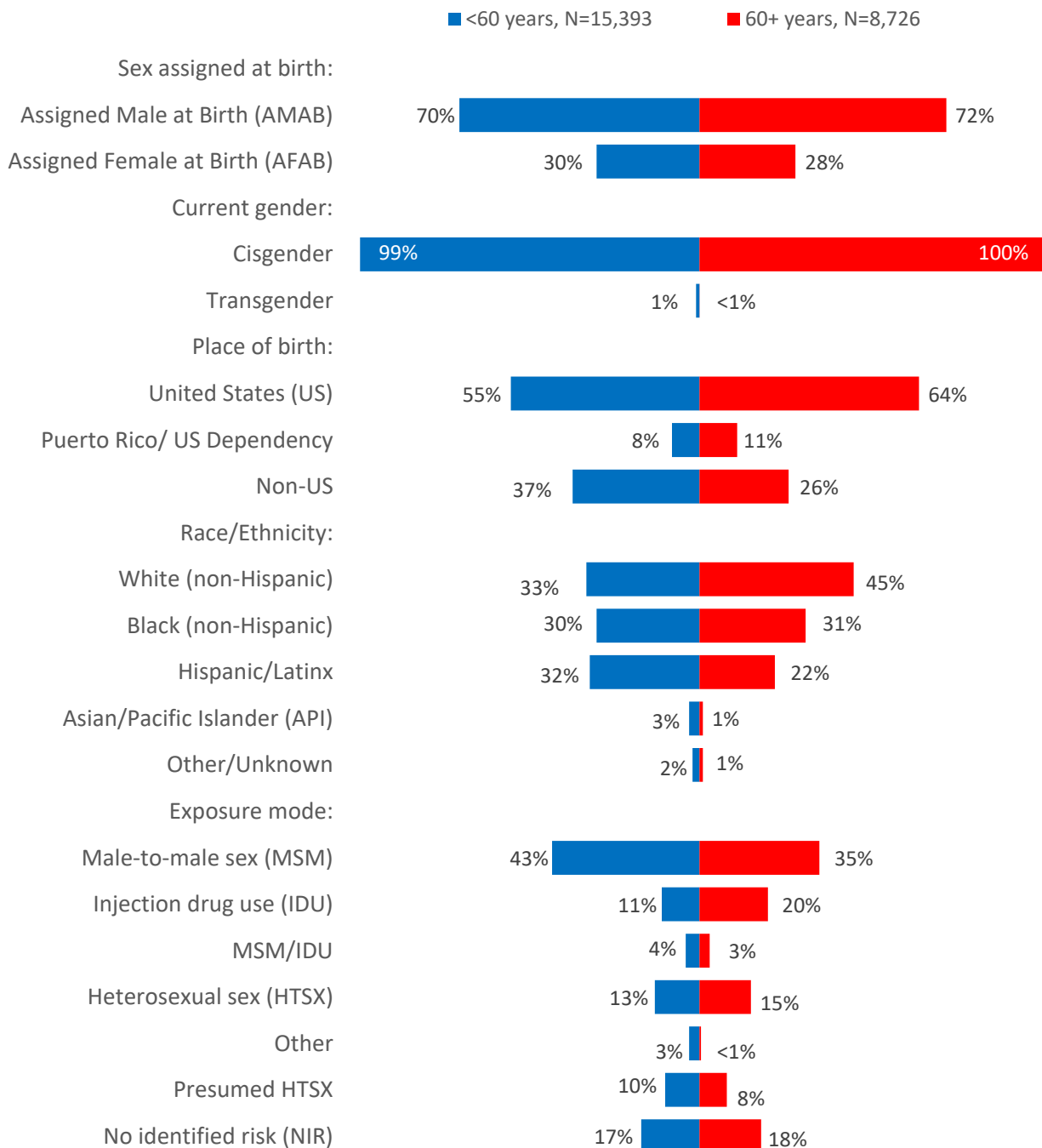
Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- In 2023,¹ the majority (68%) of PLWH aged 60 years and older were diagnosed with HIV infection at least 20 years ago. The average number of years since HIV infection diagnosis among PLWH aged 60 years and older was 22.8 years.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

OLDER INDIVIDUALS LIVING WITH HIV INFECTION

Figure 57. People aged 60 years and older living with HIV infection compared to people aged under 60 years by selected characteristics, Massachusetts 2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

- In 2023,¹ the distributions of people living with HIV infection by place of birth, race/ethnicity, and exposure mode varied by age:
 - A larger proportion of individuals aged 60+ years (64%) than <60 years (55%) was born in the US.

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

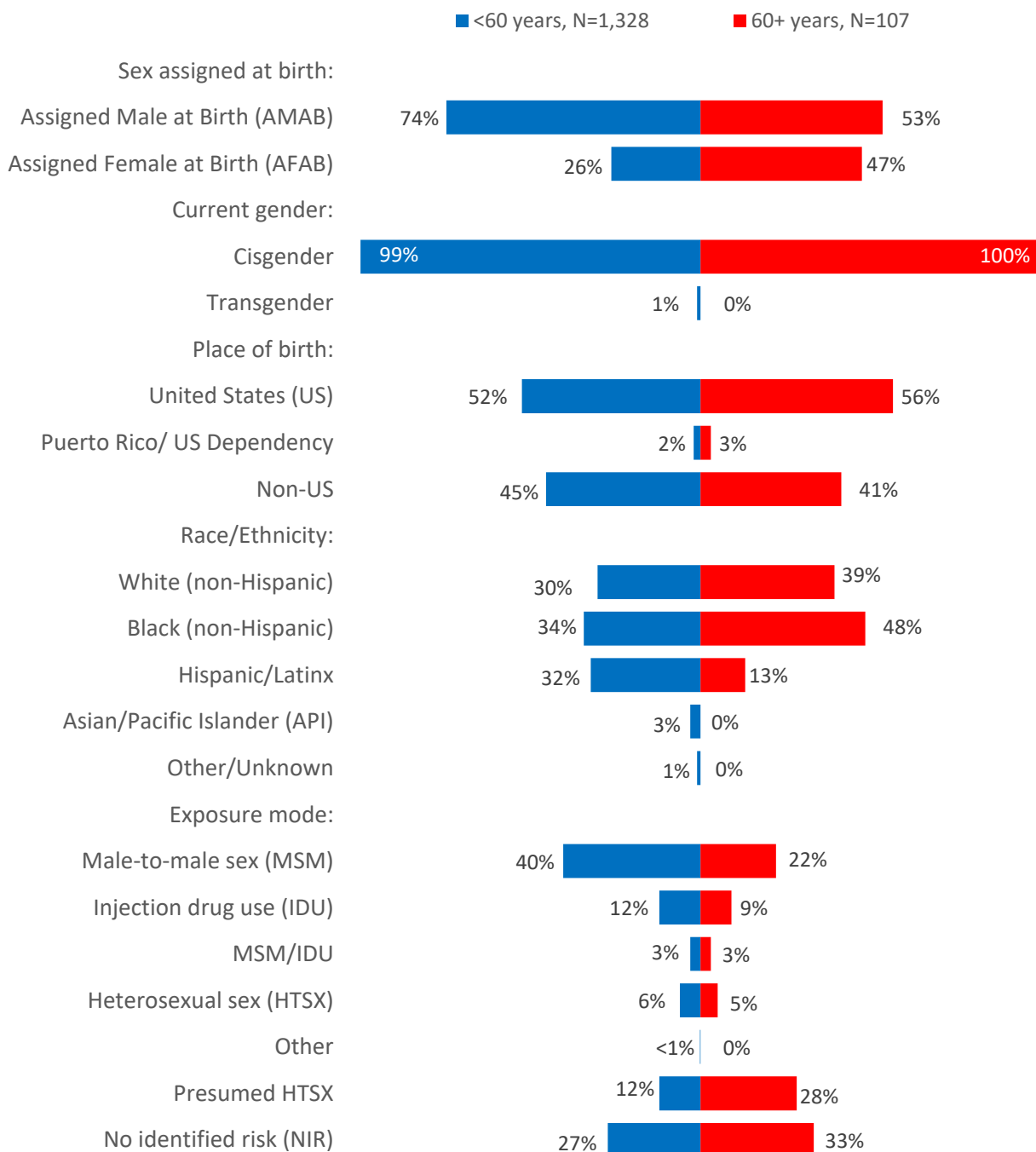
OLDER INDIVIDUALS LIVING WITH HIV INFECTION

- A larger proportion of individuals aged 60+ years (45%) than <60 years (33%) was White (non-Hispanic), and a smaller proportion was Hispanic/Latinx (22% vs. 32%).
- A larger proportion of individuals aged 60+ years (20%) than <60 years (11%) had injection drug use exposure mode and a smaller proportion had MSM exposure mode (35% vs. 43%). However, MSM was still the most frequently reported exposure mode for both age groups.
- The distributions of people living with HIV infection by sex assigned at birth and current gender identity were similar for both age groups in 2023.¹

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

OLDER INDIVIDUALS RECENTLY DIAGNOSED WITH HIV INFECTION

Figure 58. People aged 60 years and older diagnosed with HIV infection compared to people aged under 60 years by selected characteristics, Massachusetts 2021–2023



Data Source: Bureau of Infectious Disease and Laboratory Sciences, data are current as of 7/1/2024 and subject to change

OLDER INDIVIDUALS RECENTLY DIAGNOSED WITH HIV INFECTION

When reviewing the data presentations on people diagnosed with HIV infection at age 60+ years, please note that the ascertainment of accurate initial diagnosis date/age is often more difficult for individuals born outside the United States than those born in the United States or Puerto Rico. This is due to limited access to clinical documentation and/or less access to testing in the patient's country of origin. Differences between younger (<60) and older (60+) individuals diagnosed with HIV infection displayed in this report may be an artefact of this data quality discrepancy rather than actual age at diagnosis.

- During 2021 to 2023,¹ the distributions of individuals diagnosed with HIV infection by sex assigned at birth, place of birth, race/ethnicity, and exposure mode varied by age:
 - A larger proportion of individuals aged 60+ years (47%) than <60 years (26%) was assigned female at birth.
 - A larger proportion of individuals aged 60+ years (48%) than <60 years (34%) was Black (non-Hispanic).
 - A larger proportion of individuals aged 60+ years (28%) than <60 years (12%) had presumed heterosexual exposure mode and a smaller proportion had MSM exposure mode (22% vs. 40%).

¹ Please consider the impact of the COVID-19 pandemic on infectious disease screening, treatment, and surveillance in the interpretation of data from 2020 to 2023.

STRENGTHS AND LIMITATIONS OF DATA

	HIV	STI	Viral Hepatitis
Description	<ul style="list-style-type: none"> HIV, STI, and Viral Hepatitis data are: <ul style="list-style-type: none"> Collected by DPH Bureau of Infectious Disease and Laboratory Sciences Reported statewide Required by state law to be reported by all laboratories and healthcare providers 		
	<ul style="list-style-type: none"> New HIV diagnoses include only individuals who were first diagnosed in Massachusetts. HIV prevalence data include all individuals who were reported as residing in Massachusetts regardless of where they were first diagnosed. 	<ul style="list-style-type: none"> Includes individuals first reported as living in MA. 	<ul style="list-style-type: none"> Includes individuals first reported as living in MA.
Strengths	<ul style="list-style-type: none"> Completeness of race/ethnicity data is high. All clinical laboratories in MA report electronically resulting in more complete and timely reporting of disease. Data are estimated to be 99% complete. 	<ul style="list-style-type: none"> All clinical laboratories in MA report electronically resulting in more complete and timely reporting of disease. Most infectious syphilis cases agree to interview, resulting in reasonably complete race/ethnicity and sex of sex partner data. 	<ul style="list-style-type: none"> All clinical laboratories in MA report electronically resulting in more complete and timely reporting of disease.
Limitations	<ul style="list-style-type: none"> 2023 HIV prevalence data as of 7/1/2024 are preliminary. 	<ul style="list-style-type: none"> Race/ethnicity data are incomplete for gonorrhea and chlamydia. Sex of sex partner is not routinely collected for gonorrhea and chlamydia cases. Bias is introduced for some STIs, such as chlamydia infection, where screening of asymptomatic persons occurs more frequently among women than among men. 	<ul style="list-style-type: none"> Race/ethnicity data are incomplete. Risk history data are not collected on chronic HBV cases.

Massachusetts Youth Risk Behavior Survey

Description	The Massachusetts Youth Risk Behavior Survey (MYRBS) is conducted every two years through a collaborative effort between the Massachusetts Department of Elementary and Secondary Education (DESE) and Department of Public Health (DPH) to monitor health indicators, behaviors, and risk factors contributing to the leading causes of morbidity, mortality, and social and academic problems among adolescents. For more information, see https://www.mass.gov/lists/massachusetts-youth-health-survey-myhs
Strengths	A two-stage sampling method is used to produce representative samples of students in grades 9 – 12. Response rates are high.
Limitations	All data collected for the MYRBS and the MYHS are based on self-report from students. Self-reported data may be subject to error for several reasons, including inaccurate recall of events.

INTERPRETING HIV, STI, AND VIRAL HEPATITIS DATA

Hepatitis A and hepatitis B surveillance data are current as of July 17, 2024, hepatitis C (HCV) data are as of July 31, 2024, HIV data are as of July 1, 2024, and STI data are as of July 22, 2024. All data are subject to change.

I. Impact of COVID-19

The coronavirus disease 2019 (COVID-19) pandemic has had a large impact on the screening, treatment, and surveillance of other infectious diseases in 2020 and 2021. Nationally, the Centers for Disease Control and Prevention (CDC) observed a sharp decline in reported STI cases from March-April 2020, compared to March-April 2019.¹ Three factors were cited as likely contributing to the initial decrease in reported cases:

- Reduced screening – many health care clinics limited in-person visits to symptomatic cases or closed down
- Limited resources – many state and local health department STI staff were redirected from routine STI responsibilities to COVID-19 activities, which affected STI tracking capacity and reporting
- Social distancing measures – intended to reduce COVID-19 spread, they may have influenced sexual behaviors and reduced STI transmission.

After the initial decrease in 2020, an increase across STIs was observed nationally² and in the Commonwealth in 2021 and 2022. Possible factors contributing to an increase in reported cases could include:

- Increased service utilization after health care clinics re-opened
- Continued direction of services to patients most likely to be infected, increasing the number of cases identified
- Higher disease transmission - due to reduced access to care, those with a STI may have had their infections longer, providing more opportunities to transmit infection to their sexual partners. Additionally, following the initial shelter-in-place orders, sexual behaviors may have changed, including frequency of new sexual partners, leading to spread in sexual networks.³

Although the official COVID-19 states of emergency are declared over, the effects of the pandemic continue to impact public health; its full effect on case detection and reporting and efforts to control the spread of infectious disease in the Commonwealth has yet to be determined. As such, please interpret infectious disease data from 2020 to 2023 with caution.

II. Gender

Gender is a multi-dimensional construct that includes identity (e.g., man, woman, genderqueer, nonbinary) and expression (e.g., masculine, feminine, neither masculine nor feminine, or both masculine and feminine, or something else through appearance and behavior).

III. Individuals of Transgender Experience and Nonbinary Individuals

Please note reported numbers among individuals of transgender experience and individuals who are nonbinary are likely to be underestimates. Gender may be under or misreported due to the effects of stigma and discrimination, lack of experience and/or training among medical professionals in treating the unique needs of transgender and nonbinary patients, as well as the absence of appropriate collection of gender options in medical records (e.g., individuals who are genderqueer, pangender, gender fluid, androgynous, etc.).

¹ Source: CDC Press Release, July 16, 2021: Trends in STD case reports during the U.S. COVID-19 pandemic, January–December 2020 available at:

<https://www.cdc.gov/nchstp/newsroom/2021/2020-std-trend-report.html>

² CDC. Preliminary 2021 STD Surveillance Data.

<https://www.cdc.gov/std/statistics/2021/default.htm#:~:text=Preliminary%20data%20show%202.5%20million,%2C%20syphilis%2C%20and%20congenital%20syphilis>

³ CDC. Impact of COVID-19 on STDs. <https://www.cdc.gov/std/statistics/2020/impact.htm>

IV. HIV Primary Exposure Mode Definitions

The HIV primary exposure mode indicates the most probable exposure associated with HIV infection. Assignment of primary exposure mode is done in accordance with Centers for Disease Control and Prevention (CDC) guidelines when multiple exposure modes are reported. Although the reported primary exposure mode is the most likely mode of transmission, there is always the possibility that it is not the actual mode of transmission. Following is a description of the exposure mode categories:

- **MSM (Male-to-Male Sex):** Includes all individuals assigned male at birth who report any sexual contact with other individuals that identify as male. Please note that in accordance with CDC guidelines, this category is defined by an individual's assigned sex at birth and not an individual's current gender identity.
 - **Sex with Men:** This exposure mode category is used by the Bureau of Infectious Disease and Laboratory Sciences (BIDLS) to categorize sexual risk in transgender women reporting sex with men only. For the purposes of official reporting in the MA HIV Surveillance System and to CDC, exposure mode for transgender women is based on sex assigned at birth, and therefore would be reported as male-to-male sex.
- **IDU (Injection Drug Use):** Cases among persons who report injection drug use.
- **MSM/IDU:** Includes all individuals assigned male at birth who report both injection drug use and any sexual contact with other individuals that identify as male.
 - **Sex with Men/IDU:** This exposure mode category is used by BIDLS to categorize sexual risk in transgender women reporting both sex with men and injection drug use. For the purposes of official reporting in the MA HIV Surveillance System and to CDC, exposure mode for transgender women is based on sex assigned at birth, and therefore would be reported as MSM/IDU.
- **Heterosexual Sex:** Cases among persons who report heterosexual sex with a person diagnosed with, or at increased risk for, HIV infection (e.g., a PWID). The sub-categories for this mode of transmission are listed below.
 - Heterosexual Sex w/ a person who injects drugs
 - Heterosexual Sex w/ a person diagnosed w/ HIV infection or AIDS
 - Heterosexual Sex w/ a bisexual male
 - Other Heterosexual Sex: Includes all other sub-categories of heterosexual risk, such as heterosexual contact with a person infected through a blood transfusion.
- **Other:** Cases among persons with other known exposure modes, including receipt of clotting factor, receipt of transfusion or transplant, and person-to-child transmission through pregnancy, childbirth, or breastfeeding (perinatal transmission).
- **Presumed Heterosexual:** The presumed heterosexual risk category is used by BIDLS exclusively for individuals assigned female at birth to identify HIV exposure mode when sex with individuals that identify as male was the only reported risk factor, there was no evidence of current or past injection drug use (IDU), and behavioral risk and HIV status information about sexual partners that identify as male was unknown. The rationale for the application of the presumed heterosexual risk category to individuals assigned female at birth only has been addressed in the DPH Office of HIV report "Intersecting Risks: HIV Infection among Heterosexual Women and Men in Massachusetts" (2010).

INTERPRETING HIV, STI, AND VIRAL HEPATITIS DATA

- **NIR (No Identified Risk):** Cases among persons with no reported history of exposure to HIV through any of the listed exposure categories. Follow-up is conducted to determine exposure for those cases that are initially reported without an exposure mode identified. Includes cases among individuals assigned male at birth who were previously categorized in Massachusetts as Presumed Heterosexual.

V. References to Newly Diagnosed HIV Infections

Due to the extensive follow-up required to verify accurate date of diagnosis, all HIV data reflect HIV infections diagnosed through 2023. Newly diagnosed HIV infections/cases include all persons diagnosed with HIV from 2021-2023, including those who were concurrently or subsequently diagnosed with AIDS. All HIV data are presented by the year of diagnosis, not the year of report.

VI. Deaths among People Reported with HIV

The all-cause death data presented in this report include all deaths among people diagnosed and reported with HIV in Massachusetts to present a full description of trends in mortality among this population. This includes deaths from non-HIV related causes such as drug overdoses, suicides, motor vehicle accidents, and other causes. Therefore, the total number of annual deaths reported here will vary from the number of HIV-related deaths reported in Massachusetts Deaths by the Massachusetts Department of Public Health, Office of Population Health (available at <https://www.mass.gov/lists/death-data>). Data on deaths occurring in Massachusetts are from matches with the Massachusetts Registry of Vital Records and Statistics and from provider reports and are considered complete through 2023. Data on deaths occurring outside of Massachusetts are from matches with the Social Security Death Master File and were completed only partially for 2023 based on availability of data.

VII. Race/Ethnicity of STI and HIV Cases

Race/ethnicity references to White residents and Black residents represent persons who are White (non-Hispanic) and Black (non-Hispanic), respectively. All references to Hispanic/Latinx for race/ethnicity represent persons of Hispanic/Latinx heritage regardless of race.

VIII. STI Case Reports and Analyses

All information on STI cases reflects year of report. As of 1/1/2020, BIDLS calculates rates per 100,000 population using denominators estimated by the University of Massachusetts Donahue Institute using a modified Hamilton-Perry model. 2020 population estimates were used for single-year rates; for pooled year rates (i.e., 2020-2022), the 2020 population estimates were multiplied by three. For more information, see: Strate S, et al. Small Area Population Estimates for 2011 through 2020, report published Oct 2016, and <http://www.donahue.umassp.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program>. When the proportion of STI cases with unknown values is greater than or equal to 30%, incidence trends are not presented by that variable. For instance, race/ethnicity is unknown for 42% of confirmed chlamydia cases and 31% of confirmed gonorrhea cases reported in 2023. Therefore, the number of confirmed chlamydia and gonorrhea cases by race/ethnicity are not presented in this report.

IX. Cell Suppression Methodology:

Values one through four are suppressed for denominator populations less than 50,000 or for unknown population sizes. Additional values of zero and greater than or equal to five may be suppressed to prevent back calculation. Values less than five are not suppressed for compound categories (categories containing two or more subcategories, such as other/undetermined) because the exact population value of each subcategory cannot be determined.

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

In the time period of the data in this report

HIV infection

Clinical description: HIV (human immunodeficiency virus) is a retrovirus with two serologically and geographically distinct species: HIV-1 and HIV-2. It is spread via person-to-person transmission through sexual contact, the use of HIV-contaminated needles and syringes, vertical transmission from mother to infant, or the transfusion of contaminated blood or its components. HIV attacks the body's immune system, making the individual more likely to acquire infections or develop infection-related cancers. These opportunistic infections or cancers take advantage of the "opportunity" of a weakened immune system and may be one signal that the person has an AIDS diagnosis (acquired immunodeficiency syndrome), the advanced stage of HIV infection.

Case Classification

Confirmed: Positive HIV-1, Positive HIV-2, or Positive (Undifferentiated) HIV result from a differentiating immunoassay, Western Blot, IFA, or culture; Positive/Detected Qualitative HIV NAT (DNA or RNA); Quantitative HIV NAT (detectable viral load assay) or physician verified diagnosis.

Sexually transmitted infections (STI)

Chlamydia trachomatis Infection (2010)

Clinical description

Infection with *Chlamydia trachomatis* may result in urethritis, epididymitis, cervicitis, acute salpingitis, or other syndromes when sexually transmitted; however, the infection is often asymptomatic in women. Perinatal infections may result in inclusion conjunctivitis and pneumonia in newborns. Other syndromes caused by *C. trachomatis* include lymphogranuloma venereum (see Lymphogranuloma Venereum) and trachoma.

Laboratory criteria for diagnosis

Isolation of *C. trachomatis* by culture or

Demonstration of *C. trachomatis* in a clinical specimen by detection of antigen or nucleic acid

Case classification

Confirmed: a case that is laboratory confirmed.

Chlamydia trachomatis Infection (2022)

Clinical Description

Chlamydia is a sexually transmitted infection that has a variable clinical course based on the serotype causing infection. Serovars D-K of *C. trachomatis* are the typical cause of chlamydial infections in the United States, and infection with *C. trachomatis* can result in urethritis, epididymitis, cervicitis, acute salpingitis, or other syndromes when sexually transmitted; however, the infection is often asymptomatic. Perinatal infections may result in inclusion conjunctivitis and pneumonia in newborns. Other syndromes caused by *C. trachomatis* include LGV and trachoma.

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

LGV is a specific type of chlamydial infection, caused by the serovars L1, L2, and L3 of *C. trachomatis*. Symptomatic LGV can be divided into three stages. The primary stage can include a small ulcer or lesion at the site of inoculation (genital, rectal, or oral/oropharyngeal sites). The secondary stage can include a syndrome featuring cervical, inguinal, and/or femoral lymphadenopathy that may rupture or an anorectal syndrome featuring proctocolitis (including mucoid or hemorrhagic rectal discharge, anal pain, constipation, fever, and/or tenesmus). Late stage LGV typically involves sequelae, such as genital elephantiasis, lymph node scarring, chronic colorectal fistulas and strictures, perirectal abscesses, and/or anal fissures. LGV may also be asymptomatic.

Laboratory Criteria

Demonstration of *C. trachomatis* in a clinical specimen by detection of antigen or nucleic acid, OR

Detection of LGV-specific antigen or nucleic acid in a clinical specimen, OR

Isolation of *C. trachomatis* by culture

Criteria to Distinguish a New Case from an Existing Case

For surveillance purposes, a new case of *C. trachomatis* infection (caused by either non-LGV or LGV serotypes) meets the following criteria:

There is no evidence of a prior *C. trachomatis* infection that has been reported as a case;

OR

There is evidence of a prior *C. trachomatis* infection that has been reported as a case, but the prior infection's specimen collection date or treatment date was >30 days before the current infection's specimen collection date;

OR

There is evidence of a prior *C. trachomatis* infection that has been reported as a case with a specimen collection date or treatment date ≤ 30 days from the current infection's specimen collection date, but there is evidence of re-infection.

Case Classification

Confirmed

A case that meets laboratory evidence.

Case Classification Comments

The following provides guidance for health departments to use for the classification and notification of cases of *C. trachomatis* infection caused by serovars L1, L2, and L3 (also known as lymphogranuloma venereum, or LGV). Cases should be reported to the Centers for Disease Control and Prevention (CDC) through voluntary notification as *C. trachomatis* infection and should be marked as LGV in the CDC case report data, as defined below.

Classification of *C. trachomatis* infection cases to identify LGV.

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

Verified: a person with detection of LGV-specific antigen or nucleic acid in a clinical specimen. This includes asymptomatic cases.

Likely: a person with demonstration of *C. trachomatis* in a clinical specimen by detection of antigen or nucleic acid OR isolation of *C. trachomatis* by culture; AND who demonstrates clinical symptoms or signs consistent with LGV; AND has no negative test for LGV-specific antigen or nucleic acid in a clinical specimen.

Gonorrhea (2014)

Clinical description

A sexually transmitted infection commonly manifested by urethritis, cervicitis, proctitis, salpingitis, or pharyngitis. Infection may be asymptomatic.

Laboratory criteria for diagnosis

Observation of gram-negative intracellular diplococci in a urethral smear obtained from a male or an endocervical smear obtained from a female, or

Isolation of typical gram-negative, oxidase-positive diplococci by culture (presumptive *Neisseria gonorrhoeae*) from a clinical specimen, or

Demonstration of *N. gonorrhoeae* in a clinical specimen by detection of antigen or nucleic acid

Case classification

Probable: demonstration of gram-negative intracellular diplococci in a urethral smear obtained from a male or an endocervical smear obtained from a female.

Confirmed: a person with laboratory isolation of typical gram-negative, oxidase-positive diplococci by culture (presumptive *N. gonorrhoeae*) from a clinical specimen, or demonstration of *N. gonorrhoeae* in a clinical specimen by detection of antigen or detection of nucleic acid via nucleic acid amplification (e.g., polymerase chain reaction [PCR]) or hybridization with a nucleic acid probe.

Syphilis

Syphilis is a complex sexually transmitted disease that has a highly variable clinical course. Adherence to the following surveillance case definitions will facilitate understanding the epidemiology of this disease across the US.

Syphilis, primary (2014)

Clinical description

A stage of infection with *Treponema pallidum* characterized by one or more ulcerative lesions (e.g. chancre), which might differ considerably in clinical appearance.

Laboratory criteria for diagnosis

Demonstration of *T. pallidum* in clinical specimens by darkfield microscopy, or by PCR or equivalent direct molecular methods.

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

Case classification

Probable: a case that meets the clinical description of primary syphilis with a reactive serologic test (nontreponemal: Venereal Disease Research Laboratory [VDRL], rapid plasma reagin [RPR], or equivalent serologic methods; treponemal: fluorescent treponemal antibody absorbed [FTA-ABS], *T. pallidum* particle agglutination [TP-PA], enzyme immunoassay [EIA], chemiluminescence immunoassay [CIA], or equivalent serologic methods). These treponemal tests supersede older testing technologies, including microhemagglutination assay for antibody to *T. pallidum* [MHA-TP].

Confirmed: a case that meets the clinical description of primary syphilis that is laboratory confirmed.

Syphilis, primary (2018)

Clinical description

A stage of infection with *Treponema pallidum* characterized by one or more ulcerative lesions (e.g. chancre), which might differ considerably in clinical appearance.

Laboratory criteria for diagnosis

Confirmatory:

- Demonstration of *T. pallidum* by darkfield microscopy in a clinical specimen that was not obtained from the oropharynx and is not potentially contaminated by stool, **OR**
- Demonstration of *T. pallidum* by polymerase chain reaction (PCR) or equivalent direct molecular methods in any clinical specimen.

Supportive:

- A reactive nontreponemal serologic test (VDRL, RPR, or equivalent serologic methods), **OR**
- A reactive treponemal serologic test (TP-PA, EIA, CIA, or equivalent serologic methods).*

* These treponemal tests supersede older testing technologies, including MHA-TP.

Case classification

Probable: A case that meets the clinical description of primary syphilis and the supportive laboratory criteria.

Confirmed: A case that meets the clinical description of primary syphilis and the confirmatory laboratory criteria.

Syphilis, secondary (2014)

Clinical description

A stage of infection caused by *T. pallidum* characterized by localized or diffuse mucocutaneous lesions (e.g., rash – such as non-pruritic macular, maculopapular, papular, or pustular lesions), often with generalized lymphadenopathy. Other symptoms can include mucous patches, condyloma lata, and alopecia. The primary ulcerative lesion may still be present. Because of the wide array of symptoms possibly indicating secondary syphilis, serologic tests for syphilis and a thorough sexual history and physical examination are crucial to determining if a case should be classified as secondary syphilis.

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

Laboratory criteria for diagnosis

Demonstration of *T. pallidum* in clinical specimens by darkfield microscopy, or by PCR or equivalent direct molecular methods.

Case classification

Probable: a case that meets the clinical description of secondary syphilis with a nontreponemal (VDRL, RPR, or equivalent serologic methods) titer ≥ 4 and a reactive treponemal test (FTA-ABS, TP-PA, EIA, CIA, or equivalent serologic methods).

Confirmed: a case that meets the clinical description of secondary syphilis (with at least one sign or symptom) that is laboratory confirmed.

Syphilis, secondary (2018)

Clinical description

A stage of infection caused by *T. pallidum* characterized by localized or diffuse mucocutaneous lesions (e.g., rash – such as non-pruritic macular, maculopapular, papular, or pustular lesions), often with generalized lymphadenopathy. Other signs can include mucous patches, condyloma lata, and alopecia. The primary ulcerative lesion may still be present.*

*Because of the wide array of symptoms and signs possibly indicating secondary syphilis, serologic tests for syphilis and a physical examination are crucial to determining if a case should be classified as secondary syphilis.

Laboratory criteria for diagnosis

Confirmatory:

- Demonstration of *T. pallidum* by darkfield microscopy in a clinical specimen that was not obtained from the oropharynx and is not potentially contaminated by stool, **OR**
- Demonstration of *T. pallidum* by polymerase chain reaction (PCR) or equivalent direct molecular methods in any clinical specimen.

Supportive:

- A reactive nontreponemal serologic test (VDRL, RPR] or equivalent serologic methods), **AND**
- A reactive treponemal serologic test (TP-PA, EIA, CIA, or equivalent serologic methods).

Case classification

Probable: A case that meets the clinical description of secondary syphilis and the supportive laboratory criteria.

Confirmed: A case that meets the clinical description of secondary syphilis and the confirmatory laboratory criteria.

Syphilis, early latent (2014)

Clinical description

A subcategory of latent syphilis (a stage of infection caused by *T. pallidum* in which organisms persist in the body of the infected person without causing symptoms or signs) when initial infection has occurred within the previous 12 months.

Case classification

Probable: A person with no clinical signs or symptoms of syphilis who has one of the following:

- No past diagnosis of syphilis, and a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods), and a reactive treponemal test (e.g., FTA-ABS, TP-PA, EIA, CIA, or equivalent serologic methods), or
- A current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer

AND evidence of having acquired the infection within the previous 12 months based on one or more of the following criteria:

- Documented seroconversion or fourfold or greater increase in titer of a nontreponemal test during the previous 12 months
- Documented seroconversion of a treponemal test during the previous 12 months
- A history of symptoms consistent with primary or secondary syphilis during the previous 12 months
- A history of sexual exposure to a partner within the previous 12 months who had primary, secondary, or early latent syphilis (documented independently as duration <12 months)
- Only sexual contact was within the last 12 months (sexual debut).

There is no confirmed case classification for early latent syphilis.

Syphilis, early non-primary non-secondary (2018)

Clinical description

A stage of infection caused by *T. pallidum* in which initial infection has occurred within the previous 12 months, but there are no signs or symptoms of primary or secondary syphilis.

Laboratory criteria for diagnosis

Supportive:

- A current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer, unless there is evidence that this increase was not sustained for >2 weeks.

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

Case classification

Probable

- A person with no clinical signs or symptoms of primary or secondary syphilis who has one of the following:
- No prior history of syphilis, **AND** a current reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods), **AND** a current reactive treponemal test (e.g., TP-PA, EIA, CIA, or equivalent serologic methods), **OR**
- A prior history of syphilis and meets the supportive laboratory criteria.

AND evidence of having acquired the infection within the previous 12 months based on one or more of the following criteria:

- Documented seroconversion or fourfold or greater increase in titer of a nontreponemal test during the previous 12 months, unless there is evidence that this increase was not sustained for >2 weeks
- Documented seroconversion of a treponemal test during the previous 12 months
- A history of symptoms consistent with primary or secondary syphilis during the previous 12 months
- Meets epidemiologic criteria

Epidemiological Criteria:

- A history of sexual exposure to a partner within the previous 12 months who had primary, secondary, or early non-primary non-secondary syphilis (documented independently as duration <12 months).
- Only sexual contact (sexual debut) was within the previous 12 months.

Syphilis, late latent (2014)

Clinical description

A subcategory of latent syphilis (a stage of infection caused by *T. pallidum* in which organisms persist in the body of the infected person without causing symptoms or signs) when initial infection has occurred >12 months previously.

Case classification

Probable: a person with no clinical signs or symptoms of syphilis who has one of the following:

- No past diagnosis of syphilis, and a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods), and a reactive treponemal test (e.g., FTA-ABS, TP-PA, EIA, CIA, or equivalent serologic methods), or
- A past history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer.

AND who has no evidence of having acquired the disease within the preceding 12 months (see Syphilis, early latent).

There is no confirmed case classification for late latent syphilis.

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

Syphilis, unknown duration or late (2018)

Clinical description

A stage of infection caused by *T. pallidum* in which initial infection has occurred >12 months previously or in which there is insufficient evidence to conclude that infection was acquired during the previous 12 months.

Case classification

Probable

A person with no clinical signs or symptoms of primary or secondary syphilis who meets one of the following sets of criteria:

- No prior history of syphilis, and a current reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods), and a current reactive treponemal test (e.g., TP-PA, EIA, CIA, or equivalent serologic methods), **OR**
- A prior history of syphilis, and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer, unless there is evidence that this increase was not sustained for >2 weeks, **OR**
- Clinical signs or symptoms and laboratory results that meet the likely or verified criteria for neurologic, ocular, otic, or late clinical manifestations syphilis (see below)

AND who has no evidence of having acquired the disease within the preceding 12 months (see Syphilis, early non-primary non-secondary)

Comments

Although cases of syphilis of unknown duration are grouped together with late syphilis for the purposes of surveillance, the conservative clinical and public health responses to these cases will differ when there is uncertainty about the duration of infection. When faced with uncertainty, clinicians should act conservatively and treat unknown duration syphilis as if it were late infection, with three doses of benzathine penicillin. In contrast, the most conservative approach for STD control programs would be to manage cases of syphilis of unknown duration as early non-primary non-secondary infections and search for partners who may have been recently infected. Because this would not be feasible for most STD control programs, programs should consider prioritizing cases of syphilis of unknown duration with higher nontreponemal titers (e.g., 1:32 or higher) for investigation and partner services. Although nontreponemal titers cannot reliably distinguish between early infection (<12 months duration) and late infection (>12 months duration), nontreponemal titers usually are higher early in the course of syphilis infection.

Syphilis, Congenital (2015)

Clinical description

A condition caused by infection in utero with *T. pallidum*. A wide spectrum of severity exists, from inapparent infection to severe cases that are clinically apparent at birth. An infant or child (aged less than 2 years) may have signs such as hepatosplenomegaly, rash, condyloma lata, snuffles, jaundice (nonviral hepatitis),

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

pseudoparalysis, anemia, or edema (nephrotic syndrome and/or malnutrition). An older child may have stigmata (e.g., interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson teeth, saddle nose, rhagades, or Clutton joints).

Laboratory criteria for diagnosis

- Demonstration of *T. pallidum* by darkfield microscopy of lesions, body fluids, or neonatal nasal discharge, or
- PCR or other equivalent direct molecular methods of lesions, placenta, umbilical cord, or autopsy material, or
- Immunohistochemistry (IHC), or special stains (e.g., silver staining) of specimens from lesions, neonatal nasal discharge, placenta, umbilical cord, or autopsy material.

Case classification

Probable: a condition affecting an infant whose mother had untreated or inadequately treated* syphilis at delivery, regardless of signs in the infant, or an infant or child who has a reactive non-treponemal test for syphilis (VDRL, RPR, or equivalent serologic methods) AND any one of the following:

- Any evidence of congenital syphilis on physical examination (see Clinical description)
- Any evidence of congenital syphilis on radiographs of long bones
- A reactive CSF VDRL test
- In a nontraumatic lumbar puncture, an elevated CSF leukocyte (White blood cell [WBC]) count or protein (without other cause):

* Adequate treatment is defined as completion of a penicillin-based regimen, in accordance with CDC treatment guidelines, appropriate for stage of infection, initiated 30 or more days before delivery.

Suggested parameters for abnormal CSF WBC and protein values:

- During the first 30 days of life, a CSF WBC count of >15 WBC/mm³ or a CSF protein >120 mg/dL.
- After the first 30 days of life, a CSF WBC count of >5 WBC mm³ or a CSF protein >40 mg/dL, regardless of CSF serology.
- The treating clinician should be consulted to interpret the CSF values for the specific patient.

Confirmed: a case that is laboratory confirmed.

Syphilis, Congenital (2018)

Clinical Description

A condition caused by infection in utero with *Treponema pallidum*. A wide spectrum of severity exists, from inapparent infection to severe cases that are clinically apparent at birth. An infant or child (aged less than 2 years) may have signs such as hepatosplenomegaly, rash, condyloma lata, snuffles, jaundice (nonviral hepatitis), pseudoparalysis, anemia, or edema (nephrotic syndrome and/or malnutrition). An older child may have stigmata (e.g., interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson teeth, saddle nose, rhagades, or Clutton joints).

Laboratory Criteria for Diagnosis

Demonstration of *Treponema pallidum* by:

- Darkfield microscopy of lesions, body fluids, or neonatal nasal discharge, **OR**
- PCR or other equivalent direct molecular methods of lesions, neonatal nasal discharge, placenta, umbilical cord, or autopsy material, **OR**
- IHC, or special stains (e.g., silver staining) of specimens from lesions, placenta, umbilical cord, or autopsy material.

Case Classification

Probable

A condition affecting an infant whose mother had untreated or inadequately treated* syphilis at delivery, regardless of signs in the infant, **OR** an infant or child who has a reactive non-treponemal test for syphilis (VDRL, RPR, **OR** equivalent serologic methods) **AND** any one of the following:

- Any evidence of congenital syphilis on physical examination (see Clinical description)
- Any evidence of congenital syphilis on radiographs of long bones
- A reactive CSF venereal disease research laboratory test (VDRL) test
- In a non-traumatic lumbar puncture, an elevated CSF leukocyte (White blood cell, WBC) count or protein (without other cause):
 - Suggested parameters for abnormal CSF WBC and protein values:
 1. During the first 30 days of life, a CSF WBC count of >15 WBC/mm³ or a CSF protein >120 mg/dl is abnormal.
 2. After the first 30 days of life, a CSF WBC count of >5 WBC/mm³ or a CSF protein >40 mg/dl, regardless of CSF serology.

The treating clinician should be consulted to interpret the CSF values for the specific patient.

*Adequate treatment is defined as completion of a penicillin-based regimen, in accordance with CDC treatment guidelines, appropriate for stage of infection, initiated 30 or more days before delivery.

Confirmed

A case that is laboratory confirmed.

Comments

Congenital and acquired syphilis may be difficult to distinguish when a child is seropositive after infancy. Signs of congenital syphilis may not be obvious, and stigmata may not yet have developed. Abnormal values for CSF VDRL, WBC count, and protein may be found in either congenital or acquired syphilis. Findings on radiographs of long bones may help because radiographic changes in the metaphysis and epiphysis are considered classic signs of congenitally acquired syphilis. While maternal antibodies can complicate interpretation of serologic tests in an infant, reactive tests past 18 months of age are considered to reflect the status of the child. The decision may ultimately be based on maternal history and clinical judgment. In a young child, the possibility of sexual abuse should be considered as a cause of acquired rather than congenital syphilis, depending on the clinical picture. For reporting purposes, congenital syphilis includes cases of congenitally acquired syphilis among infants and children as well as syphilitic stillbirths.

Viral Hepatitis

Hepatitis is inflammation of the liver. It can impair vital liver functions such as processing nutrients, filtering the blood and fighting infection. Viral hepatitis is inflammation of the liver caused by infection with a virus. In Massachusetts, the most common types of viral hepatitis are hepatitis A, hepatitis B and HCV. Non-viral hepatitis can also result from heavy alcohol use, toxins, some medications, and certain medical conditions.

Hepatitis A, Acute (2019)

Clinical Criteria - An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine)

AND

- a) jaundice or elevated total bilirubin levels ≥ 3.0 mg/dL, **OR**
- b) elevated serum alanine aminotransferase (ALT) levels >200 IU/L,

AND

- c) the absence of a more likely diagnosis

Laboratory Criteria for Diagnosis

Confirmatory laboratory evidence:

- Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive,

OR

- Nucleic acid amplification test (NAAT; such as Polymerase Chain Reaction [PCR] or genotyping) for hepatitis A virus RNA positive

Epidemiologic Linkage

Contact (e.g., household or sexual) with a laboratory-confirmed hepatitis A case 15-50 days prior to onset of symptoms.

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

Criteria to Distinguish a New Case from an Existing Case

Hepatitis A is usually self-limiting and does not result in chronic infection. However, up to 10% of persons with hepatitis A may experience a relapse during the 6 months after acute illnesses. Cases of relapsing hepatitis A should not be enumerated as new cases. In addition, a case should not be counted as a hepatitis A case if there is an alternate, more likely diagnosis.

Case Classification

Confirmed:

- A case that meets the clinical criteria and is IgM anti-HAV positive §, **OR**
- A case that has hepatitis A virus RNA detected by NAAT (such as PCR or genotyping), **OR**
- A case that meets the clinical criteria and occurs in a person who had contact (e.g., household or sexual) with a laboratory-confirmed hepatitis A case 15-50 days prior to onset of symptoms.
§ And not otherwise ruled out by IgM anti-HAV or NAAT for hepatitis A virus testing performed in a public health laboratory.

Hepatitis B, Chronic (2012)

Confirmed:

IgM antibodies to hepatitis B core antigen (IgM anti-HBc) negative

AND

A positive result on one of the following tests: hepatitis B surface antigen (HBsAg), hepatitis B e antigen (HBeAg), or nucleic acid test for hepatitis B virus DNA (including qualitative, quantitative and genotype testing),

OR

HBsAg positive or nucleic acid test for hepatitis B virus DNA (including qualitative, quantitative and genotype testing), or HBeAg positive two times at least 6 months apart (Any combination of these tests performed 6 months apart is acceptable.)

Probable:

A case with a single HBsAg positive or HBV DNA positive (including qualitative, quantitative and genotype testing), or HBeAg positive lab result when no IgM anti-HBc results are available

Hepatitis B, Acute (2012)

Clinical Presentation: An acute illness with a discrete onset of symptoms consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain) and either a) jaundice or b) elevated serum alanine aminotransferase levels > 100 IU/L

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

Confirmed:

Clinically compatible case* not known to have chronic hepatitis B and

HBsAg positive

AND

IgM antibody to hepatitis B core antigen (IgM anti- HBc) positive, if done *

A documented negative hepatitis B surface antigen (HBsAg) laboratory test result within 6 months prior to a positive test (either HBsAg, Hepatitis B “e” antigen (HBeAg), or hepatitis B virus nucleic acid testing (HBV NAT) including genotype) result does NOT require an acute clinical presentation to meet the surveillance case definition.

Suspect:

Positive IgM antibody to hepatitis B core antigen (IgM anti-HBc) that does not meet the clinical definition

Note that the year into which a case is categorized is based upon the case’s “Event Date”, which is assigned by the following case characteristics, in decreasing order of specificity, dependent on availability of information: symptom onset date, specimen collection date, diagnosis date, or case report date

HCV, Acute (2012)

Clinical description – An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g. fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain), and either a) jaundice, or b) elevated ALT levels >400 IU/L. A documented negative HCV antibody laboratory test result followed within 6 months by a positive test result does not require an acute clinical presentation to meet the surveillance case definition.

Laboratory criteria for diagnosis – One or more of the following three criteria (except in persons less than 18 months of age, for whom only the third criterion would meet the case classification criteria):

- Anti-HCV screening-test-positive with a signal to cut-off ratio predictive of a true positive as determined for the particular assay as defined by CDC, or
- HCV recombinant immunoblot assay positive, or
- Nucleic acid test (NAT) for HCV RNA positive (including qualitative, quantitative, or genotype testing) and, if done meets the following two criteria:
 - Absence of IgM antibody to hepatitis A virus
 - Absence of IgM antibody to hepatitis B core antigen

Confirmed – A case that meets the clinical case definition, is laboratory confirmed, and is not known to have chronic HCV.

HCV, Past or Present (2012)

Laboratory criteria for diagnosis – One or more of the following three criteria (except in persons less than 18 months of age, for whom only the third criterion would meet the case classification criteria):

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

- Anti-HCV screening-test-positive with a signal to cut-off ratio predictive of a true positive as determined for the particular assay as defined by CDC, or
- HCV recombinant immunoblot assay positive, or
- NAT for HCV RNA positive (including qualitative, quantitative, or genotype testing)

Probable – A case that does not meet the case definition for acute HCV, is anti-HCV positive (repeat reactive) by EIA, and has ALT values above the upper limit of normal, but the anti-HCV EIA result has not been verified by an additional more specific assay or the signal to cut-off ratio is unknown.

Confirmed – A case that is laboratory confirmed and does not meet the case definition for acute HCV.

HCV, Acute (2016)

Clinical criteria – An illness with discrete onset of any sign or symptom consistent with viral hepatitis (e.g. fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain) and a) jaundice or b) a peak elevated serum ALT level >200 IU/L during the period of acute illness.

Laboratory criteria for diagnosis

- A positive test for antibodies to HCV
- HCV detection test: NAT for HCV RNA positive, including qualitative, quantitative, or genotype testing
- A positive test indicating presence of HCV antigen when and if a test for HCV antigen is approved by FDA and available

Probable – A case that meets clinical criteria and has a positive anti-HCV antibody test, but has no reports of a positive HCV NAT or positive HCV antigen tests and does not have test seroconversion within 12 months or has no report of test conversion.

Confirmed – A case that meets clinical criteria and has a positive HCV NAT or HCV antigen, or a documented negative HCV antibody, HCV antigen or NAT laboratory test result followed within 12 months by a positive result of any of these tests (test conversion).

HCV, Chronic (2016)

Laboratory criteria for diagnosis

- A positive test for antibodies to HCV
- HCV detection test: NAT for HCV RNA positive, including qualitative, quantitative, or genotype testing
- A positive test indicating presence of HCV antigen when and if a test for HCV antigen is approved by FDA and available

Probable – A case that does not meet clinical criteria or has no report of clinical criteria, and does not have test conversion within 12 months or has no report of test conversion, and has a positive anti-HCV antibody test, but no report of a positive HCV NAT or positive HCV antigen test.

Confirmed – A case that does not meet clinical criteria or has no report of clinical criteria, and does not have test conversion within 12 months or has no report of test conversion, and has a positive HCV NAT or HCV antigen test.

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

HCV, Acute (2020)

Clinical Criteria - All HCV virus cases in each classification category should be > 36 months of age, unless known to have been exposed non-perinatally.

One or more of the following:

- Jaundice, **OR**
- Peak elevated total bilirubin levels ≥ 3.0 mg/dL, **OR**
- Peak elevated serum alanine aminotransferase (ALT) levels >200 IU/L,

AND

The absence of a more likely diagnosis (which may include evidence of acute liver disease due to other causes or advanced liver disease due to pre-existing chronic HCV virus (HCV) infection or other causes, such as alcohol exposure, other viral hepatitis, hemochromatosis, etc.)

Laboratory Criteria

Confirmatory laboratory evidence:

- Positive HCV virus detection test: NAT for HCV RNA positive (including qualitative, quantitative, or genotype testing), **OR**
- A positive test indicating presence of HCV viral antigen(s) (HCV antigen)

Presumptive laboratory evidence:

- A positive test for antibodies to HCV virus (anti-HCV)

Epidemiologic Linkage

No epidemiologic linkage is required for case classification.

Criteria to Distinguish a New Case from an Existing Case

A new acute case is an incident case that is over the age of 36 months and has not previously been reported meeting case criteria for chronic HCV or for whom there is laboratory evidence of re-infection. Cases under the age of 36 months should be classified under the Perinatal HCV Position Statement (17-ID-08) unless the exposure mode is not perinatal (e.g., healthcare acquired).

All jurisdictions are encouraged to track negative HCV viral detection tests to document both spontaneous clearance of infection or sustained viral response to HCV treatment. Cases that have evidence of having cleared the infection at time of initial report or are considered false positive should not be reported to CDC.

Acute cases determined via anti-HCV test conversion do not need to have a positive HCV viral detection test reported to be considered confirmed acute cases.

A new probable acute case may be reclassified as confirmed acute if a positive HCV viral detection test is reported in the same reporting year (e.g. prior to CDC closing reporting for the calendar year).

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

Collection of risk history data is recommended for probable and confirmed acute HCV cases. Timing of risk history data to collect ranges from 2 weeks to 12 months prior to symptom onset or diagnosis. The time frame to employ depends on the method of classification (e.g. if a case meets clinical criteria and has a positive HCV detection test, a risk history time frame of 2 weeks to 6 months prior to onset should be used; for a case classified via anti-HCV test conversion or HCV RNA test conversion, 2 weeks to 12 months prior to onset should be considered).

If evidence indicating resolution of infection is received after a confirmed acute case has been reported to CDC, the case report does not need to be modified as it was a confirmed case at the time of initial report. However, negative HCV viral detection test results received on confirmed acute case, subsequent to an initial positive result, should be appended to case reports, as feasible, and considered for the purpose of data analysis by each jurisdiction.

For probable acute cases, the presence of a negative HCV viral detection test result, in the absence of criteria that would allow for confirmation, indicates that a case should not be classified as probable acute and should not be reported to CDC.

A confirmed acute case may be classified as a confirmed chronic case if a positive HCV viral detection test is reported one year or longer after acute case onset. A confirmed acute case may not be reported as a probable chronic case (i.e. HCV antibody positive, but with an unknown HCV viral detection test). For purposes of incidence and prevalence calculations, confirmed acute and chronic HCV cases should be counted.

Case Classification

Probable

- A case that meets clinical criteria and has presumptive laboratory evidence,
AND
- Does not have a HCV virus detection test reported,
AND
- Has no documentation of anti-HCV or HCV RNA test conversion within 12 months,

Confirmed

- A case that meets clinical criteria and has confirmatory laboratory evidence,
OR
- A documented negative HCV antibody followed within 12 months by a positive HCV antibody test (anti-HCV test conversion) in the absence of a more likely diagnosis,
OR
- A documented negative HCV antibody **OR** negative HCV virus detection test (in someone without a prior diagnosis of HCV infection) followed within 12 months by a positive HCV virus detection test (HCV RNA test conversion) in the absence of a more likely diagnosis

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

HCV, Chronic (2020)

Clinical Criteria - All HCV virus cases in each classification category should be > 36 months of age, unless known to have been exposed non-perinatally.

One or more of the following:

- Jaundice, **OR**
- Peak elevated total bilirubin levels ≥ 3.0 mg/dL, **OR**
- Peak elevated serum alanine aminotransferase (ALT) levels >200 IU/L,

AND

The absence of a more likely diagnosis (which may include evidence of acute liver disease due to other causes or advanced liver disease due to pre-existing chronic HCV virus (HCV) infection or other causes, such as alcohol exposure, other viral hepatitis, hemochromatosis, etc.)

Laboratory Criteria

Confirmatory laboratory evidence:

- Positive HCV virus detection test: NAT for HCV RNA positive (including qualitative, quantitative, or genotype testing), **OR**
- A positive test indicating presence of HCV viral antigen(s) (HCV antigen)

Presumptive laboratory evidence:

- A positive test for antibodies to HCV virus (anti-HCV)

Epidemiologic Linkage - No epidemiologic linkage is required for case classification.

Criteria to Distinguish a New Case from an Existing Case

All jurisdictions are encouraged to track negative HCV viral detection tests to document both spontaneous clearance of infection or sustained viral response to HCV treatment. Cases that have evidence of having cleared the infection at time of initial report or are considered false positive should not be reported to CDC.

If evidence indicating resolution of infection is received after a confirmed chronic case has been reported to CDC, the case report does not need to be modified as it was a confirmed case at the time of initial report. However, negative HCV viral detection test results received on confirmed chronic cases, subsequent to an initial positive result, should be appended to case reports, as feasible, and considered for the purpose of data analysis by each jurisdiction.

Evidence for re-infection may include a case of confirmed chronic HCV infection that has at least two sequential negative HCV viral detection tests reported, indicative of treatment initiation and sustained virologic response, followed by a positive HCV viral detection test. Under current treatment recommendations, those two negative tests should be at least three months apart, however, the timing may change as standard of care for HCV treatment evolves. Other evidence of reinfection should be considered, including a report of a new genotype on

HIV, STI, AND VIRAL HEPATITIS CASE CLASSIFICATIONS

a case that has previously cleared a different genotype. Jurisdictions are encouraged to ensure that cases of HCV treatment failure are not classified as new cases of HCV infection to the extent that it can be determined. Jurisdictions tracking re-infection should also consider collecting data on prior treatment completion (when relevant and possible to document), treatment failure, change in reported genotype if that applies, and the known time frame for reinfection.

For probable chronic cases, the presence of a negative HCV viral detection test result, in the absence of criteria that would allow for confirmation, indicates that a case should not be classified as probable chronic and should not be reported to CDC.

A new chronic case is a newly reported case that does not have evidence of being an acute case of HCV infection. A confirmed acute case may be classified as a confirmed chronic case if a positive HCV viral detection test is reported one year or longer after acute case onset. A confirmed acute case may not be reported as a probable chronic case (i.e. HCV antibody positive, but with an unknown HCV viral detection test). For purposes of incidence and prevalence calculations, confirmed chronic HCV cases should be counted.

Jurisdictions are also encouraged to track and classify possible re-infection cases that may have been previously submitted to CDC as a confirmed or probable chronic HCV infection case. Jurisdictions tracking re-infection should also consider collecting data on prior treatment completion (when relevant and possible to document), treatment failure, change in reported genotype if that applies, and the known time frame for reinfection.

Case Classification

Suspect

NUL

Probable

- A case that does not meet **OR** has no report of clinical criteria,
AND
- Has presumptive laboratory evidence,
AND
- Has no documentation of anti-HCV or RNA test conversion within 12 months,
AND
- Does not have an HCV RNA detection test reported.

Confirmed

- A case that does not meet **OR** has no report of clinical criteria,
AND
- Has confirmatory laboratory evidence,
AND
- Has no documentation of anti-HCV or HCV RNA test conversion within 12 months.

HIV, STI, AND VIRAL HEPATITIS PROGRAM STAFF CONTACT INFORMATION

Topic	Contact	E-Mail	Phone
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ADDITIONAL HIV, STI, AND VIRAL HEPATITIS RESOURCES

Topic	Contact Information and Website
STI Education, STI Partner Notification, and STI Reporting	617-983-6940 www.mass.gov/dph/cdc/std
HIV Reporting and Surveillance Projects	617-983-6560 www.mass.gov/dph/cdc/aids
HIV Provider Trainings	617-624-5338 www.mass.gov/dph/aids
Viral Hepatitis Education	617-983-6800 www.mass.gov/HepA www.mass.gov/HepB www.mass.gov/HepC
STI Diagnosis, Treatment, and Management	617-983-6945 www.RatellePTC.org
Massachusetts HIV Epidemiologic Profile	617-983-6560 https://www.mass.gov/lists/hivaids-epidemiologic-profiles
HIV Reporting for Health Care Providers	617-983-6560 https://www.mass.gov/infectious-disease-surveillance-reporting-and-control
STI, and HIV Posters and Brochures	617-983-6800 https://massclearinghouse.ehs.state.ma.us/
STI Diagnosis, Treatment, and Management Toolkits	617-983-9645 www.RatellePTC.org
Partner Services Program Information	617-983-6999 https://www.mass.gov/partner-services-program-bsp

DPH and DPH Funded Websites

Bureau of Infectious Disease and Laboratory Sciences

www.mass.gov/orgs/bureau-of-infectious-disease-and-laboratory-sciences

Office of HIV/AIDS

www.mass.gov/dph/aids

Viral Hepatitis Programs

www.mass.gov/HepA

www.mass.gov/HepB

www.mass.gov/HepC

Sylvie Ratelle STD/HIV Prevention Training Center

www.RatellePTC.org

Division of STD Prevention

www.mass.gov/dph/cdc/std

National Websites

Centers for Disease Control and Prevention

www.cdc.gov

Division of STD Prevention

www.cdc.gov/std

Division of HIV Prevention

www.cdc.gov/hiv

Division of Viral Hepatitis

www.cdc.gov/hepatitis

National Network of STD/HIV Prevention

www.nnptc.org

Training Centers