County of Los Angeles
Department of Health Services
Public Health

# THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

Volume 2 • Number 8 September 2002

# DHS Closes 11 Health Centers; Additional Cuts in Public Health

On August 20, 2002, the Los Angeles County Board of Supervisors unanimously approved the Department of Health Services' recommendation to cut nearly $57 million dollars from the Department's budget. The move will close 11 health care centers and four school-based clinics, reduce some Public Health clinical services and convert High Desert Hospital to an outpatient facility.

The health centers that will be closed by the end of September are:

Alhambra, Azusa, Bell Gardens, Florence/Firestone, Imperial Heights, Lawndale, North Hollywood, Norwalk, Pico Rivera, San Antonio and Tujunga.

Patients that have been treated in the past year at one of the affected health centers will be notified that the centers will be closed, and depending on the patient's medical condition, a referral will be made to other sites nearby for continued treatment.

### Factors that went into recommendations:

- A report on Ambulatory Care Capitol Needs (2000) found that all 11 health centers were in need of critical maintenance and repairs estimated at $20 million.
- 10 of the 11 were recommended for replacement or major remodel estimated at $27.5 million.

Continued on page 2

## L.A. County's Annual Influenza Campaign 2002-2003

Public Health is sponsoring over 180 influenza clinics at community sites throughout the county. The kick-off date is October 21st; clinics will continue throughout November or early December. These clinics are limited to persons age 60 and older and individuals of any age with medical conditions that make them high-risk for influenza complications.

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## Varicella Vaccine — Return to the Routine Immunization Schedule

On August 2, 2002, the CDC reported that the supply of varicella vaccine had increased.[1] Health care providers were advised to return to the routine recommended immunization schedule which calls for immunizing children at 12 to 18 months of age and older children who have not had chickenpox. Health care providers should recall children whose vaccination was deferred.

Continued on page 2

**Invasive Pneumococcal Disease** ***will soon be a reportable disease in L.A. County. Information on reporting will be included in the next issue. Information on invasive pneumococcal disease in L.A. County is available at*** **http://lapublichealth.org/acd/index.htm**

# THE PUBLIC'S HEALTH

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## Clinic Closures (from page 1)

- There are few sources of funding for outpatient specialty care for the uninsured. DHS is the major provider of this care and is trying to preserve these services that, for the most part, are provided through the outpatient departments of DHS hospitals and at DHS Comprehensive Health Centers.
- The PPP program is more economical for primary care: on average a PPP visit costs the county $90 while the average at these 11 county facilities is $150.

### Next Steps

DHS is working with state and federal officials to secure additional funds to stave off additional cuts. The decision to make additional cuts – including closing additional health centers – will be reviewed in October and will depend largely on the Department's prospects for fiscal relief.

## Annual Influenza Campaign (from page 1)

For nearly 30 years, the county's public health centers have conducted influenza vaccination clinics at community sites. Public Health staff, Red Cross and other volunteer nurses, and volunteers from sponsoring community sites work together to immunize seniors 60 years of age and older and vulnerable populations. Last year, approximately 70,000 immunizations were given at these community sites. Vaccine is supplied through the State of California with additional vaccine purchased by Public Health.

Information about the influenza vaccination clinic sites (available September 30th) can be obtained by calling 1-800-427-8700 or visiting www.lapublichealth.org/ip/. The influenza Vaccine Information Statements (VISs) and health education materials can also be found on the web site.

## Varicella Vaccine (from page 1)

In California, varicella vaccination or documentation of prior disease is required for children 18 months of age and older attending child-care facilities and for children entering kindergarten. In addition, documentation of disease or varicella immunization is required of children (under 18 years of age) who are new to California schools entering other grades.

### References


1. CDC. Notice to readers: Resumption of routine schedule for varicella vaccine. MMWR 2002;51(30): 679. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm5130a5.htm

# ACIP's 2002 Influenza Vaccination Recommendations

In April 2002, the CDC's Advisory Committee on Immunization Practices (ACIP) published its annual updated recommendations for the prevention of influenza.[1] These recommendations include five principal changes or updates, as follows:

1. The 2002-2003 trivalent vaccine contains A/Moscow/10/99 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Hong Kong/330/2001-like viral strains. These were chosen because of their growth properties and because they are representative of influenza viruses most likely to circulate in the U.S. during the 2002-2003 influenza season.

2. ACIP recommends that vaccination efforts in October focus on:

   - persons at highest risk for influenza-related complications (i.e., persons aged ≥65 years; residents of nursing homes and other chronic-care facilities; persons who have chronic disorders of the pulmonary or cardiovascular systems, including asthma; persons who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases [including diabetes mellitus], renal dysfunction, hemoglobinopathies, or immunosuppression [including immunosuppression caused by medications or by HIV]; children and adolescents [aged 6 months-18 years] who are receiving long-term aspirin therapy; and women who will be in the second or third trimester of pregnancy during the influenza season)
   - health care workers
   - household contacts of persons at increased risk for influenza-related complications (including household contacts and out-of-home caretakers of children 0 – 23 months, particularly for contacts of children aged 0 - 5 months because influenza vaccines have not been approved by the FDA for use among children aged <6 months)
   - children aged 6 months to <9 years receiving influenza vaccine for the first time (two doses a month apart are required for protection)

   Vaccination of other groups should begin in November (e.g., healthy persons 50-64 years of age, general population).

3. Vaccination efforts for all groups should continue into December and later, for as long as vaccine is available. This is especially important for high-risk persons who missed immunization earlier and should be immunized. Since, in many years, peak influenza activity is not reached until late December to early March, vaccination can still offer protection.

4. Influenza vaccination of healthy children aged 6-23 months is encouraged when feasible as young, otherwise healthy children are at substantially increased risk for influenza-related hospitalization. A full recommendation to vaccinate this group is expected within the next couple of years. Vaccination of children aged ≥6 months who have medical conditions that make them high-risk for influenza complications continues to be strongly recommended.

5. A limited amount of influenza vaccine with reduced thimerosal content will be available for the 2002—2003 influenza season. However, this reduced thimerosal vaccine, which is produced by Evans Vaccines, is only licensed for persons 4 years of age and older.

In the U.S., epidemics of influenza are responsible for approximately 20,000 deaths (on average) and result in over 114,000 hospitalizations each year. Although influenza viruses cause disease among all age groups, rates of infection are highest among children. However, rates of serious illness and death are highest among persons aged ≥65 years and persons of any age who have medical conditions that place them at increased risk for complications from influenza. Accordingly, vaccination is critical for these groups since it is the primary method for preventing influenza and its severe complications.

A link to the ACIP report and other information related to influenza can be accessed at http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm.

### References

1. CDC. Prevention and control of influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2002;51(RR03): 1-31. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5103a1.htm

# CONTROLLING ANTIBIOTIC RESISTANCE: What Physicians Can Do

As the cold and flu season approaches, the number of patient requests for antibiotics will increase. Unfortunately, many of these requests are not medically warranted, yet physicians will comply in an effort to satisfy their patients. Giving unnecessary prescriptions is a serious public health problem since it may lead to antibiotic resistence in your patients. Antibiotics are inappropriate for treating viral illnesses such as the common cold and flu. In a national survey of adult medical practices, antibiotics were prescribed to 46% of patients with colds, 47% with upper respiratory tract infections (URIs) and 60% with bronchitis — all conditions for which antibiotics are not indicated.[2] Accordingly, physicians should take steps to change their prescribing behaviors and educate patients about the appropriate use of antibiotics so that bacterial resistance to these drugs can be controlled.

***The CDC estimates that up to 50% of the 235 million doses of antibiotics prescribed annually in the US are unnecessary.[1]***

Educational interventions aimed at physicians and patients have shown success in reducing prescription rates.[3-5] Additionally, the national rate of overall antimicrobial prescribing by office-based physicians for children and adolescents younger than 15 years decreased by 40% between 1989-1990 and 1999-2000.[6]

## Pressures to prescribe

Patients often expect antibiotics from physicians, and these expectations and patient pressure are difficult for physicians to ignore. In a national survey among pediatricians, 48% reported that parents always, most of the time, or often pressure them to prescribe antibiotics when their children are ill but antibiotics are not indicated.[7] However, other studies have shown that communication by the physician influenced patient satisfaction more than the receipt of an antibiotic.[8,9] In particular, one study found that patients were significantly more satisfied with their visit if they were told by their physicians to contact them if symptoms did not improve.[8] If physicians can clearly explain diagnoses and appropriate treatment to patients and parents, inappropriate antibiotic prescriptions can be prevented.

***Studies have shown that communication by the physician influenced patient satisfaction more than the receipt of an antibiotic.***

## What you can do to control antibiotic resistance

All physicians can take a leading role to control antibiotic resistance by changing their prescribing behaviors and conducting patient education with the following strategies:

- **Prescribe judiciously**. Conduct a complete evaluation of the patient before coming to an informed decision that antibiotics are the appropriate treatment. Follow clinical practice guidelines for treating viral versus bacterial illnesses. For example, only 15% of acute sore throats are caused by group A streptococcus and the other 85% of the cases are mainly due to viral causes.[10] Use a rapid strep test and let the results guide your management. The CDC provides clinical practice guidelines for otitis media, rhinitis, sinusitis, pharyngitis, and cough illness/bronchitis available online at: http://www.cdc.gov/drugresistance/technical/prevention_tools.htm

  Other clinical practice guidelines can be found at the Infectious Diseases Society of America (IDSA) web site: www.idsociety.org or in major medical journals.

- **Offer alternatives.** Recommend alternatives to alleviate symptoms for viral illnesses. Patients should be reassured that symptomatic treatment for their viral illness is appropriate and sufficient. The CDC has developed "prescription pads" that physicians can use to explain to their patients why an antibiotic is not being prescribed and recommend symptomatic treatments (Figure 1).

**Continued on page 5**


***Stay tuned for monthly updates regarding antibiotic use and the prevention of antibiotic over-prescription.***

***Information about the L.A. County Antibiotic Resistance Prevention Project is available at:***
**http://lapublichealth.org/acd/special.htm**

# Controlling Antibiotic Resistance (from page 4)

Name:_____ Date:____/____/____

Diagnosis: o Cold or Flu o Middle ear fluid (Otitis Media with Effusion, OME)
o Cough o Viral sore throat
o Other: _____

Rx

You have been diagnosed as having an illness caused by a virus. **Antibiotic treatment does not cure viral infections.** If given when not needed, antibiotics can be harmful. The treatments prescribed below will help you feel better while your body's own defenses are defeating the virus.

**General instructions:**
- o Increase fluids.
- o Use cool mist vaporizer or saline nasal spray to relieve congestion.
- o Soothe throat with ice chips, or sore throat spray; lozenges for older children and adults.

**Specific medicines:**
- o Fever or aches:
- o Ear pain:
- o _____:_____
- o _____:_____

Use medicines as directed by your doctor or the package instructions. Stop the medication when the symptoms get better.

**Follow up:**
- o If not improved in ____ days, if new symptoms occur, or if you have other concerns, please call or return to the office for a recheck.
- o Other:_____

Signed:_____

CDC

U.S. GPO: 2000-533-020/26013

**Figure 1: CDC Prescription Pad**

Source: Centers for Disease Control and Prevention
http://www.cdc.gov/antibioticresistance/files/Viral%20Prescription%20Pad.pdf
A version with four images on a page, suitable for mass replications, is available on the ACDC web site at: http://lapublichealth.org/acd/antibio.htm

- **Explain why.** Give patients a clear explanation of their diagnosis and the rationale for the use or non-use of antibiotics since there is a lot of misinformation in the general public. For example, a study showed that 79% of college students believed that antibiotics were effective for a discolored nasal discharge.[11] In addition, patients should know that they increase their risk for acquiring a resistant bacterial infection when taking antibiotics that are not necessary.
- **Instruct proper use.** If antibiotics are the appropriate treatment, ensure that patients follow the exact course of treatment — this includes taking the entire prescription and never stopping medication just because the patient feels better. Additionally, patients should be instructed to never share antibiotics with others or save them for their own future use.
- **Promote prevention.** Patients should be informed of ways to prevent themselves from getting sick which includes basic handwashing and disinfecting areas at home and in the workplace. Additionally, patients should be getting their immunizations up-to-date, which includes flu and pneumococcal vaccinations.

## Resources

Campaign efforts are underway at the local, state, and federal level to increase education and awareness about the appropriate use of antibiotics and the problem of antibiotic resistance. In November of 2002, CDC will release a nation-wide media campaign encouraging the public to learn more about antibiotics. To learn more about antibiotic awareness activities in the area please visit the following web sites:

Los Angeles Antibiotic Resistance Education Advocates (LA AREA)
http://www.lapublichealth.org/acd/antibio.htm

Alliance Working for Antibiotic Resistance Education (AWARE) – California Medical Association
http://www.aware.md/

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/drugresistance/community/

## References


1. Wenzel RP, Edmond MB. Managing antibiotic resistance. N Engl J Med 2000;343(26):1961-3.

2. Cantrell R, Young AF, Martin BC. Antibiotic prescribing in ambulatory care settings for adults with colds, upper respiratory tract infections, and bronchitis. Clin Ther 2002;24(1):170-82.

3. Belongia EA, Sullivan BJ, Chyou P, Madagame E, Reed KD, Schwartz B. A community intervention trial to promote judicious antibiotic use and reduce penicillin-resistant Streptococcus pneumoniae carriage in children. Pediatrics 2001;108:575-583.

4. Hennessy TW, Petersen KM, Bruden D, Parkinson AJ, Hurlburt D, Getty M, Schwartz B, Butler JC. Changes in antibiotic-prescribing practices and carriage of penicillin-resistant Streptococcus pneumoniae: A controlled intervention trial in rural Alaska. Clin Infect Dis 2002;34(12):1543-50.

5. Perz JF, Craig AS, Coffey CS, Jorgensen DM, Mitchel E, Hall S, Schaffner W, Griffin MR. Changes in antibiotic prescribing for children after a community-wide campaign. JAMA 2002;287(23):3103-9.

6. McCaig LF, Besser RE, Hughes JM. Trends in antimicrobial prescribing rates for children and adolescents. JAMA 2002;287(23):3096-102.

7. Bauchner H, Pelton SI, Klein JO. Parents, physicians, and antibiotic use. Pediatrics 1999;103(2):395-401.

8. Mangione-Smith R, McGlynn EA, Elliott MN, McDonald L, Franz CE, Kravitz RL. Parent expectations for antibiotics, physician-parent communication, and satisfaction. Arch Pediatr Adolesc Med 2001;155(7):800-6.

9. Brody DS, Miller SM, Lerman CE, Smith DG, Lazaro CG, Blum MJ. The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. Med Care 1989;27(11):1027-35.

10. Tanz RR, Shulman ST Diagnosis and treatment of group A streptococcal pharyngitis. Semin Pediatr Infect Dis. 1995; 6:69-78

11. Mainous AG 3rd, Zoorob RJ, Oler MJ, Haynes DM. Patient knowledge of upper respiratory infections: Implications for antibiotic expectations and unnecessary utilization. J Fam Pract 1997;45(1):75-83.

# Pneumococcal Conjugate Vaccine (PCV7) Update

The national shortage of pneumococcal conjugate vaccine (PCV7) continues and is now expected to last throughout 2002. In December 2001, ACIP requested that all health-care providers reduce the number of vaccine doses used and ordered, regardless of their vaccine supply, so that vaccine was more widely available. This request remains in effect. Until adequate supplies are available, the following table should be used to determine who should be immunized and the number of doses needed:

**ACIP - based recommendations for pneumococcal conjugate vaccine (PCV7) use during current (2002) moderate and severe shortages[1]**

| Age at first Vaccination | High-Risk Children[2] | Low- to Moderate[3]-Risk Children | |
|---|---|---|---|
| | Standard Schedule[1] | Moderate Vaccine Shortage[4] | Severe Vaccine Shortage[5] |
| ≤6 months | 2, 4, 6, and 12-15 months | 2, 4, 6 months (defer 4th dose) | 2 doses at 2-month interval in 1st 6 months of life (defer 3rd and 4th doses) |
| 7-11 months | 2 doses at 2-month interval; also 12-15 month dose | 2 doses at 2-month interval; also 12-15 month dose | 2 doses at 2-month interval (defer 3rd dose) |
| 12-23 months | 2 doses at 2-month interval | 2 doses at 2-month interval | 1 dose (defer 2nd dose) |
| 24-59 months | 2 doses at 2-month interval for high-risk children[6] | Defer vaccination | Defer vaccination |

1. During the current national vaccine shortage, all providers are requested to conserve vaccine by implementing one of the two shortage schedules. Only use the Standard Schedule for infants and children 2 months to 59 months of age who are high-risk for invasive pneumococcal disease.

2. Children at high-risk for invasive pneumococcal disease include children with sickle cell disease, congenital or acquired asplenia, chronic cardiac or pulmonary disease, diabetes mellitus, renal failure, nephrotic syndrome, or who are immunosuppressed, including those with human immunodeficiency virus [HIV] infection.

3. Moderate-risk children for invasive pneumococcal disease include children aged 24 - 35 months, children of Alaskan Native, American Indian or African American descent, and children who attend group day care 4 or more hours a week.

4. Moderate vaccine shortage is defined as a shortfall of less than 25% of the 4-dose infant schedule.

5. Severe vaccine shortage is defined as a shortfall of 25 - 50% of the 4-dose infant schedule. If shortages are estimated to be more severe (greater than 50%), health-care providers should set infant vaccination priorities based on the assessment of risk, deferring infants at lowest risk.

6. When the national vaccine supply is sufficient, one PCV7 dose should be considered for low- and moderate-risk children 24-59 months of age, with priority given to moderate-risk children.

# Appointment of Maternal Health and Family Planning Director

Robert Hurd Settlage, MD, MPH, FACOG, was appointed Director of Maternal Health and Family Planning for the county's Maternal, Child and Adolescent Health (MCAH) Programs last month. Prior to his new appointment, Dr. Settlage served as the Medical Director for the county's Sexually Transmitted Disease Program for 5 years. From 1983 to 1996 he was the Perinatal Care Coordinator for the Women's Hospital catchment area in East Los Angeles.

In his new position, he will serve as one of the two State-required maternal and child health medical directors for the county. His new duties include provision of leadership, coordination, and participation in the planning, development, and support of programs designed to ensure the optimal health of pregnant women in the county, and to ensure that all women of reproductive age have access to information and methods to delay or space their pregnancies.

"Returning to Maternal and Child Health feels like coming home," says Dr. Settlage whose first full-time job at the County was a rotating obstetrics intern at L.A. County General Hospital 39 summers ago.

"My sojourn in the STD Program had its high points, and opened my eyes to many opportunities to address important public health issues. It was not easy to leave the current staff—I enjoyed working with them, and hope to continue, perhaps on such issues as congenital syphilis."

Dr. Settlage received both his medical degree (1963) and masters degree in public health (1969) from the University of California at Los Angeles. He also completed his clinical training in ob/gyn at UCLA.

Dr. Settlage is replacing Dr. Robert Bragonier, who retired from county service in July.

If you would like to contact Dr. Settlage, please call him at 213-639-6416, or by e-mail at rsettlage@dhs.co.la.ca.us.

## Calendar

### Immunization Coalition of Los Angeles County Quarterly Meeting

The mission of the coalition is to bring together individuals and organizations to work together to protect the Los Angeles community against vaccine preventable diseases through sharing information, coordinating activities, and collaborating on immunization efforts to achieve and maintain immunization coverage rates based on the Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Date: Thursday, October 10, 2002
Time: 9:30 a.m. - 12:00 noon
Place: California Hospital Medical Center
1401 S. Grand Ave, Los Angeles, CA 90015
(Parking entrance at the Grand Ave. Garage - corner of Venice & Grand)
Topic: The Los Angeles Immunization Network (LINK): The Immunization Registry for Los Angeles County, Robyn Davis, Registry Regional Manager
Contact: Wendy Berger (213) 351-7800, wberger@dhs.co.la.ca.us

### Epidemiology and Prevention of Vaccine-Preventable Diseases

This live 2-day course is designed to provide updates on schedules, contraindications, standard immunization practices, vaccine-preventable diseases, and vaccine management and safety. Registration form must be mailed in; no phone calls or faxes can be accepted.

Date: November 18-19, 2002
Time: 8:00 a.m. – 5:00 p.m.
Place: Norwalk Marriott, 13111 Sycamore Drive
Norwalk, CA 90650
Contact: Sandra Jo Hammer at shammer@dhs.ca.gov or 510-540-2198.

For brochure and registration form, visit
http://www.lapublichealth.org/ip/train&conf/E&PVPDs.pdf

# Calendar

**Public-Private Partnership: A New Model for Community Mobilization Against AIDS**

This CDC broadcast will discuss public-private partnerships, HIV/AIDS legal issues, business and labor issues, and resources for HIV/AIDS prevention programs. The target audience includes managers, human resources directors, medical staffs an other persons at community and national organizations, business/labor organizations, public health agencies, trade associations, and foundations.

For more information or to register for the broadcast, please contact Mary Lee Gray, Office of AIDS Programs and Policy at (213) 637-8452.

Date: Thursday, November 21, 2002
Time: 10:00 a.m. - 12:00 noon PST
Place: Health Services Administration - Auditorium
313 North Figueroa Street, Los Angeles, CA 90012

## This Issue . . .




# THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

County of Los Angeles
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## Selected Reportable Diseases (Cases)[1] - June 2002

| Disease | THIS PERIOD June 2002 | SAME PERIOD LAST YEAR June 2001 | YEAR TO DATE 2002 | YEAR TO DATE 2001 | YEAR END TOTALS 2001 | YEAR END TOTALS 2000 | YEAR END TOTALS 1999 |
|---|---|---|---|---|---|---|---|
| AIDS[2] | 143 | 74 | 837 | 607 | 1,415 | 1,652 | 1,876 |
| Amebiasis | 10 | 6 | 54 | 49 | 136 | 116 | 142 |
| Campylobacteriosis | 81 | 108 | 434 | 492 | 1,084 | 1,332 | 1,100 |
| Chlamydial Infections | 2,577 | 2,782 | 16,850 | 16,548 | 32,784 | 30,642 | 27,561 |
| Encephalitis | 6 | 3 | 30 | 25 | 44 | 51 | 7 |
| Gonorrhea | 503 | 664 | 3,614 | 3,922 | 7,800 | 7,212 | 6,053 |
| Hepatitis Type A | 27 | 43 | 276 | 263 | 517 | 1,025 | 1,258 |
| Hepatitis Type B, Acute | 2 | 5 | 12 | 23 | 44 | 65 | 61 |
| Hepatitis Type C, Acute | 0 | 0 | 0 | 0 | 1 | 28 | 21 |
| Measles | 0 | 3 | 0 | 8 | 8 | 5 | 1 |
| Meningitis, viral/aseptic | 41 | 44 | 271 | 219 | 534 | 491 | 390 |
| Meningococcal Infections | 2 | 4 | 27 | 43 | 53 | 53 | 49 |
| Mumps | 0 | 1 | 14 | 1 | 17 | 29 | 24 |
| Non-gonococcal Urethritis (NGU) | 68 | 116 | 672 | 730 | 1,423 | 1,575 | 1,742 |
| Pertussis | 8 | 4 | 67 | 31 | 100 | 102 | 237 |
| Rubella | 0 | 0 | 0 | 1 | 0 | 3 | 0 |
| Salmonellosis | 78 | 78 | 411 | 376 | 893 | 1,119 | 1,027 |
| Shigellosis | 43 | 46 | 279 | 203 | 596 | 878 | 687 |
| Syphilis, primary & secondary | 15 | 15 | 133 | 83 | 184 | 136 | 88 |
| Syphilis, early latent (<1 yr.) | 18 | 14 | 148 | 80 | 209 | 194 | 335 |
| Tuberculosis | 114 | 71 | 403 | 339 | 1,046 | 1,065 | 1,170 |
| Typhoid fever, Acute | 3 | 3 | 11 | 13 | 24 | 25 | 16 |

1. Case totals are provisional and are subject to change following publication.
2. Case totals are interim and may vary following periodic updates of the database.

Data provided by DHS' Public Health programs: Acute Communicable Disease Control, Data Collection & Analysis, HIV/Epidemiology, Sexually Transmitted Diseases, and Tuberculosis Control.