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## Epidemiological Profile of Tuberculosis in South Dakota, 2011

By Kristin Rounds, Tuberculosis Control Coordinator, SD Department of Health

During the last ten years, South Dakota averaged 15 cases of tuberculosis (TB) per year. During 2011, there were 15 cases of TB reported to the South Dakota Department of Health, which is the same number of cases reported in 2010. Figure 1 shows the 10-year trend of TB cases reported in South Dakota.

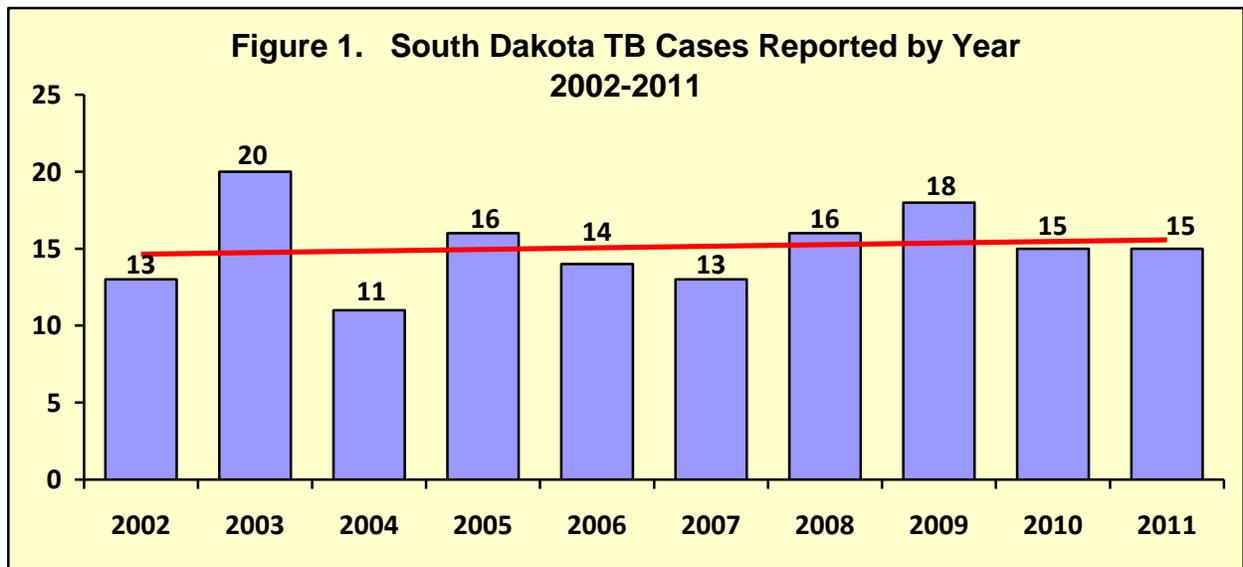
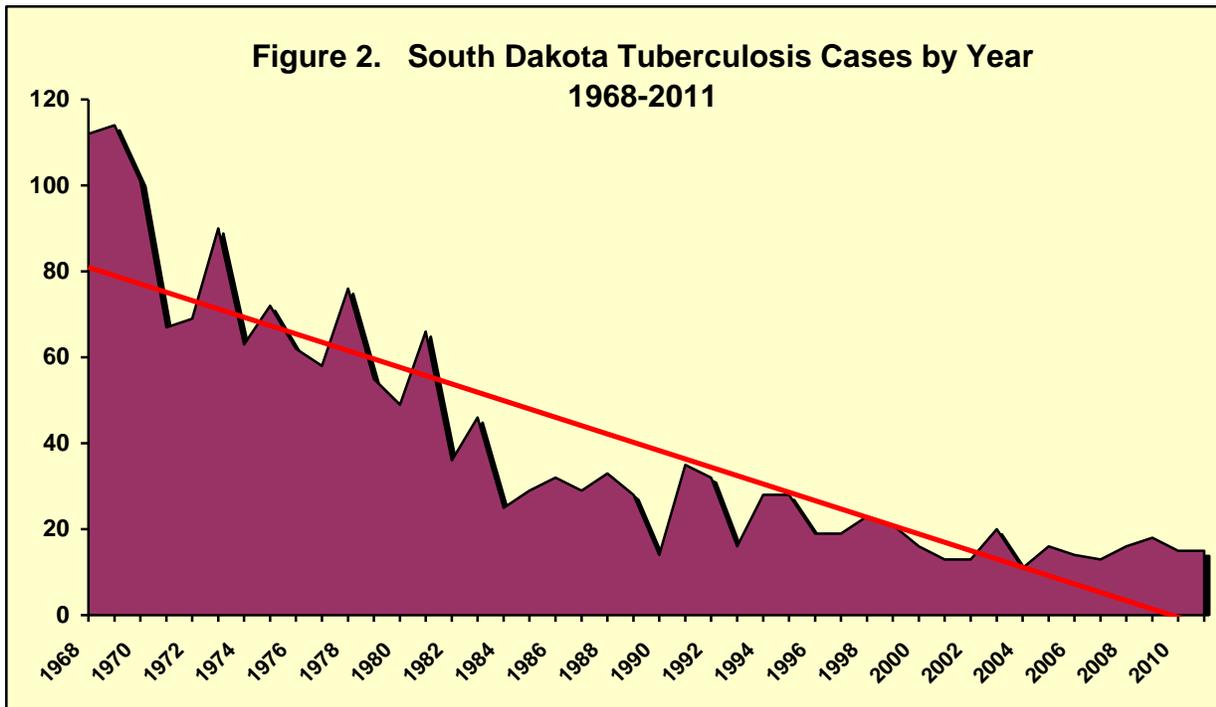


Figure 2 illustrates the historical decreasing trend of reported tuberculosis cases in South Dakota since 1968. This dramatic decrease is a result of mandatory reporting of suspected TB cases to the Department of Health along with case management, treatment and comprehensive contact investigations to ensure those exposed to tuberculosis receive prompt treatment and appropriate intervention efforts.



The most recent data available nationally and regionally is from calendar year 2010. Figure 3 provides a comparison of the TB case rate per 100,000 population for the United States as well as a regional comparison of South Dakota and our border states of North Dakota, Minnesota, Iowa, Nebraska, Wyoming and Montana. Please note that South Dakota has the second highest TB case rate behind Minnesota when comparing these 7 states.

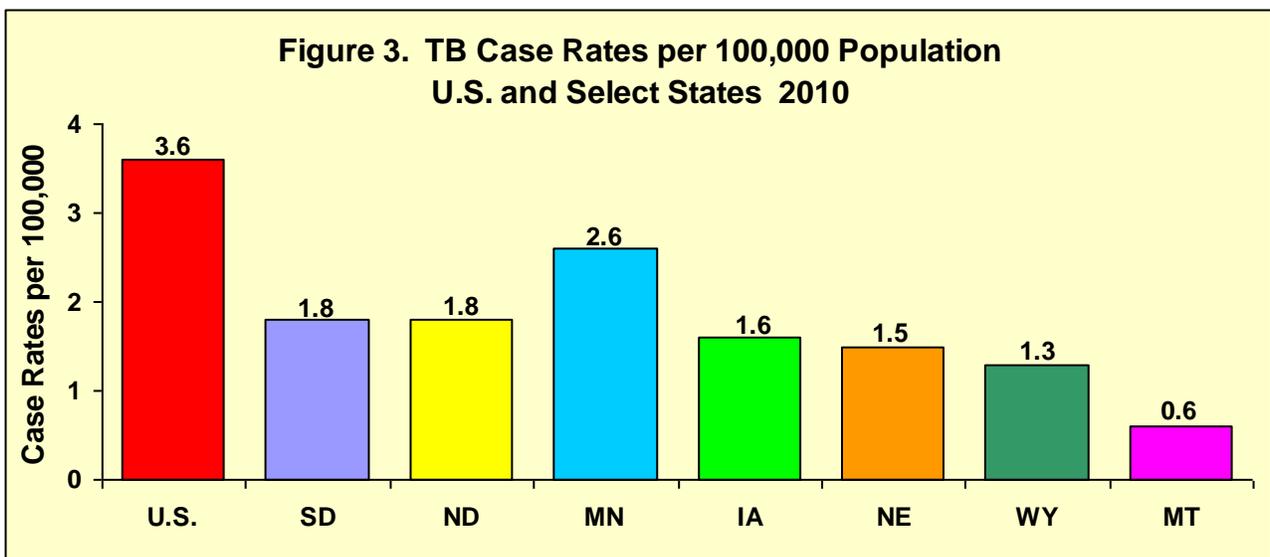
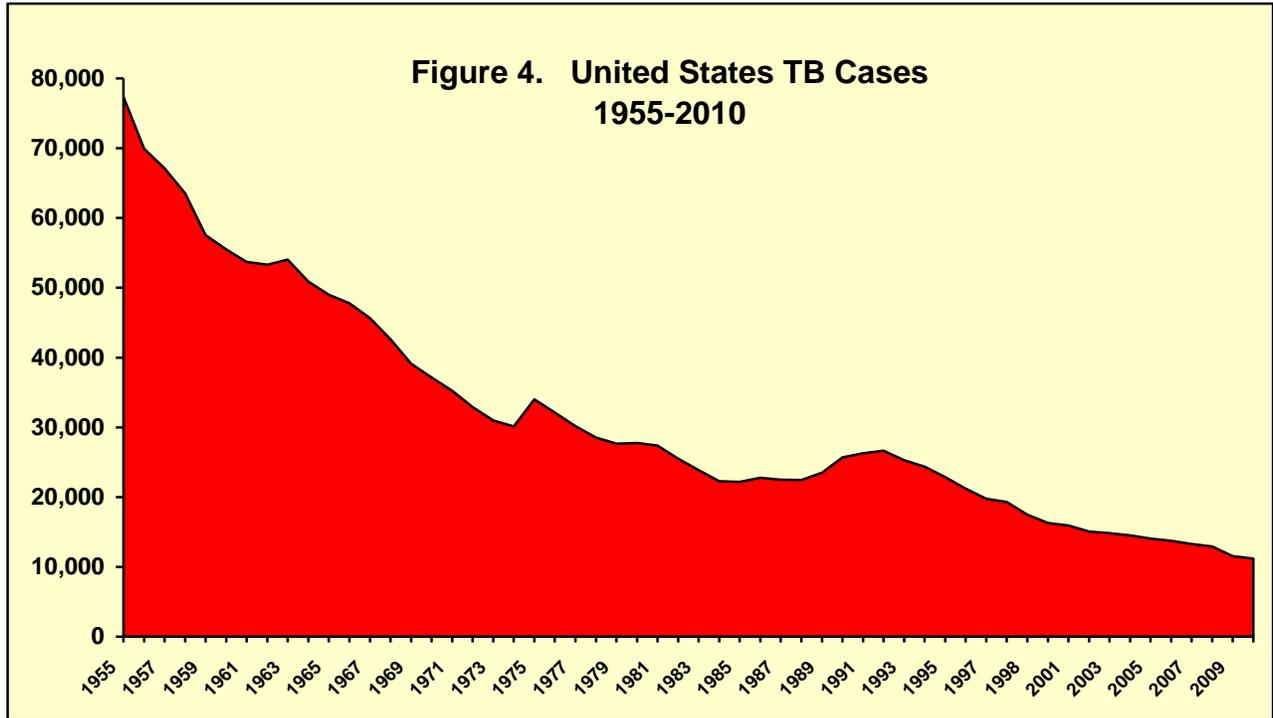


Figure 4 illustrates the historical trend of decreasing TB cases reported in the United States. In 2010 there were 11,182 TB cases reported in the US which was the lowest year on record, representing a 3.1% decrease from 2009. During 2010, 19 states reported increased case counts from 2009. The 4 states of California, Texas, New York and Florida accounted for 50% of the national case total. During 2010, 1.2% of the reported cases had primary multi-drug resistance which is defined as resistance to the TB medications of at least isoniazid and rifampin. During 2010, 60% of TB cases nationally were in foreign-born persons, the highest percentage ever reported.

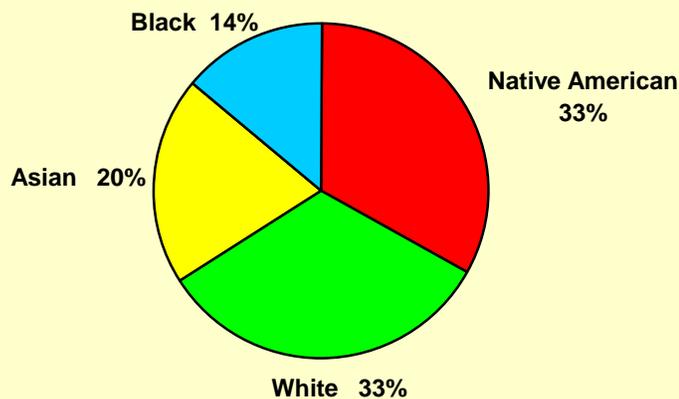


Native Americans have historically had the highest percentage of TB cases by race, however in 2011 they only contributed 33% of the total TB cases reported. Table 1 and Figure 5 provide information on TB cases by race in 2011.

**Table 1. Tuberculosis Cases Reported by Sex and Race, South Dakota 2011**

Race	Male	Female	Total	% of Cases
Native American	4	1	5	33%
White	4	1	5	33%
Black	0	2	2	14%
Asian	1	2	3	20%
<b>Total</b>	<b>9</b>	<b>6</b>	<b>15</b>	<b>100%</b>

**Figure 5. TB Cases by Race  
South Dakota 2011**



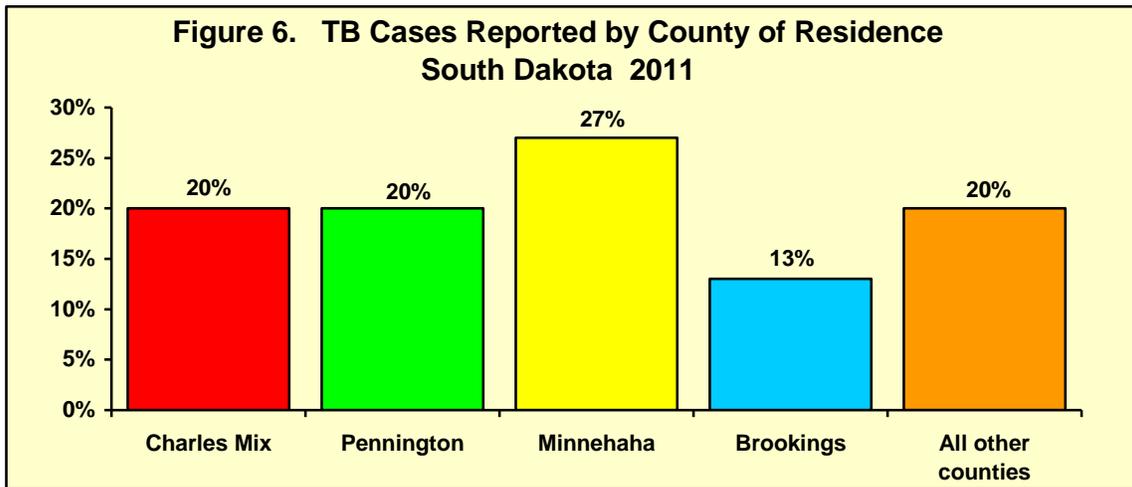
The TB incidence rate, which measures the number of TB cases per 100,000 population, is the best measure for determining the progress towards the elimination of TB in South Dakota. Historically, Native American TB case rates have dropped considerably while white cases have consistently remained low. The Black, Asian and other races mainly represent TB cases born outside of the United States who were diagnosed in South Dakota. Table 2 provides additional information on TB case rates for the last 6 years.

**Table 2. Tuberculosis Morbidity Incidence Rates per 100,000 by Race & Year, South Dakota, 2006-2011**

Race	2006	2007	2008	2009	2010	2011
US Case Rate (All Races)	4.6	4.4	4.2	3.8	3.6	Not available*
SD All Races	1.8	1.7	2.1	2.2	1.8	1.8
SD Native American	8.8	10.3	5.9	10.3	15.0	6.1
SD White	0.1	0.4	0.1	0.9	0.3	0.7
SD Black	64.5	32.3	161.3	64.5	24.6	13.6
SD Asian	52.1	17.4	17.4	17.4	0.0	39.4
All Other SD Races	0.0	0.0	0.0	0.0	0.0	0.0

\*2011 US case rate data is not yet available.

The South Dakota TB elimination goal is to reduce tuberculosis cases to an incidence of no more than 3.5 cases per 100,000 by the year 2015. In addition there is a special population target goal of reducing Native American tuberculosis cases to less than 15 cases per 100,000 by 2015. As referenced in Table 2, both of these objectives have been met in 2011.

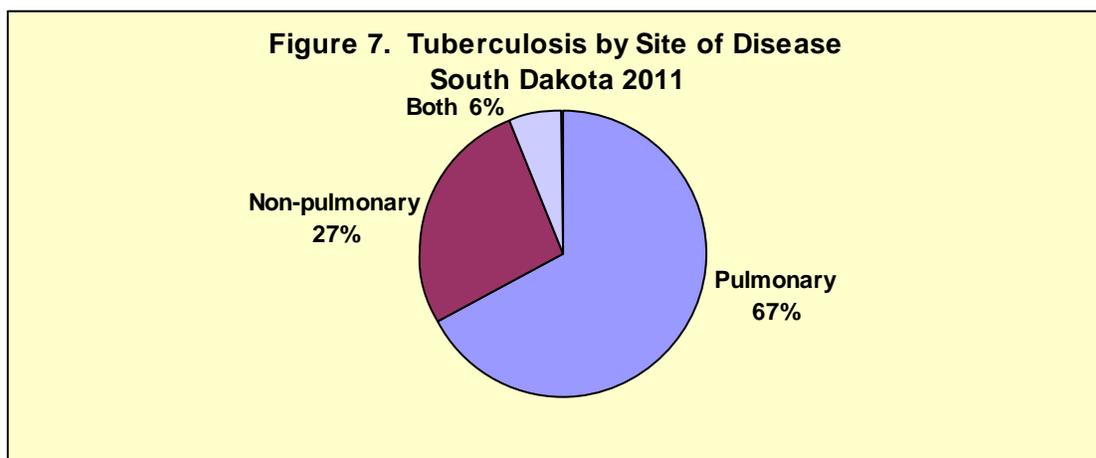


Tuberculosis cases in South Dakota have historically been located in a few geographic locations that consistently report the majority of TB cases. These include Minnehaha County which reports the highest number of foreign-born TB cases and Shannon, Todd and Pennington counties which report the highest number of Native American TB cases. Figure 6 and Table 3 provide additional information on the counties of residence of the TB cases in 2011.

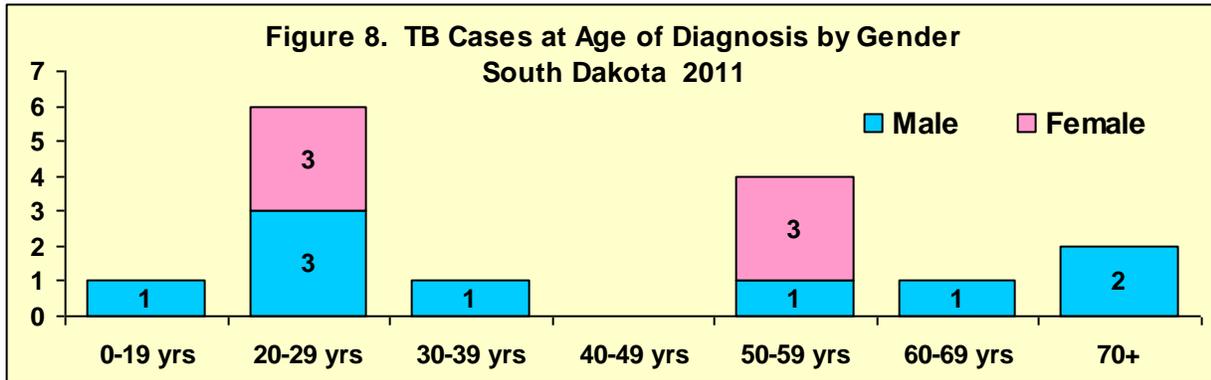
**Table 3. TB Cases Reported by County of Residence, South Dakota 2011**

County	# of TB Cases	County	# of TB Cases
Brookings	2	Minnehaha	4
Brown	1	Pennington	3
Charles Mix	3	Shannon	1
Douglas	1	<b>TOTAL</b>	<b>15</b>

Tuberculosis remains primarily a pulmonary disease with approximately 85% of cases nationally reported as pulmonary disease and 15% as non-pulmonary disease. South Dakota has historically reported a higher percentage of non-pulmonary TB disease. In 2011 this trend continued with 5 cases (33%) reported as non-pulmonary or both pulmonary and non-pulmonary sites of disease as described in Figure 7. The non-pulmonary sites of disease in 2011 included TB reported in brachial cleft cyst, eye, pericardium and bone.

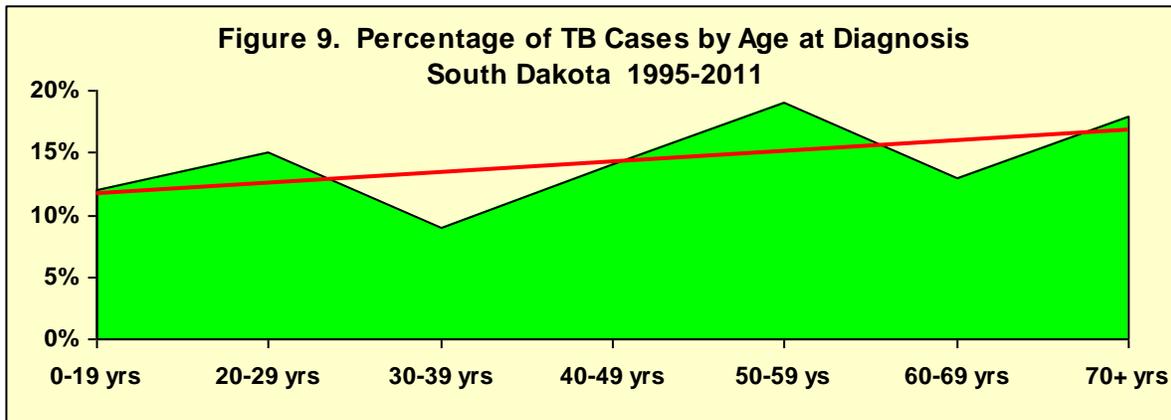


The average age of the TB case in 2011 was 42 years of age. This is a shift to older patients as compared to 2010 when the average age was 34 years of age. There was one child less than 10 years of age reported during this time period. Figure 8 illustrates the age at diagnosis by gender for tuberculosis cases reported in 2011.

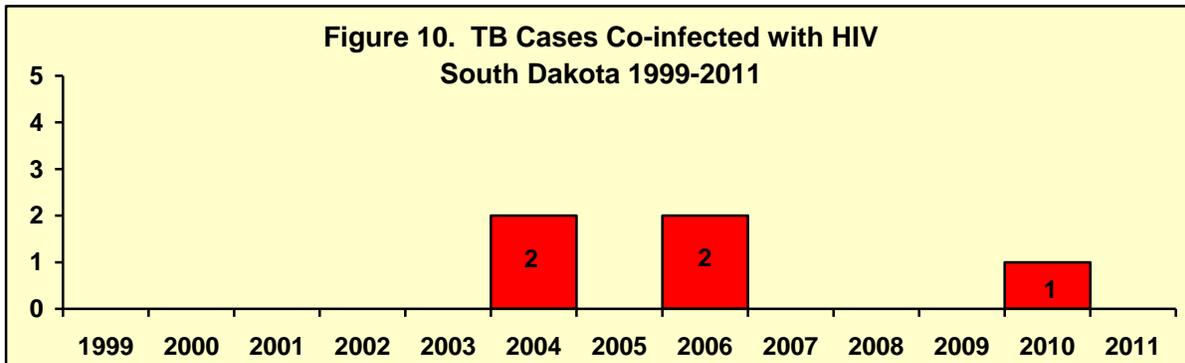


Historically most tuberculosis cases are diagnosed as adults in South Dakota. Figure 9 shows the majority of TB cases diagnosed in South Dakota were 50 years of age or older at the time of diagnosis from 1995 through 2011.

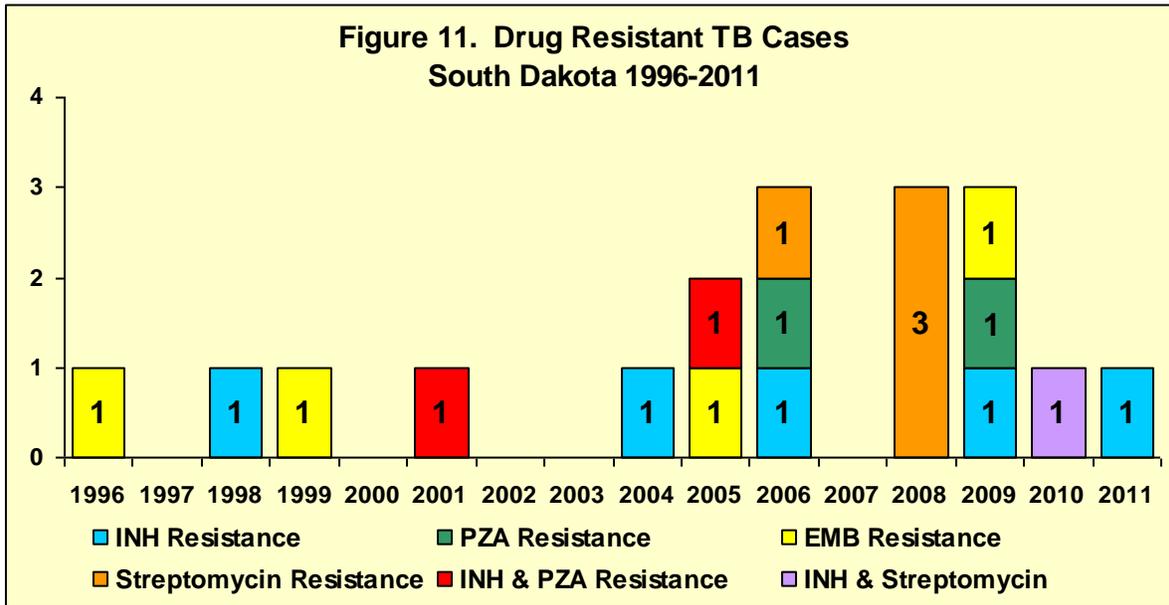
Co-infection with HIV is an important risk factor for the development of active TB. Because of this,



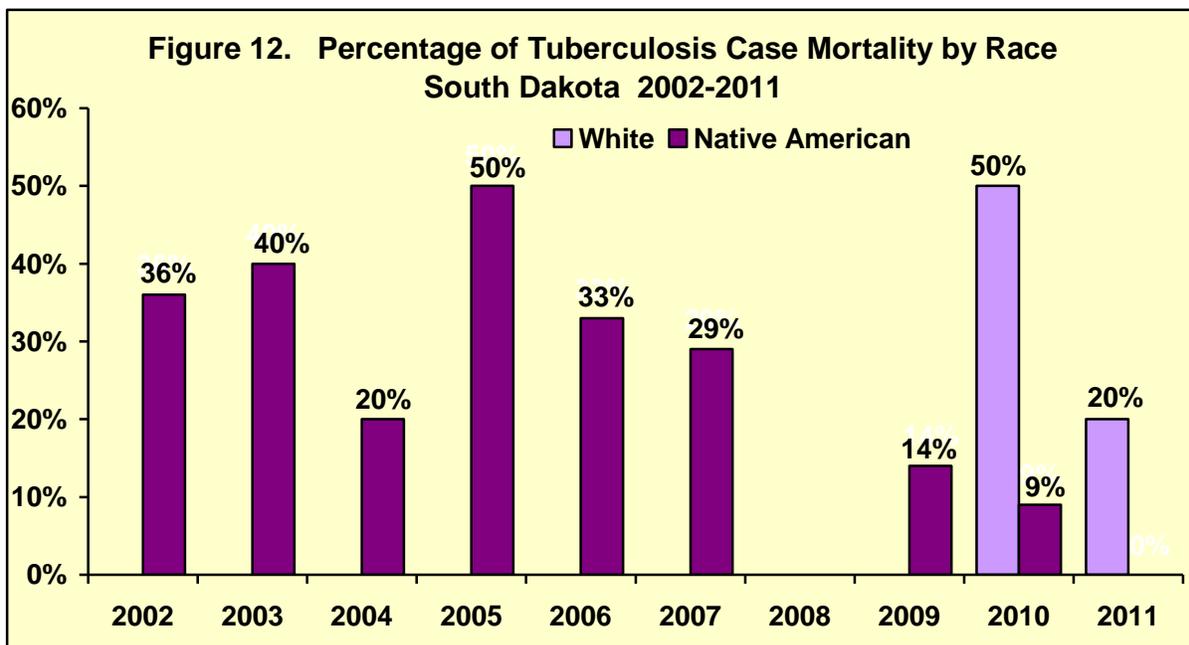
all TB cases diagnosed in South Dakota aged 25-44 years of age are offered HIV testing. Co-infected TB cases require more monitoring for toxicity and are frequently treated with second line TB medications. Figure 10 describes the number of TB cases co-infected with HIV since 1999 documenting that HIV co-infected TB cases remain uncommon.



All culture positive TB isolates are tested for drug resistance to first-line TB medications including isoniazid (INH), rifampin (RIF), pyrazinamide (PZA), ethambutol (EMB) and streptomycin (SM). Multi-drug resistant TB is defined by CDC as resistance to at least INH and RIF and is a significant public health problem because of the difficulty in achieving a successful treatment outcome. Figure 11 shows drug resistant TB cases since 1996 illustrating that South Dakota most often has single drug resistant cases. No multi-drug resistant TB cases have been reported in South Dakota although the Department of Health has managed several MDR-TB cases reported in other states that have moved to South Dakota.



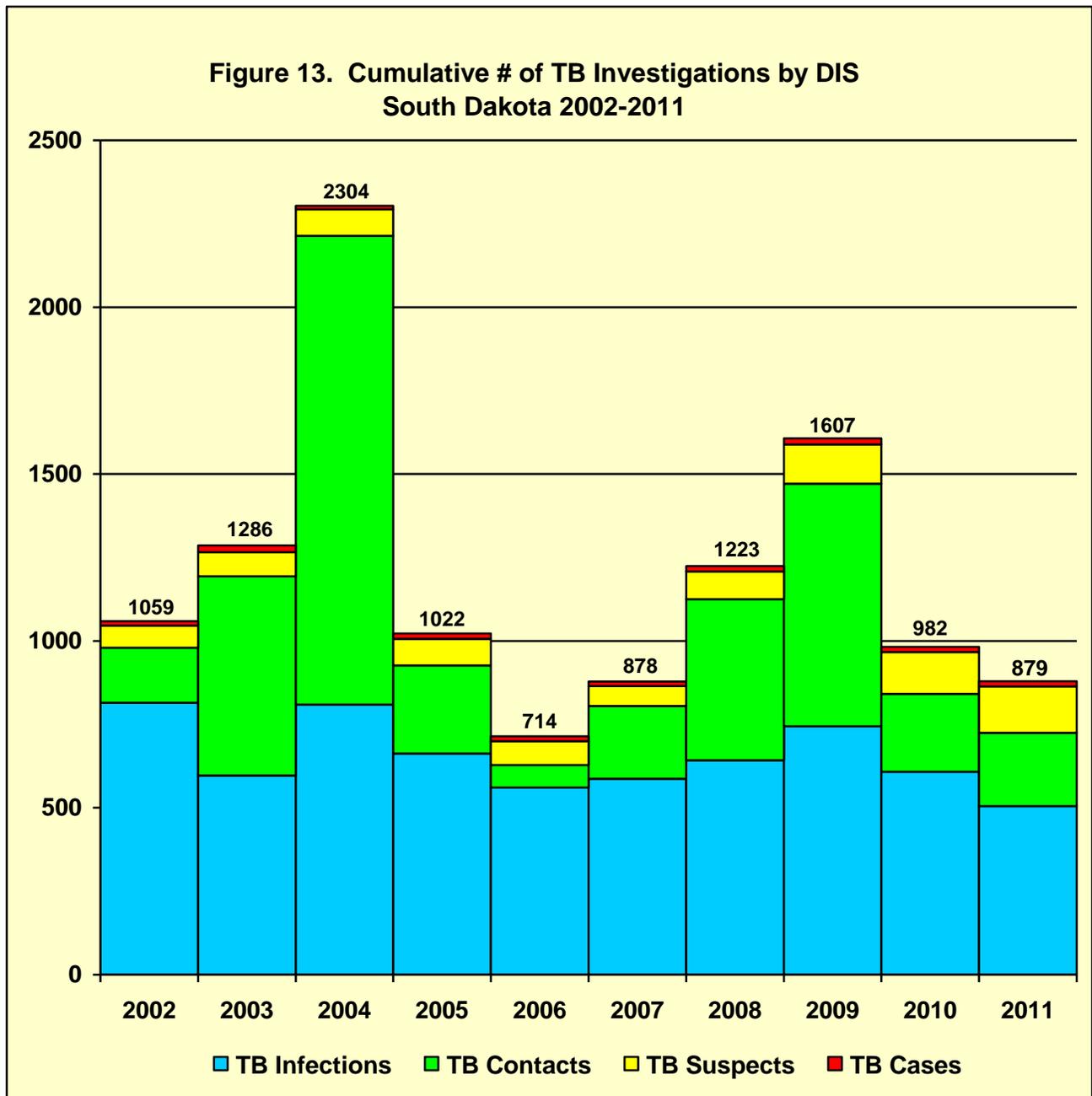
South Dakota has reported a higher than expected mortality rate during certain years, especially among Native American patients. Figure 12 shows the mortality rates by race since 2002 showing the higher trend among Native American cases. Mortality rates are calculated by the percentage of TB cases by race that die during the year of their diagnosis.



The workload in the TB Control Program consists of four categories of patients:

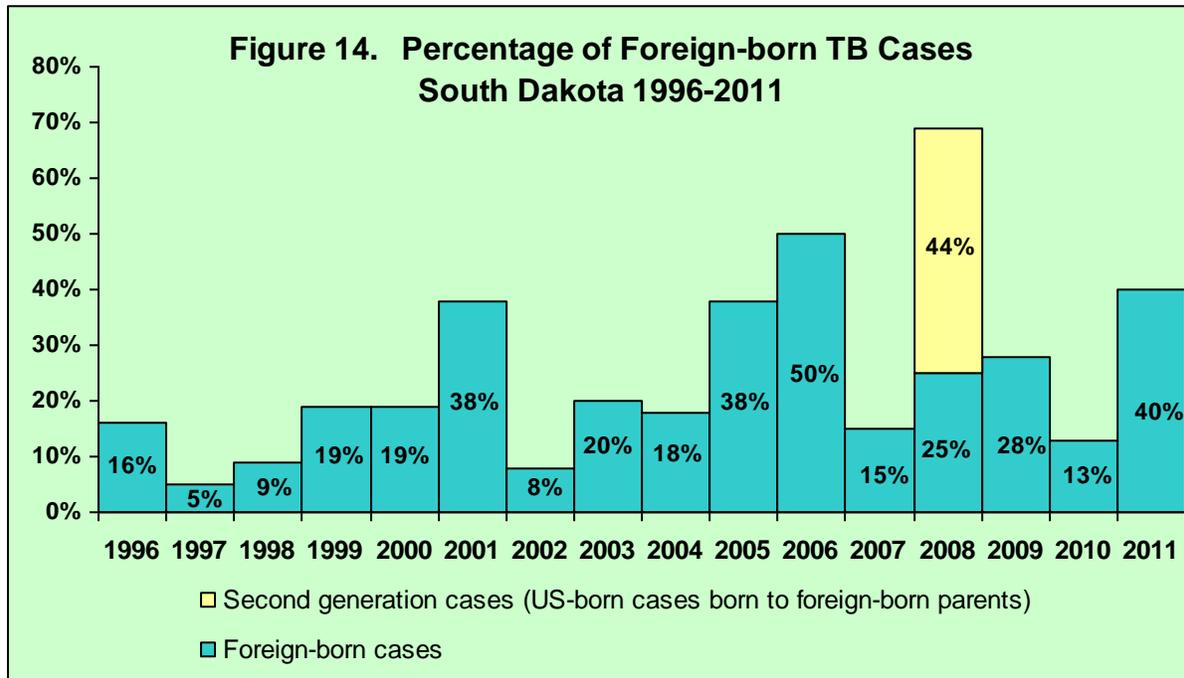
- 1) **TB cases** (persons diagnosed with active TB)
- 2) **TB suspects** (persons suspected of active TB with a pending diagnosis)
- 3) **TB contacts** (persons exposed to an infectious TB case)
- 4) **Latent TB infection** (persons reported with a positive TB skin test or positive IGRA test [interferon gamma release assay])

Disease Intervention Specialist (DIS) staff are responsible for ensuring appropriate investigation, treatment and follow-up of these individuals statewide. Figure 13 describes this cumulative caseload which is divided among 19 DIS staff illustrating that the active TB cases and suspect TB cases represent the smallest number of patients reported. TB contacts and patients with latent TB infection make up the greatest percentage of assigned workload for DIS staff within the TB Control Program.

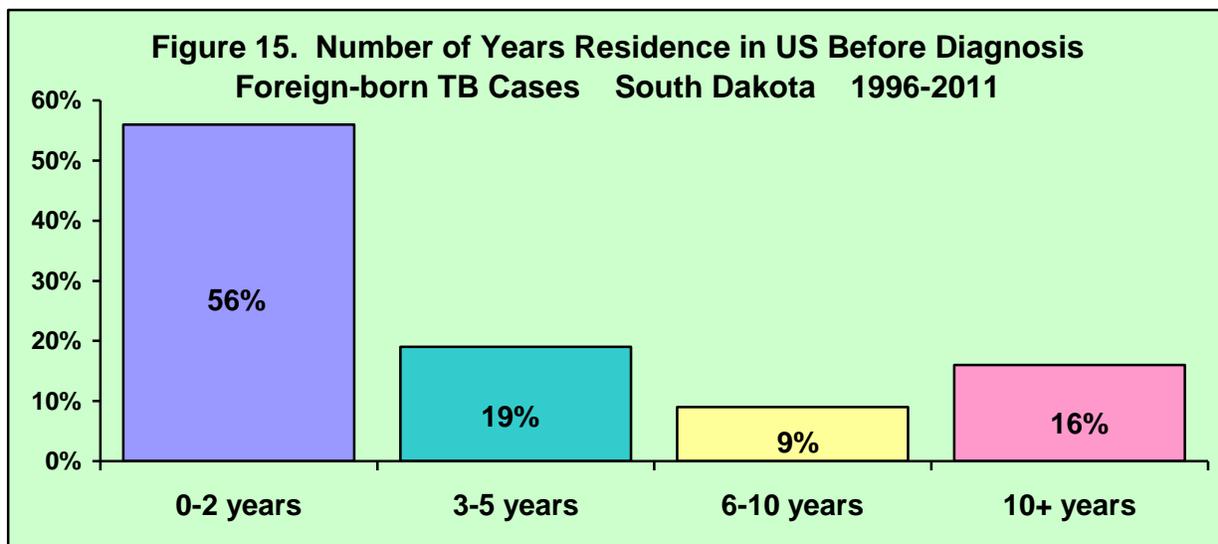


## Analysis of Foreign-born TB Cases in South Dakota

Tuberculosis cases who were born outside the United States continue to represent an important risk group in the United States as well as in South Dakota. Figure 14 describes the percentage of foreign-born TB cases in South Dakota. Second generation TB cases (US-born TB cases born to foreign-born parents) are a relatively new risk group that has been identified nationally. TB cases were first reported in this group in South Dakota in 2008.

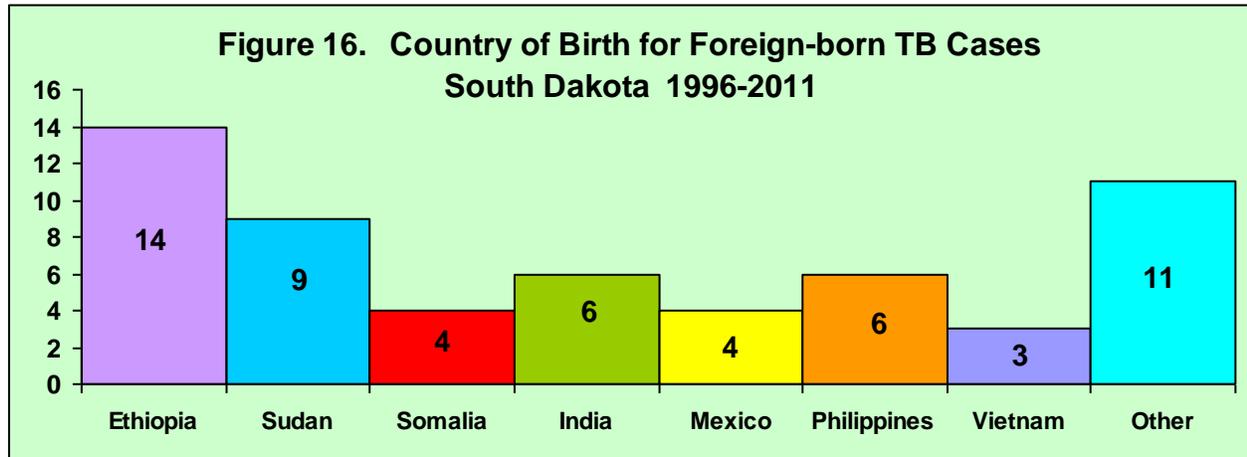


Most foreign-born persons who develop active TB usually do so within the first 2 years after arrival in the United States. Figure 15 describes that 75% of foreign-born TB cases since 1996 developed active TB within the first 5 years of their arrival. Because of this increased risk, these individuals are targeted for preventive TB program activities including targeted TB skin testing and preventive treatment programs.

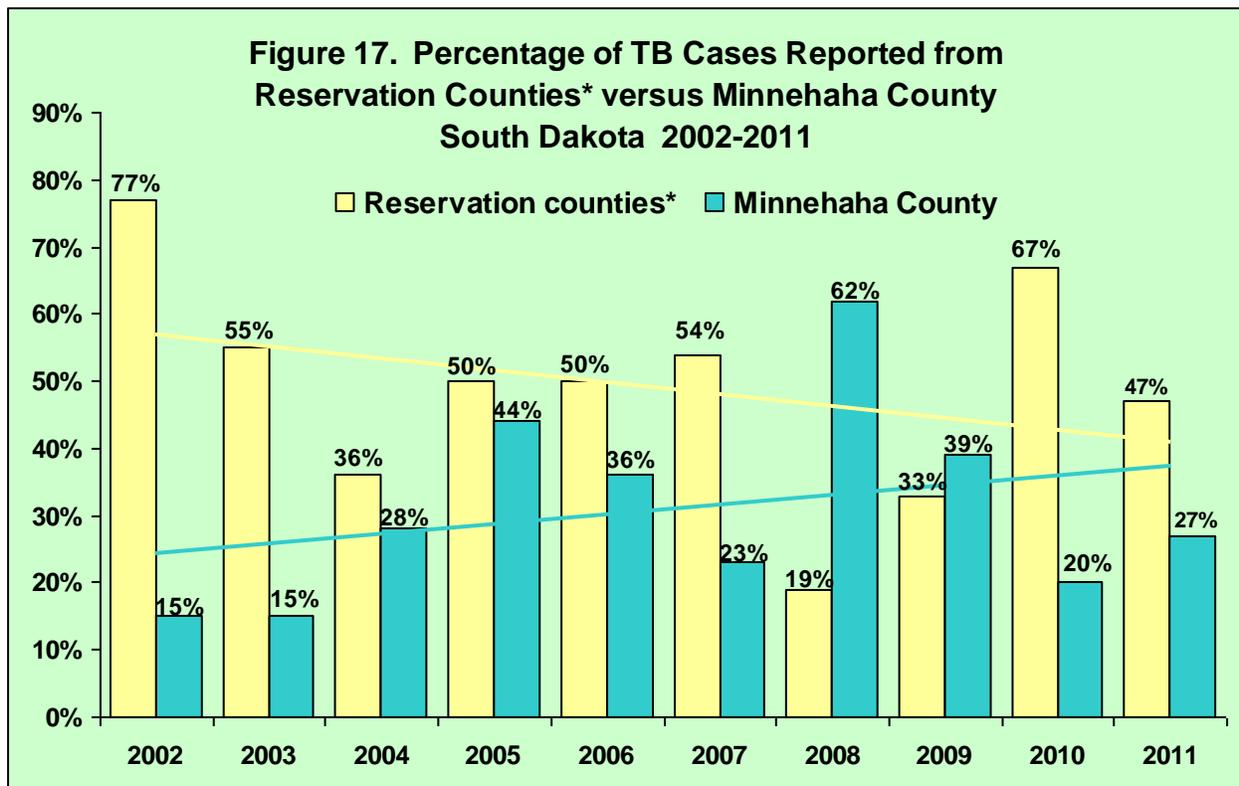


Foreign-born TB cases continue to come from many areas of the world however the majority of the TB cases reported in South Dakota are of African descent. Figure 16 describes the country of

birth for the foreign-born TB cases reported in South Dakota since 1996. Countries of birth for the “other” category include Afghanistan, China, El Salvador, Indonesia, Romania, Russia, South Africa, Nepal and Mauritania.

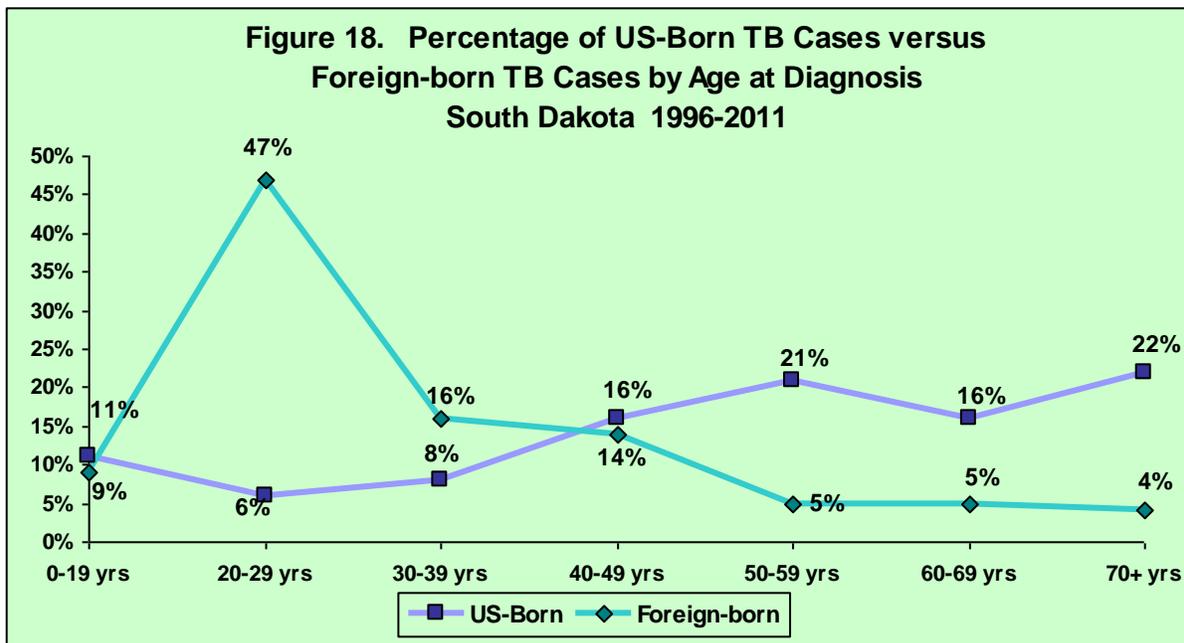


Another factor in the increase of foreign-born TB cases in South Dakota is the change in geography where TB cases are reported. Historically, the highest percentage of TB cases were reported from counties that included and bordered American Indian Reservations. As Native American TB cases decreased and foreign-born TB cases increased, there has been a geographic shift of TB cases from reservation counties to Minnehaha County as illustrated in Figure 17. This is due to the fact that most foreign-born persons who resettle in South Dakota do so in Minnehaha County.

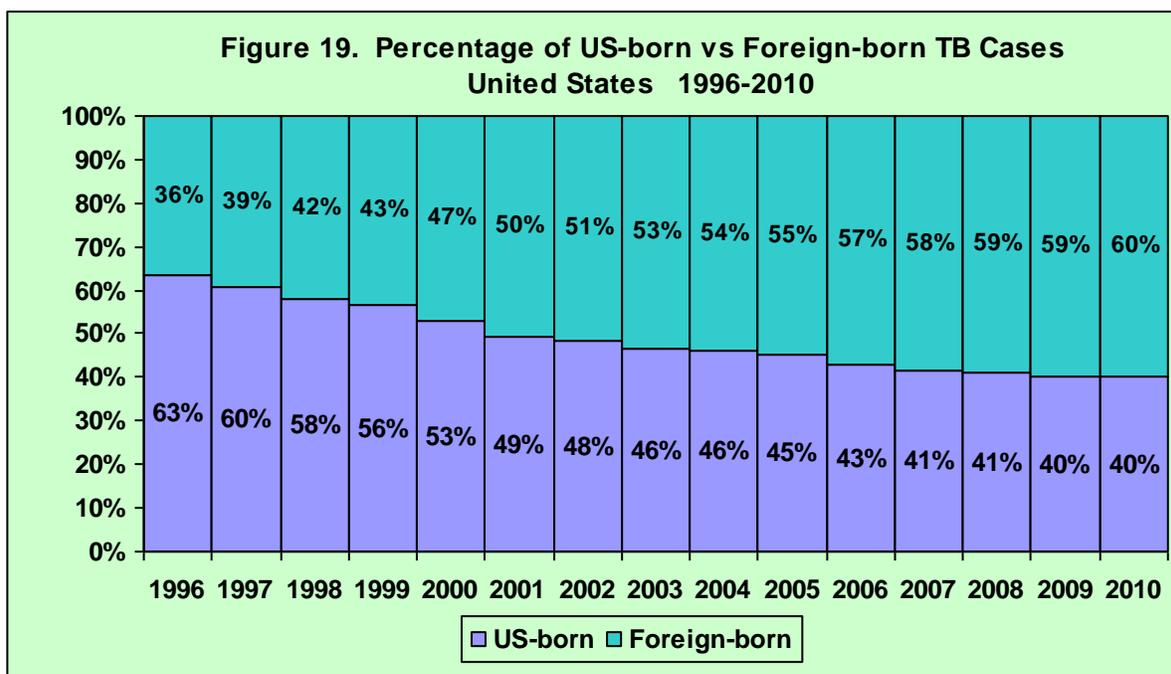


\* Reservation counties include Bennett, Brule, Buffalo, Charles Mix, Corson, Dewey, Jackson, Mellette, Moody, Pennington, Roberts, Shannon, Todd, Tripp, Walworth and Ziebach.

Foreign-born TB cases are consistently reported in younger persons as compared to US born patients in South Dakota. This presents additional TB program management issues as these TB cases more commonly have young children who have been exposed at home and are typically employed requiring an investigation at their worksite which increases the number of contacts that must be screened and treated. Figure 18 illustrates that the majority of foreign-born TB cases are diagnosed while young adults.



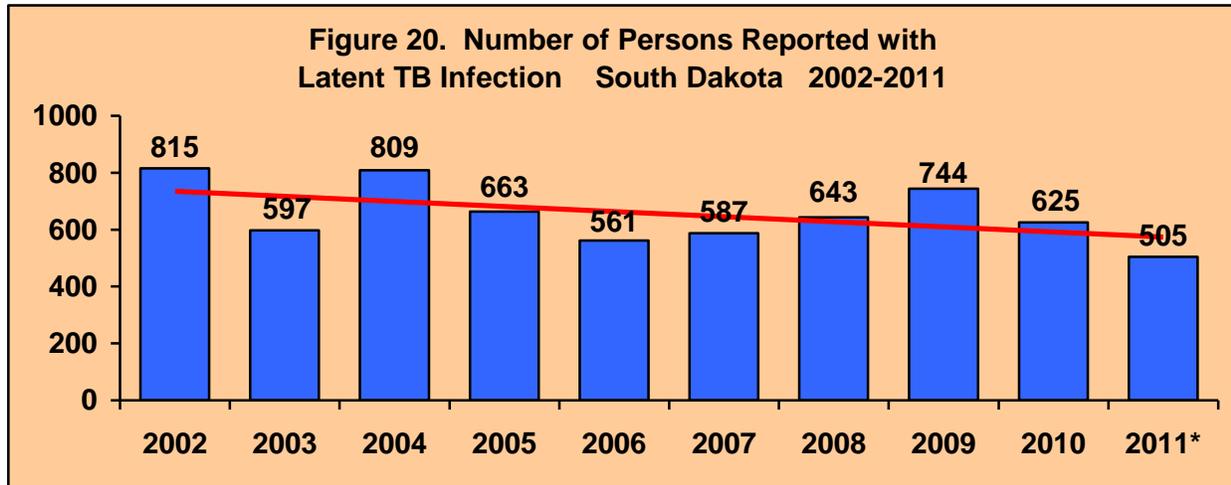
Foreign-born TB cases represent a unique challenge to the South Dakota TB Control Program because of cultural issues, language barriers and a greater likelihood of drug resistance. As these cases continue to increase in South Dakota, additional time and resources will need to be dedicated to address these unique issues. Figure 19 describes the ever increasing trend of the percentage of foreign-born TB in the United States since 1996.



## Latent TB Infection and Prevention Activities

Ensuring for appropriate treatment and follow-up of active TB cases and suspects is the highest priority of the Tuberculosis Control Program. However, in order to achieve TB elimination in South Dakota, an emphasis must be made on preventing future cases of TB. This is accomplished by follow-up of persons infected with latent TB infection. These individuals are infected with the TB bacteria (*Mycobacterium tuberculosis*) but have not yet developed an active form of the disease. By finding and treating these individuals, future TB cases can be prevented and therefore the TB Control Program dedicates time and resources to this preventive strategy.

Figure 20 presents the number of patients reported with latent TB infection (positive TB skin tests or positive IGRA testing) over the last 10 years. All of these individuals have the potential to develop active TB disease and potentially be infectious to others.



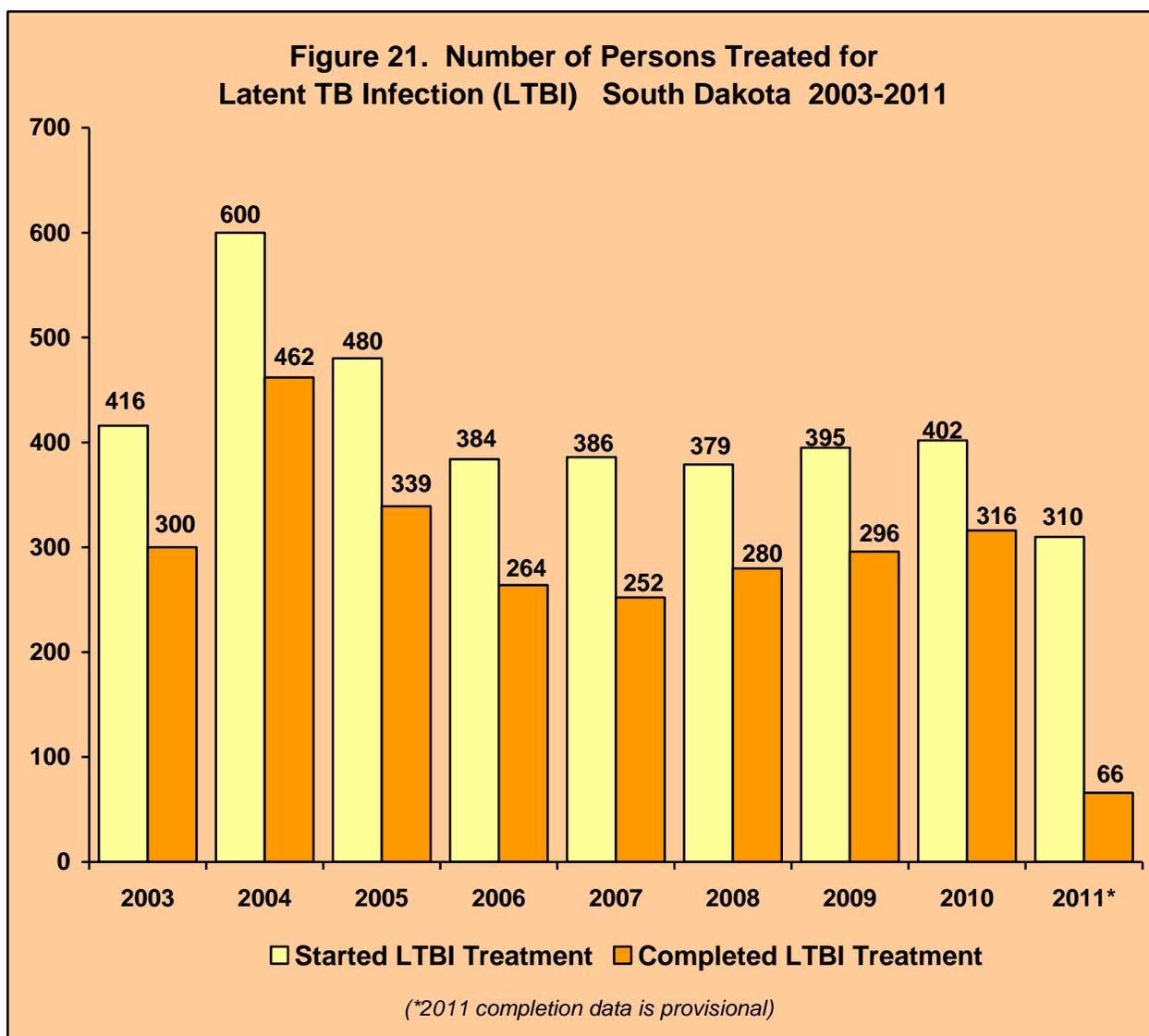
\* Decreased LTBI reports are in part due to a change in the reporting requirement for latent TB infection on 8-2-2011.

On August 2, 2011, the South Dakota Department of Health implemented an administrative rule change which changed the reporting requirement for latent TB infection. Prior to that, all persons diagnosed with latent TB infection were reportable to the South Dakota Department of Health. As of August 2, 2011, only patients with latent TB infection who have at least one of the following TB risk factors are now reportable:

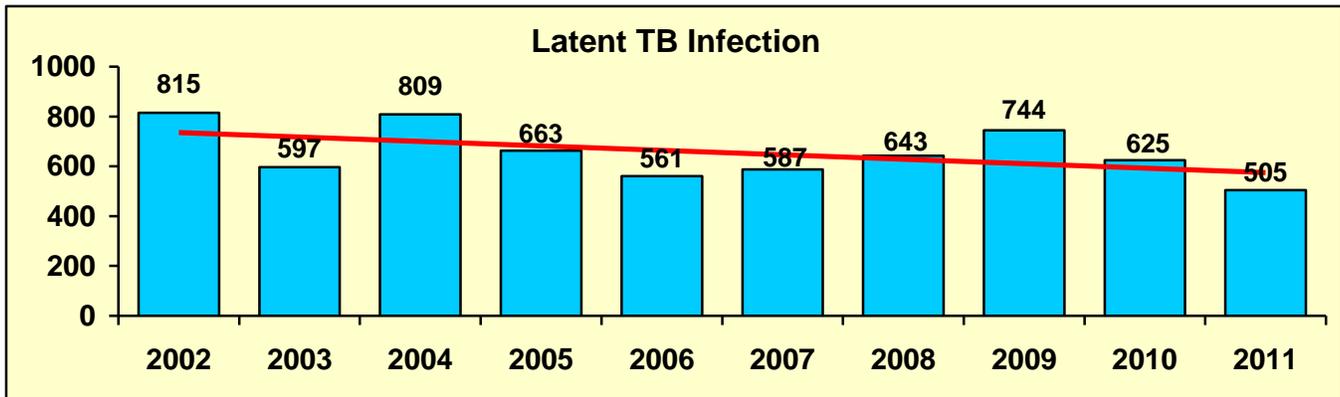
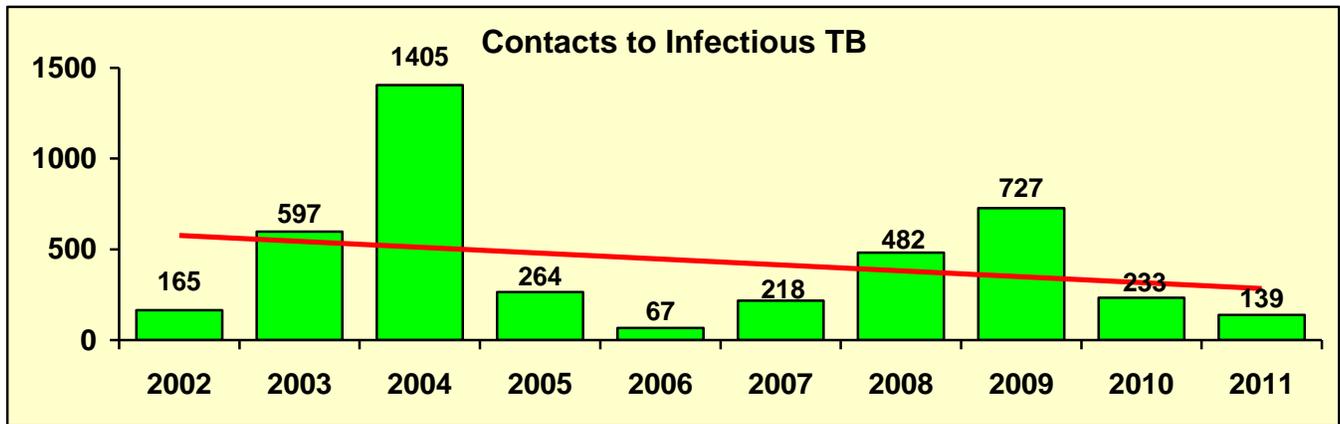
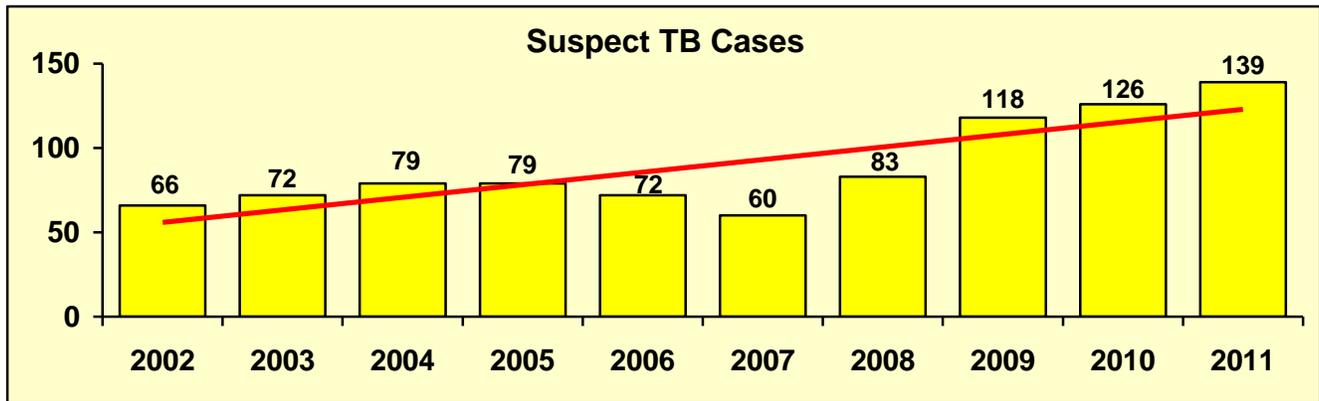
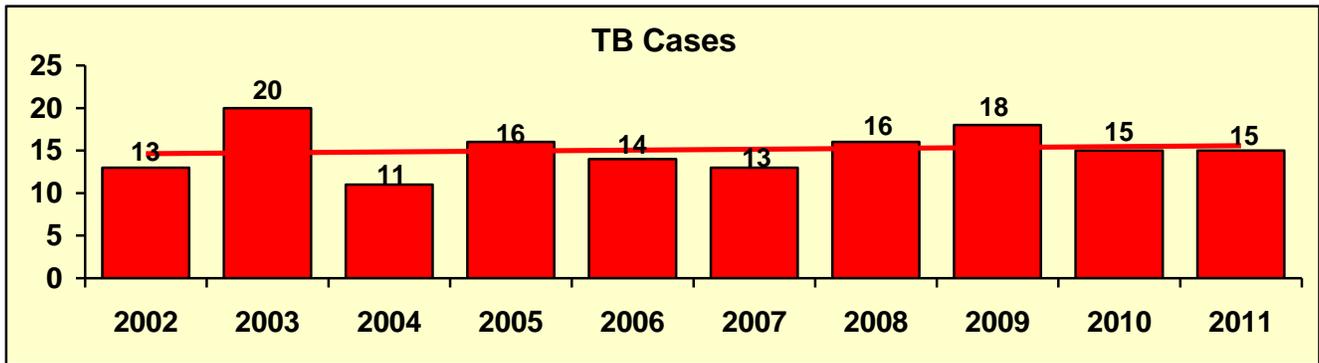
<b>REPORTABLE TB RISK FACTORS</b>	
+	Foreign-born persons who entered the US within the last 5 years
+	Persons evaluated for tumor necrosis factor-alpha therapy
+	Immunosuppressive therapies (i.e. high dose steroids)
+	Radiographic evidence of prior TB
+	Children less than 5 years of age
+	Close contact to infectious TB
+	HIV infection
+	Diabetes
+	Renal dialysis
+	Silicosis
+	Organ transplant
+	Head and neck cancers
+	Leukemia
+	Hodgkin's disease

This reporting change will allow the Department of Health to focus staff time, medication and resources towards those patients who have the highest risk of developing active tuberculosis. Due to this change, only the above patients will be eligible for Department of Health nurse case management and medication. Health care providers and facilities are asked to report only patient with LTBI who meet this new reporting requirement by mailing or faxing the “*Latent Tuberculosis infection Report Form*” to the TB Control Program (reporting instructions are on the form). The form is available on the South Dakota Department of Health website: [www.doh.sd.gov/tb](http://www.doh.sd.gov/tb). Patients who do not meet this reporting criteria should be referred to their private health care provider for evaluation and treatment at their own expense. All patients currently being managed by Department of health staff will be allowed to finish their prescribed course of treatment regardless of their risk factor status.

Figure 21 presents the number of patients with latent TB infection that started a course of preventive treatment as well as the number who completed this treatment. The treatment is usually done with Isoniazid (INH) which is provided free of charge to patients by the TB Control Program.



Summary of TB Control Program Caseload South Dakota 2002-2011



## Governor's Task Force on Infant Mortality makes recommendations

On December 15, 2011, the Governor's Task Force on Infant Mortality presented its final report Gov. Dennis Daugaard, recommending such things as improved access to early prenatal care and increased awareness of safe sleep practices for infants.

The group's recommendations and strategies are reprinted below. The full report of the South Dakota Governor's Task Force on Infant Mortality can be found on the Department of Health website at [http://doh.sd.gov/InfantMortality/documents/final\\_report.pdf](http://doh.sd.gov/InfantMortality/documents/final_report.pdf).

### RECOMMENDATIONS AND STRATEGIES

During his 2011 State of the State address, Governor Dennis Daugaard committed to addressing the problem of infant mortality in South Dakota. In May 2011, the Governor appointed a 27-member Task Force on Infant Mortality chaired by the First Lady Linda Daugaard to study infant mortality and recommend strategies to improve birth outcomes and infant health in South Dakota. Task force members were a diverse group from rural and urban areas across the state representing family physicians, obstetricians, neonatologists, perinatologists, pediatricians, forensic pathologists, nurses, nurse midwives, nurse practitioners, hospitals, rural clinics, social work, the School of Medicine, Aberdeen Area Indian Health Services (IHS), Great Plains Tribal Epidemiology Center and state agencies.

The Task Force met throughout the summer and fall of 2011 with meetings held across the state – Sioux Falls, Rapid City, and Pierre – to allow for task force members to receive input from the public. Three subcommittees were established to specifically look at the issues of prenatal care, alcohol and tobacco use, and Sudden Infant Death (SIDS)/Sudden Unexplained Infant Death (SUID). The subcommittees were charged with identifying best practices in South Dakota and nationally that could be adapted or replicated statewide, identifying potential data gaps, and looking at clinical recommendations for consideration by the full Task Force.

#### South Dakota Infant Mortality Task Force Goals

- Reduce infant mortality rate to 6.0 per 1,000 live births by 2015
- Reduce neonatal mortality rate to 4.1 per 1,000 live births by 2015
- Reduce postneonatal mortality rate to 2.0 per 1,000 live births by 2015
- Increase the percent of women who receive first trimester prenatal care to 77.8% by 2015
- Reduce the percent of women who smoke during pregnancy to 15% by 2015

Throughout the Task Force's discussions, four overarching themes were identified that need to be incorporated into any recommendation or strategy in order to improve birth outcomes and health of infants in South Dakota. These themes include:



- Work in partnership
- Recognize cultural diversity
- Use evidence-based interventions
- Reduce health disparities

The Governor's Task Force on Infant Mortality developed six recommendations and accompanying strategies to reduce the state's infant mortality rate. Because South Dakota has a

disproportionate number of its infants dying in the postneonatal period, many of the recommendations and strategies of the Task Force focus on providing a safe, healthy environment for the baby once home from the hospital.

Infant mortality is a complex issue. The recommendations and accompanying strategies of the Task Force presented in this report are intended to be a starting point for action by state government, health care providers, hospitals, tribes, parents, communities, and others to reduce infant mortality and improve infant health in South Dakota.

## RECOMMENDATION 1

### Improve access to early, comprehensive prenatal care

Early and regular prenatal care is an important part of improving pregnancy and health outcomes for the mother and baby. Regular prenatal care helps the health care provider monitor the pregnancy and identify and manage any potential health problems (i.e., gestational diabetes, preeclampsia) before they become serious.

#### *Strategies:*

- Pilot alternative models of delivery of prenatal care in rural South Dakota
- Replicate and expand best practice systems of prenatal care for pregnant women with chronic health conditions to ensure appropriate management of conditions to optimize birth outcomes
- Screen all pregnant women for tobacco, alcohol and drug use, mental health and domestic violence throughout pregnancy and provide support and referral to appropriate services
- Improve access to perinatology and neonatology services via regionalized systems of care
- Identify transportation assistance options for pregnant women to attend prenatal care visits
- Promote preconception and interconception education and care to women of childbearing age



## RECOMMENDATION 2

### Promote awareness and implementation of safe sleep practices



Safe sleep environments can lower the risk for sleep-related infant deaths, including SIDS/SUID. There are many preventive steps parents can take to ensure a safe sleep environment for their baby including placing the baby on their back to sleep, eliminating bed sharing, using a firm sleep surface with only a fitted sheet, removing soft objects and loose bedding from the crib (i.e., pillows, stuffed animals, bumper pads, quilts, etc.), prohibiting smoking around the baby, and avoiding overheating of the baby. Parents should also make sure everyone caring for their baby knows and follows these steps.

#### *Strategies:*

- Develop a crib distribution program for families in need of a safe sleep environment for their infant

- Develop a comprehensive, culturally diverse safe sleep education program to reduce the risk of injury and death of infants due to unsafe sleep practices
- Partner with health profession associations, healthcare providers, community organizations, worksites, senior centers, and child care to distribute safe sleep information throughout Communities

### RECOMMENDATION 3

#### Develop community-based systems of support for mothers and families

Community-based systems of care help remove barriers and connect pregnant women and families to the resources they need during pregnancy and after delivery. These resources make it more likely their baby will be born healthy and cared for in a positive, safe home environment.

##### *Strategies*

:

- Expand nurse home visiting programs to meet the needs of women, infants, and their families who are at high risk of poor birth outcome
- Seek partners and resources to expand incentive programs for pregnant and parenting women and families
- Encourage parents to seek ongoing primary and preventive care for their baby (i.e., immunizations, well baby check-ups, etc.)
- Identify transportation assistance options for mothers and families to attend well baby care visits
- Provide resources and education to parents and caregivers regarding infant crying and appropriate responses
- Facilitate access to appropriate services for tobacco use, alcohol/substance abuse, mental health, and domestic violence
- Provide breastfeeding support and education to new mothers and promote adoption of policies for breastfeeding in worksites



### RECOMMENDATION 4

#### Conduct statewide education campaigns to reduce infant mortality



Public education campaigns help to create awareness, change attitudes, and motivate individuals and communities to engage in healthy behavior with the overall intent of reducing infant mortality. Successful campaigns target specific audiences taking into account the unique preferences and needs of each target population.

##### *Strategies:*

- Develop a statewide campaign to increase awareness of safe sleep recommendations for parents, grandparents, caregivers, and childcare providers
- Provide education for school-age children in out-of-school time and community-based organizations regarding alcohol/substance abuse, tobacco use, and healthy lifestyles
- Develop public education messages regarding pregnancy awareness and the importance of early and regular prenatal care

- Support ongoing messages and training regarding child safety seats, traumatic head injury/shaken baby syndrome, and other injury prevention efforts
- Develop public messaging to increase awareness of the effects of tobacco, alcohol, and drugs on pregnancy outcomes and infant mortality
- Utilize social media (i.e., texting, Facebook, Twitter, internet, etc.) to provide information regarding healthy behaviors before, during and after pregnancy

## RECOMMENDATION 5

### Develop resources for health professionals specific to infant mortality prevention

Health care professionals can have a significant influence on patients and their behaviors. Recent studies show that even brief advice from a patient’s provider resulted in patient action or change. It is also important for health care providers to understand how social, cultural, and environmental factors impact pregnant women and families seeking pregnancy and infant care and have the necessary resources to respond to identified needs.



#### *Strategies:*

- Conduct series of Grand Rounds focused on neonatal, obstetric, and infant care (i.e., safe sleep practices, immunizations, etc.)
- Develop series of updates related to preconception, prenatal, and infant care (i.e., safe sleep practice, immunizations, etc.), for professional journals, newsletters, listservs, websites, etc.
- Develop resources for healthcare providers to screen and refer patients for tobacco, alcohol/drug use/addiction, mental health, and domestic violence
- Model safe sleep practices in hospitals

## RECOMMENDATION 6

### Improve data collection and analysis

Data is needed to identify and target the underlying causes of infant mortality in South Dakota and the populations most at risk as well as to monitor progress and evaluate programs and interventions. While vital records data can provide detailed information about an infant birth or death, additional data sources must be identified and enhanced to look at other medical, social, and environmental factors that can lead to infant mortality.

#### *Strategies:*

- Expand South Dakota’s established infant mortality review committees to include areas not currently served
- Enhance technical assistance available to health care providers when completing birth and infant death certificates
- Enhance county coroner training to include death certificate completion
- Provide training on infant death scene investigations for county coroners and law enforcement
- Enhance state and county-level data regarding pregnancy experiences, risks, barriers, outcomes, and infant care practice

# SOUTH DAKOTA HIV/AIDS SURVEILLANCE REPORT

JANUARY 2012

21 New HIV/AIDS cases were reported in 2011.

13 Males  
8 Females

405 people are estimated to be living with HIV/AIDS in South Dakota.

Disproportionately impacted by HIV/AIDS:

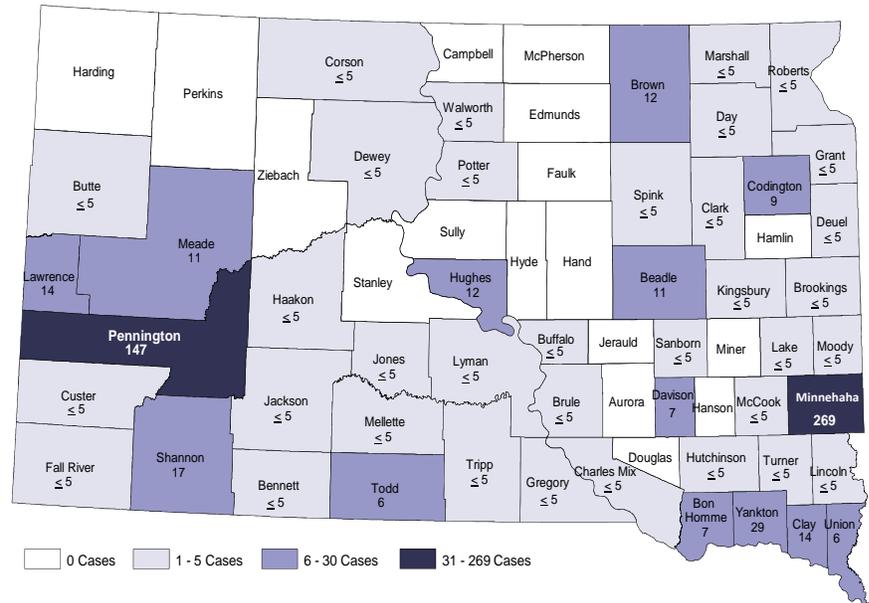
Blacks: 23% of living cases  
<1% of the population

Native Americans: 15% of living cases, 9% of population

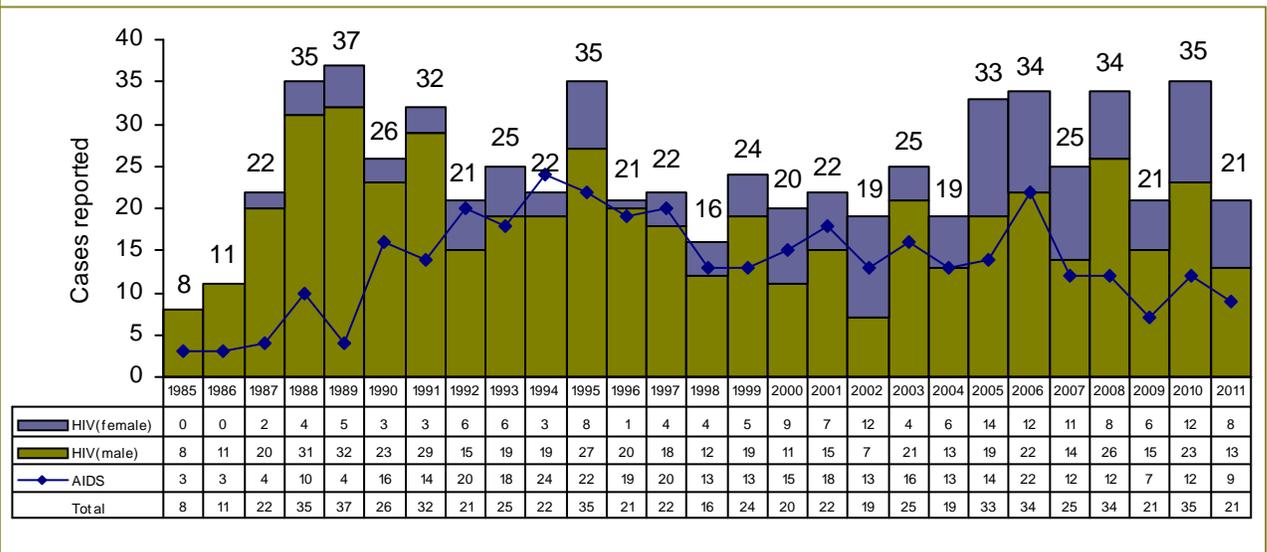
665 Cumulative cases of HIV/AIDS were reported in South Dakota from 1985-2011.

South Dakota HIV/AIDS Web site:  
<http://doh.sd.gov/Disease/statistics.aspx>

South Dakota Residents Reported Infected with HIV/AIDS: Cumulative Cases by County, 1985 - 2011



South Dakota Residents by Gender Infected with HIV and AIDS, 1985-2011



At the end of 2011, 665 SD residents had been reported as infected with HIV (500 male, 164 female) and 366 of those had also been diagnosed with AIDS. Some cases may have been reported as an HIV case in a different year than they were diagnosed with AIDS.

**Routine Interstate Duplicate Review (RIDR)** Interstate duplicate review initiated by the CDC in 2004, compares patient records throughout the nation to identify duplicate cases. Because of this process, the cumulative number of cases within South Dakota may change.



## Characteristics of South Dakota HIV/AIDS Infected Persons as of December 31, 2011



	Total HIV/AIDS Diagnoses <i>Total number of persons diagnosed with HIV or AIDS (1985-2011)</i>		Persons Living with HIV/AIDS <i>Minimum estimate of persons living with HIV or AIDS</i>		Department of Health Confidential HIV Testing Centers <i>or call Toll Free 1-800-592-1861</i>
	Cases	Percent	Cases	Percent	
<b>TOTAL</b>	665	100%	405	100%	<b>Aberdeen</b> 402 S. Main St. Aberdeen, SD 57401 605-626-2373 1-866-805-1007
<b>Sex</b>					<b>Rapid City</b> 909 E. St. Patrick Rapid City, SD 57701 605-394-2289 1-866-474-8221
Female	164	25%	120	30%	<b>Watertown</b> 2001 9th Avenue SW., Ste. 500 Watertown, SD 57201 605-882-5096 1-866-817-4090
Male	501	75%	285	70%	<b>Sioux Falls</b> 1200 N. West Ave. Sioux Falls, SD 57104 605-367-5365 1-866-315-9214
<b>Race and Ethnicity</b>					<b>Pierre</b> 302 E Dakota Pierre, SD 57501 605-773-5348 1-866-229-4927
American Indian	119	18%	60	15%	<b>Dupree</b> Ziebach County Court House Dupree, SD 57623 605-365-5164 1-866-778-5157
Black	110	17%	94	23%	<b>CDC HOTLINE</b> <b>1-800-232-4636</b>
Hispanic and Other **	19	2%	19	5%	The South Dakota Department of Health is authorized by SDCL 34-22-12 and ARSD 44:20 to collect and process mandatory reports of communicable diseases.
White	417	63%	232	57%	<b>How to report:</b> Secure Website: <a href="http://www.state.sd.us/doh/diseasereport">www.state.sd.us/doh/diseasereport</a>
<b>Country of Origin</b>					Telephone: 1-800-592-1804 (Confidential answering device) or 1-800-592-1861 or 605-773-3737
United States	585	88%	331	82%	
Other	80	12%	74	18%	
<b>Age Group</b>	<b>(Age at HIV Diagnosis)</b>		<b>(Age December 31, 2011)</b>		
< 2 years	9	1%	0	0%	
2-12 years	8	1%	6	1%	
13-24 years	91	14%	8	2%	
25-44 years	430	65%	177	44%	
45-65 years	124	18%	201	50%	
>65 years	3	1%	13	3%	
<b>Exposure Category</b>					
Heterosexual	147	22%	122	30%	
IDU (Injection Drug User)	95	14%	60	15%	
MSM (Men who have Sex with Men)	279	42%	147	36%	
MSM & IDU	28	4%	11	3%	
Perinatal/Pediatric	12	2%	7	2%	
Transfusion/Hemophilia	20	3%	10	2%	
Unspecified	84	13%	48	12%	
<b>HIV Prevention Region</b>					
Central	62	9%	30	8%	
Northeast	63	10%	37	9%	
Southeast	325	49%	234	58%	
West	206	31%	104	25%	
Unknown/Other***	9	1%	0	0%	

\*\*Hispanic and Other denotes cases that are Asian, Hispanic, or Multi-race.

\*\*\*Unknown/Other denotes cases in which the HIV/AIDS county is unknown or in a state other than South Dakota.

Questions regarding the surveillance report may be directed to Christine Olson 605-773-3737 or [Christine.Olson@state.sd.us](mailto:Christine.Olson@state.sd.us).

**South Dakota Department of Health  
Infectious Disease Surveillance**

**Morbidity Report, 1 January – 31 Dec 2011**

(provisional numbers) see <http://doh.sd.gov/ID/site.aspx>

Disease		2011 year- to-date	5-year median	Percent change
<b>Vaccine-Preventable Diseases</b>	Diphtheria	0	0	n/a
	Tetanus	0	0	n/a
	Pertussis	32	58	-45%
	Poliomyelitis	0	0	n/a
	Measles	0	2	n/a
	Mumps	0	2	n/a
	Rubella	0	0	n/a
	<i>Haemophilus influenzae</i> type b	1	0	n/a
<b>Sexually Transmitted Infections and Blood-borne Diseases</b>	HIV infection	20	34	-41%
	Hepatitis B, acute	1	4	-75%
	Chlamydia	3,177	2,942	8%
	Gonorrhea	573	367	56%
	Syphilis, early	0	4	n/a
<b>Tuberculosis</b>	Tuberculosis	15	15	0%
<b>Invasive Bacterial Diseases</b>	Meningococcal, invasive	3	3	0%
	Invasive Group A <i>Streptococcus</i>	22	22	0%
<b>Enteric Diseases</b>	<i>E. coli</i> , Shiga toxin-producing	38	50	-24%
	Campylobacteriosis	295	262	13%
	Salmonellosis	159	172	-8%
	Shigellosis	6	76	-93%
	Giardiasis	109	102	7%
	Cryptosporidiosis	142	108	31%
	Hepatitis A	2	3	-33%
<b>Vector-borne Diseases</b>	Animal Rabies	40	32	25%
	Tularemia	8	7	14%
	Rocky Mountain Spotted Fever	1	2	-50%
	Malaria (imported)	2	1	-50%
	Hantavirus Pulmonary Syndrome	1	0	n/a
	Lyme disease	4	1	n/a
	West Nile Virus disease	2	39	-95%
<b>Other Diseases</b>	Legionellosis	2	4	-50%
	<i>Streptococcus pneumoniae</i> , invasive	41	0	n/a
	Additionally, the following were reported: Chicken Pox (58); Erlichiosis (3); Haemophilus influenzae b (1) Hepatitis B, chronic (44); Hepatitis C, chronic (274); Listeria (1); MRSA, invasive (86), Strep B, invasive (12); Q Fever (2)			

Communicable diseases are obligatorily reportable by physicians, hospitals, laboratories, and institutions.

The **Reportable Diseases List** is found at <http://doh.sd.gov/Disease/report.aspx> or upon request.

Diseases are reportable by telephone, fax, mail, website, or courier.

**Secure website:** [www.state.sd.us/doh/diseasereport](http://www.state.sd.us/doh/diseasereport)

**Telephones:** 24 hour answering device 1-800-592-1804; for a live person at any time call 1-800-592-1861; after hours emergency 605-280-4810. **Fax** 605-773-5509.

**Mail** in a sealed envelope addressed to the DOH, Office of Disease Prevention, 615 E. 4th Street, Pierre, SD 57501, marked "Confidential Medical Report".

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