Preliminary 2024

ANNUAL TUBERCULOSIS
SURVEILLANCE REPORT

ALABAMA DEPARTMENT OF PUBLIC HEALTH (ADPH)

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Acknowledgement

We would like to thank the district health office TB managers and coordinators, county health department staff, and state TB surveillance staff who collected and reported the data used in this annual report.

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Data Sources

1) Surveillance data were obtained from the Alabama NEDSS-Based System (ALNBS) as of June 23, 2025; 2) Population data were obtained from the Alabama Department of Public Health Vital Statistics Division that is reported annually to the U.S Census Bureau July of the following year

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Tuberculosis: Brief Overview and Quick Facts

Description and Background

Tuberculosis (TB) is a disease caused by the bacterium, *Mycobacterium tuberculosis,* and can spread from person to person through droplets of saliva after a person infected with active TB coughs, sings, talk, or projects their voice in any other way. TB typically affects the lungs, but it can also affect other parts of the body, such as the brain, bone, kidneys, or other soft tissues or organs. A person with active TB can die if treatment is not provided. Not everyone that is infected with the TB bacteria becomes sick with disease. Persons who do have symptoms- such as a cough, fever, night sweats, weight loss, chest pain, or fatigue – are most likely suffering from TB disease. Those with TB disease may be infectious. Prompt treatment is essential to end symptoms and prevent disability or death. Those who are infected with TB bacteria but do not have any symptoms and have a normal chest radiograph have latent TB infection (LTBI). Those with LTBI still require treatment to decrease the risk of developing active TB disease.

TB Screening and Treatment

There are two tests that can be used to help detect the presence of TB bacteria within host: a tuberculin skin test (TST) or an interferon gamma release assay (IGRA) blood test. The TST is performed by injecting a small amount of tuberculin purified protein derivative (PPD) into the skin in the forearm. Tested individuals must return 48 to 72 hours to have a trained health care worker look for a reaction on the arm and determine if the TST is positive or negative for TB infection. In recent years, blood tests known as interferon gamma release assays (IGRAs) have been developed to screen for TB. White blood cells release interferon gamma (IFN-g) in response to contact with TB antigens. If the test result is positive, there is an immune response indicating the presence of TB bacteria.

Treating TB disease generally requires up to four medications given for a minimum of six months. Treating individuals with drug-resistant TB requires costly medications that may be used for an extended period. LTBI can be treated with one of the short course regimens listed below:

- Six or nine months of daily INH (6H/9H)
- Three months of once-weekly isoniazid plus rifapentine (3HP)
- Four months of daily rifampin (4R)
- Three months of daily isoniazid plus rifampin (3HR)

Short-course treatment regimens for LTBI given over 3-4 months tend to have higher completion rates and less hepatoxicity than 6-9 months of Isoniazid (INH) monotherapy (6H/9H). Treatment of persons suspected of TB varies according to the outcome of their diagnostic tests.

Executive Summary

A total of 90 active TB cases were reported in Alabama in 2024, representing a 2.17% decrease from 92 cases in 2023. In 2024, Alabama had a TB incidence rate of 1.7 TB cases per 100,000 persons, representing a 5.6% increase from the previous year's (2023) incidence rate of 1.8 TB cases per 100,000 persons. (Figure 1).

In 2024, TB incidence rates by public health district ranged from 0.5 cases per 100,000 persons in the Southwestern public health district to 2.4 cases per 100,000 persons in the Northern public health district. Three health districts (Northern, Northeastern, and West Central) reported higher incidence rate than the overall state incidence rate for 2024 (Table 2). Northern and Northeastern public health districts reported 29 & 18 cases respectively in 2024, accounting for 52.2% of reported cases statewide (Table 2).

Of the 90 active TB cases reported in Alabama in 2024, 50 (55.5%) were non-U.S.- born (Figure 7). The top three countries of origin for non-U.S.- born persons reported with active TB disease in Alabama were Guatemala, Mexico, and India (Figure 8). Active TB cases among persons born in these countries accounted for 50% (25) of the total cases among non-U.S.- born persons in Alabama.

HIV status was reported for 95.3% of Alabama active TB cases in 2024. Among the 82 cases with a known HIV status, four were reported as positive for HIV infection (Figure 9).

Persons living in congregate settings such as prisons, long term care facilities, homeless shelters etc., are at high risk for TB bacteria exposure. In 2024, 7 cases (7.8%) cases reported experiencing homelessness within the twelve months before diagnosis, 6 cases (6.7%) were diagnosed with active TB while residing in a correctional facility, and 16 cases reported substance abuse (17.8%) (Figure 10). In 2024, there was zero cases of multidrug-resistant TB (resistant to Isoniazid (INH), RIFAMPIN (RIF), Pyrazinamide (PZA), and Ethambutol (EMB), 3 cases resistant to INH, and 2 case resistant to PZA diagnosed in Alabama (Table 4).

In 2024, Alabama completed 47 contact investigations on active TB cases. Among the 3,281 identified contacts of active TB cases reported, 2,819 (85.9%) completed a medical evaluation, and 245 (8.7%) were diagnosed with latent tuberculosis infection (LTBI). Of the 245 contacts diagnosed with LTBI, 211 (86.1%) started LTBI treatment and, of those, 42 (19.9%) completed LTBI treatment. * (Table 8)

*All 2024 contact investigation data is preliminary until March 2026

TB Surveillance in Alabama

TB is a nationally notifiable disease. All Alabama physicians, laboratories, and other health care providers are required by law to immediately report clinical and laboratory- confirmed TB cases under their care to Alabama public health authorities. TB cases may be directly reported to a county health department, a district health office, or to the state TB program central office. The TB epidemiology section of the ADPH is responsible for the systematic collection of all reported TB cases in the state. Immediate reporting of TB cases enables public health staff to follow up with patients, administer directly observed therapy (DOT), monitor TB treatment until completion, evaluate, and screen contacts of a TB case, and control TB outbreaks.

TB cases in Alabama are reported electronically through Alabama NEDSS-Based System (ALNBS), a secure web-based surveillance software specific to ADPH.

Public health authorities collect demographic, clinical, and risk factor data for reported TB cases and their contacts. Cases are counted in the jurisdiction in which they reside at the time of diagnosis. Total case counts may change slightly as information is verified. These data are analyzed to describe the distribution of the disease, trends in morbidity, mortality & drug resistance, treatment outcomes, clusters of TB cases, and infection rates among high-risk groups and contacts to TB cases in the state. These data are used at the state and local level to guide policy and decision making, set priorities for program interventions, evaluate program performance for the prevention and control of TB in Alabama, and educate key stakeholders and the general public on TB. Alabama's TB surveillance data are transmitted electronically to the U.S. Centers for Disease Control and Prevention (CDC) through the report of verified case of TB (RVCT) form and become part of the national TB surveillance database.

TB Case Definitions for Public Health Surveillance

ADPH utilizes the 2009 Council of State and Territorial Epidemiologist (CSTE) case definition for tuberculosis (Position Statement 09-ID-65) that can be accessed at: https://ndc.services.cdc.gov/case-definitions/tuberculosis-2009/.

Clinical Description

A chronic bacterial infection caused by *Mycobacterium tuberculosis*, usually characterized pathologically by the formation of granulomas. The most common site of infection is the lung, but other organs may be involved.

Clinical Criteria

A case that meets all the following criteria:

- A positive tuberculin skin test or positive interferon gamma release assay for M. tuberculosis
- Signs and symptoms compatible with TB (abnormal chest radiograph, abnormal chest imaging study or clinical evidence of current disease)
- Treatment with two or more anti-TB medications
- A complete diagnostic evaluation

Laboratory Criteria for Diagnosis

- Isolation of M. tuberculosis complex on a culture from a clinical specimen,
- Demonstration of M. tuberculosis complex from a clinical specimen by nucleic acid application test
- Demonstration of acid-fast bacilli (AFB) in a clinical specimen when a culture has not been or cannot be obtained, is falsely negative, or contaminated

Case Classification

- A case that meets the clinical definition or is laboratory confirmed.

Epidemiology of TB in Alabama

Alabama reported 90 active TB cases in 2024. This represents 2.2% decrease from the active 92 TB cases reported in 2023 (Figure 1). The incidence rate of active TB cases in Alabama has decreased by 63.8% since 2005 (Figure 2). The TB Incidence rate in Alabama for 2024 is 1.7 cases per 100,000 persons. This incidence is lower than the national incidence rate of 3.0 cases per 100,000 persons reported for 2024 by the CDC. According to CDC, Alabama ranked 26th highest for the number of new active TB cases and ranked 34th highest for TB incidence rate (per 100,000 population) among the 51 reporting states and jurisdictions for 2024.

Geographic Distribution

Among the 67 counties in Alabama, four counties in Alabama reported the highest number of active TB cases in 2024: Marshall (8 cases), Tuscaloosa (8 cases), Madison (7 cases), and Mobile (7 cases) (Table 1). These four counties accounted for a total of 33.3% of all active TB cases reported in Alabama in 2024. Figure 3 shows the geographic distribution of active TB cases by county in 2024.

Each of the eight public health districts have responsibility for TB control in their assigned counties. In 2024, the Northern district had the highest TB incidence rate with 2.4 cases per 100,000 population, followed by West Central district with an incidence rate of 2.2 cases per 100,000 population, and Northeastern district with an incidence rate of 2.1 cases per 100,000 population (Table 2).

Sex and Age Distribution

In 2024, active TB cases in Alabama occurred predominantly among males (71.1%), compared to females (28.9%) (Figure 4). When stratified by age, the highest proportion of TB cases occurred among persons between the ages of 25-44 (34.4%). Among persons 25-44 years old, 19 cases (61.2%) were male, and 12 cases (38.7%) were female (Figure 4). The age range of 25-44 has the highest incidence rate (2.4 cases per 100,000 persons), while the lowest incidence rate among age groups was among 5–14-year-olds (0.0 per 100,000 persons) (Table 6).

Race/Ethnicity Distribution and TB Disparities

In 2024, Hispanic, and non-Hispanic Blacks accounted for 38.9%, and 23.3% of active TB cases in Alabama, respectively. Non-Hispanic Asians contribute to 17.8% of TB cases in 2024 (Figure 5). Pacific Islanders had the highest active TB incidence rate among race/ethnic groups (69.8 cases per 100,000), followed by Asian (23.2 cases per 100,000), Hispanic (12.1 cases per 100,000), non-Hispanic Blacks (1.4 cases per 100,000 and non-Hispanic Whites (0.7 cases per 100,000) (Table 7).

High-Risk Populations

Non-U.S.-Born Persons

Active TB among persons born outside of the U.S. accounted for 55.6% of active TB cases with a known country of origin in Alabama in 2024. Majority of the non-U.S.-born cases reported in 2024 came from Guatemala (22%), followed by Mexico (16%), and India (12%) – all countries where TB is endemic (Figure 8). The two public health districts in Alabama that reported having the highest number of non-US-born cases Northern (18 cases) and Northeastern (8 cases) (Table 3).

Persons with HIV Co-Infection

HIV testing should be performed for all TB cases, as TB treatment may change if antiretroviral therapy for HIV is given concurrently. Active TB often accelerates the natural progression of HIV infection to AIDS. Of the 90 reported active TB cases in 2024, 86 of the active TB cases reported having HIV results recorded in the RVCT with 4 cases reported being positive for HIV. HIV testing was reported in 95.3% of the active TB cases, with 4 (4.7%) case not having a test performed belonged to the less than 5 years old age group. (Figure 9).

Persons in Congregate Settings

Persons residing in crowded congregate settings such as homeless shelters, prisons, and long-term care facilities have a higher risk of TB bacteria exposure due to a shared airspace, environment, crowding, and poor ventilation. In 2024, 7 (7.8%) active TB cases in Alabama experienced homelessness within the past 12 months of diagnosis and 6 cases (6.7%) were residence of a correctional facility at the time of diagnosis. (Table 3, Figure 10).

Persons with Reported Substance Abuse and Medical Risk Factors

Substance abuse is the most reported behavioral risk factor among patients with active TB patients, in the U.S. TB patients who abuse substances, such as drugs or alcohol, often experience treatment failure and can remain infectious longer, which, extends the infectious period risking continued TB bacteria growth and transmission in the community. In 2024, 16 (17.8%) active TB cases, reported abuse of either illicit drugs or alcohol (Table 3, Figure 10). Certain conditions or treatments that weaken the immune system can increase the risk of TB bacteria overgrowth within the body. Among the cases of active TB for Alabama,15 (16.7%) of active cases had diabetes mellitus, 2 (2.2%) of active cases were diagnosed with end-stage renal disease, 6 (6.7%) of cases active have a form of hepatitis, 8 (8.9%) of active cases are non-HIV immunosuppressed individuals, 3 (3.3%) of active cases were previously diagnosis with TB, and 12 (13.3%) of active cases were previously diagnosed with latent TB infection (LTBI).(Figure 11)

Pediatric TB

TB in children is considered a sentinel public health event as it often indicates recent transmission from an infectious adult case. Children younger than 5 years of age are more likely to develop life-threatening forms of TB disease. Young children are more likely to have TB bacteria spread through their bloodstream and cause complications and deadlier forms of active TB disease, such as TB meningitis and disseminated TB than older children and adults. Moreover, potentially lethal forms of active TB disease, such as TB meningitis or disseminated TB, can develop in very young children since the infection is more likely to spread through the bloodstream in young children and cause complications. In 2024, children younger than the age of 15 years old comprised 7.8% of active TB cases, in Alabama. Seven cases (2.4 cases per 100,000 persons) were reported in children less than 5 years of age. There was 0 pediatric case of TB meningitis.

*Diagnosis and Treatment Outcomes

Initial Diagnosis, Treatment, and Drug Administrations

In Alabama, most cases are initially diagnosed with TB in a hospital or outside clinic and are followed up by TB staff in the health district in with the patient resides after discharge to continue their TB treatment. Treatment outcome was analyzed for eligible 2024 cases. Eligible cases include persons alive at time of diagnosis, initial drug regimen of one or more anti-TB drugs, and who did not die within one year of initiating treatment, excluding cases are those with RIF-resistant isolates, cases with bone and/or joint listed as site of disease, cases with meningeal TB, pediatric patients (ages 0 - 14 years) with disseminated TB disease, and those who moved out of the country within one year of initiating treatment. Among the 70 eligible active pulmonary TB cases counted in 2023, a total of 53* cases (75.7%) completed treatment and of those 53 cases who completed treatment 52 cases (98.1%) completed treatment within 12 months of diagnosis* (Table 5, Figure 12). Of the 70 eligible active TB cases, 1 case completed treatment after 12 months, 2 cases were lost to follow-up, 1 case refused treatment, and 13 active cases are still on treatment.

District TB staff provided directly observed therapy (DOT) to TB patients, which entails watching the patient swallow every dose of their TB treatment for the duration of their treatment. Of the 90 active cases with available data on treatment administration collect in 2024, 39 cases (43.3%) received TB treatment entirely by DOT only, 10 cases (11.1%) received treatment through video DOT, 26 cases (28.9%) were treated by a combination of DOT and EDOT administered therapy, and 15 cases* (16.7%) are unknown. (Figure 14).

*Preliminary until final report in December 2025

Pulmonary TB

Cases with pulmonary or laryngeal TB have a greater potential to spread the TB bacteria and infect others. Infectiousness is higher if a case's sputum smear is positive for acid-fast bacilli (AFB), or cavity lesions are present on chest radiography. In 2024, 61 (67.8%) of the 90 TB cases were pulmonary TB. Of the 61 active pulmonary TB cases, 35 cases (57.4%) were sputum AFB smear positive.

Drug Resistance

Drug Resistance

Among the 76 culture positive TB cases in Alabama, 71 cases (93.4%) were tested for initial drug susceptibility to all four of the first-line anti-TB medications. Of the 76 tested isolates from cases with no previous history of TB, 3 case (3.9%) had primary resistance to INH only, 2 case (2.6%) had primary resistance to PZA only, and zero case had multidrug-resistant (MDR)(Table 4).

MDR-TB is caused when the TB bacteria is resistant to at least INH and RIF (Figure 11). MDR-TB cases often require longer and more complicated treatment, which can be costly for patients and TB programs. Patients treated for MDR-TB can experience serious side effects including hearing loss, hepatitis, kidney impairment, and psychological changes.

The average cost of treating a TB patient increases as drug resistance increases. On average, the direct cost of treating a patient with drug-susceptible TB in 2020 was $20,000, compared to $568,000 for a patient with extensively drug resistant TB (XDR-TB, i.e. TB resistant to INH and RIF, a fluroquinolone and a second-line injectable, bedaquiline, or linezolid). Funding mechanisms are available to patients with treatment costs but can add additional strain to TB programs. More information about drug-resistant TB can be found on CDC's Division of TB Elimination website at https://www.cdc.gov/TB/topic/drTB/.

Molecular Epidemiology

TB genotyping is a laboratory method that determines the genetic relatedness of TB strains among different cases with culture-positive TB disease. Identical genotyping among persons with TB disease suggest recent person-to-person transmission. The state TB program routinely analyzes TB genotyping clusters, which are comprised of two or more TB cases with identical genotypes, to identify recent TB transmission, describe risk factors for transmission, identify possible sources of transmission, and determine ways to mitigate transmission.

Between 2022 - 2024, there were 3 clusters of various sizes in Alabama (Figure 15). Figure 16 displays the number of genotype cluster alerts by alert levels. According to CDC, alert level is determined by the log likelihood ratio (LLR) for a given cluster, identifying higher than expected geospatial concentrations for a TB genotype cluster in a specific county, compared to the national distribution of that genotype. The Tuberculosis Genotyping Information Management System (TB GIMS) generates low and medium alert level notifications with a LLR between 5≤ 10, and a high alert is for clusters with LLRs ≥ 10. Large Outbreak of Tuberculosis in the United States (LOTUS) alerts are generated when clusters of ≥10 genotype-matched cases within a 3-year period that are related by recent transmission are identified.

TABLES AND FIGURES

TABLE 1: TUBERCULOSIS (TB) CASES AND INCIDENCE RATES* BY COUNTY, 2023 - 2024

COUNTY	2023		2024	
	CASES	RATE*	CASES	RATE*
Autauga	0	0.0	1	1.6
Baldwin	2	0.8	1	0.4
Barbour	0	0.0	3	12.3
Bibb	0	0.0	1	4.6
Blount	1	1.7	2	3.3
Bullock	0	0.0	0	0.0
Butler	0	0.0	0	0.0
Calhoun	1	4.0	4	3.4
Chambers	1	2.9	2	5.9
Cherokee	0	0.0	0	0.0
Chilton	0	0.0	0	0.0
Choctaw	0	0.0	0	0.0
Clarke	0	0.0	0	0.0
Clay	0	0.0	0	0.0
Cleburne	0	0.0	0	0.0
Coffee	3	5.5	2	3.5
Colbert	5	8.6	1	1.7
Conecuh	0	0.0	0	0.0
Coosa	1	9.8	0	0.0
Covington	0	0.0	0	0.0
Crenshaw	0	0.0	0	0.0
Cullman	0	0.0	0	0.0
Dale	1	2.0	0	0.0
Dallas	0	0.0	0	0.0
DeKalb	0	0.0	0	0.0
Elmore	0	0.0	0	0.0
Escambia	0	0.0	0	0.0
Etowah	5	4.9	3	2.9
Fayette	0	0.0	1	6.3

TABLE 1: TUBERCULOSIS (TB) CASES AND INCIDENCE RATES* BY COUNTY, 2023 - 2024

COUNTY	2023		2024	
	CASES	RATE*	CASES	RATE*
Franklin	2	6.3	3	9.5
Geneva	1	3.7	1	3.7
Greene	0	0.0	0	0.0
Hale	0	0.0	0	0.0
Henry	0	0.0	0	0.0
Houston	3	2.8	0	0.0
Jackson	0	0.0	0	0.0
Jefferson	11	1.7	6	0.9
Lamar	0	0.0	0	0.0
Lauderdale	4	4.2	4	4.1
Lawrence	2	6.0	0	0.0
Lee County	3	1.7	0	0.0
Limestone	1	0.9	2	1.7
Lowndes	0	0.0	1	10.4
Macon	2	10.8	0	0.0
Madison	9	2.2	7	1.7
Marengo	0	0.0	0	0.0
Marion	0	0.0	0	0.0
Marshall	6	6.0	8	7.8
Mobile	4	1.0	7	1.7
Monroe	0	0.0	0	0.0
Montgomery	8	3.5	6	2.7
Morgan	1	0.8	4	3.2
Perry	2	24.9	0	0.0
Pickens	0	0.0	0	0.0
Pike	2	6.1	1	3.0
Randolph	0	0.0	0	0.0
Russell	0	0.0	1	1.7
St. Clair	1	1.1	2	2.1

TABLE 1: TUBERCULOSIS (TB) CASES AND INCIDENCE RATES* BY COUNTY, 2023 - 2024

COUNTY	2023		2024	
	CASES	RATE*	CASES	RATE*
Shelby	2	0.9	5	2.1
Sumter	1	8.4	0	0.0
Talladega	0	0.0	2	2.5
Tallapoosa	1	2.4	0	0.0
Tuscaloosa	5	2.1	8	3.4
Walker	0	0.0	0	0.0
Washington	0	0.0	0	0.0
Wilcox	0	0.0	1	10.3
Winston	1	4.2	0	0.0
TOTAL	92	1.8	90	1.8

*Rate per 100,000 population; Reported cases and calculated rates in these counties exclude cases from corresponding prisons and detention centers; Denominators for prison and detention centers are unknown

Data Sources: 1) Case counts for numerator were obtained from the National Tuberculosis Surveillance System Reports as of June 23, 2025). 2) Rates were calculated using population estimates for denominator obtained from the Alabama Department of Public Health Vital Statistics Division that is reported to the U.S. Census Bureau

TABLE 2: TUBERCULOSIS (TB) CASES AND INCIDENCE RATES* BY PUBLIC HEALTH DISTRICT, 2023 - 2024

PUBLIC HEALTH DISTRICT	2023		2024	
	CASES	INCIDENCE*	CASES	INCIDENCE*
Northern	31	2.4	29	2.4
Northeastern	10	1.5	18	2.1
West Central	8	1.7	10	2.2
East Central	16	2.2	11	1.5
Southwestern	2	0.5	2	0.5
Southeastern	10	2.6	7	1.8
Jefferson	11	1.7	6	0.9
Mobile	4	1.0	7	1.7
TOTAL	92	1.8	90	1.7

*Incidence per 100,000 population; Reported cases and calculated rates in these counties exclude cases from corresponding prisons and detention centers; Denominators for prisons and detention centers are unknown

Data Sources: 1) Case counts for numerator were obtained from the National Tuberculosis Surveillance System Reports as of June 23, 2025). 2) Rates were calculated using population estimates for denominator obtained from the Alabama Department of Public Health Vital Statistics Division that is reported to the U.S. Census Bureau

TABLE 3: PERCENTAGE OF TB CASES WITH KNOWN TB RISK FACTORS BY PUBLIC HEALTH DISTRICTS, 2024

PUBLIC HEALTH DISTRICT	NON - U.S.-BORN (%)	HOMELESS IN THE PAST YEAR (%)	*RESISDENCE OF CORRECTIONAL FACILITY AT DIAGNOSIS (%)	+LONG TERM CARE FACILITY AT DIAGNOSIS (%)	#REPORTED SUBSTANCE ABUSE (%)
Northern	62.1	3.5	3.5	0.0	20.7
Northeastern	44.4	11.1	0.0	5.6	16.7
West Central	70.0	0.0	10.0	0.0	0.0
East Central	63.6	0.0	0.0	0.0	27.3
Southwestern	50.0	0.0	0.0	0.0	0.0
Southeastern	28.6	14.2	42.9	0.0	14.3
Jefferson	33.3	33.3	16.7	0.0	33.3
Mobile	71.4	14.2	0.0	0.0	14.3
TOTAL	55.6	7.8	6.7	1.1	17.8

*Correctional Facility: Patients was incarcerated or detained in a jail, prison, or other detention center when TB diagnostic evaluations was performed or initiated.

+Long Term Care Facility: Patient was/or reside in a long-term care facility at time of diagnostic evaluation was performed of initiated.

#Substance Abuse: Consist of patients who use noninjecting drugs and injecting drugs in the past 12 months that is not prescribe by a medical practitioner or heavy alcohol consist of patients who binge drink 5 or more days in a month.

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

TABLE 4: PRIMARY RESISTANCE TO FIRST-LINE ANTI-TB MEDICATIONS, 2024

STATE	Isoniazid (INH)		Pyrazinamide (PZA)		Multi-Drug (INH, RIF, PZA and EMB)	
	CASES	PRECENT*	CASES	PRECENT*	CASES	PRECENT*
Alabama	3	3.9	2	2.6	0	0

*Percent of cases with completed drug susceptibility testing and no prior treatment with anti-TB medications (N=76) with positive cultures.

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2023.

TABLE 5: COMPLETION OF TB TREATMENT BY PUBLIC HEALTH DISTRICT, 2025 (N=90)*!

Public Health District	Completion of TB Treatment (%)	Completion of TB Treatment Within 12 Months (%)
Northern	81.5	100.0
Northeastern	71.4	100.0
West Central	85.7	83.3
East Central	88.9	100.0
Southwestern	100.0	100.0
Southeastern	100.0	100.0
Jefferson	50.0	100.0
Mobile	0.0	0.0

*Denominator includes persons alive at time of diagnosis, with initial drug regimen of one or more drugs prescribed, who did not die within one year of initiating treatment; excluding persons with initial rifampin-resistant isolates, patients, or pediatric patients (ages 0 – 14 years) with disseminated TB disease, and those who moved out of the country within one year of initiating treatment.
!Some active TB patients are still on treatment until December 2025

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

TABLE 6: TB INCIDENCE RATES* BY AGE GROUP, 2020 - 2024

| Age (Years)	2020 (N = 72)	2021 (N = 91)	2022 (N = 65)	2023 (N = 92)	2024 (N = 90)
< 5	1.0	1.7	0.3	0.7	2.4
5 – 14	0.0	0.2	0.2	0.0	0.0
15- 24	0.8	1.8	1.2	1.6	2.3
25 – 44	2.0	1.6	1.4	2.1	2.4
45 – 64	1.5	2.3	1.7	2.3	1.6
65+	2.1	2.6	1.6	2.5	1.7

*Rate per 100,000 population
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

TABLE 7: TB CASE INCIDENCE* BY RACE/ETHNICITY, 2020-2024

RACE/ETHNICITY	INCIDENCE RATE				
	2020 (N = 72)	2021 (N = 91)	2022 (N = 65)	2023 (N = 92)	2024 (N = 90)
Asian, Non-Hispanic	15.0	17.4	11.5	13.5	23.3
Black, Non – Hispanic	2.5	2.8	1.3	2.5	1.4
White, Non – Hispanic	1.0	0.4	0.7	0.6	0.4
Native Hawaiian	0.0	0.0	0.0	0.0	69.8
Hispanic	5.3	8.0	7.2	8.9	12.1

*Rate per 100,000 population, ** Estimated Pacific Islander Population for 2024 in Alabama is 5,728

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

TABLE 8: CONTACT INVESTIGATION, 2023 - 2024

	Final 2023	*Preliminary 2024
Number of Contacts	1,493	3,281
Number of Cases without Contacts	3	9
U.S. Born	455	378
Non-U.S.-Born	390	136
Evaluated	245	2,819
TST	104	78
IGRA	534	2,741
LTBI Diagnosis	98	245
Started Treatment	87	211
Completed Treatment	79	42

*Current year data is preliminary until March the following year.

Data Source: Data was collected from the CDC National Tuberculosis Indicators Project as of June 23, 2025.

Figure 1: TB CASES AND INCIDENCE RATES*, 2005 - 2024
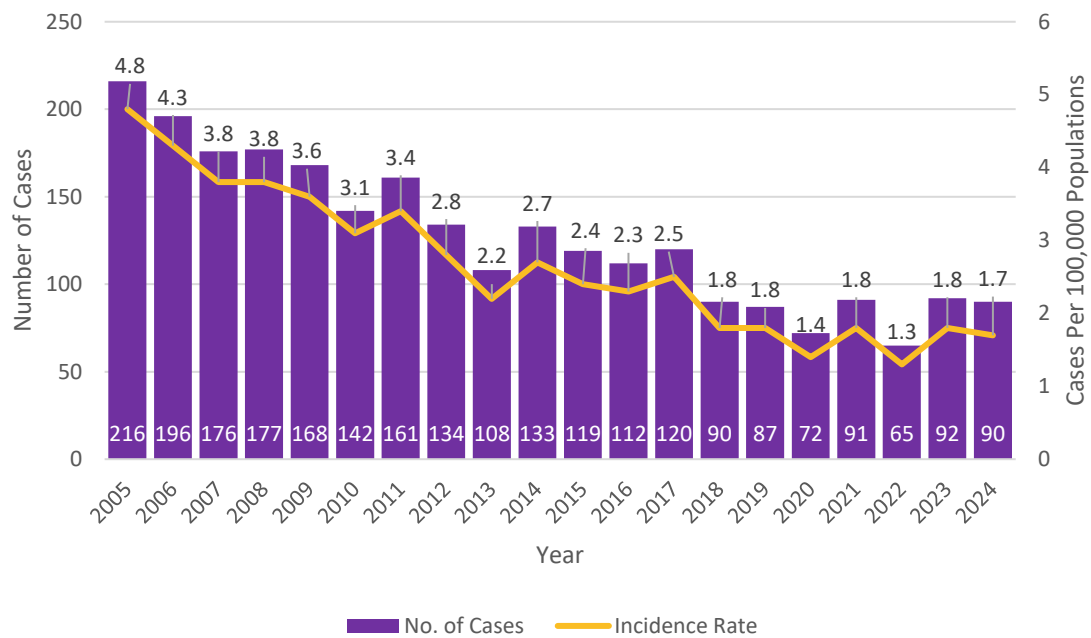
*Rate per 100,000 persons population

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

FIGURE 2: ALABAMA TB INCIDENCE RATES COMPARED TO UNITED STATES, 2005 - 2024
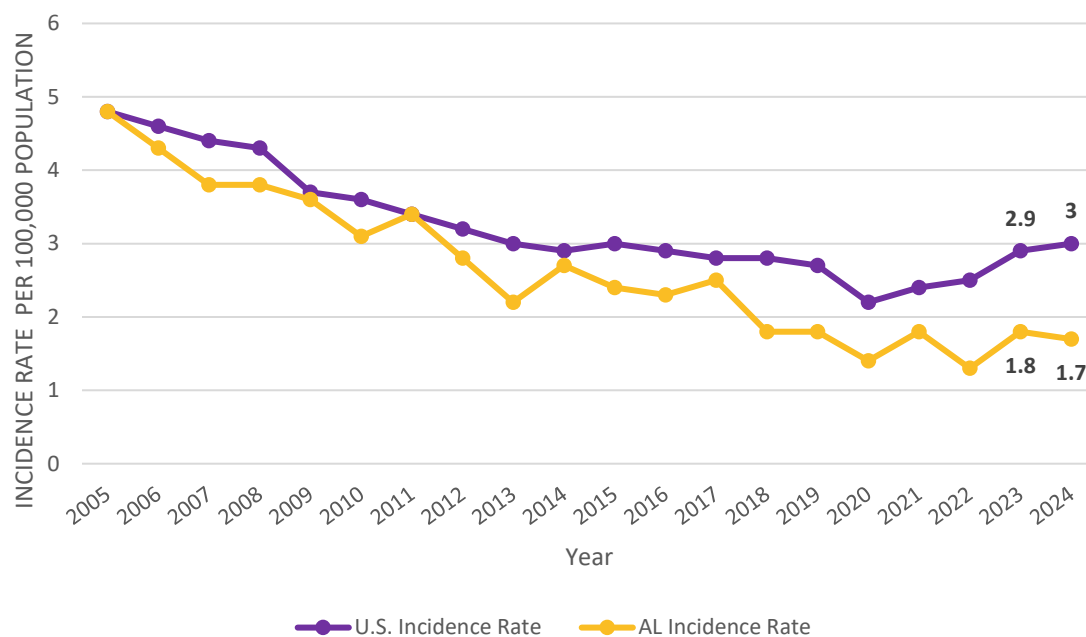
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025. United States incidence rate was obtained from the CDC at cdc.gov/tb/statistics/tbcases.htm as of June 23, 2025.

Figure 3: TB CASES BY COUNTY, 2024 (N = 90)

Lauderdale, 4
Limestone, 2
Madison, 7
Jackson, 0
Colbert, 1
Lawrence, 0
Franklin, 3
Morgan, 4
Marshall, 8
DeKalb, 0
Marion, 0
Winston, 0
Cullman, 0
Cherokee, 0
Etowah, 3
Blount, 2
Lamar, 0
Walker, 0
St. Clair, 2
Calhoun, 4
Fayette, 1
Cleburne, 0
Jefferson, 6
Talladega, 2
Pickens, 0
Tuscaloosa, 8
Shelby, 5
Clay, 0
Randolph, 0
Bibb, 1
Greene, 0
Coosa, 0
Chambers, 2
Chilton, 0
Tallapoosa, 0
Hale, 0
Perry, 0
Elmore, 0
Lee County, 0
Sumter, 0
Autauga, 1
Macon, 0
Dallas, 0
Russell, 1
Marengo, 0
Montgomery, 6
Lowndes, 1
Bullock, 0
Choctaw, 0
Wilcox, 1
Barbour, 3
Pike, 1
Butler, 0
Crensha...
Clarke, 0
Henry, 0
Monroe, 0
Washington, 0
Conecuh, 0
Coffee, 2
Dale, 0
Covington, 0
Houston, 0
Escambia, 0
Geneva, 1
Mobile, 7
Baldwin, 1

No. of Cases
0   8

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2023.

FIGURE 4: TB CASES BY AGE AND SEX, 2024 (N = 90)

Bar chart of number of cases by age group (years):

Age Group	Male	Female
< 5	5	2
5 - 14	0	0
15 - 24	13	3
25 - 44	19	12
45 - 64	17	3
65+	10	6

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2024.

FIGURE 5: TB CASES BY RACE/ETHNICITY, 2023 (N = 90)

Pie chart:
- Native Hawaiian 4.4%
- White, Non-Hispanic 13.3%
- Black, Non-Hispanic 23.3%
- Asian, Non-Hispanic 17.8%
- Hispanic 38.9%
- Multi-Racial

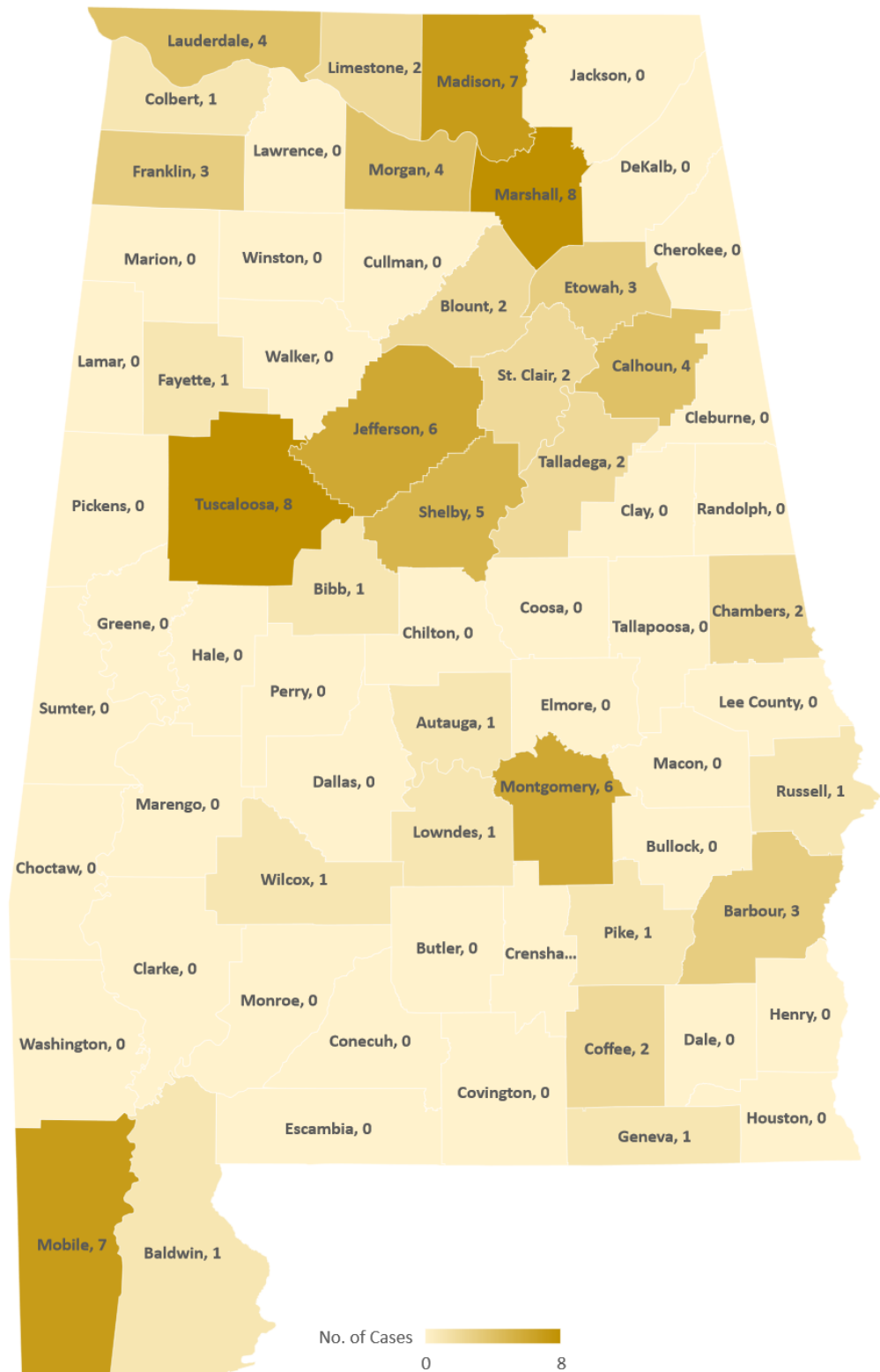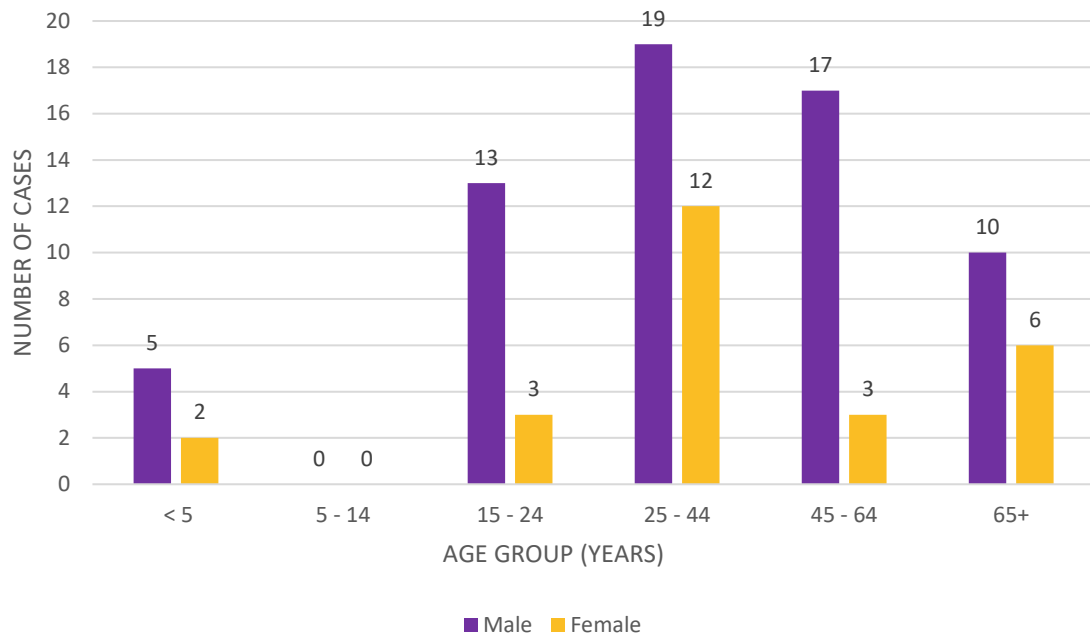Legend: White, Non-Hispanic ∙ Black, Non-Hispanic ∙ Asian, Non-Hispanic ∙ Hispanic ∙ Native Hawaiian ∙ Multi-Racial

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

FIGURE 6: TB INCIDENCE RATES*AMONG NON-HISPANIC BLACK, NON-HISPANIC WHITE, AND HISPANIC PERSONS, 2016 - 2024

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

FIGURE 7: U.S.-BORN AND NON-U.S.-BORN TB CASES, 2014 - 2024
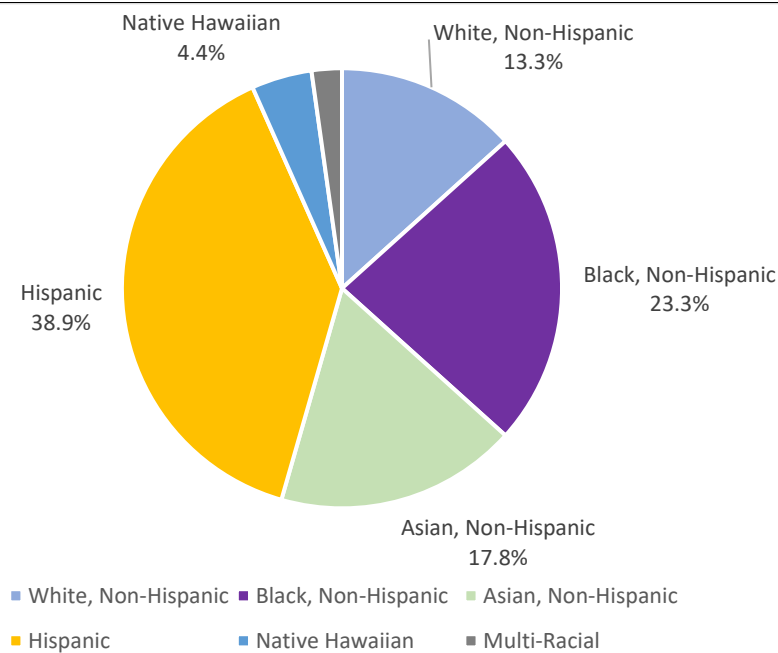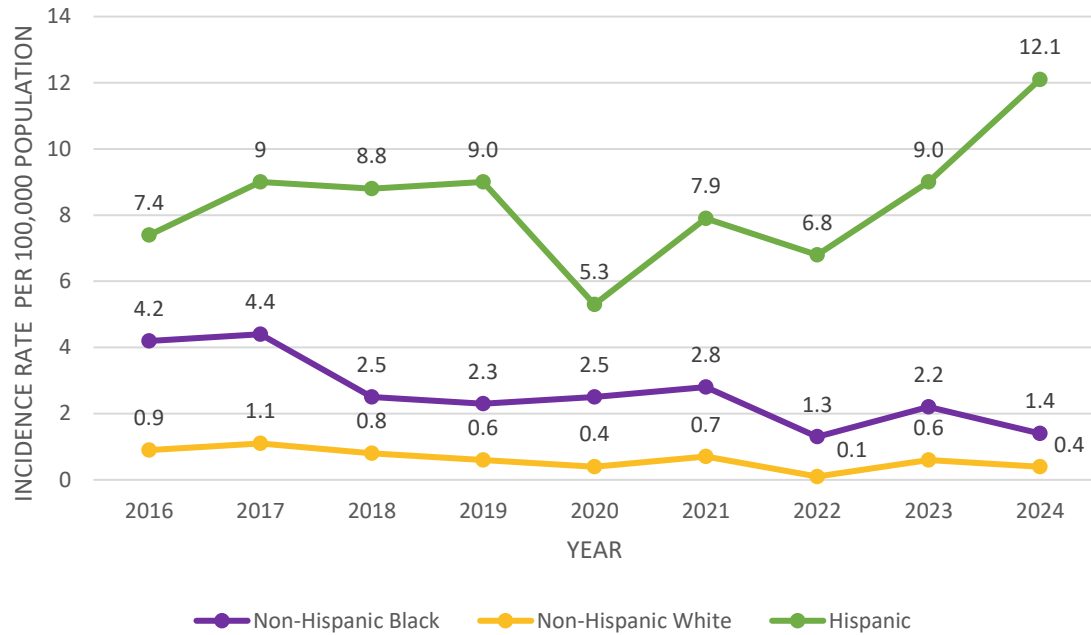

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

FIGURE 8: COUNTRY OF ORGIN FOR NON-U.S.-BORN TB CASES, 2024 (N=50)

Haiti 2.0%
Senegal 2.0%
Morocco 2.0%
Indonisa 2.0%
Fed States of Micronesia (2.0%)
Peru 2.0%
Guatemala (22.0%)
Philippines (4.0%)
Nicaragua (4.0%)
Mexico (16.0%)
Nepal (6.0%)
Vietnam (8.0%)
India (12.0%)
Venezuela (8.0%)
Colombia (8.0%)

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of April 3, 2024.
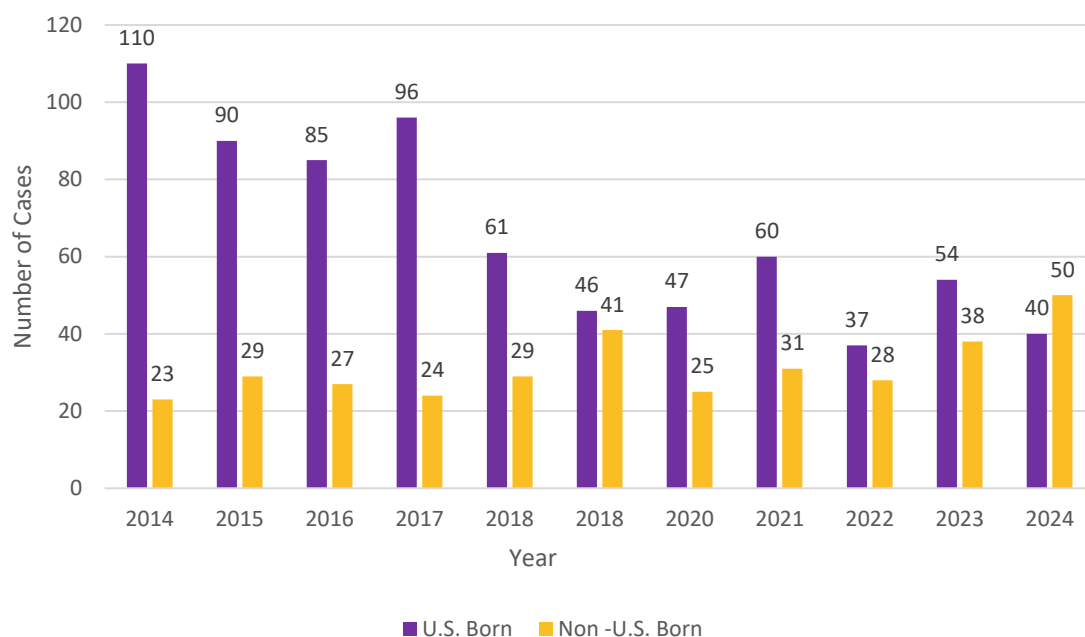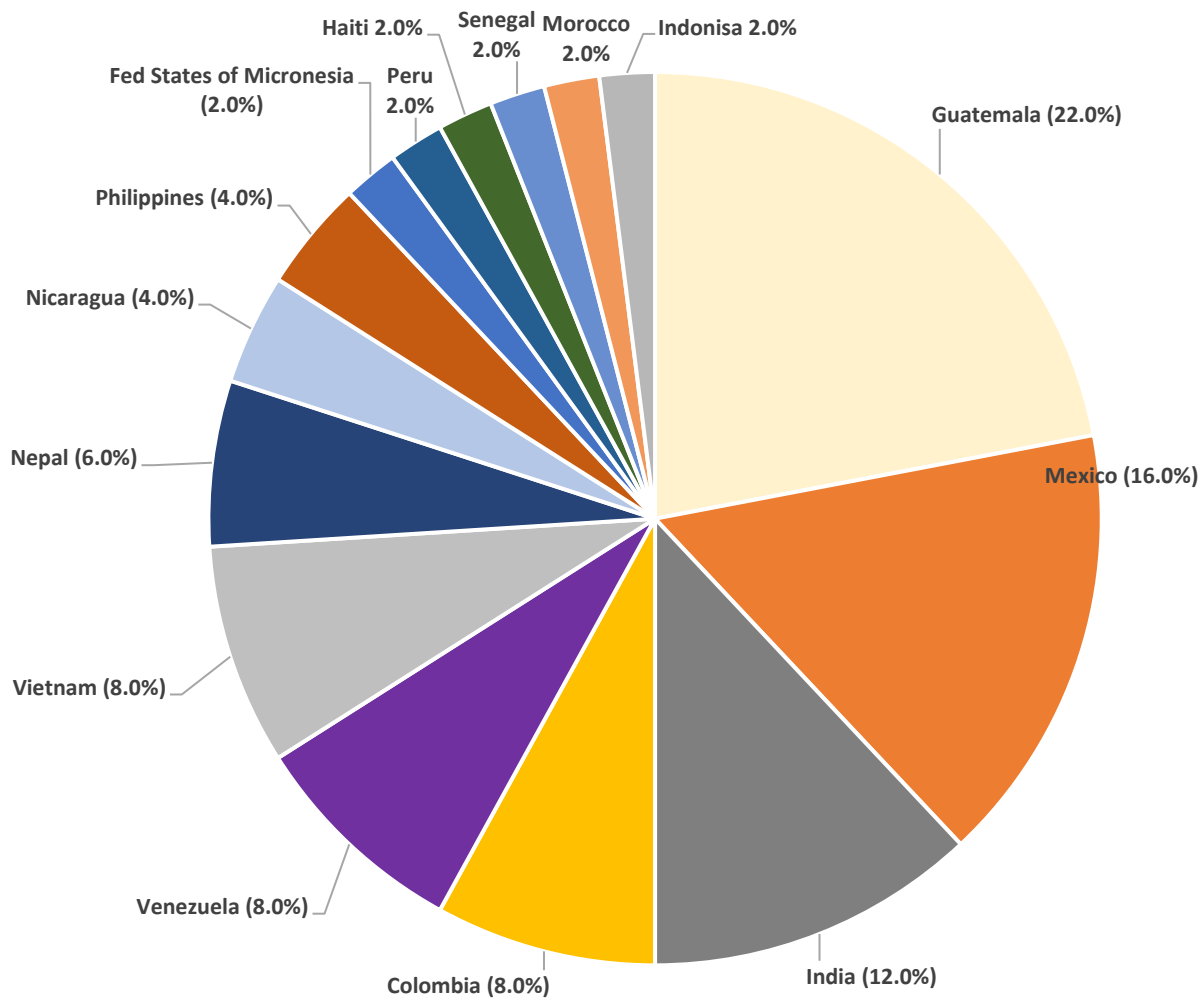
FIGURE 9: HIV STATUS OF TB CASES, 2014-2024

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2024.

Figure 10: SOCIAL RISK FACTORS AMONG TB PATIENTS, 2020-2023

Number of Cases vs Year bar chart.

Legend:
- Homelessness
- Residence of Correctional Facility at time of diagnosis
- Ever in Correctional Facility
- Residence of Long-Term Care Facility at time of Diagnosis
- Reported Substance Abuse

Year	Homelessness	Residence of Correctional Facility	Ever in Correctional Facility	Residence of Long-Term Care Facility	Reported Substance Abuse
2020	4	3	3	2	12
2021	13	4	4	0	12
2022	8	6	6	0	9
2023	8	2	15	0	20
2024	7	6	13	1	16

*Substance abuse consist of heavy alcohol use, non-injecting drugs use and injecting drug uses within the past 12 months prior to TB diagnosis. Ever in Correctional Facility consist of individuals who have ever been in a correctional facility prior to be diagnosed
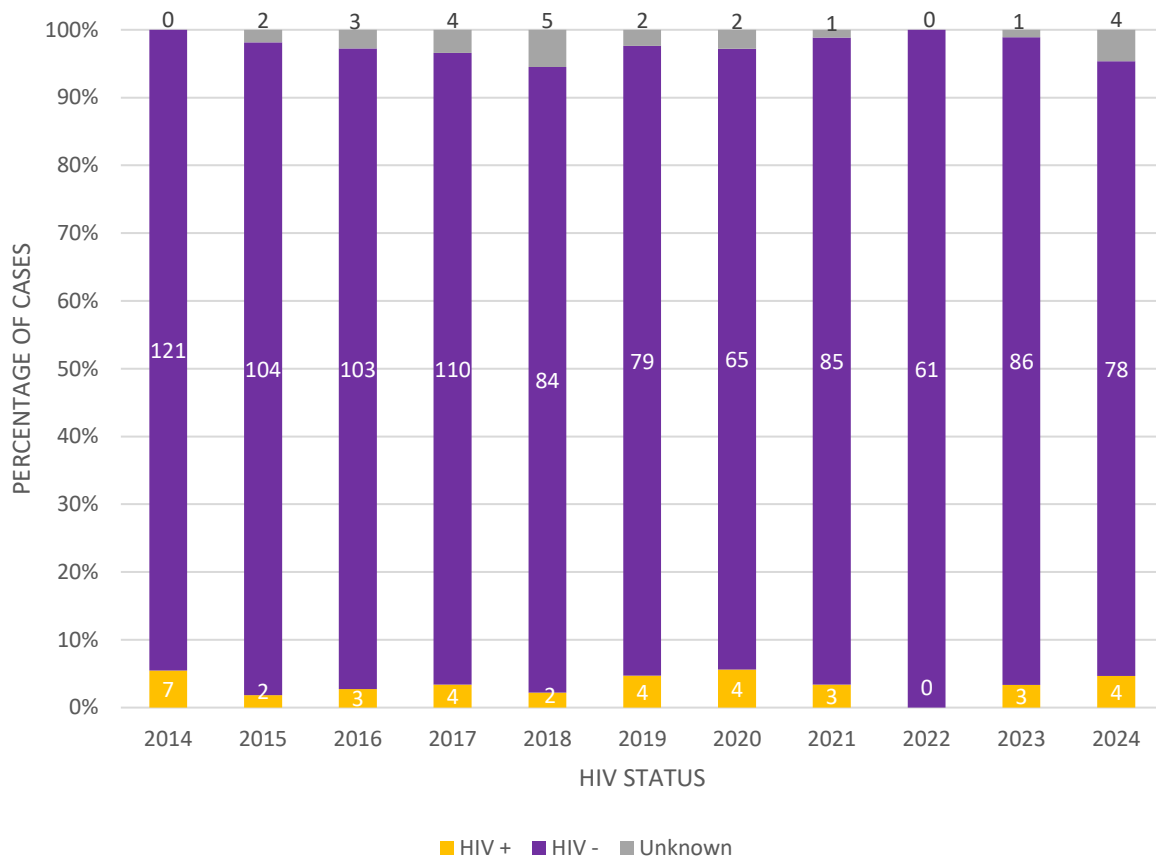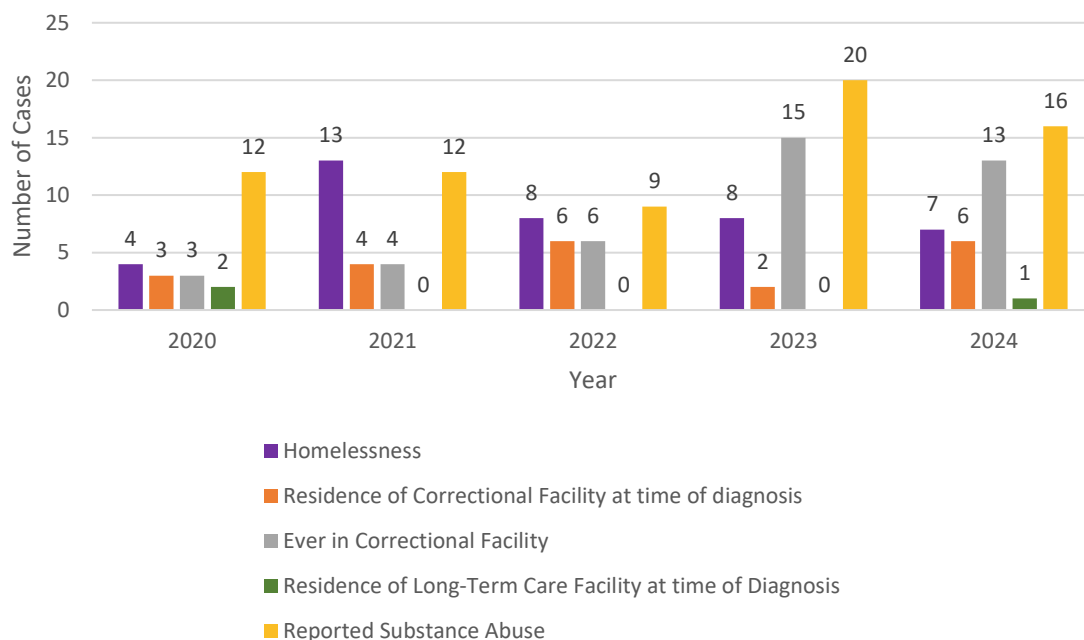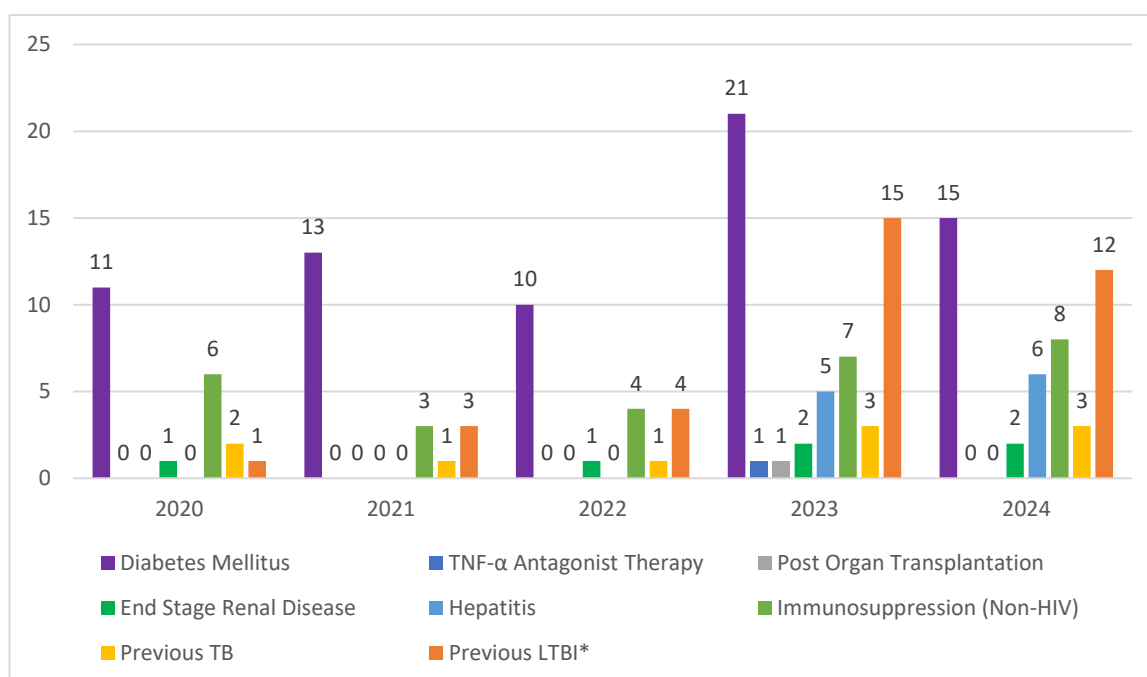
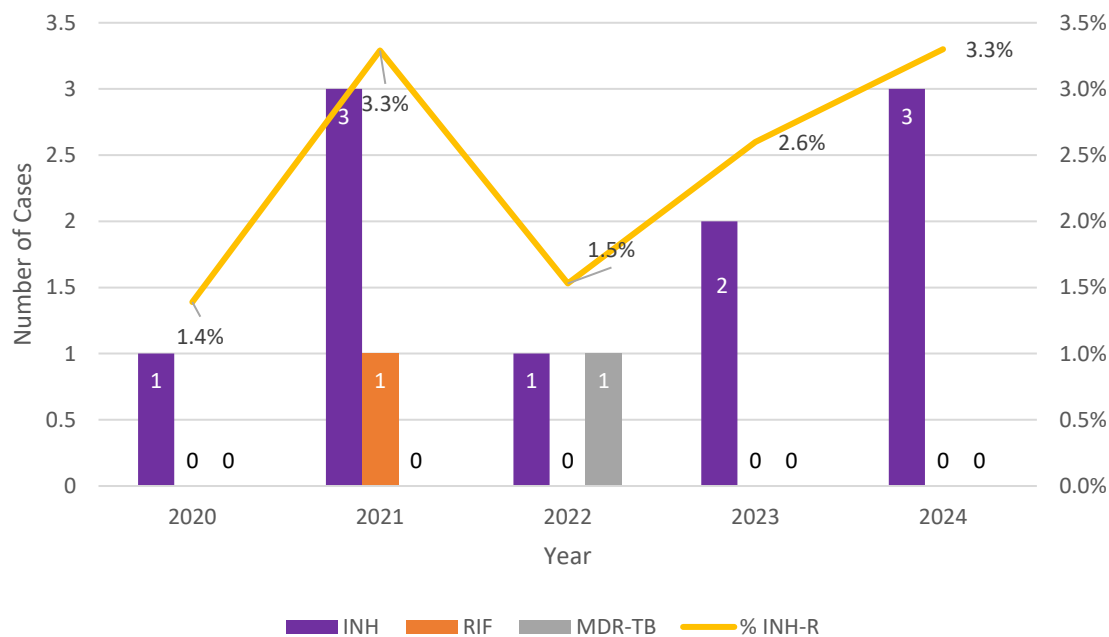**Data Source:** Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

Figure 11: MEDICAL RISK FACTORS AMONG TB PATIENTS, 2020-2024

Bar chart.

Legend:
- Diabetes Mellitus
- TNF-α Antagonist Therapy
- Post Organ Transplantation
- End Stage Renal Disease
- Hepatitis
- Immunosuppression (Non-HIV)
- Previous TB
- Previous LTBI*

Year	Diabetes Mellitus	TNF-α Antagonist Therapy	Post Organ Transplantation	End Stage Renal Disease	Hepatitis	Immunosuppression (Non-HIV)	Previous TB	Previous LTBI*
2020	11	0	0	1	0	6	2	1
2021	13	0	0	0	0	3	1	3
2022	10	0	0	1	0	4	1	4
2023	21	1	1	2	5	7	3	15
2024	15	0	0	2	6	8	3	12

*Latent TB Infection (LTBI) condition where a person has been infected with the bacteria that causes tuberculosis (TB), but the bacteria are inactive and the person doesn't have any symptoms of active TB disease. Individuals with LTBI are not contagious and cannot spread TB to others.

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.
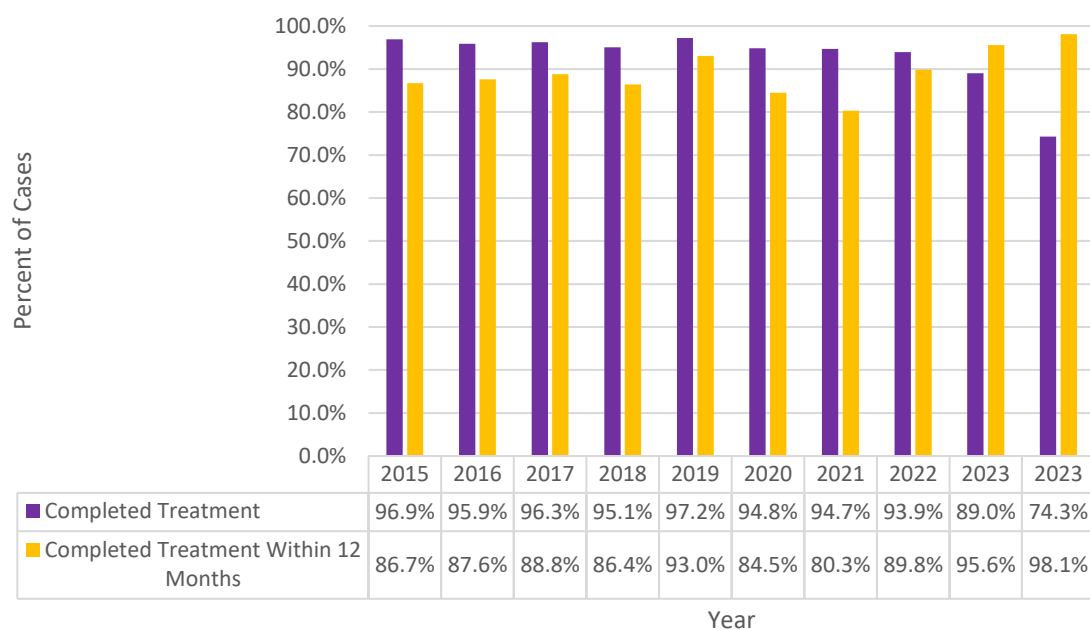
FIGURE 12: PRIMARY DRUG RESISTANCE (INH-R)* AND MULTI-DRUG RESISITANT TB (MDR-TB)**, 2020-2024

*Having no previous diagnosis of TB and having resistance of INH at first occurrence of disease; **having resistance to at least INH and RIF

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.
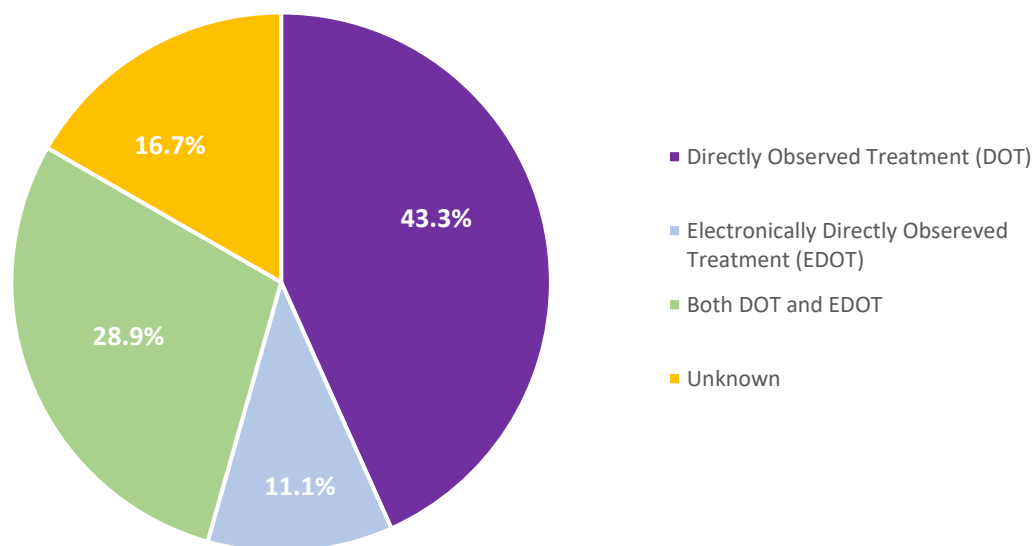
FIGURE 12: COMPLETION OF THERAPY, 2015 - 2024

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2023
■ Completed Treatment	96.9%	95.9%	96.3%	95.1%	97.2%	94.8%	94.7%	93.9%	89.0%	74.3%
■ Completed Treatment Within 12 Months	86.7%	87.6%	88.8%	86.4%	93.0%	84.5%	80.3%	89.8%	95.6%	98.1%

Year

Percent of Cases

Note: Completion of therapy include the completion of total prescribe medication in which TB is fully treated and prevents further spreading of M. tuberculosis. Figure includes persons alive at time of diagnosis, with initial drug regimen of one or more drugs prescribed, who did not die within one year of initiating treatment; excluding persons with initial rifampin-resistant isolate, patients with bone and joint diseases, meningeal disease of the central nervous system, or pediatric patients (ages 0 – 14 years) with military disease or positive blood culture nucleic acid amplification test on a blood specimen, and those who moved out of the country within one year of initiating treatment

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

FIGURE 14: MODE OF TREATMENT ADMINISTRATION AMONG PERSONS REPORTED WITH TB, 2024 (N=90*)

- Directly Observed Treatment (DOT) — 43.3%
- Electronically Directly Obsereved Treatment (EDOT) — 11.1%
- Both DOT and EDOT — 28.9%
- Unknown — 16.7%

*Unknown cases are still on treatment

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of October 15, 2024.
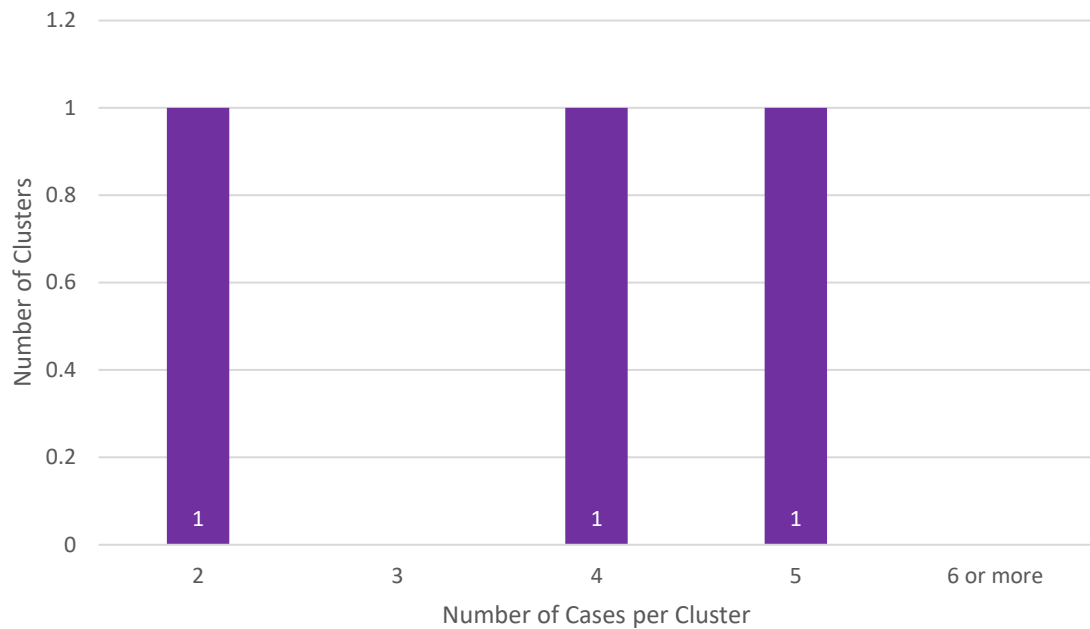
FIGURE 15: TB GENOTYPE CLUSTERS* BY CLUSTER SIZE, 2022-2024

*Genotype clusters are defined as two or more cases with matching spoligotype and 24-locus MIRU-VNTR (GENType) within the specified 3-year period in a geographic concentration of a county genotype cluster compared with the national average.

Data Source: Case counts was obtained from the Tuberculosis Genotyping Information Management System (TB GIMS) data as of June 23, 2025.

# FIGURE 16: TB GENOTYPE CLUSTER ALERTS BY TB GIMS* ALERT LEVEL, 2022 - 2024
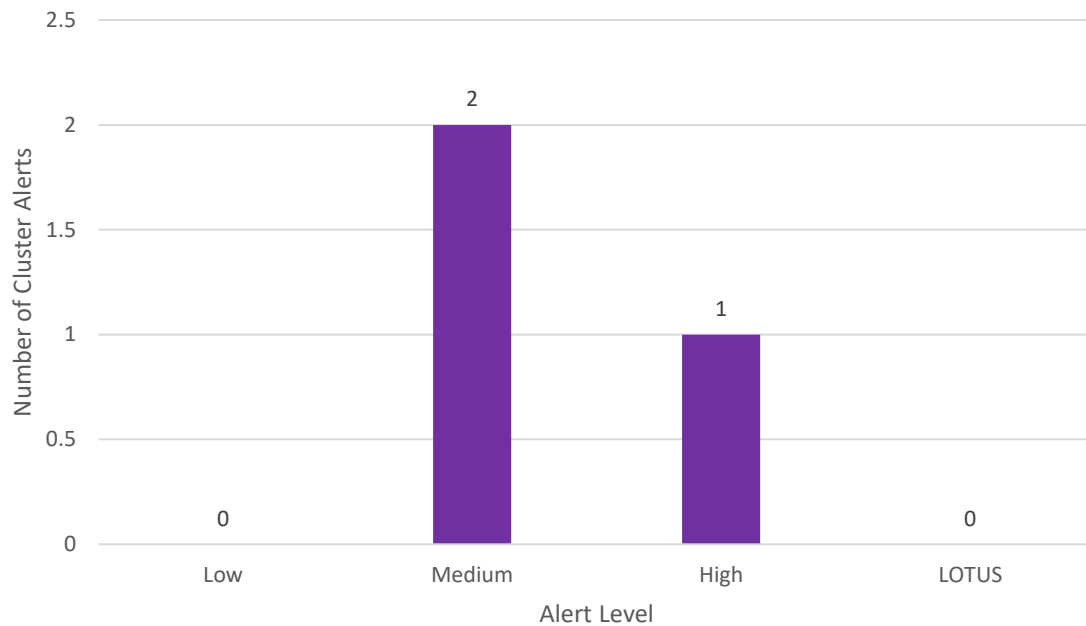
*Tuberculosis Genotyping Information Management System; According to the CDC, alert level is determined by the log likelihood ratio (LLR) for a given cluster, identifying higher than expected geospatial concentrations for a TB genotype cluster in a specific county, compared to the national distribution of that genotype. The Tuberculosis Genotyping Information Management System (TB GIMS) generates alert level notifications between 5≤ 10, and "high" alert is for clusters with LLRs ≥ 10. LOTUS (Large Outbreak of Tuberculosis in the United States) alerts are generated when clusters of ≥10 genotype-matched cases within a 3-year period that related by recent transmission are identified.

Data Source: Case counts was obtained from the Tuberculosis Genotyping Information Management System (TB GIMS) data as of June 23, 2025.
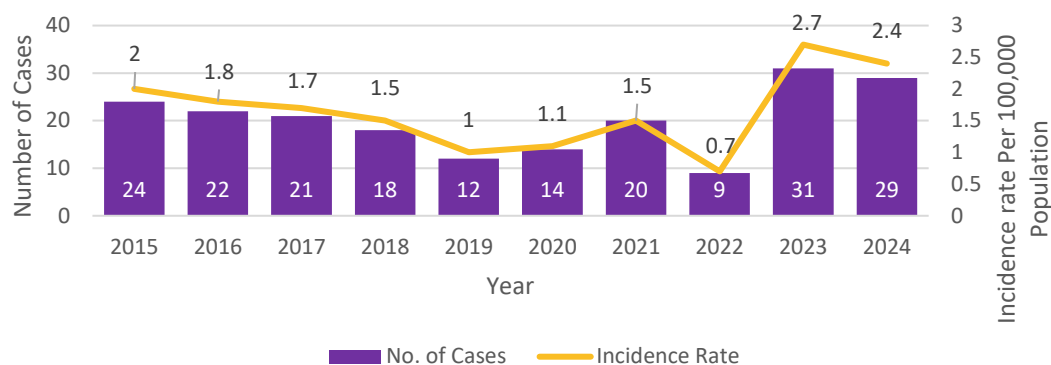
2015 – 2024

TUBERCULOSIS MORBIDITY TRENDS

BY PUBLIC HEALTH DISTRICT
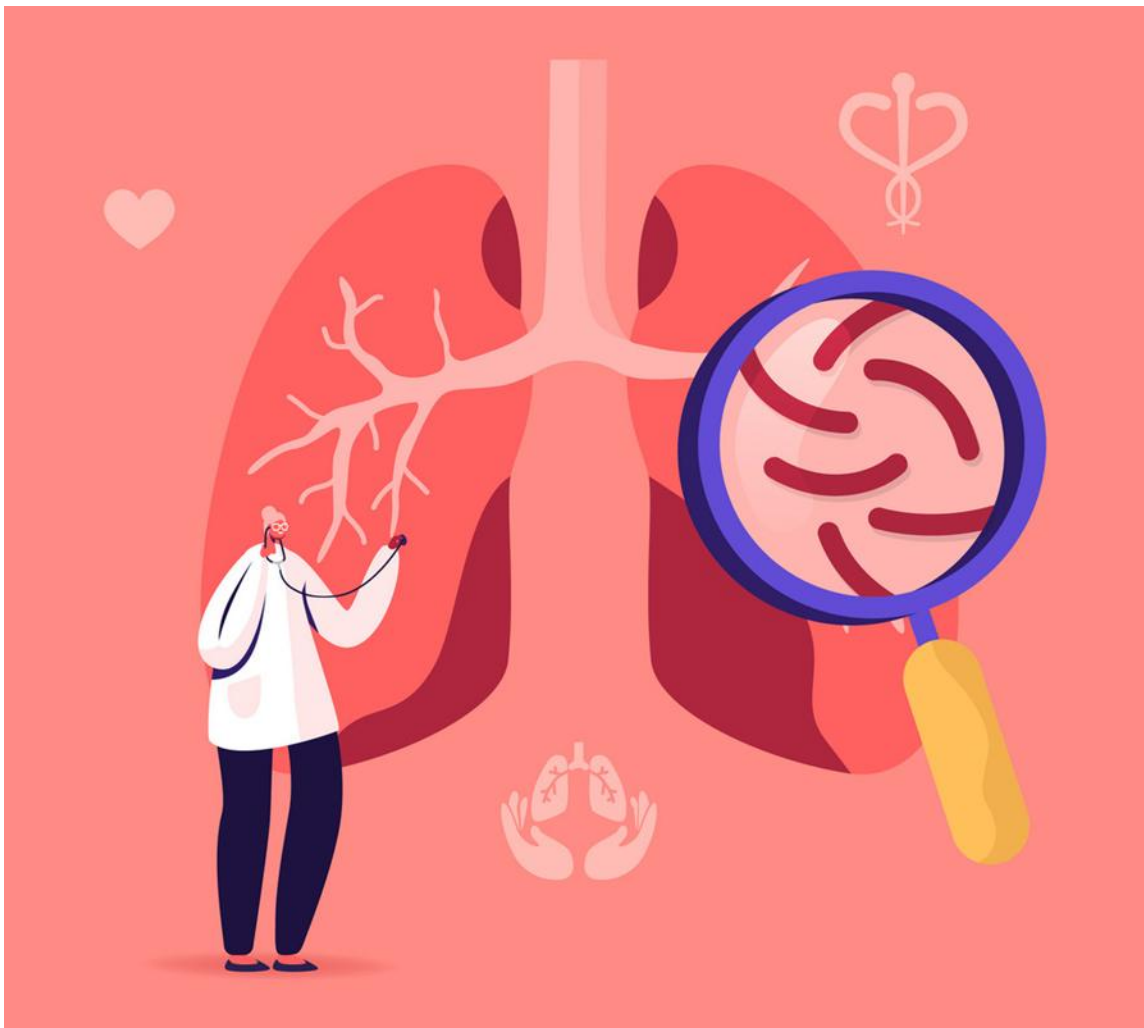
NORTHERN PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2015 – 2024, N=29

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

2024 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	12	US Born	18
Female	17	Non-US Born	11

Site of Disease					
Pulmonary	18	Extra-Pulmonary	6	Both	5

Age		Race/Ethnicity	
< 5	3	Asian	4
5-14	-	African American	6
15-24	3	Pacific Islander	4
25-44	14	Multi-Racial	1
45-64	6	Native American/Alaskan	-
65+	3	White	2
		Hispanic	12

Medical Risk Factors		Social Risk Factors	
Diabetes	3	Homeless with 12 Months of Diagnosis	1
TNF-α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	-
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	1	Injecting Drug Use	-
Viral Hepatitis	1	Non-injecting Drug Use	2
Non-HIV/AIDS Immunocompromised	2	Heavy Alcohol Use	4

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

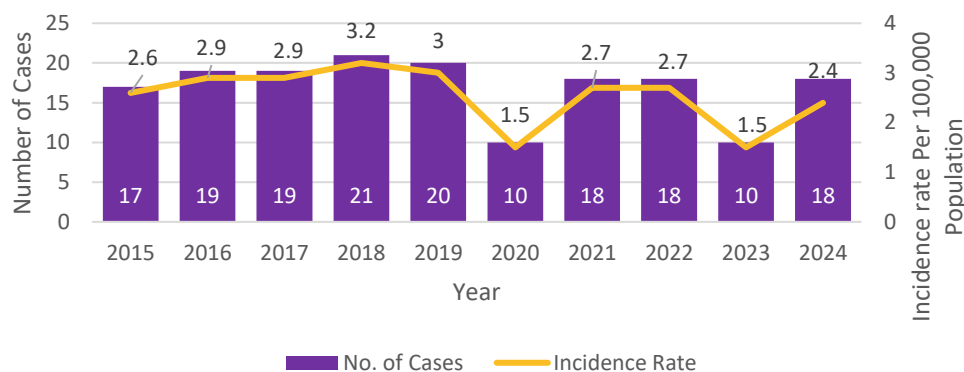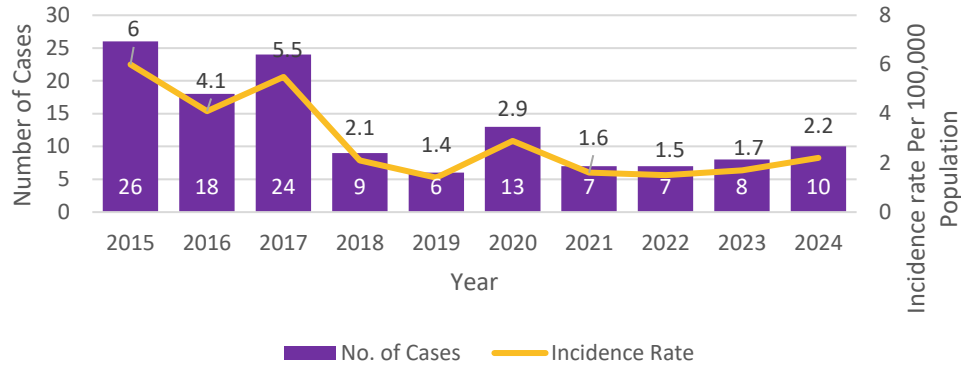## NORTHEASTERN PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2015 – 2024, N=18

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

2024 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	14	US Born	10
Female	4	Non-US Born	8

Site of Disease					
Pulmonary	13	Extra-Pulmonary	3	Both	2

Age		Race/Ethnicity	
< 5	3	Asian	2
5-14	-	African American	5
15-24	4	Pacific Islander	-
25-44	5	Multi-Racial	1
45-64	3	Native American/Alaskan	-
65+	3	White	1
		Hispanic	9

Medical Risk Factors		Social Risk Factors	
Diabetes	5	Homeless with 12 Months of Diagnosis	2
TNF-α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	-
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	-	Injecting Drug Use	2
Viral Hepatitis	1	Non-injecting Drug Use	3
Non-HIV/AIDS Immunocompromised	1	Heavy Alcohol Use	3

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

WEST CENTRAL PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2015 – 2024, N=10

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

2024 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	6	US Born	3
Female	4	Non-US Born	7

Site of Disease					
Pulmonary	6	Extra-Pulmonary	3	Both	1

Age		Race/Ethnicity	
< 5	-	Asian	4
5-14	-	African American	2
15-24	-	Pacific Islander	-
25-44	3	Multi-Racial	-
45-64	3	Native American/Alaskan	-
65+	4	White	2
		Hispanic	2

Medical Risk Factors		Social Risk Factors	
Diabetes	4	Homeless with 12 Months of Diagnosis	-
TNF-α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	-
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	-	Injecting Drug Use	-
Viral Hepatitis	-	Non-injecting Drug Use	-
Non-HIV/AIDS Immunocompromised	2	Heavy Alcohol Use	-

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

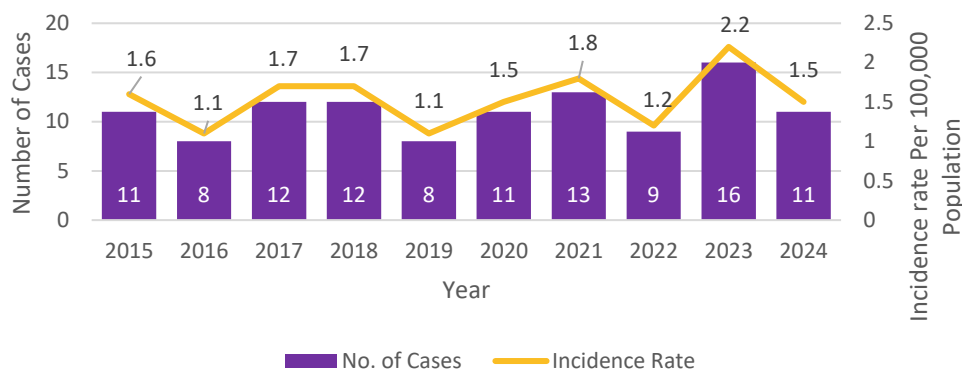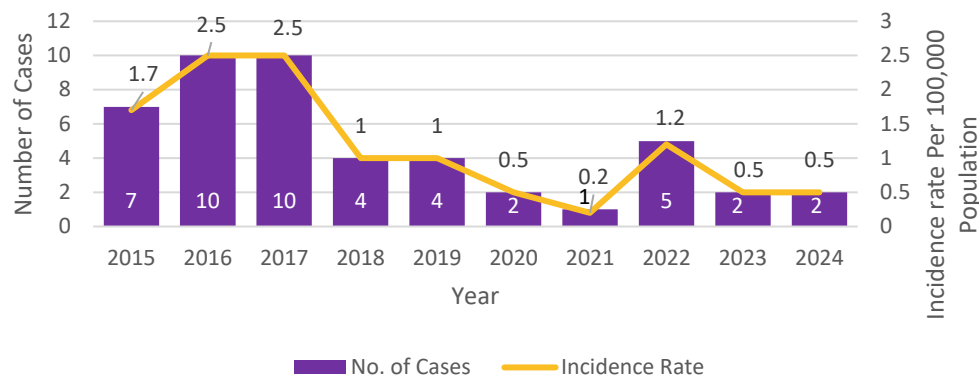## EAST CENTRAL PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2015 – 2024, N=11

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

2024 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	9	US Born	4
Female	2	Non-US Born	7

Site of Disease					
Pulmonary	8	Extra-Pulmonary	3	Both	-

Age		Race/Ethnicity	
< 5	1	Asian	-
5-14	-	African American	1
15-24	4	Pacific Islander	-
25-44	4	Multi-Racial	-
45-64	2	Native American/Alaskan	-
65+	-	White	1
		Hispanic	8

Medical Risk Factors		Social Risk Factors	
Diabetes	1	Homeless with 12 Months of Diagnosis	-
TNF-α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	-
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	-	Injecting Drug Use	-
Viral Hepatitis	-	Non-injecting Drug Use	2
Non-HIV/AIDS Immunocompromised	1	Heavy Alcohol Use	1

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

SOUTHWESTERN PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2015 – 2024, N=2

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

2024 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	-	US Born	1
Female	2	Non-US Born	1

Site of Disease					
Pulmonary	2	Extra-Pulmonary	-	Both	-

Age		Race/Ethnicity	
< 5	-	Asian	1
5-14	-	African American	1
15-24	-	Pacific Islander	-
25-44	1	Multi-Racial	-
45-64	-	Native American/Alaskan	-
65+	1	White	-
		Hispanic	-

Medical Risk Factors		Social Risk Factors	
Diabetes	-	Homeless with 12 Months of Diagnosis	-
TNF-α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	-
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	-	Injecting Drug Use	-
Viral Hepatitis	-	Non-injecting Drug Use	-
Non-HIV/AIDS Immunocompromised	1	Heavy Alcohol Use	-

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

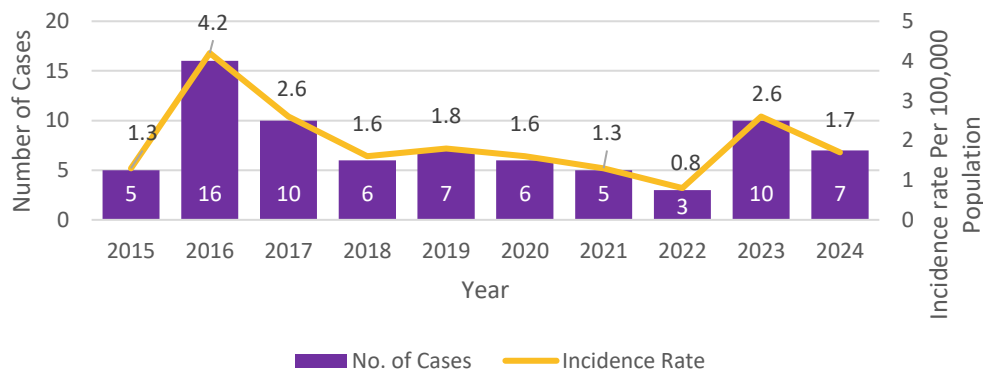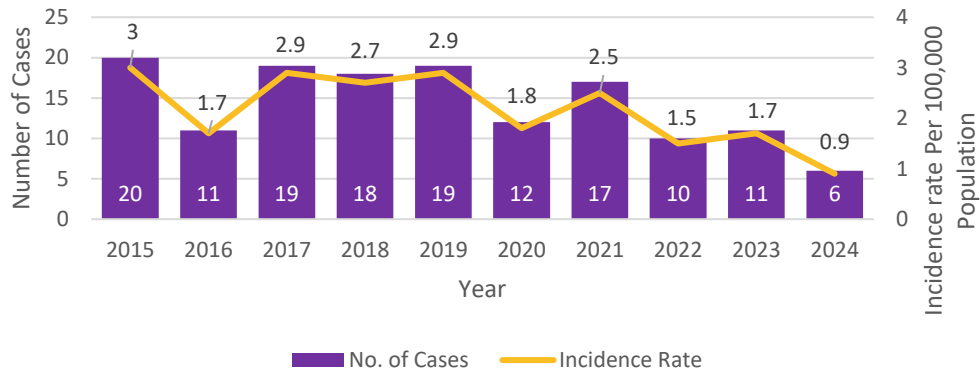## SOUTHEASTERN PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2015 – 2024, N=7

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

2024 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	6	US Born	5
Female	1	Non-US Born	2

Site of Disease					
Pulmonary	7	Extra-Pulmonary	-	Both	-

Age		Race/Ethnicity	
< 5	-	Asian	-
5-14	-	African American	2
15-24	2	Pacific Islander	-
25-44	-	Multi-Racial	-
45-64	4	Native American/Alaskan	-
65+	1	White	3
		Hispanic	2

Medical Risk Factors		Social Risk Factors	
Diabetes	-	Homeless with 12 Months of Diagnosis	1
TNF-α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	-
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	-	Injecting Drug Use	-
Viral Hepatitis	1	Non-injecting Drug Use	1
Non-HIV/AIDS Immunocompromised	-	Heavy Alcohol Use	1

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

JEFFERSON PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2015 – 2024, N=6

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.
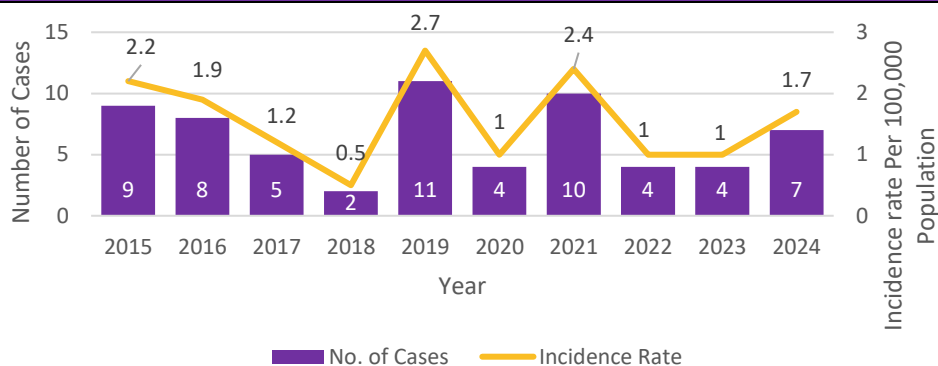
2024 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	6	US Born	4
Female	-	Non-US Born	2

Site of Disease					
Pulmonary	2	Extra-Pulmonary	4	Both	-

Age		Race/Ethnicity	
< 5	-	Asian	2
5-14	-	African American	3
15-24	-	Pacific Islander	-
25-44	2	Multi-Racial	-
45-64	-	Native American/Alaskan	-
65+	4	White	1
		Hispanic	-

Medical Risk Factors		Social Risk Factors	
Diabetes	1	Homeless with 12 Months of Diagnosis	2
TNF-α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	-
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	1	Injecting Drug Use	1
Viral Hepatitis	1	Non-injecting Drug Use	2
Non-HIV/AIDS Immunocompromised	1	Heavy Alcohol Use	1

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

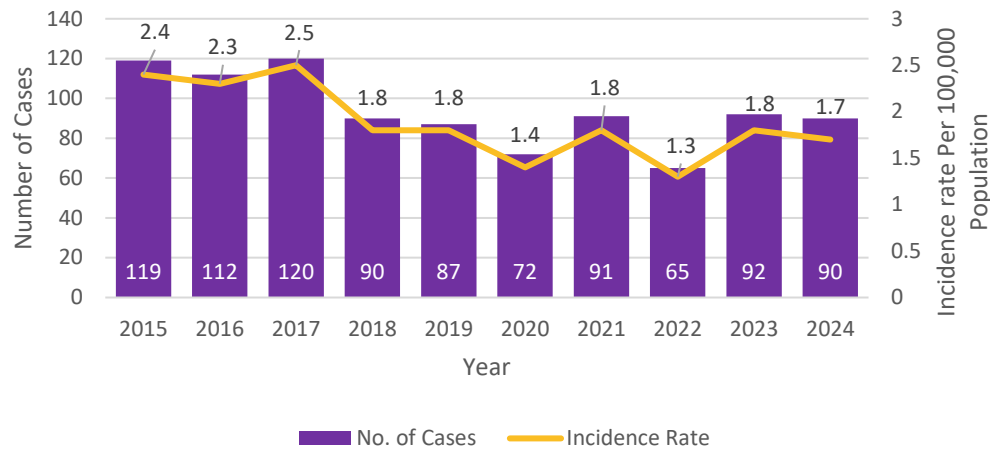## MOBILE PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2015 – 2024, N=7

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

2024 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	6	US Born	2
Female	1	Non-US Born	5

Site of Disease					
Pulmonary	5	Extra-Pulmonary	2	Both	-

Age		Race/Ethnicity	
< 5	-	Asian	3
5-14	-	African American	-
15-24	3	Pacific Islander	-
25-44	2	Multi-Racial	-
45-64	2	Native American/Alaskan	-
65+	-	White	2
		Hispanic	2

Medical Risk Factors		Social Risk Factors	
Diabetes	3	Homeless with 12 Months of Diagnosis	1
TNF-α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	-
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	1	Injecting Drug Use	-
Viral Hepatitis	1	Non-injecting Drug Use	2
Non-HIV/AIDS Immunocompromised	2	Heavy Alcohol Use	4

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

ALABAMA: TB CASES AND RATES 2015 – 2024, N=90

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.

2024 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	64	US Born	40
Female	26	Non-US Born	50

Site of Disease					
Pulmonary	61	Extra-Pulmonary	21	Both	8

Age		Race/Ethnicity	
< 5	7	Asian	16
5-14	-	African American	21
15-24	16	Pacific Islander	4
25-44	31	Multi-Racial	2
45-64	20	Native American/Alaskan	-
65+	16	White	12
		Hispanic	55

Medical Risk Factors		Social Risk Factors	
Diabetes	15	Homeless with 12 Months of Diagnosis	7
TNF-α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	-
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	2	Injecting Drug Use	2
Viral Hepatitis	6	Non-injecting Drug Use	11
Non-HIV/AIDS Immunocompromised	8	Heavy Alcohol Use	10

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of June 23, 2025.