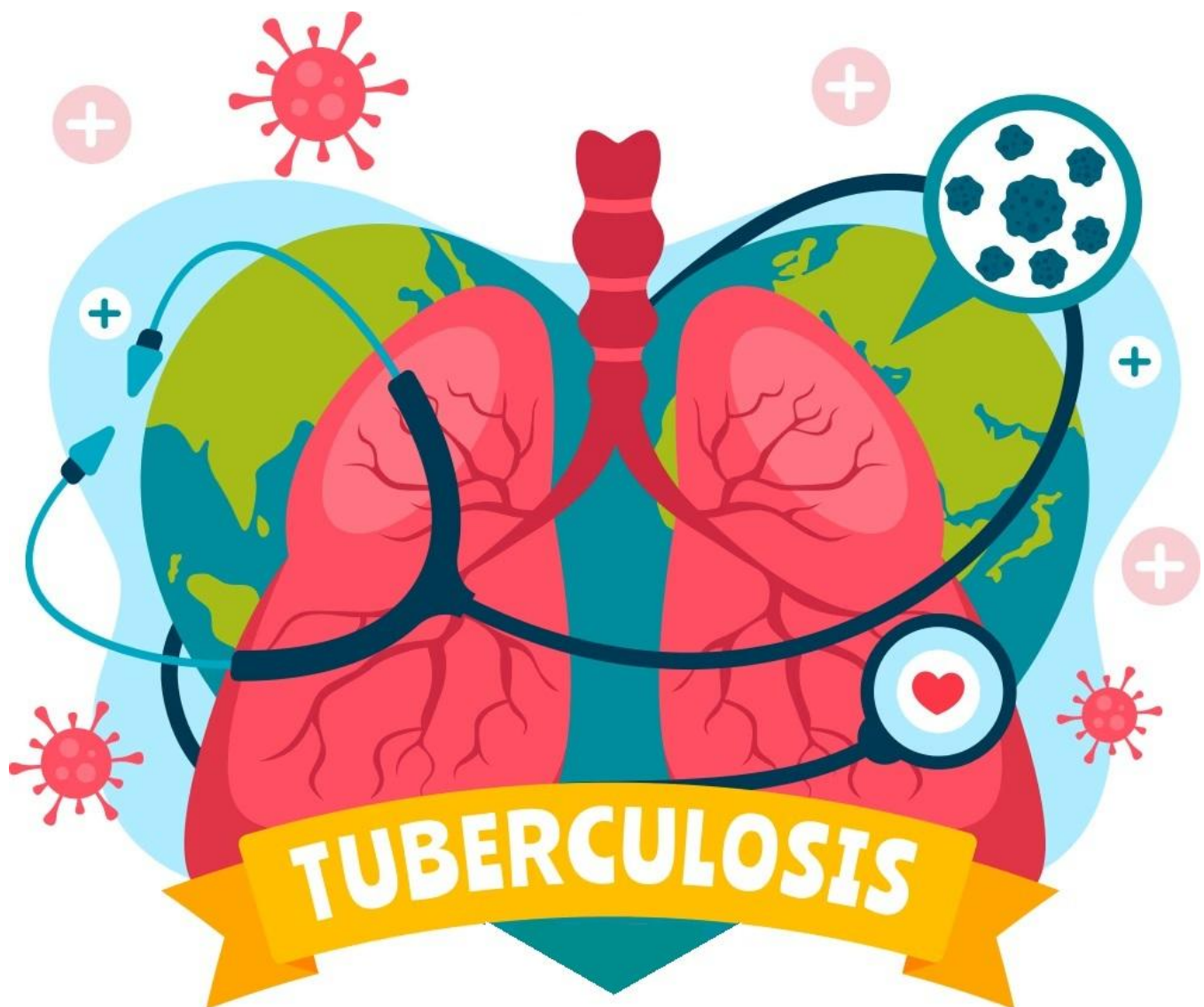


Preliminary 2025

ANNUAL TUBERCULOSIS
SURVEILLANCE REPORT

ALABAMA DEPARTMENT OF PUBLIC HEALTH (ADPH)



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Data Sources

- 1) Surveillance data were obtained from the Alabama NEDSS-Based System (ALNBS) as of August 26, 2026; 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 hepatotoxicity 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 89 active TB cases were reported in Alabama in 2025, representing a 1.1% decrease from 90 cases in 2024. In 2025, Alabama had a TB incidence rate of 1.7 TB cases per 100,000 persons, representing a 0% increase from the previous year's (2024) incidence rate of 1.7 TB cases per 100,000 persons. (Figure 1).

In 2025, TB incidence rates by public health district ranged from 1.1 cases per 100,000 persons in the West Central public health district to 2.3 cases per 100,000 persons in the Southeastern public health district. Three health districts (Southeastern, Jefferson, and East Central) reported higher incidence rate than the overall state incidence rate for 2025 (Table 2). Northern, Northeastern, and East Central public health districts reported 17, 15, & 15 cases respectively in 2025, accounting for 52.8% (47) of reported cases statewide (Table 2).

Of the 89 active TB cases reported in Alabama in 2025, 47 (52.8%) 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 Mexico, Guatemala, and Vietnam (Figure 8). Active TB cases among persons born in these countries accounted for 46.8% (22) of the total cases among non-U.S.- born persons in Alabama.

HIV status was reported for 92% of Alabama active TB cases in 2025. Among the 87 cases with a known HIV status, 3 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 2025, 5 (5.6%) cases reported experiencing homelessness within the twelve months before diagnosis, 7 (7.9%) cases were diagnosed with active TB while residing in a correctional facility, and 17 (19.1%) cases reported substance abuse (Figure 10). In 2025, there were 1 (1.1%) cases of multidrug-resistant TB (resistant to Isoniazid (INH), RIFAMPIN (RIF), Pyrazinamide (PZA), and Ethambutol (EMB), 7 cases resistant to INH, and 1 case resistant to PZA diagnosed in Alabama (Table 4).

In 2025, Alabama completed 63 contact investigations on active TB cases. Among the 1,800 identified contacts of active TB cases reported, 1,465 (81.4%) completed a medical evaluation, and 133 (9.1%) were diagnosed with latent tuberculosis infection (LTBI). Of the 133 contacts diagnosed with LTBI, 132 (99.2%) started LTBI treatment and, of those, 74 (56.1%) completed LTBI treatment. * (Table 8)

*All 2025 contact investigation data is preliminary until March 2027

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 89 active TB cases in 2025. This represents 1.1% decrease from the active 90 TB cases reported in 2024 (Figure 1). The incidence rate of active TB cases in Alabama has decreased by 63.8% since 2006 (Figure 2). The TB Incidence rate in Alabama for 2025 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 2025 by the CDC. According to CDC, Alabama ranked 28th highest for the number of new active TB cases and ranked 38th highest for TB incidence rate (per 100,000 population) among the 51 reporting states and jurisdictions for 2025.

Geographic Distribution

Among the 67 counties in Alabama, four counties in Alabama reported the highest number of active TB cases in 2025: Jefferson (14 cases), Baldwin (7 cases), Montgomery (7 cases), and Mobile (6 cases) (Table 1). These four counties accounted for a total of 38.2% of all active TB cases reported in Alabama in 2025. Figure 3 shows the geographic distribution of active TB cases by county in 2025.

Each of the eight public health districts have responsibility for TB control in their assigned counties. In 2025, the Southeastern district had the highest TB incidence rate with 2.3 cases per 100,000 population, followed by Jefferson public health district with an incidence rate of 2.1 cases per 100,000 population, and East Central Public health district with an incidence rate of 2.0 cases per 100,000 population (Table 2).

Sex and Age Distribution

In 2025, active TB cases in Alabama occurred predominantly among 58 males (65.2%), compared to 31 females (34.8%) (Figure 4). When stratified by age, the highest proportion of TB cases occurred among persons between the ages of 25-44 (29, 32.6 %). Among persons 25-44 years old, 18 cases (62.1%) were male, and 11 cases (37.9%) were female (Figure 4). The age range of 25-44 has the highest incidence rate (2.2 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 2025, Hispanic (28), and non-Hispanic Blacks (24) accounted for 31.5%, and 26.9% of active TB cases in Alabama, respectively. Non-Hispanic Asians (18) contribute to 22.2% of TB cases in 2025 (Figure 5). Pacific Islanders (1) and Asian (18) persons had the highest active TB incidence rate among race/ethnic groups (19.3 cases per 100,000), followed by Hispanic (8.3 cases per 100,000), non-Hispanic Blacks (1.5 cases per 100,000, American Indian (3.5 per 100,000 persons) and non-Hispanic Whites (0.5 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 52.8% of active TB (47) cases with a known country of origin in Alabama in 2025. Majority of the non-U.S.-born cases reported in 2025 came from Mexico (23.4%), followed by Guatemala (12.8%), and Vietnam (10.6%) – all countries where TB is endemic (Figure 8). The two public health districts in Alabama reported having the highest number of non-US-born cases Northern (11 cases) and East Central (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 89 reported active TB cases in 2025, 87 of the active TB cases reported having HIV results recorded in the RVCT with 3 cases reported being positive for HIV. HIV testing was reported in 92% of the active TB cases, with 7 (8.1%) cases not having a test performed belonging 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 2025, 5 (5.6%) active TB cases in Alabama experienced homelessness within the past 12 months of diagnosis and 7 cases (7.9%) 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 2025, 17 (19.1%) 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, 21 (23.6%) of active cases had diabetes mellitus, 0 (0 %) of active cases were diagnosed with end-stage renal disease, 7 (7.9%) of cases active have a form of hepatitis, 17 (19.1%) of active cases are non-HIV immunosuppressed individuals, 4 (4.5%) of active cases were previously diagnosis with TB, and 14 (15.7%) 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 2025, children younger than the age of 15 years old comprised 5.6% of active TB cases, in Alabama. Five (5) cases (1.7 cases per 100,000 persons) were reported in children less than 5 years of age. There were 0 pediatric cases 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 2025 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 74 eligible active pulmonary TB cases counted in 2025, a total of 67* cases (90.5%) completed treatment and of those 67 cases who completed treatment 66 cases (98.5%) completed treatment within 12 months of diagnosis* (Table 5, Figure 12). Of the 74 eligible active TB cases, 1 case completed treatment after 12 months, 3 cases were lost to follow-up, 2 case refused treatment, and 2 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 89 active cases with available data on treatment administration collect in 2025, 45 cases (50.6%) received TB treatment entirely by DOT only, 8 cases (8.9%) received treatment through video DOT, 21 cases (23.6%) were treated by a combination of DOT and EDOT administered therapy, and 4 cases* (4.5%) 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 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 2025, 75 (84.3%) of the 89 TB cases were pulmonary TB. Of the 75 active pulmonary TB cases, 39 cases (52%) were sputum AFB smear positive.

Drug Resistance

Drug Resistance

Among the 72 culture positive TB cases in Alabama, 68 cases (97.4%) were tested for initial drug susceptibility to all four of the first-line anti-TB medications. Of the 68 tested isolates from cases with no previous history of TB, 7 cases (10.3%) had primary resistance to INH only, 1 case (1.5%) had primary resistance to PZA only, and 1 case (1.5%) 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, mostly covered by the public sector, averaged \$134,000 per MDR TB and \$430,000 per XDR TB patient; in comparison, estimated cost per non-MDR TB patient is \$17,000. Drug resistance was extensive, care was complex, treatment completion rates were high, and treatment was expensive¹.

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/>.

¹https://wwwnc.cdc.gov/eid/article/20/5/13-1037_article

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 suggests 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 2023 - 2025, there were 21 clusters of various sizes alerts in Alabama. Figure 15 displays the number of genotype cluster alerts by year and 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 $5 \leq 10$, and a high alert is for clusters with $LLRs \geq 10$. 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.

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Tuberculosis Morbidity Trends by Public Health Districts

Northern

Northeastern

West Central

East Central

Southwestern

Southeastern

Jefferson

Mobile

Alabama

TABLE 1: TUBERCULOSIS (TB) CASES AND INCIDENCE RATES* BY COUNTY, 2024 - 2025

	2024		2025	
COUNTY	CASES	RATE*	CASES	RATE*
Autauga	1	1.6	0	0.0
Baldwin	1	0.4	7	2.6
Barbour	3	12.3	3	12.2
Bibb	1	4.6	0	0.0
Blount	2	3.3	4	6.6
Bullock	0	0.0	0	0.0
Butler	0	0.0	2	11.0
Calhoun	4	3.4	2	1.7
Chambers	2	5.9	1	2.9
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	1	4.5
Clay	0	0.0	0	0.0
Cleburne	0	0.0	0	0.0
Coffee	2	3.5	1	1.8
Colbert	1	1.7	0	0.0
Conecuh	0	0.0	0	0.0
Coosa	0	0.0	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	0	0.0	1	2.0
Dallas	0	0.0	0	0.0
DeKalb	0	0.0	2	2.7
Elmore	0	0.0	2	2.2
Escambia	0	0.0	0	0.0
Etowah	3	2.9	4	3.9
Fayette	1	6.3	0	0.0

TABLE 1: TUBERCULOSIS (TB) CASES AND INCIDENCE RATES* BY COUNTY, 2024 - 2025

	2024		2025	
COUNTY	CASES	RATE*	CASES	RATE*
Franklin	3	9.5	0	0.0
Geneva	1	3.7	0	0.0
Greene	0	0.0	0	0.0
Hale	0	0.0	0	0.0
Henry	0	0.0	0	0.0
Houston	0	0.0	1	0.9
Jackson	0	0.0	1	1.8
Jefferson	6	0.9	14	2.1
Lamar	0	0.0	0	0.0
Lauderdale	4	4.1	1	1.0
Lawrence	0	0.0	0	0.0
Lee County	0	0.0	3	1.6
Limestone	2	1.7	3	2.4
Lowndes	1	10.4	0	0.0
Macon	0	0.0	0	0.0
Madison	7	1.7	5	1.2
Marengo	0	0.0	0	0.0
Marion	0	0.0	0	0.0
Marshall	8	7.8	2	1.9
Mobile	7	1.7	6	1.5
Monroe	0	0.0	0	0.0
Montgomery	6	2.7	7	3.1
Morgan	4	3.2	4	3.2
Perry	0	0.0	0	0.0
Pickens	0	0.0	1	5.5
Pike	1	3.0	1	3.0
Randolph	0	0.0	0	0.0
Russell	1	1.7	1	1.7
Shelby	2	0.9	1	1.0

TABLE 1: TUBERCULOSIS (TB) CASES AND INCIDENCE RATES* BY COUNTY, 2024 - 2025

	2024		2025	
COUNTY	CASES	RATE*	CASES	RATE*
St. Clair	2	2.1	0	0.0
Sumter	0	0.0	0	0.0
Talladega	2	2.5	2	2.5
Tallapoosa	0	0.0	1	2.4
Tuscaloosa	8	3.4	3	1.2
Walker	0	0.0	1	1.5
Washington	0	0.0	0	0.0
Wilcox	1	10.3	0	0.0
Winston	0	0.0	0	0.0
TOTAL	90	1.7	89	1.7

*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 August 26, 2026. 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, 2024 - 2025

PUBLIC HEALTH DISTRICT	2024		2025	
	CASES	INCIDENCE*	CASES	INCIDENCE*
Northern	29	2.4	17	1.4
Northeastern	18	2.1	15	1.8
West Central	10	2.2	5	1.1
East Central	11	1.5	15	2.0
Southwestern	2	0.5	8	1.8
Southeastern	7	1.8	9	2.3
Jefferson	6	0.9	14	2.1
Mobile	7	1.7	6	1.5
TOTAL	90	1.7	89	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 August 26, 2026). 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, 2025

PUBLIC HEALTH DISTRICT	NON - U.S.-BORN (%)	HOMELESS IN THE PAST YEAR (%)	*RESIDENCE OF CORRECTIONAL FACILITY AT DIAGNOSIS (%)	*LONG TERM CARE FACILITY AT DIAGNOSIS (%)	#REPORTED SUBSTANCE ABUSE (%)
Northern	64.7	5.9	0.0	0.0	23.5
Northeastern	40.0	6.6	13.3	0.0	13.3
West Central	80.0	0.0	0.0	0.0	0
East Central	53.3	0.0	0.0	0.0	26.7
Southwestern	75.0	0.0	0.0	0.0	12.5
Southeastern	22.2	0.0	33.3	0.0	33.3
Jefferson	57.1	14.3	14.3	7.14	14.3
Mobile	33.3	16.7	0.0	0.0	16.7
TOTAL	52.8	5.6	7.9	1.1	19.1

***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 August 26, 2026.

TABLE 4: PRIMARY RESISTANCE TO FIRST-LINE ANTI-TB MEDICATIONS, 2025

STATE	Isoniazid (INH)		Pyrazinamide (PZA)		Multi-Drug (INH, RIF, PZA and EMB)	
	CASES	PERCENT*	CASES	PERCENT*	CASES	PERCENT*
Alabama	7	10.3	1	1.5	1	1.5

*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=89)*!

Public Health District	Completion of TB Treatment (%)	Completion of TB Treatment Within 12 Months (%)
Northern	75.0	87.5
Northeastern	84.6	84.6
West Central	100.0	100.0
East Central	88.9	88.9
Southwestern	100.0	100.0
Southeastern	88.8	88.8
Jefferson	81.8	81.8
Mobile	100.0	100.0

*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 August 26, 2026.

TABLE 6: TB INCIDENCE RATES* BY AGE GROUP, 2021 - 2025

Age (Years)	2021 (N = 91)	2022 (N = 65)	2023 (N = 92)	2024 (N = 90)	2025 (N = 89)
< 5	1.7	0.3	0.7	2.4	1.7
5 – 14	0.2	0.2	0.0	0.0	0.0
15- 24	1.8	1.2	1.6	2.3	1.6
25 – 44	1.6	1.4	2.1	2.4	2.2
45 – 64	2.3	1.7	2.3	1.6	2.1
65+	2.6	1.6	2.5	1.7	1.7

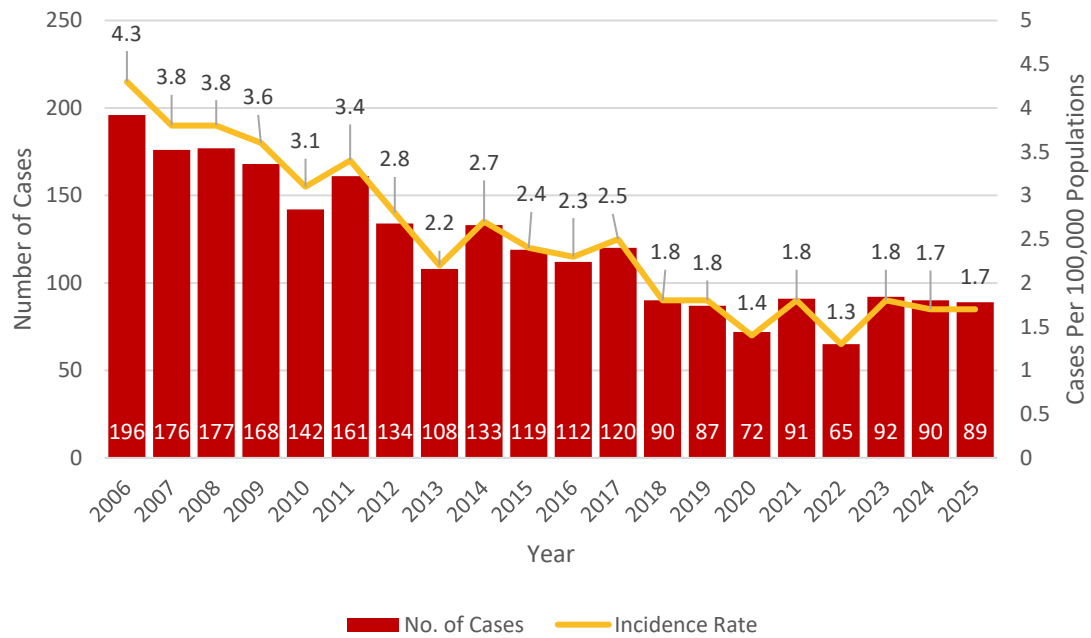
*Rate per 100,000 population

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

TABLE 7: TB CASE INCIDENCE* BY RACE/ETHNICITY, 2021-2025					
INCIDENCE RATE					
RACE/ETHNICITY	2021 (N = 91)	2022 (N = 65)	2023 (N = 92)	2024 (N = 90)	2025 (N = 89)
Asian, Non-Hispanic	17.4	11.5	13.5	23.3	19.3
Black, Non – Hispanic	2.8	1.3	2.5	1.4	1.5
White, Non – Hispanic	0.4	0.7	0.6	0.4	0.5
American Indian/Native Alaskan	0.0	0.0	0.0	0.0	3.5
Native Hawaiian	0.0	0.0	0.0	69.8	19.3
Hispanic	8.0	7.2	8.9	12.1	8.3
*Rate per 100,000 population, ** Estimated Pacific Islander Population for 2025 in Alabama is 5,193,088 Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.					

TABLE 8: CONTACT INVESTIGATION, 2024 - 2025		
	Final 2024	*Preliminary 2025
Number of Contacts	3,333	1,800
Number of Cases without Contacts	12	8
U.S. Born	351	1,506
Non-U.S.-Born	117	233
Evaluated	2,834	1,465
TST	24	5
IGRA	2,810	1,459
LTBI Diagnosis	213	133
Started Treatment	197	132
Completed Treatment	195	74
*Current year data is preliminary until March the following 2 nd year. Data Source: Data was collected from the CDC National Tuberculosis Indicators Project as of August 26, 2026.		

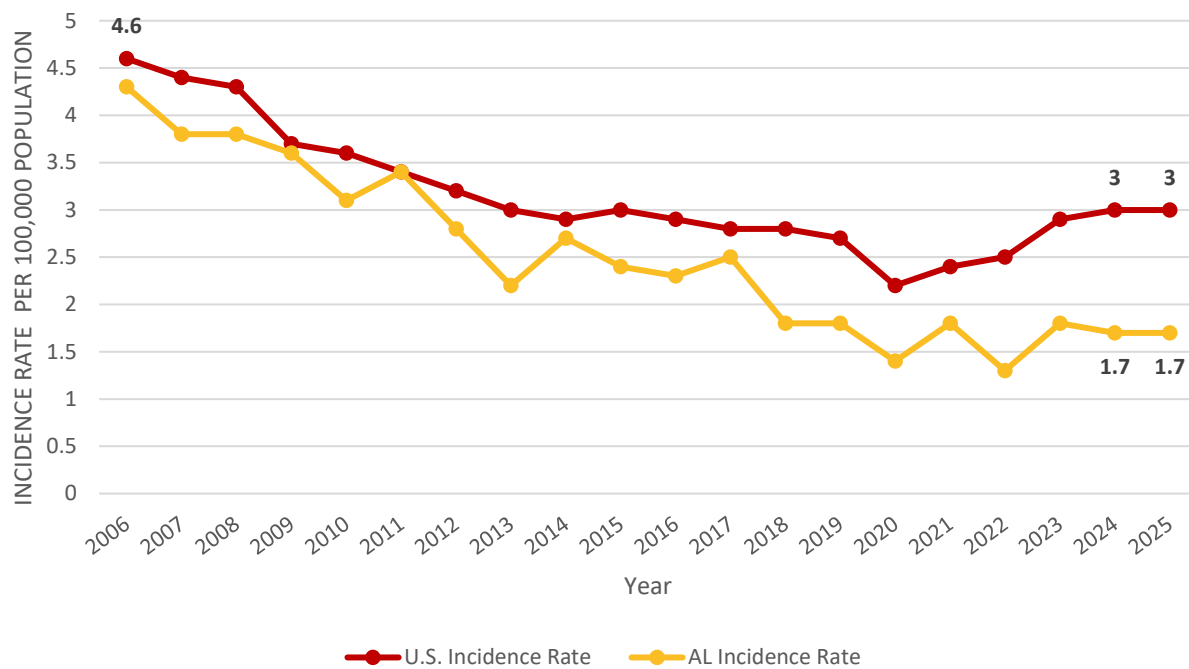
Figure 1: TB CASES AND INCIDENCE RATES*, 2006 - 2025



*Rate per 100,000 persons population

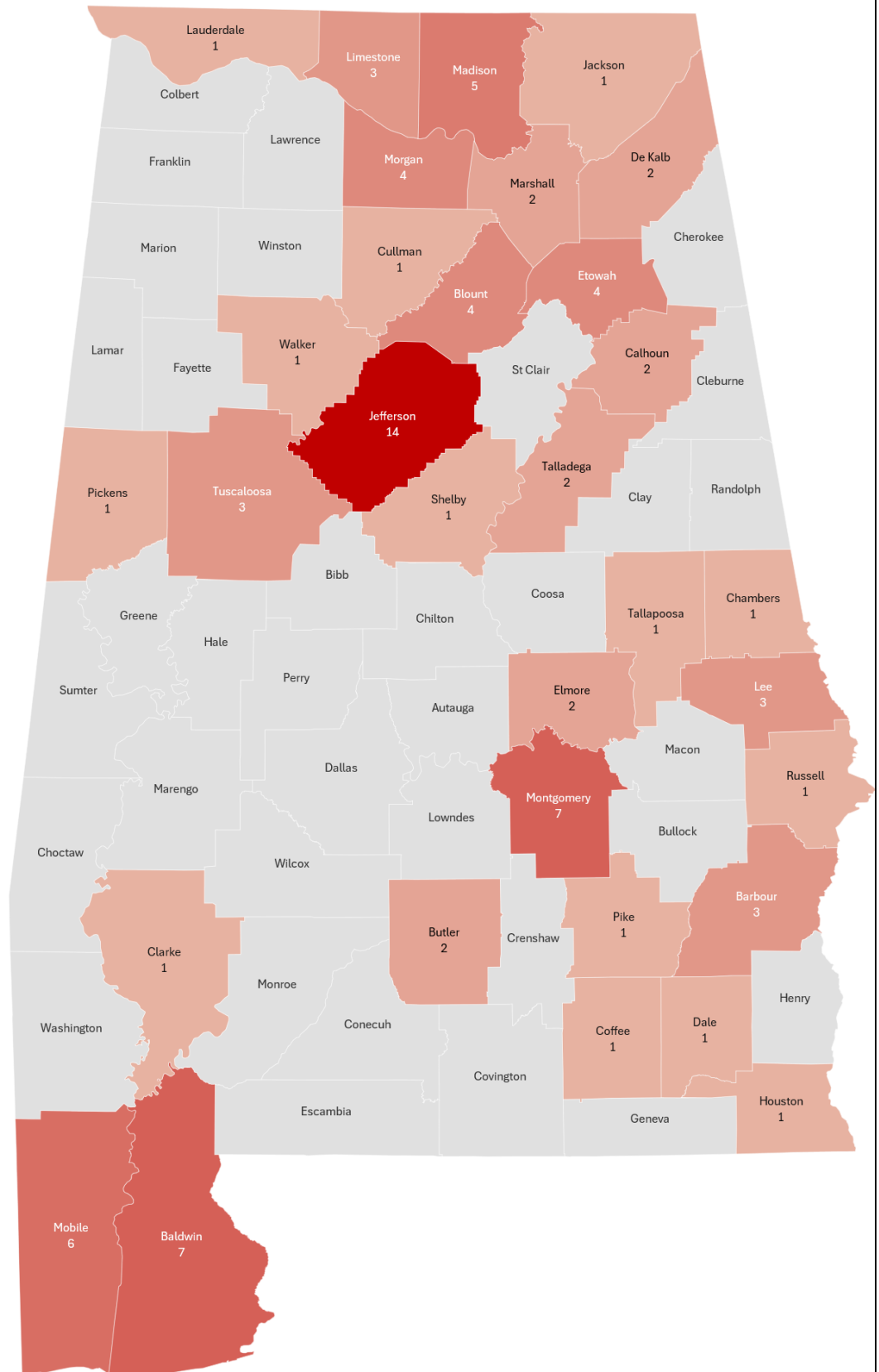
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

FIGURE 2: ALABAMA TB INCIDENCE RATES COMPARED TO UNITED STATES, 2006 - 2025



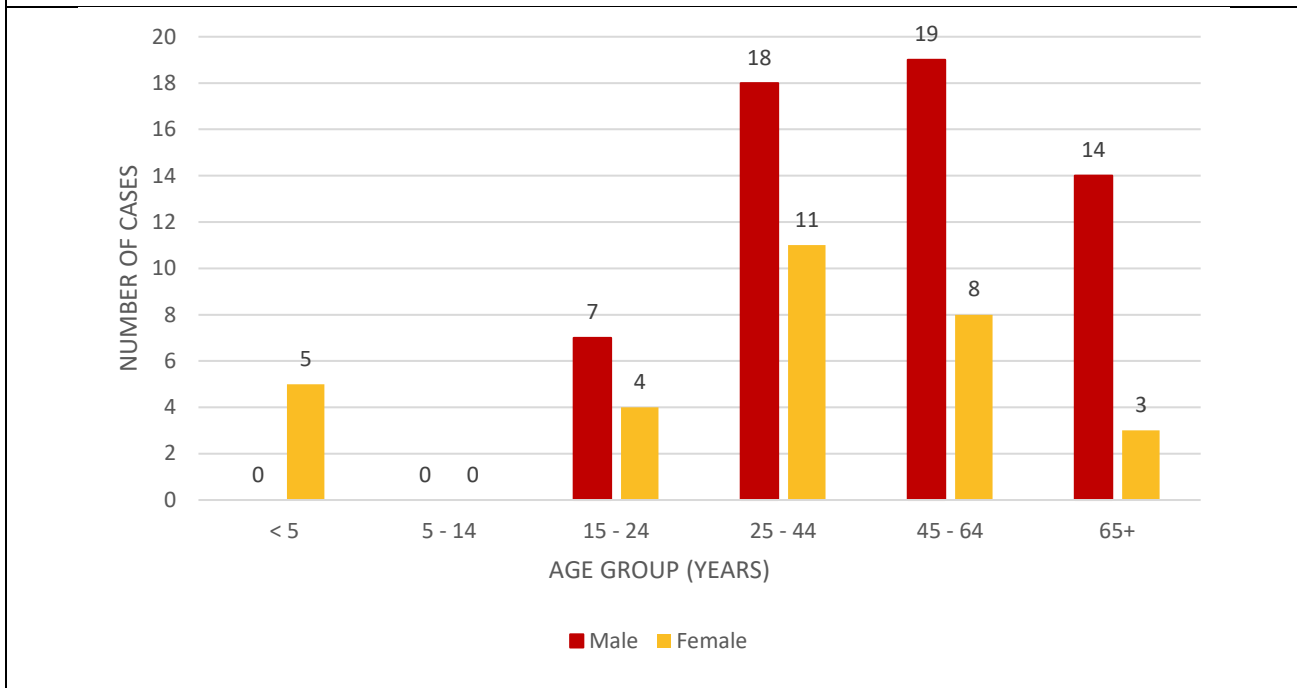
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026. United States incidence rate was obtained from the CDC at cdc.gov/tb/statistics/tbcases.htm as of August 26, 2026.

Figure 3: TB CASES BY COUNTY, 2025 (N = 89)



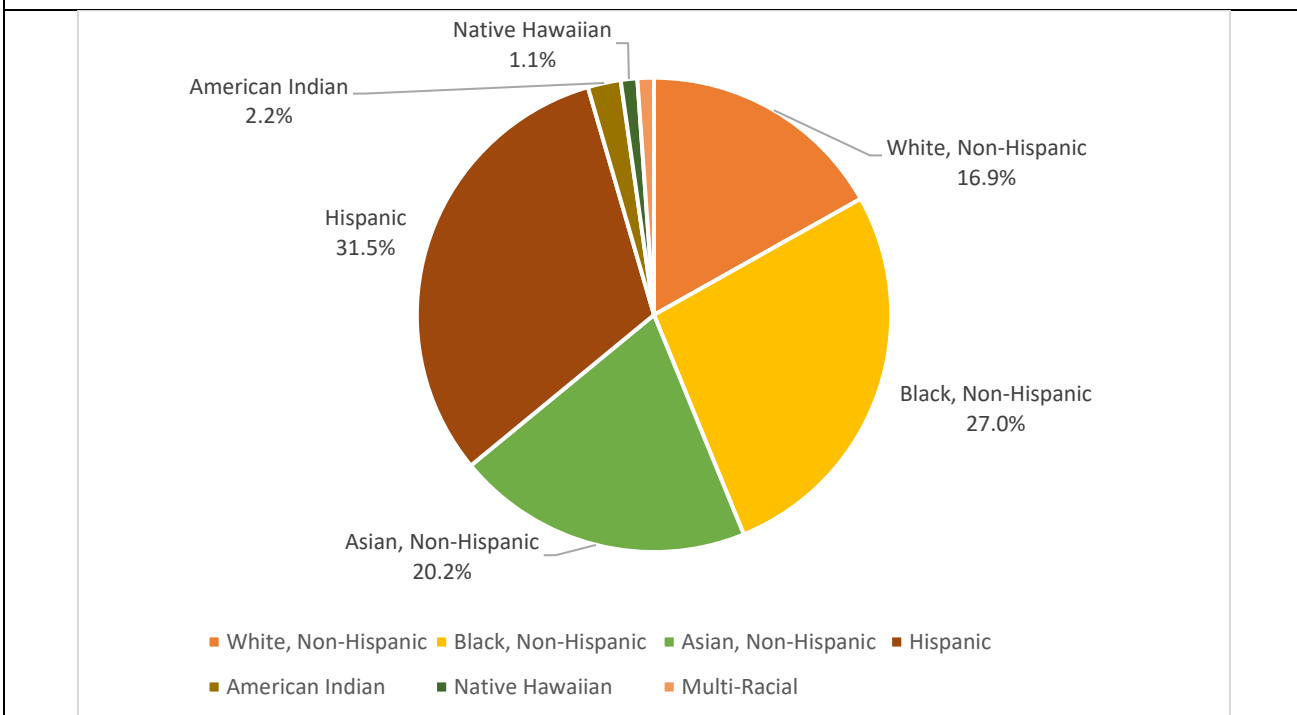
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

FIGURE 4: TB CASES BY AGE AND SEX, 2025 (N = 89)



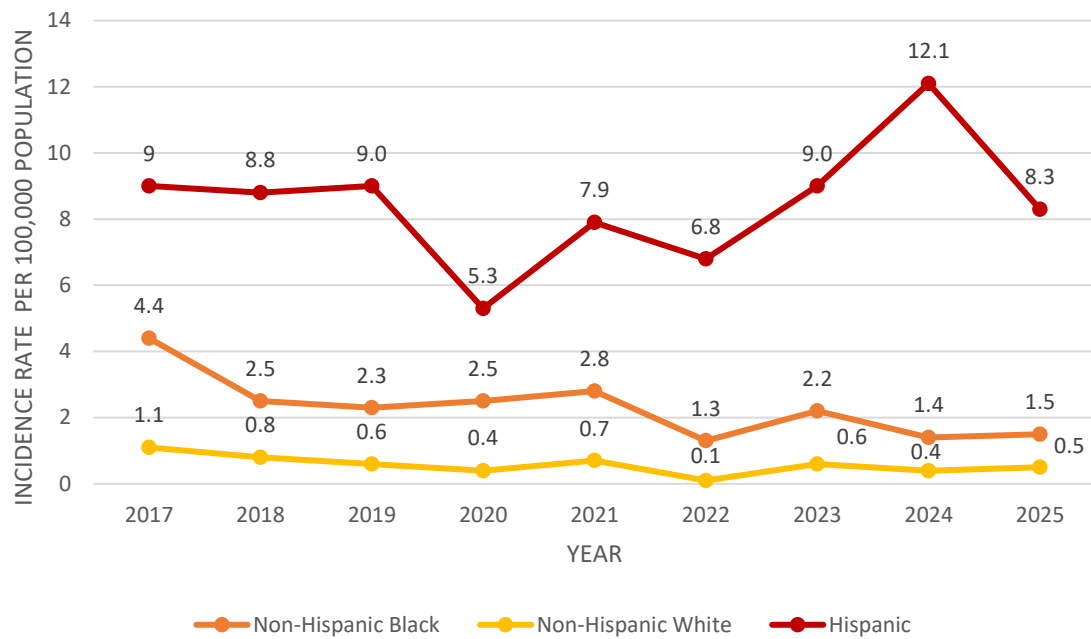
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

FIGURE 5: TB CASES BY RACE/ETHNICITY, 2025 (N = 89)



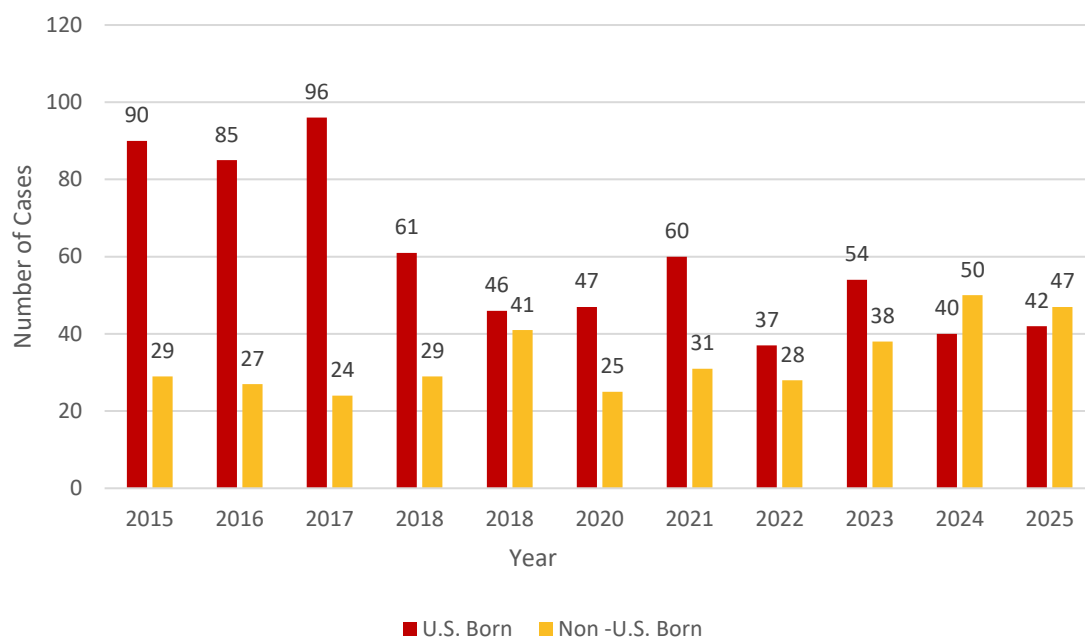
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

FIGURE 6: TB INCIDENCE RATES*AMONG NON-HISPANIC BLACK, NON-HISPANIC WHITE, AND HISPANIC PERSONS, 2017 - 2025



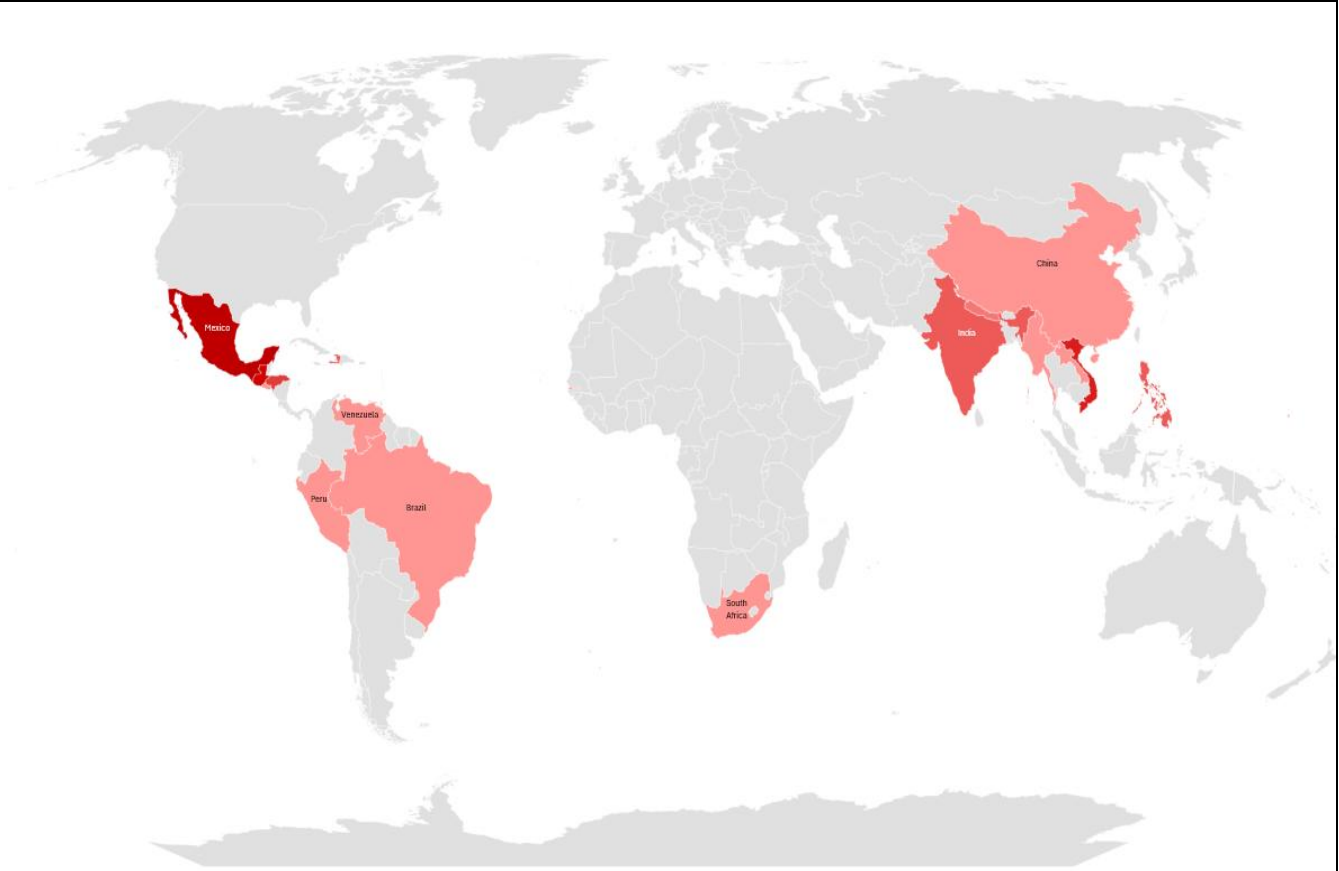
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

FIGURE 7: U.S.-BORN AND NON-U.S.-BORN TB CASES, 2015 - 2025



Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

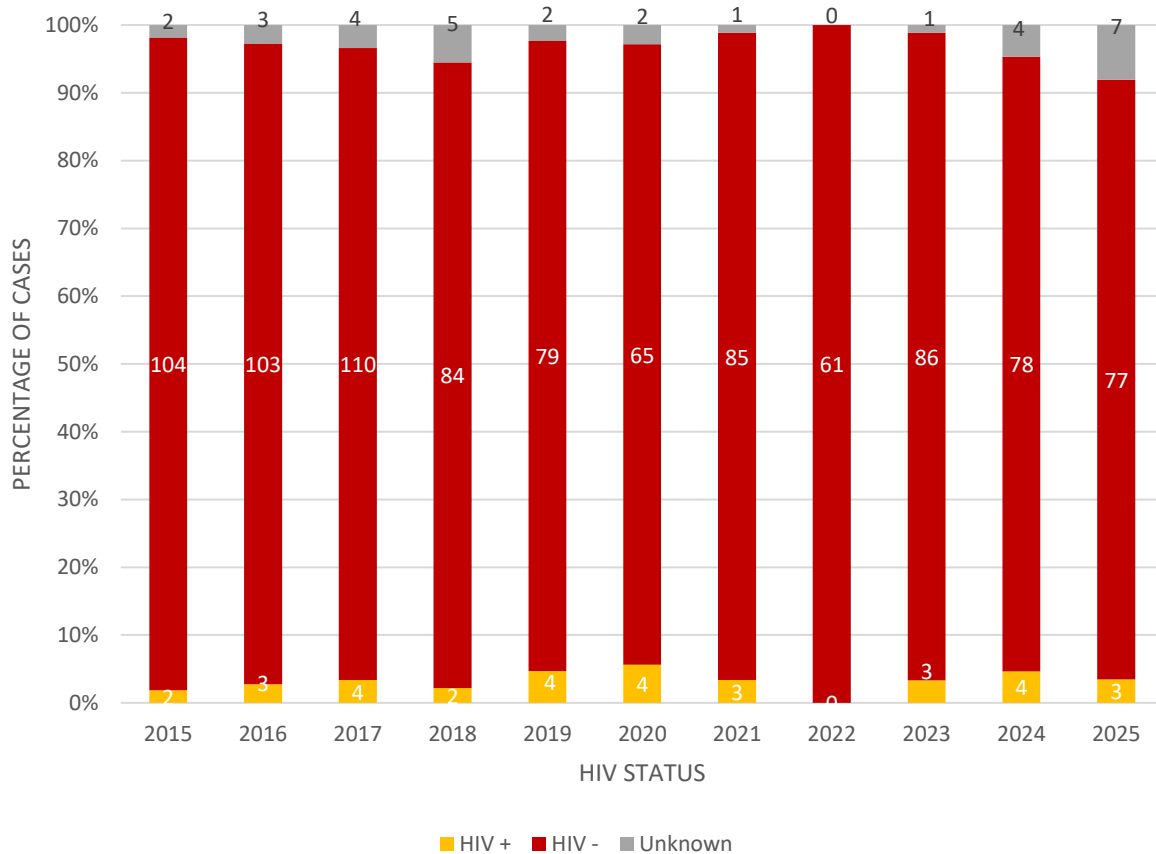
FIGURE 8: COUNTRY OF ORIGIN FOR NON-U.S.-BORN TB CASES, 2025 (N=47)



Country	Case	Country	Case	Country	Case
Mexico	11 (23.4%)	Philippines	3 (6.4%)	Micronesia	1 (2.1 %)
Guatemala	6 (12.8%)	Nepal	2 (4.2%)	Gambia	1 (2.1 %)
Vietnam	5 (10.6%)	Brazil	1 (2.1 %)	Laos	1 (2.1 %)
Honduras	4 (8.5%)	Burma	1 (2.1 %)	Peru	1 (2.1 %)
Haiti	3 (6.4%)	China	1 (2.1 %)	South Africa	1 (2.1 %)
India	3 (6.4%)	El Salvador	1 (2.1 %)	Venezuela	1 (2.1 %)

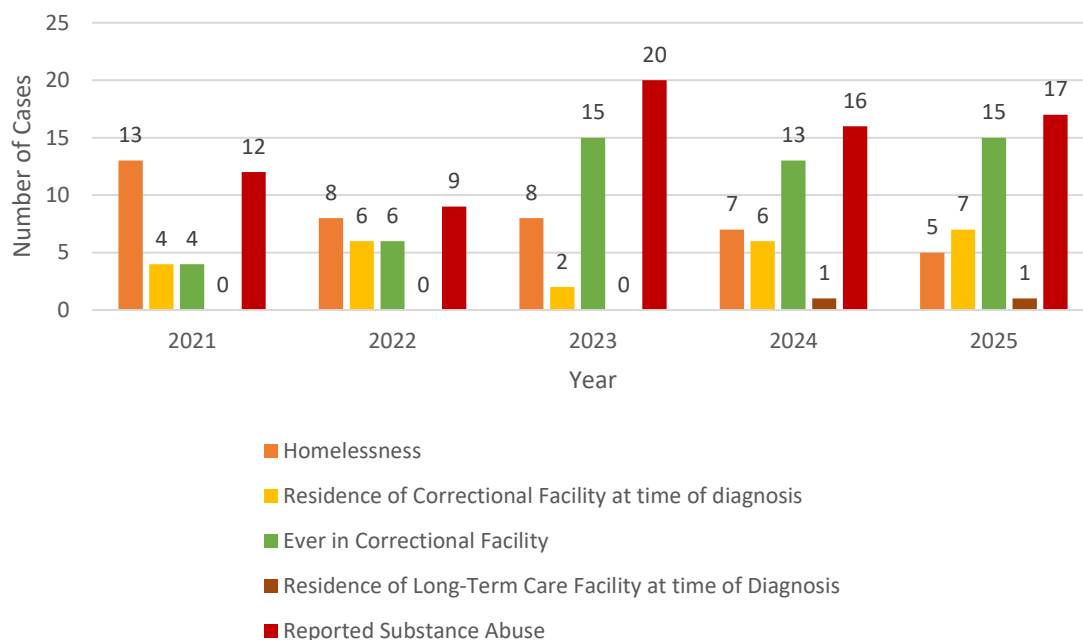
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

FIGURE 9: HIV STATUS OF TB CASES, 2015-2025



Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

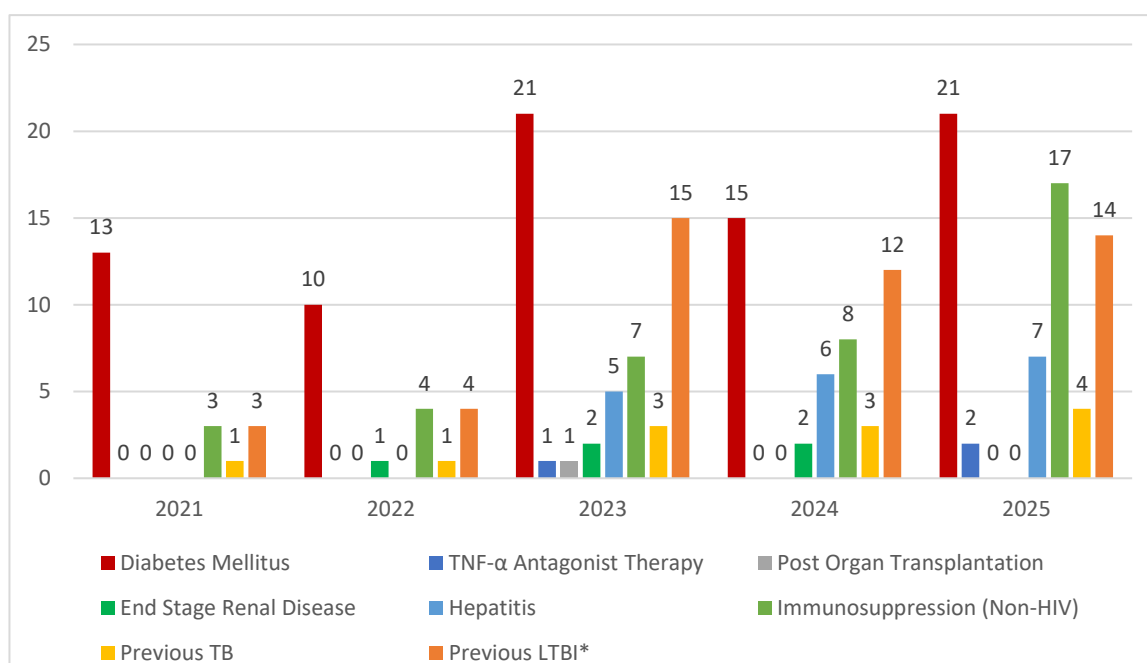
Figure 10: SOCIAL RISK FACTORS AMONG TB PATIENTS, 2021-2025



*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 August 26, 2026.

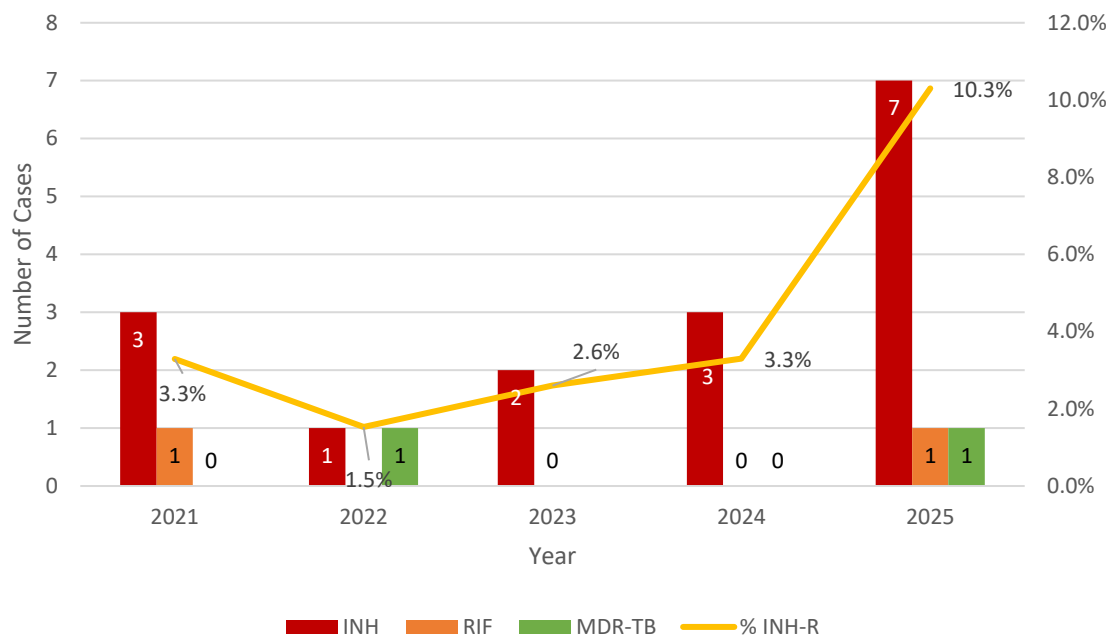
Figure 11: MEDICAL RISK FACTORS AMONG TB PATIENTS, 2021-2025



*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 August 26, 2026.

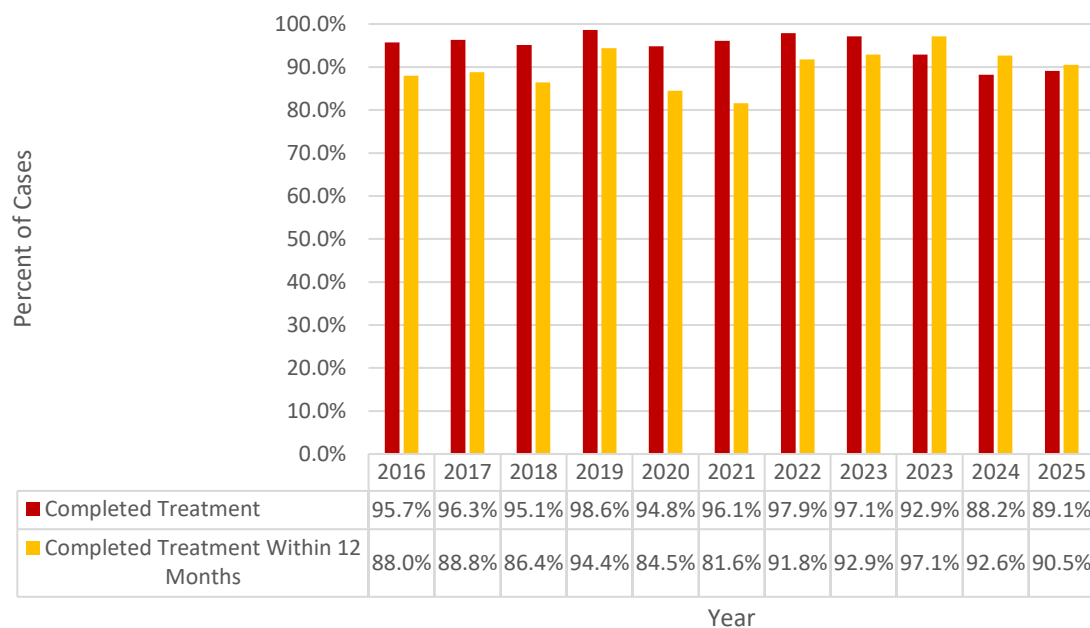
FIGURE 12: PRIMARY DRUG RESISTANCE (INH-R)* AND MULTI-DRUG RESISTANT TB (MDR-TB), 2021-2025**



*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 August 26, 2026.

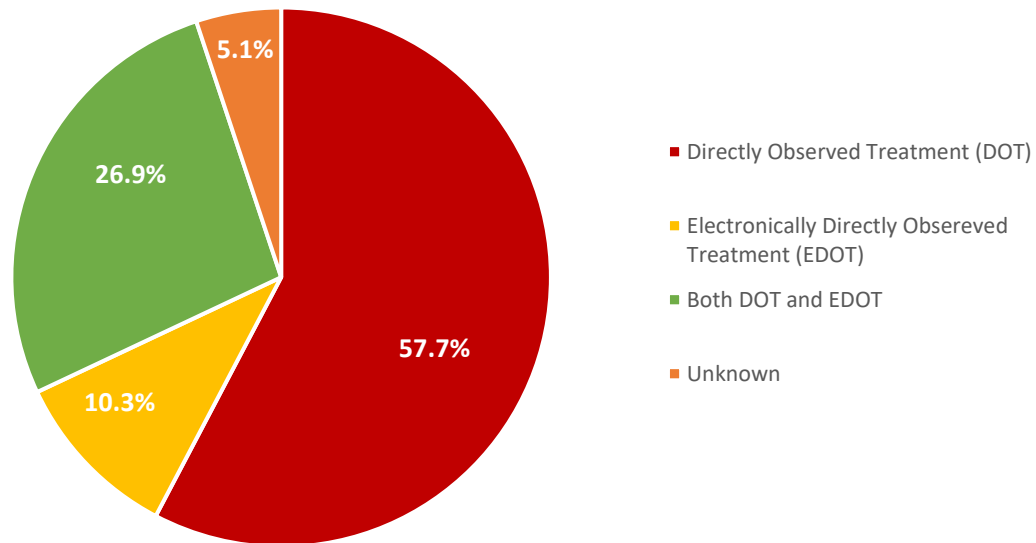
FIGURE 12: COMPLETION OF THERAPY, 2016 - 2025



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 August 26, 2026.

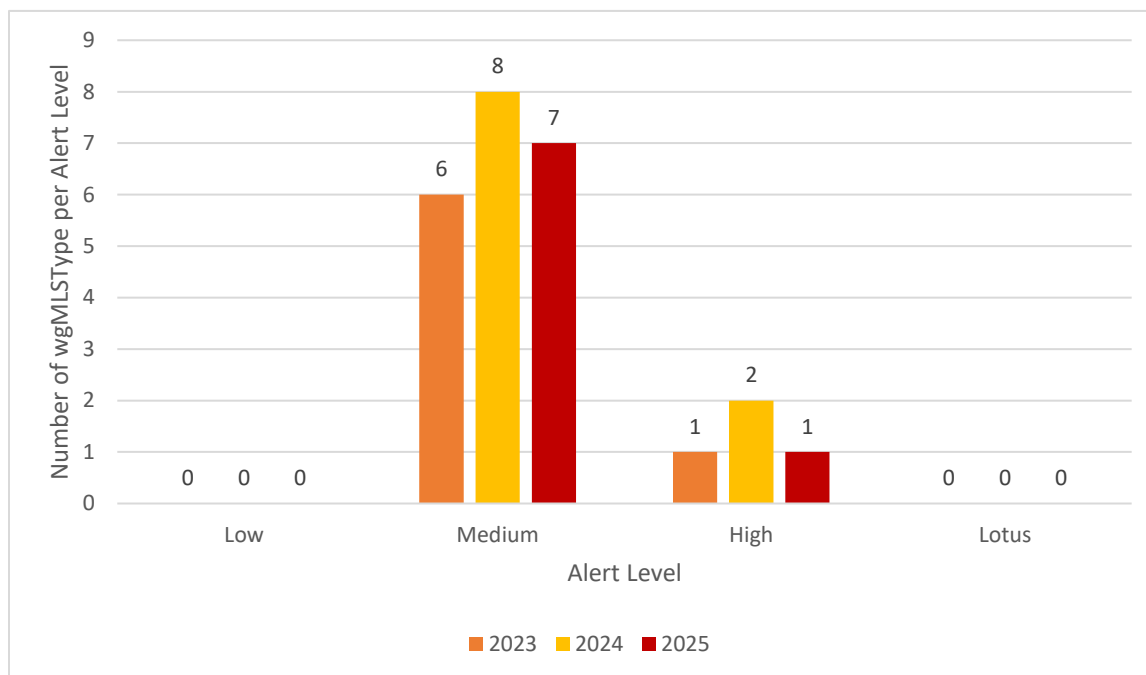
FIGURE 14: MODE OF TREATMENT ADMINISTRATION
AMONG PERSONS REPORTED WITH TB, 2025 (N=78*)



*Some cases were deceased at diagnosis

Data Source: Case counts were obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

FIGURE 15: TB GENOTYPE CLUSTERS* BY CLUSTER SIZE, 2023-2025



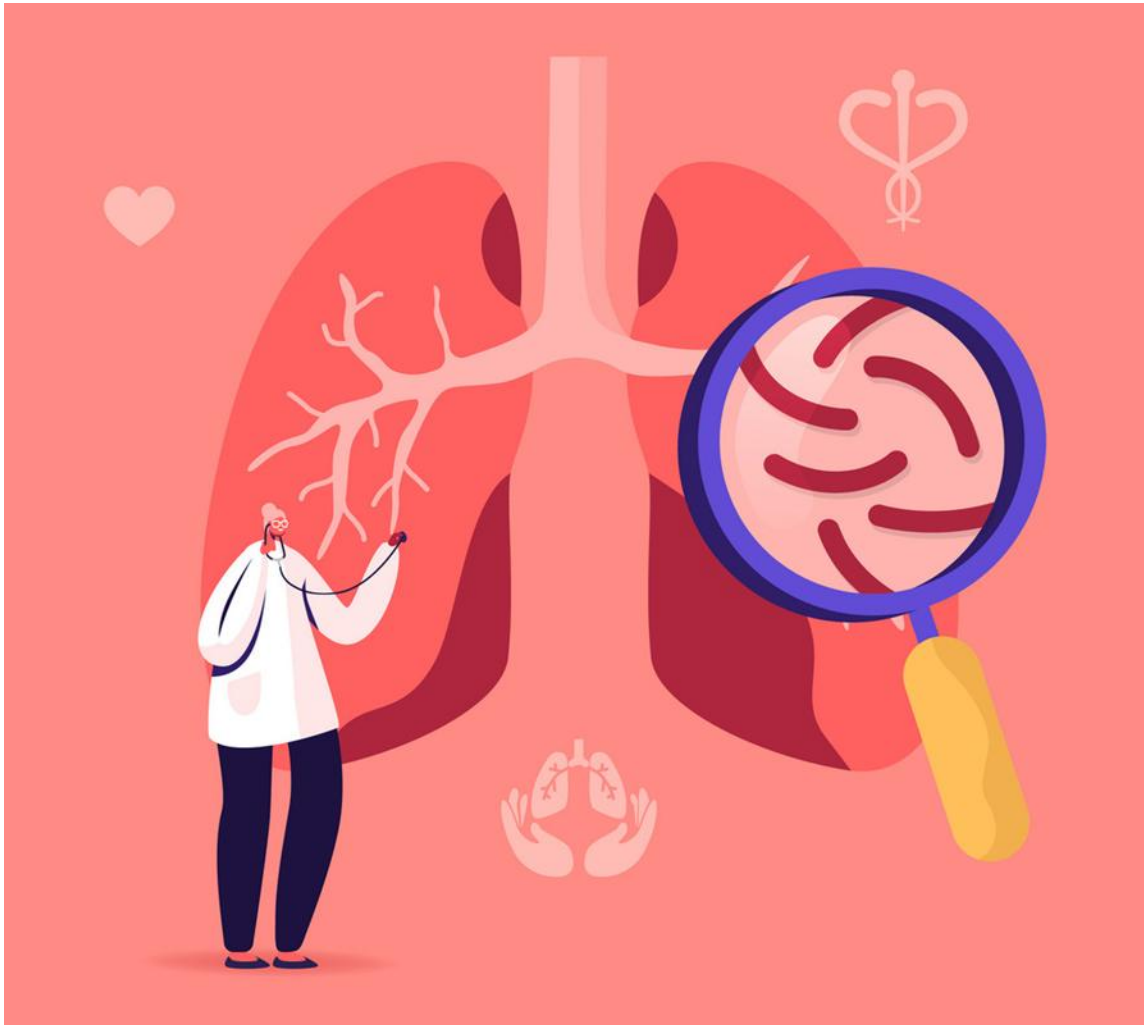
*Genotype clusters are defined as two or more cases with matching spoligotype and 24-locus MIRU-VNTR (GENType) within the specified 3-year period in a geographic concentration of a county genotype cluster compared with the national average. According to the CDC, alert level is determined by the log likelihood 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 $5 \leq 10$, and "high" alert is for clusters with $LLRs \geq 10$. 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 August 26, 2026.

2016 – 2025

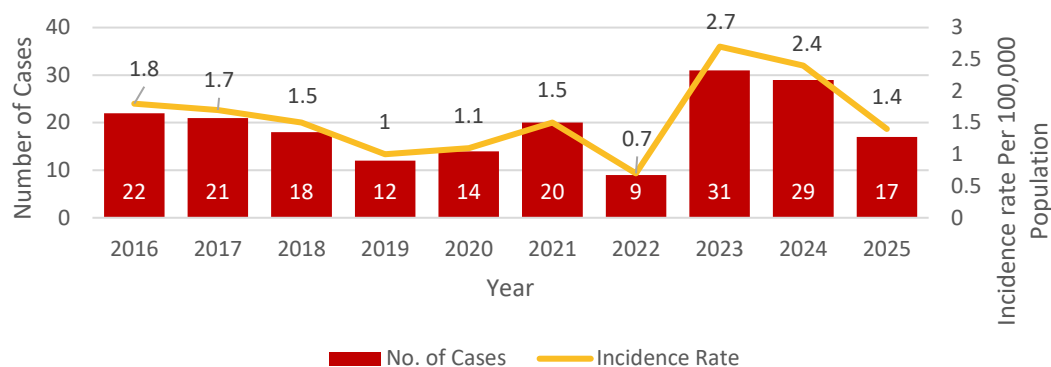
TUBERCULOSIS MORBIDITY TRENDS

BY PUBLIC HEALTH DISTRICT



NORTHERN PUBLIC HEALTH DISTRICT: TB CASES AND RATES

2016 – 2025, N=17



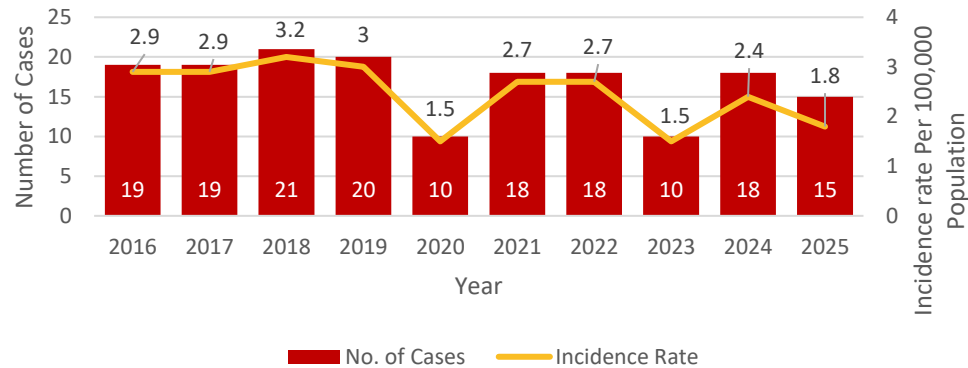
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

2025 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	11	US Born	6
Female	6	Non-US Born	11
Site of Disease			
Pulmonary	14	Extra-Pulmonary	1
		Both	2
Age		Race/Ethnicity	
< 5	1	Asian	6
5-14	-	African American	4
15-24	2	Pacific Islander	1
25-44	15	Multi-Racial	-
45-64	7	Native American/Alaskan	-
65+	2	White	3
		Hispanic	3
Medical Risk Factors		Social Risk Factors	
Diabetes	4	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	2
Non-HIV/AIDS Immunocompromised	2	Heavy Alcohol Use	2

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

NORTHEASTERN PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2016 – 2025, N=115



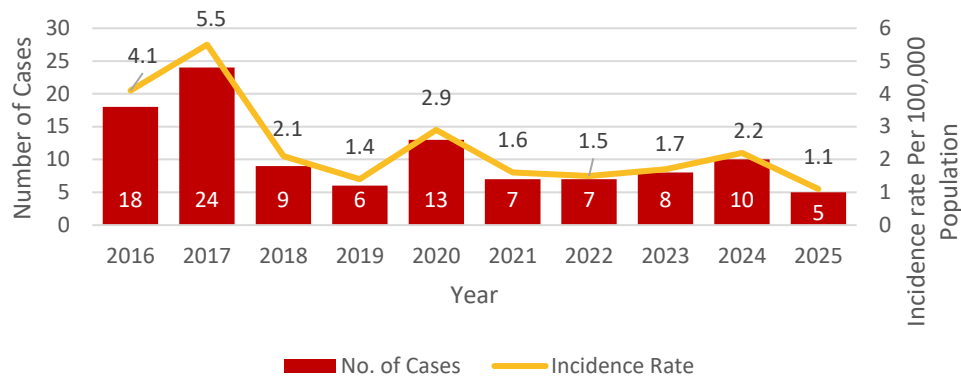
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

2025 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	8	US Born	9
Female	7	Non-US Born	6
Site of Disease			
Pulmonary	11	Extra-Pulmonary	3
		Both	1
Age		Race/Ethnicity	
< 5	2	Asian	1
5-14	-	African American	5
15-24	2	Pacific Islander	-
25-44	5	Multi-Racial	-
45-64	5	Native American/Alaskan	1
65+	1	White	2
		Hispanic	6
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	2
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	-	Injecting Drug Use	-
Viral Hepatitis	-	Non-injecting Drug Use	1
Non-HIV/AIDS Immunocompromised	1	Heavy Alcohol Use	1

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

WEST CENTRAL PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2016 – 2025, N=5



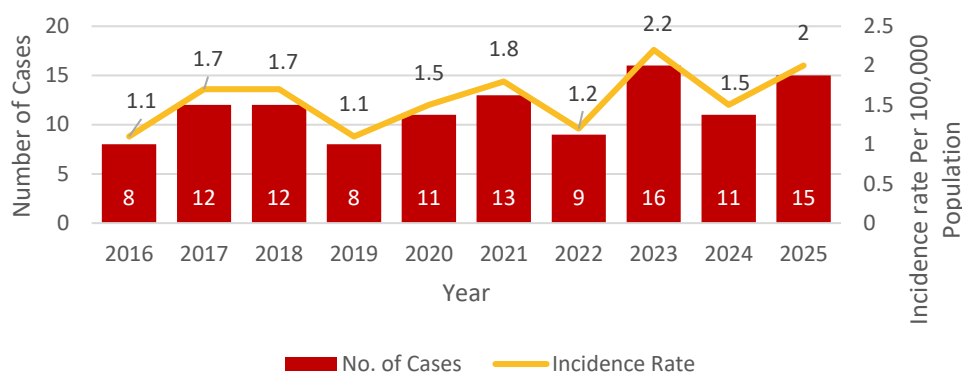
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

2025 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	3	US Born	1
Female	2	Non-US Born	4
Site of Disease			
Pulmonary	4	Extra-Pulmonary	1
		Both	-
Age		Race/Ethnicity	
< 5	-	Asian	3
5-14	-	African American	-
15-24	2	Pacific Islander	-
25-44	1	Multi-Racial	-
45-64	2	Native American/Alaskan	-
65+	-	White	-
		Hispanic	2
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	-
Non-HIV/AIDS Immunocompromised	-	Heavy Alcohol Use	-

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

EAST CENTRAL PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2016 – 2025, N=15



Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

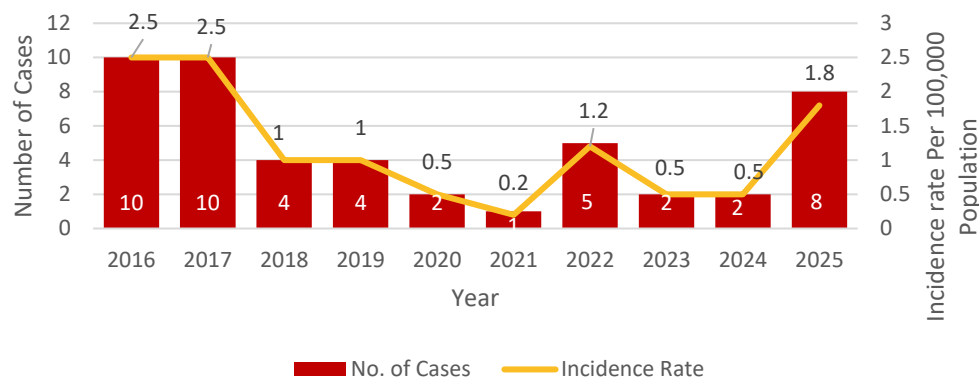
2025 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	9	US Born	7
Female	6	Non-US Born	8
Site of Disease			
Pulmonary	13	Extra-Pulmonary	2
		Both	-
Age		Race/Ethnicity	
< 5	-	Asian	2
5-14	-	African American	6
15-24	2	Pacific Islander	-
25-44	7	Multi-Racial	-
45-64	4	Native American/Alaskan	-
65+	2	White	2
		Hispanic	5
Medical Risk Factors		Social Risk Factors	
Diabetes	5	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	1	Non-injecting Drug Use	4
Non-HIV/AIDS Immunocompromised	4	Heavy Alcohol Use	-

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

SOUTHWESTERN PUBLIC HEALTH DISTRICT: TB CASES AND RATES

2016 – 2025, N=8



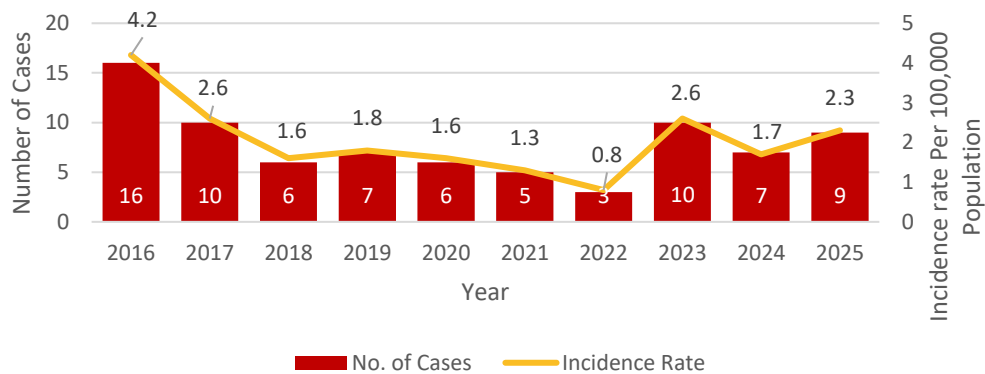
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

2025 DEMOGRAPHICS AND RISK FACTORS

Sex			Nativity		
Male	7		US Born		2
Female	1		Non-US Born		6
Site of Disease					
Pulmonary	7	Extra-Pulmonary	-	Both	1
Age		Race/Ethnicity			
< 5	-	Asian			1
5-14	-	African American			1
15-24	-	Pacific Islander			-
25-44	5	Multi-Racial			-
45-64	-	Native American/Alaskan			-
65+	3	White			1
		Hispanic			5
Medical Risk Factors			Social Risk Factors		
Diabetes	1	Homeless with 12 Months of Diagnosis			-
TNF- α antagonist therapy	1	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			1
Non-HIV/AIDS Immunocompromised	1	Heavy Alcohol Use			-

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

SOUTHEASTERN PUBLIC HEALTH DISTRICT: TB CASES AND RATES 2016 – 2025, N=9



Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

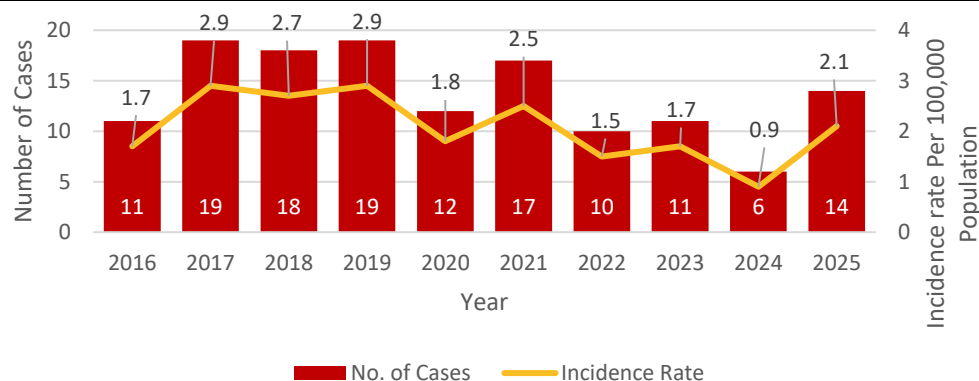
2025 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	9	US Born	7
Female	-	Non-US Born	2
Site of Disease			
Pulmonary	8	Extra-Pulmonary	-
		Both	1
Age		Race/Ethnicity	
< 5	-	Asian	-
5-14	-	African American	4
15-24	1	Pacific Islander	-
25-44	2	Multi-Racial	-
45-64	3	Native American/Alaskan	-
65+	3	White	3
		Hispanic	2
Medical Risk Factors		Social Risk Factors	
Diabetes	2	Homeless with 12 Months of Diagnosis	-
TNF- α antagonist therapy	-	Resident of Correctional Facility at Diagnosis	3
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	-	Injecting Drug Use	-
Viral Hepatitis	3	Non-injecting Drug Use	2
Non-HIV/AIDS Immunocompromised	5	Heavy Alcohol Use	1

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

JEFFERSON PUBLIC HEALTH DISTRICT: TB CASES AND RATES

2016 – 2025, N=14



Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

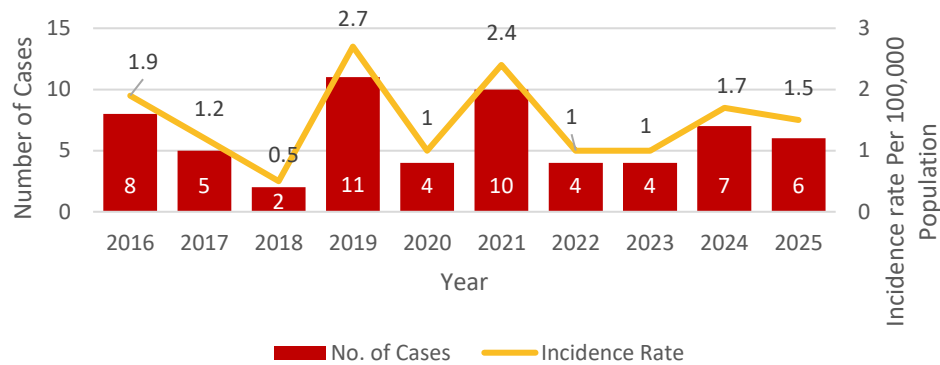
2025 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	8	US Born	6
Female	6	Non-US Born	8
Site of Disease			
Pulmonary	13	Extra-Pulmonary	1
		Both	-
Age		Race/Ethnicity	
< 5	1	Asian	2
5-14	-	African American	3
15-24	2	Pacific Islander	-
25-44	4	Multi-Racial	1
45-64	3	Native American/Alaskan	1
65+	4	White	2
		Hispanic	5
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	2
Post Organ Transplant	-	Resident of Long-Term Care Facility at Diagnosis	-
End State Renal Disease	-	Injecting Drug Use	-
Viral Hepatitis	2	Non-injecting Drug Use	1
Non-HIV/AIDS Immunocompromised	3	Heavy Alcohol Use	1

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

MOBILE PUBLIC HEALTH DISTRICT: TB CASES AND RATES

2016 – 2025, N=6



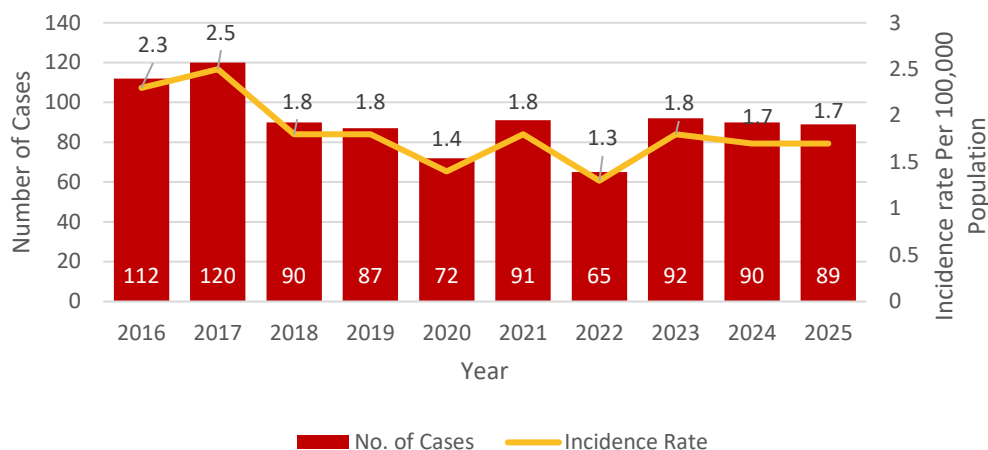
Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

2025 DEMOGRAPHICS AND RISK FACTORS

Sex		Nativity	
Male	4	US Born	4
Female	2	Non-US Born	2
Site of Disease			
Pulmonary	5	Extra-Pulmonary	1
		Both	-
Age		Race/Ethnicity	
< 5	1	Asian	3
5-14	-	African American	2
15-24	-	Pacific Islander	-
25-44	-	Multi-Racial	-
45-64	3	Native American/Alaskan	-
65+	2	White	1
		Hispanic	-
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	1
End State Renal Disease	-	Injecting Drug Use	-
Viral Hepatitis	-	Non-injecting Drug Use	1
Non-HIV/AIDS Immunocompromised	1	Heavy Alcohol Use	-

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

ALABAMA: TB CASES AND RATES 2016 – 2025, N=89



Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

2025 DEMOGRAPHICS AND RISK FACTORS

Sex			Nativity		
Male	58		US Born	42	
Female	31		Non-US Born	47	
Site of Disease					
Pulmonary	75	Extra-Pulmonary	9	Both	5
Age		Race/Ethnicity			
< 5	5	Asian			18
5-14	-	African American			24
15-24	11	Pacific Islander			1
25-44	29	Multi-Racial			1
45-64	27	Native American/Alaskan			2
65+	17	White			15
		Hispanic			28
Medical Risk Factors			Social Risk Factors		
Diabetes	21	Homeless with 12 Months of Diagnosis			5
TNF-α antagonist therapy	2	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	7	Non-injecting Drug Use			12
Non-HIV/AIDS Immunocompromised	17	Heavy Alcohol Use			5

Data Source: Case counts was obtained from the National Tuberculosis Surveillance System data as of August 26, 2026.

