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UNIVERSAL HEALTH CARE - "HEALTHY KIDS" GOES LIVE JULY, 2004!

Santa Cruz County will join a small number of other California counties on July 1st with its own universal health insurance program for children and teens. The plan known as "Healthy Kids" will provide health insurance to children 0-18 years of age who are in families up to 300% of the Federal Poverty Level who do not qualify for other health insurance such as MediCal or Healthy Families. The program will cover all children regardless of immigration status.

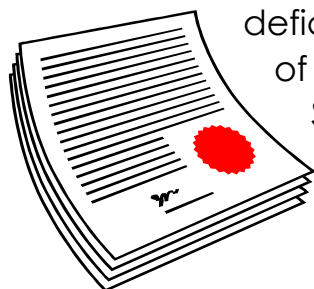
Modeled after similar plans in Santa Clara, San Mateo and San Francisco Counties, the concept for Santa Cruz County grew out of the "Summit on the Uninsured" held at Cabrillo College on June 29, 2002. Some 23 partners have pooled their experience, resources and collective determination to give low-income kids a healthy start in life. Pledges of nearly \$1.7 million have been secured to begin the program, that will eventually cover 2,300 kids by the end of 2007. At that time, the annual program cost will be \$2.6 million. Funding commitments have been made from First Five of Santa Cruz County, the County of Santa Cruz Board of Supervisors and Health Department, the Community Foundation of Santa Cruz County, the Pajaro Valley Community Health Trust, United Way of Santa Cruz County, The David and Lucile Packard Foundation and the California Healthcare Foundation. Other major grants from private and public foundations as well as Federal matching funds are also being sought.

Healthy Kids insurance premiums will cost \$95 per child, per month and will largely come from the funding agencies. In addition, each family will pay a share of costs for the Plan, ranging from \$4 to \$18 per child, per month, depending on their income level. Eligibility for Healthy Kids will be determined in a seamless manner by trained eligibility workers who will first sign-up those kids who are eligible for MediCal or Healthy Families and those who don't qualify for these plans will be enrolled into Healthy Kids. The Central Coast Alliance for Health has obtained a license to manage the plan, and Healthy Kids beneficiaries will utilize most of the medical and dental providers who serve children in the Healthy Families program.

Healthy Kids will be announced widely at a community celebration event Saturday, June 26th at 10:00 a.m. in the Watsonville City Plaza and active enrollment will begin at numerous sites throughout the county in July.

SPRING BRINGS BUDGET WOES

When spring comes to California, State and Local Governments struggle to balance their respective budgets for the 2004/05 period. Currently, there are unprecedented challenges to this process. The huge State Budget deficit created a turbulent political landscape that led to the recall of Governor Gray Davis and the election of Governor Arnold Schwarzenegger. These events were followed very quickly by the passage of a State referendum to issue 15 billion dollars in bonds to better finance the state's large debt. Even political insiders were surprised by the rapidity of these dramatic events. As the 2003/04 Budget period winds down, the State



Legislature is very busy trying to put together a budget bill for 2004/05 that will pass. California is one of a very few states in the country that requires a "supermajority" (two-third of the legislature) to pass a budget. During the March primary election there was a ballot measure that would have reduced this requirement to 55%. It was soundly defeated, largely because of a concern that it would be easier for the legislature to raise taxes, in addition to passing a budget.

In California, the Governor sent budget proposals to the legislature to consider in forming a budget bill, that will eventually be passed in some form and sent to the governor for signature. The budget proposals that the new Governor sent to the legislature in early 2004 were problematic in many areas that affect health. However, the Governor's revision of the Budget Proposal in May addresses some of these concerns, such as the reduction in MediCal reimbursement rates. Other wide ranging cuts in State spending were proposed as well. The Governor has said that unless significant cuts are made, all of the State programs are in jeopardy. The Legislature has begun budget hearings in Sacramento and expressed deep concern over cuts in service. The Governor has said that he will not support any proposals to raise taxes. And in California, the governor has line-item veto over any budget appropriation made by the legislature. Override of that veto power takes a two-third vote of the legislature and is rare. Since local government is heavily dependent on the State, counties will be in a precarious situation until some agreement is reached. As the 2003/04 Budget period ends in June 30, 2004 and the California State Government faces the challenge to produce a new budget by the July 1 deadline, local government will face anxious times.



WHAT'S IT ALL ABOUT, ALPHA?

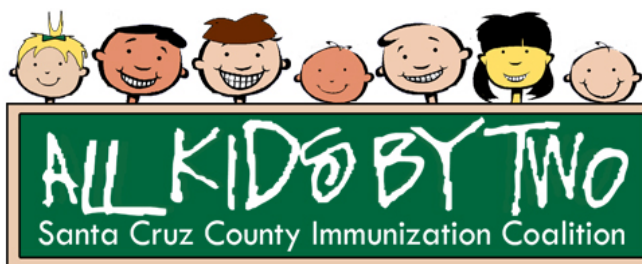
The Public Health Department has a new unit dedicated to emergency preparedness called All Hazards Public Health Authority, or ALPHA, for short. ALPHA was formed as a result of a grant our county received from the Centers for Disease Control and Prevention (CDC). This is a multi-year federal grant that was given to every county to plan for a Public Health response to new, emerging infectious diseases and the threat from bioterrorism. ALPHA's mission is to prepare, prevent and protect our residents from communicable disease and other emergency situations. To that end, we have published a new *Essential Reporting Guidelines* for physicians, clinics, and laboratories. This

latest edition is in a binder so that we may send page revisions to the health care community without having the expense of printing an entirely new booklet when changes occur and/or new diseases emerge. Our goal is to have at least 90% of practicing physicians in the county receive an ALPHA binder by November 2004. Our hope is that it becomes a well-used resource for information on communicable diseases and reporting guidelines. We have posted the contents of the *Essential Reporting Guidelines* on our web site at www.santacruzhealth.org. If you would like a hard copy of the guidelines, please call us at 831-454-7529.



THERE'S A NEW NUMBER - CRUNCHER IN TOWN!

Santa Cruz County has a new epidemiologist, Will Forest, M.P.H. Will works two jobs in one: half time with the Disease Control Unit (DCU), and half time with ALPHA. In his DCU hat, he uses public health surveillance data to identify county disease incidence and to determine trends of the over 90 reportable diseases. He will also be directly involved in outbreak investigations, performing data evaluation and intervention planning. In his ALPHA hat, he has lead responsibility for Focus Area B of the bioterrorism grant, which deals with disease surveillance. He will be looking for ways to improve disease reporting systems' timeliness and completeness — especially through electronic reporting mechanisms — and to use surveillance systems to more quickly identify disease outbreaks. He'll also be exploring the possible usefulness of animal disease reporting for public health purposes, studying the capacity of local health care facilities to respond to catastrophic demand surges, and helping to prepare for outbreaks of relatively new diseases such as SARS, West Nile Virus, and new influenza strains. Should you have any questions regarding epidemiological issues, Will can be reached at 831-454-7561.



Vaccine-preventable diseases continue to afflict children and other residents in Santa Cruz County. There was a notable rise in the number of reported Pertussis cases to 54 in 2003, the highest since 1999, and 12 cases year to date in 2004. Last year, the county had its first pediatric Tetanus case. There are a variety of factors that can contribute to the occurrence of vaccine-preventable diseases, but one that is of particular concern to public health officials and child health advocates is the higher rate of Santa Cruz County's personal belief exemption (PBE) rate. Parents of children who enter childcare or school may sign a PBE waiver that exempts their child from meeting immunization requirements. PBE rates rose dramatically in 2001 to almost 5% for kindergarten entry and over 4% for childcare entry, compared to statewide rates of just over 1%. PBEs are generally associated with parents' fears due to lack of accurate, research-based information about vaccine safety and an understanding of the potential consequences of not getting their children fully immunized in a timely manner.

All Kids by Two (AKT) Coalition is committed to working with health care providers, schools, childcare centers, community service agencies and other groups and individuals towards the goal of disease prevention through immunization across the life-span. AKT is looking to expand its membership to others who share this vision for our community. To find out more about AKT, contact the new AKT Coordinator, Katie LeBaron at 454-5477.

NEW TUBERCULOSIS CONTROLLER FOR SANTA CRUZ COUNTY

Dr. Judy Kelley, the acting Santa Cruz County TB Controller for nearly seven years, has passed the TB baton. She has expertly diagnosed, treated and guided many patients through lengthy episodes of active or latent TB. She also provided consultation to outside providers as well as our own TB clinic staff. We wish to thank Dr. Kelley for her dedication as she passes the task to another Santa Cruz County Public Health Physician, Dr. Marin Muller. Dr. Muller, became the acting TB Controller for Santa Cruz County in March, 2004. Dr Muller is also board certified in internal medicine. He has experience working in the County TB clinics

with Dr. Kelley, as well as a TB clinic in Africa. He says he is looking forward to assisting in TB control.

Welcome Dr. Muller!



RAPID HIV TESTING COMING TO SANTA CRUZ COUNTY

The Food and Drug Administration approved the first HIV “rapid” test called OraQuick in 2003. The rapid HIV test will allow clients to receive their HIV test results in 20 minutes. The entire testing process, from obtaining a blood sample to disclosing the test result, can occur within 30 to 60 minutes. Currently, the OraSure device, which is an oral test, is being used. The testing encounter takes approximately 20 minutes, including counseling and conducting the test and two weeks to receive the results.

The OraQuick test was granted a waiver under the CLIA (Clinical Laboratory Improvement Amendments) regulations in January of 2003. As a result, it may be administered in CLIA-certified but nontraditional laboratory settings by non-laboratory personnel. The Health Services Agency successfully applied for a waiver and listed all possible test sites where OraQuick would be used.

The rapid test requires a finger stick blood sample. The tester must place the blood sample from the finger stick on a specimen collection loop; a toothpick sized plastic stick with a tiny loop at one end to collect the blood. The tester then mixes the sample into a vial containing a solution. Next, the testing device must be placed inside the vial. The testing device consists of a flat pad at one end and a result window at the other. During the test, the flat end touches the bottom of the vial and draws the fluid and blood mixture up into the testing device’s result window.



As previously mentioned, it takes a minimum of 20 minutes for the chemical reaction to occur and for the test results to appear in the result window. The results must be read within 60 minutes of administering the test. The test is sensitive to both temperature and motion. There are various quality assurance measures that must be followed in order to ensure OraQuick is properly administered. The temperature must be between 59 and 80 degrees, and it must be undisturbed during processing.

The accuracy rate of the OraQuick is 99.9%. However, it requires a standard laboratory test to confirm any reactive (positive) OraQuick results. If a client tests positive it is referred to as a “preliminary positive” test. A tester can either collect a standard blood draw sample or an oral test. The sample is then sent to a laboratory for standard processing with both the ELISA and Western Blot confirmatory test. HIV-negative results are considered highly accurate and it is not necessary to confirm.

Staff from the HIV Prevention and Testing Program attended a rapid testing training sponsored by the State Office of AIDS that focused on single session counseling and quality assurance protocols. Our goal is to implement rapid testing at our mobile testing sites and drop-in centers. Rapid testing will also be initiated at Equinox, a community based Harm Reduction and HIV Prevention Center for gay and bisexual men.

If you have any further questions, please contact Socorro Gutiérrez at 454-4302.

A BITE OF SANTA CRUZ



The recent detection of West Nile Virus in dead birds (WNV) and mosquito pools in Southern California Counties heralds the potential of a robust WNV season in California. The virus was detected earlier than expected this year, probably due to the unseasonably warm weather this winter.

What does this bode for the Central Coast region of California?

There is a high likelihood that WNV will be detected in animals and humans in Santa Cruz County sometime this summer or fall.

Once we have local detection of WNV in animals/mosquitoes/birds, the medical community should think WNV, especially in patients over 50 years, who present with a positive mosquito bite history and unexplained cases of:

- encephalitis,
- aseptic meningitis >18 years of age or <18 years of age after R/O enterovirus.
- acute flaccid paralysis/ atypical Guillain-Barre, and transverse myelitis
- acute febrile illness lasting >7 days consistent with WNV.



Clinical Features

- Incubation period, 3-14 days
- Most human infections (\pm 80 %) are not clinically apparent
- 1 in 5 infected persons develop mild febrile illness
- 1 in 150 infected persons develops encephalitis or meningitis

- **Older age (>50 years) is the most significant risk factor** for neurological disease; encephalitis is typical presentation.

Mild Infections (West Nile fever)

Described as a febrile illness of sudden onset lasting 3-6 days, characterized by headache, malaise, anorexia, nausea, vomiting, myalgia, lymphadenopathy, and eye pain. Occasional transient muscle tremors or fasciculation have been reported.



Severe Infection

- The full clinical spectrum of WNV has not been determined.
- Neurological presentations have included:
 - ✓ Severe muscle weakness
 - ✓ Myelitis
 - ✓ Acute flaccid paralysis
 - ✓ Optic neuritis
 - ✓ Polyradiculitis
 - ✓ Cranial nerve abnormalities
 - ✓ Seizures
 - ✓ Ataxia & extrapyramidal signs
- Other common symptoms include:
 - ✓ fever (90%)
 - ✓ weakness (56%)
 - ✓ nausea/vomiting (52%)
 - ✓ headache (47%)
 - ✓ changes in mentation (46%)
 - ✓ diarrhea (27%)
 - ✓ rash (19%)





Atypical transmission

- Patients with lab confirmed WNV should be questioned about blood donation in the preceding 14 days, and any donated units should be withdrawn. Banks have instituted screening and testing procedures for WNV.
- In 2002 there were documented cases of transmission from both organ transplantation and blood (whole blood, packed RBC's, platelets and plasma) transfusion.
- A single case involved a postpartum woman who developed an acute febrile illness after a transfusion. It is recommended that women continue to breast feed, take precautions to avoid mosquito bites, and only be screened if they are symptomatic of WNV.
- In the 2002 season, 5 pregnant women were diagnosed with WNV. (Only one of the five had an infant infected with WNV and had an adverse birth outcome, although no correlation between the two events was established.) Pregnant women should take precautions to avoid mosquito bites. Screening is not indicated unless they are symptomatic of WNV.



Laboratory Diagnosis

Diagnosis is based on clinical suspicion and WNV IGM antibody testing of CSF and serum.

- Recommended specimen collection for diagnosis of WNV is:
 1. 2 cc of serum collected in a "red

- top" tube (not heparinized) less than 7 days after onset of symptoms
2. 1-2 cc of CSF if LP was performed
3. 2cc serum collected 10-14 days after onset of symptoms if acute serum negative and WNV suspected.

Because WNV is a public health concern, we encourage you to utilize regional Public Health laboratories for specimen processing. The PH Labs will perform exhaustive testing. Specimens must be sent in a cold pack. A completed WN Case History form must accompany specimens. Please contact your Local Health Department (LHD) at (831) 454-4114 to arrange for specimen processing.



Treatment

Treatment remains supportive, often involving hospitalization, IV hydration, respiratory support and prevention of secondary infection in persons with severe disease. There is no evidence to date to support the use of antivirals.

Patient Education

- **DRAIN** standing water.
- **DUSK & DAWN**—limit outdoor activities or take precaution to prevent mosquito bites.
- **DEET** is an effective mosquito repellent if the label instructions are followed carefully.
- **DRESS** in long sleeves and pants when and where mosquitoes are active.

REPORT cases of WNV encephalitis/meningitis/fever to the Local Health Department:

**Disease Control Unit
(831) 454-4114**



TUBERCULOSIS SKIN TESTING AND PREGNANCY: WHAT'S NEW?

Pregnancy has little influence on the pathogenesis of tuberculosis (TB) and probably does not increase the likelihood that a latent TB infection (LTBI) will progress to active TB. Therefore, pregnant women only require TB skin testing (TST) if they are in a risk group targeted for TB testing.

Since the year 2000 there has been a new approach to TB skin testing called "targeted tuberculin testing". It is designed to identify those who are at highest risk of progression to active TB. The Centers for Disease Control, the American Thoracic Society and the California Department of Health Services endorse the targeted TST. It limits testing to higher risk groups to increase the predictive value of the TST, which has limited specificity and sensitivity. The targeted risk groups include people who have been recently infected with TB through exposure to an active infectious case, or that have a clinical condition that increases their risk of progression from untreated latent TB to active. Recommended management of TB and targeted TST in the pregnant population will be discussed in detail in this article.



If a pregnant woman has been tested and her TST result is positive, she needs a chest x-ray to rule out active TB and to consider starting treatment for LTBI. The timing for the chest x-ray and treatment vary depending on the risk for rapid progression to active TB versus the potential (but low) risk of fetal injury from x-rays. Treatment for active disease during pregnancy prevents complications that

accompany active TB in pregnant women, including a rare, but often deadly occurrence, congenital TB in the newborn.

The following treatment guidelines are recommended according to sources consulted at the Francis J. Curry National Tuberculosis Center in San Francisco.

1. Pregnant women with any of the following risk factors need a chest-x-ray (with appropriate abdominal shielding) as soon as possible, **even if they are in their first trimester of pregnancy, regardless of their TST status:**

- Symptoms of active tuberculosis (chronic, productive cough lasting at least three weeks, unexplained weakness or fatigue, night sweats, weight loss, or fever)
- Recent close contact to a confirmed case of active TB
- History of untreated active TB, or of previously treated active TB that is not clearly documented or adequate, even if the woman is presently asymptomatic



If the woman has an abnormal chest x-ray suggestive of active TB, she should be fully evaluated for TB disease immediately. If active TB is suspected, she can be treated during pregnancy. Generally, the benefits of treatment outweigh the risk. Women who have had active TB in the past and a stable chest x-

ray need further evaluation. Those women with normal chest x-rays should start treatment for LTBI during pregnancy. The risk for maternal hepatotoxicity from anti TB medicine is less than the benefit of treatment.

2. Pregnant women that fall within the following target groups **and have a positive TST** need a chest x-ray (with appropriate abdominal shielding) **even if they are in their first trimester of pregnancy**. They have high risk for progression to active TB if they are:

- HIV infected
- Chronically Immunosuppressed (immunosuppressive medications, organ transplant, chemotherapy)
- A documented TST converter (an increase of 10 mm or more in induration in the last 24 months)

If the chest x-ray is suggestive of active TB, the woman should be evaluated and treated. It is recommended to start treatment for LTBI during pregnancy if the chest x-ray is normal - the benefit of treatment outweighs the risk in this group.

3. Pregnant women that fall within the following target groups **with a positive TST** need a chest x-ray, which can be done **after their first trimester of pregnancy** (with appropriate abdominal shielding). If active disease is ruled out, these women can delay treatment for LTBI until two months or more after delivery. The risk of maternal hepatotoxicity with LTBI treatment during pregnancy generally outweighs their risk for



progression to active TB:

- Diabetic
- Foreign-born women who have arrived in the U.S. within the last five years from Mexico, Central and South America, Asia, Pacific Islands, Africa, Eastern Europe, or the Middle East.
- Injection-drug users known to be HIV negative
- Homeless
- Experiencing malnutrition or poor weight gain
- Staff or inmates at a jail or prison
- Healthcare workers with direct patient care
- Staff or residents at a long-term care facility
- Silicosis cases
- Alcoholics
- Women with hematological cancers or other hematological or reticuloendothelial diseases



4. Pregnant women, in general, do not need a TST unless they fall into one of the target/risk groups listed in sections 2 and 3.



Please contact the County TB Coordinator Connie Wainwright, for TB information and resources at 454-4333.



For MD consultation contact Dr. Muller at 454-7530 or the Curry National TB Center advice warmline at (415) 502-4700.

SHIGELLA CASE STUDY

This is a composite of cases we have investigated over the last year in Santa Cruz County.

An 8-year-old Hispanic female arrives in the physician's office complaining of stomach cramps, diarrhea streaked with blood for 3 days, and fever. Her mother has been giving her immodium but she seems to be getting worse. The child is tearful and in obvious distress, but does not appear dehydrated. According to her mother, no one else in the household has had similar symptoms. To her knowledge, none of the case's playmates had been ill, although she mentions that the case's developmentally delayed 10 year old cousin with whom she plays had a similar illness after he returned from Mexico a few months ago.

From her symptoms, the differential diagnoses include: *Campylobacter*, *E. Coli* 0157:H7, and *Shigella*. The provider decides the fastest way to get a diagnosis is to do a rectal swab for culture, but the case absolutely refuses to cooperate. The mother agrees to try and obtain stool cultures at home and take them to the lab. She requests something to "slow down the diarrhea", but the provider prefers to wait for the culture results; in the meantime the mother is told to have the child drink water frequently and to stick to a BRAT diet. The physician also cautions the mother to stop using over the counter anti-diarrheals, because he suspects it will prolong the enteric infection.

A few days later the results come back positive for *Shigella sonnei*, and the provider calls in a prescription for trimethoprim/sulfamethoxazole (TMP/SMX), which the child takes for 72 hours before her follow-up visit with the doctor. The

provider sends a confidential morbidity report to County Public Health. At the return appointment her fever has resolved but her GI symptoms persist. The susceptibility report arrives showing that the *Shigella* is resistant to both ampicillin and TMP/SMX, but sensitive to Cipro and Ofloxacin. After consulting the Red Book, the provider suggests a shot of ceftriaxone, but the child vehemently refuses the shot.

The public health nurse contacts the family and interviews the parents regarding the illness. The parents are frustrated that the case is still ill and out of school, and the "doctor didn't do anything for her". The nurse explains *Shigella* transmission and prevention with the family. She also explains why the medication the child took didn't cure her, and why the shot offered by the doctor is an appropriate alternative. The mother seemed relieved to find out that the child would probably improve without treatment, but expressed concern about how long it may take.

Meanwhile, another nurse at Santa Cruz County is discussing her *Shigella* case, a food handler, at the morning communicable disease huddle. She mentions that a contact to her case was a 10-year-old developmentally delayed housemate who denied symptoms but was tested because he is in a special day class and wears diapers. He tested positive for *Shigella sonnei*, and was restricted from school until his stools clear; unfortunately, the isolate is resistant to TMP/SMX and ampicillin. She suspects he may have gotten ill while in Mexico a few months ago. The two nurses compare notes, and realized the 10-year-old boy is a link between the two cases.

The above case illustrates some important facts about *Shigella*, which is a fairly

common enteric illness in the U.S., and even more so in developing countries. *Shigella sonnei* (group D) accounts for about 2/3 of *Shigella* cases in this country, and *Shigella Flexneri* (group B) accounts for most of the remaining cases. Humans are the only significant reservoir of *Shigella* and most cases are transmitted either directly or indirectly via the fecal-oral route. Although both ampicillin and trimethoprim/sulfamethoxazole are commonly used to treat *Shigella*, resistance to antibiotics is an increasing problem, especially in California. In Santa Cruz County in 2003, there were 34 reported cases of *Shigella*. Of the cases of *S. sonnei* for which susceptibility testing was done, all had the same resistance pattern: resistant to ampicillin and TMP/SMX, and sensitive to Ciprofloxacin and Ofloxacin. Since most cases of *Shigella* occur in

children, and fluoroquinolones are generally not recommended for persons under 18 years of age, oral treatment for *Shigella* is a problem. Fortunately, most people without underlying illness will recover without treatment. In rare cases, a carrier state may persist for several months, although treatment with appropriate antibiotics may eliminate it within a few days. Providers may wish to consult *The Medical Letter* (www.medletter.com) for the latest recommendations for treatment. Due to the very low infective dose (ingesting as few as 10 organisms), *Shigella* is easily transmitted from person to person. Preventing transmission by good hygiene practices is extremely important in avoiding the misery known as *Shigella*... another reason to wash your hands and your food!!!

ESTABLISHING A MEDICAL RESERVE CORPS (MRC) IN SANTA CRUZ COUNTY

The health department and the Santa Cruz County Medical Society are exploring the feasibility of establishing a Medical Reserve Corps (MRC). An MRC is an organization comprised of volunteer health care providers who are willing and able to serve the community during a disaster or other public health emergency.

The objectives for the MRC's first year are to:

- develop and maintain a directory of all physicians by specialty in Santa Cruz County,
- conduct a training needs assessment of physicians,
- publicize existing training opportunities, and
- encourage participation in emergency preparedness exercises.

A Medical Reserve Corps is necessary for emergency preparedness efforts. Providers in the community possess expert knowledge and skill that may be vital to response efforts. Moreover, the health department does not have sufficient personnel to conduct all necessary activities involved in a large-scale outbreak. While public health staff conduct case investigations, contact tracing, surveillance and monitoring for compliance with isolation and quarantine orders, medical reserve corps volunteers could assist in provision of mass prophylaxis/vaccination, and/or care of patients.

Please consider serving your community in this very important way. As the project develops, more information will be sent to providers via the health department and Medical Society.

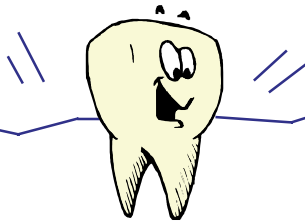


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HEALTH SERVICES
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para tener dientes saludables

AFFIX LABEL

Reportable Cases of Communicable Disease
Santa Cruz County 2000 - 2003

<u>Disease/Condition/Agent</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>
AIDS	21	11	13	17
Campylobacter	91	60	49	68
Chlamydia	544	572	525	585
Gonorrhea	41	47	33	65
Hepatitis A	18	10	16	11
Hepatitis B, Acute	6	8	2	4
Hepatitis B, Chronic	30	35	48	38
Hepatitis C, All	241	264	277	269
Lyme Disease	4	10	3	8
Measles	4	1	0	0
Meningococcal Disease	6	4	5	2
Pertussis	10	34	46	54
Pelvic Inflammatory Disease	48	45	41	24
Rubella	0	0	0	0
Salmonella	35	43	53	32
Shigella	15	13	26	34
Syphilis, Infectious*	0	0	3	12
Tuberculosis, Active	4	7	6	9
Viral Meningitis	20	25	39	44

*primary, secondary & early latent