of STDs, lack of awareness of one's HIV status, homophobia, HIV-related stigma and discrimination, and socioeconomic issues. CDC's Heightened National Response to the HIV/AIDS Crisis among African Americans aims to reduce HIV/AIDS in this population by expanding the reach of prevention services, increasing opportunities for diagnosis and treatment, developing new prevention interventions,[††] and mobilizing broader community action.[§§] In the United States, reducing the toll of HIV/AIDS on young black MSM will require a combination of strategies, including culturally specific behavioral interventions, expanded testing programs, and comprehensive campaigns to combat stigma.

Acknowledgments

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References

1. CDC. Subpopulation estimates from the HIV incidence surveillance system—United States, 2006. MMWR 2008;57:985–9.
2. CDC. Trends in HIV/AIDS diagnoses among men who have sex with men—33 states, 2001–2006. MMWR 2008;57:681–6.
3. CDC. HIV/AIDS surveillance in men who have sex with men. Available at http://www.cdc.gov/hiv/topics/surveillance/resources/slides/msm/index.htm.
4. Bingham TA, Harawa NT, Johnson DF, Secura GM, MacKellar DA, Valleroy LA. The effect of partner characteristics on HIV infection among African American men who have sex with men in the Young Men's Survey, Los Angeles, 1999–2000. AIDS Educ Prev. 2003;15(1 Suppl A):39–52.
5. Marks G, Crepaz N, Senterfitt JW, Janssen RS. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. J Acquir Immune Defic Syndr 2005;39:446–53.
6. CDC. Revised guidelines for HIV counseling, testing, and referral. MMWR 2001;50(No. RR-19):1–67.
7. CDC. HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—five U.S. cities, June 2004–April 2005. MMWR 2005;54:597–601.
8. CDC. HIV transmission among black college student and non-student men who have sex with men—North Carolina, 2003. MMWR 2004;53:731–4.

[††] Additional information available at http://www.cdc.gov/hiv/topics/aa/resources/factsheets/pdf/aa.pdf.

[§§] Additional information available at http://www.cdc.gov/hiv/topics/aa/cdc.htm.

Respiratory and Ocular Symptoms Among Employees of a Hotel Indoor Waterpark Resort — Ohio, 2007

During January–March 2007, the Warren County Combined Health District (WCCHD) received 665 reports of respiratory and eye irritation from patrons and lifeguards at a hotel indoor waterpark resort in Ohio. Tests revealed normal water chemistry and air chlorine concentrations, and exposure to airborne trichloramine in the waterpark was suspected as the cause of the symptoms. Because of the number of symptom reports and WCCHD's limited ability to measure trichloramine, the district requested an investigation by CDC's National Institute for Occupational Safety and Health (NIOSH). This report describes the results of that investigation, which revealed that trichloramine concentrations in the waterpark ranged from below the limit of detection to 1.06 mg/m^3, and some concentrations were at levels that have been reported to cause irritation symptoms (≥0.5 mg/m^3) (*1*). Lifeguards reported significantly more work-related symptoms (e.g., cough, wheezing, shortness of breath, chest tightness, and eye irritation) than unexposed hotel employees. Lifeguards also reported significantly more eye irritation and cough on days when hotel occupancy was high versus low. Insufficient air movement and distribution likely led to accumulation of trichloramine and exacerbation of symptoms. Based on recommendations to increase air movement and distribution at pool deck level, hotel management modified the ventilation system extensively, and subsequently no new cases were reported to WCCHD. The results of this investigation emphasize the importance of appropriate design and monitoring of ventilation and water systems in preventing illness in indoor waterparks.

The indoor waterpark measures approximately 80,000 square feet and has a maximum occupancy of 3,746 persons. It contains 11 waterslides, two activity pools, two hot tubs, a wave pool, a leisure river, a four-story interactive play system, and several features that splash, spray, and aerate large amounts of water. Water flows by gravity through the main drains and gutter systems from the pool into designated surge tanks. The water is pumped out of the surge tanks and filtered. An automated chemical controller tests and adjusts the water's pH and chlorine concentration as needed by adding a sodium hypochlorite solution (to disinfect) and sulfuric acid (for pH).

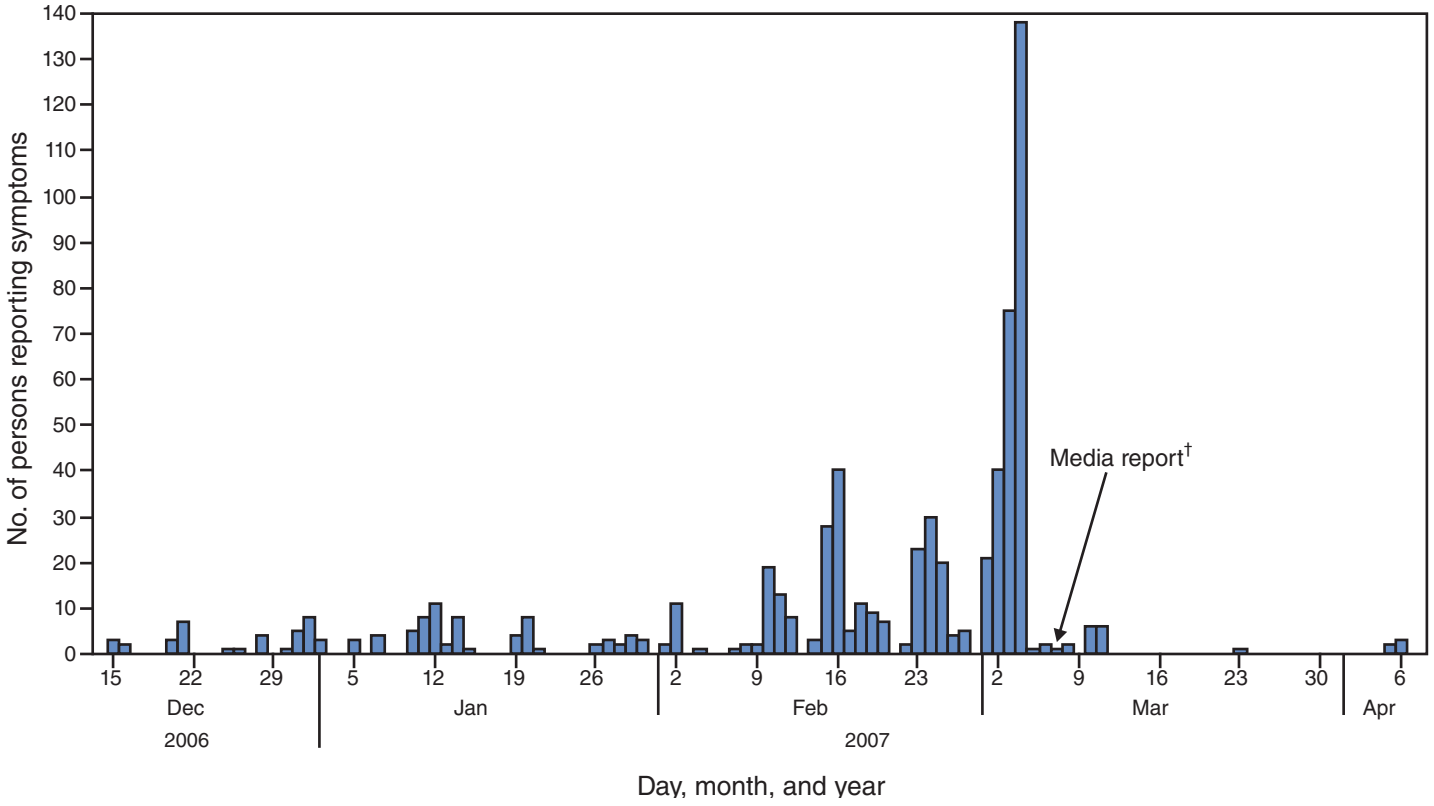
The indoor waterpark opened in December 2006. Within 1 month, WCCHD had received 79 reports of eye and respiratory irritation from patrons and employees. Symptoms included red, burning, or itchy eyes; itchy or runny nose;

cough; wheezing; shortness of breath; chest tightness; and sore throat. Initial tests revealed normal water chemistry and air chlorine concentrations. In February and March 2007, management added additional air distribution outlets to the ventilation system, increased the frequency of water chemistry checks, and added more fresh water to all systems; however WCCHD continued to receive health complaints. By March 2007, WCCHD had received an additional 586 symptom reports (Figure). A marked increase in reported symptoms with onset of March 4 might be attributed to media coverage; on March 7, a family reported symptoms to the local media, and the ensuing media coverage resulted in a marked increase in telephone calls to the local health department with reports of symptoms with earlier onset dates. WCCHD's concern over the number of reports and limited technical resources prompted a technical assistance request to NIOSH, which focused its investigation on resort employees.

The investigation began in early March 2007. Initially, NIOSH investigators interviewed 10 lifeguards. All 10 reported having a cough during work at the waterpark that improved on days off work. Seven reported eye irritation, and three reported nose irritation. Symptoms were worse when the number of persons using the waterpark was high. In March and April 2007, investigators reviewed the facility water chemistry logs and tested pool water on 2 separate days at multiple locations for pH and free and total chlorine. Investigators also reviewed facility plans to assess water and ventilation system designs. To assess the effect of the number of occupants in the pools (bather load) on trichloramine air concentrations, investigators collected 99 trichloramine area air samples on 2 high bather load days (more than 1,000 guests) and 1 low bather load day (fewer than 100 guests). Because no direct counting of bathers was possible, the number of persons booked at the hotel (i.e., hotel occupancy) was used as a proxy for bather load.

During March 20–April 24, 2007, NIOSH investigators conducted a survey of lifeguards working inside the waterpark (exposed) and hotel employees working outside the waterpark (unexposed). All participants filled out an initial questionnaire during this period concerning demographics, work and medical history, and work-related symptoms occurring during the

FIGURE. Number of patrons and employees* reporting respiratory symptoms or irritation of eyes or skin at a hotel indoor waterpark resort, by date of symptom onset — Ohio, December 2006–April 2007



* N = 665.

† The marked increase in reported symptoms with onset of March 4 might be attributed to media coverage; on March 7, a family reported symptoms to the local media, and the ensuing media coverage resulted in a marked increase in telephone calls to the local health department with reports of symptoms with earlier onset dates.

preceding month. Symptoms were considered work-related if they occurred on work days and improved on days off work. Lifeguards also completed an additional questionnaire about symptoms experienced during their shift on each day of trichloramine air sampling. Employees were defined as having asthma if they reported having asthma currently, it was diagnosed by a health professional, and it began before starting work at the waterpark.

Using data from the initial questionnaire, prevalence ratios (PRs) with 95% confidence intervals (CIs) were calculated to compare work-related symptoms during the preceding month for exposed and unexposed employees. Generalized linear models were used to compare respiratory symptoms for the exposure groups while controlling for smoking status and asthma. Using data from the questionnaires filled out on days of air sampling, work-related symptoms for lifeguards on days of high occupancy were compared with symptoms on days of low occupancy. Because some lifeguards filled out this questionnaire on more than 1 day of air sampling, generalized estimating equations were used to account for possible correlations between responses. The analyses involving respiratory symptoms for lifeguards on high and low occupancy days were adjusted for smoking status, and employees with asthma were excluded.

Seventy (68%) of 103 lifeguards working inside the waterpark and 74 (75%) of 99 employees working outside the waterpark completed the initial questionnaire. Lifeguards had significantly higher prevalences of work-related symptoms than unexposed employees (Table 1). Lifeguards also had significantly more work-related cough (PR = 2.2; CI = 1.1–4.5) and eye irritation (PR = 2.0; CI = 1.2–3.2) on days when hotel occupancy was high (Table 2). No other symptoms were significantly more prevalent on high occupancy days.

A total of 99 area air samples for trichloramine were taken at approximately 3–4 feet above pool deck level over 3 separate sampling days: March 20 (high occupancy day 1), April 14 (high occupancy day 2), and April 24, 2007 (low occupancy day). Twenty-four of the samples were quantifiable (i.e., concentrations could be determined); the remaining samples were found at trace levels (i.e., trichloramine was detected but levels were too low to quantify) or trichloramine was not detected. All quantifiable samples were collected on high occupancy days, and 13 (54%) of the 24 exceeded 0.5 mg/m^3, the level at which irritation symptoms have been documented (*1*). The highest trichloramine concentration found was 1.06 mg/m^3. On the low occupancy day, no samples were quantifiable. However, on this day, the lowest level at which investigators could quantify samples was substantially higher than on the other days (*2*).

TABLE 1. Number and percentage of employees at a hotel indoor waterpark resort who reported work-related symptoms during the preceding month,* by symptom and exposure status — Ohio, 2007

Symptom	Exposed (i.e., lifeguards)† No.	(%)	Unexposed (i.e., hotel employees working outside the waterpark) No.	(%)	Prevalence ratio (95% CI§)
Sore throat	22/69	(32)	2/74	(3)	11.8 (2.9–48.3)
Cough	48/69	(70)	5/74	(7)	10.2 (4.3–24.2)**
Wheezing	20/69	(29)	2/74	(3)	9.7 (2.4– 40.2)**
Eye irritation	51/70	(73)	6/74	(8)	9.0 (4.1–19.6)
Shortness of breath	26/68	(38)	4/74	(5)	6.7 (2.5–18.2)**
Chest tightness	19/68	(28)	3/74	(4)	6.7 (2.1–21.4)**
Nose irritation	33/69	(48)	10/74	(14)	3.5 (1.9–6.6)

* Symptoms experienced on any days or evenings that the employee worked during the month before filling out the initial questionnaire, and which improved on days off work; analysis restricted to questionnaires received during March 20–April 2, 2007.
† Denominator varies because of missing data for some symptoms reported.
§ Confidence interval.
** Generalized linear models were used to compare respiratory symptoms for the exposure group while controlling for smoking status and asthma. Employees were defined as having asthma if they reported having asthma currently, it was diagnosed by a health professional, and it began before starting work at the waterpark.

TABLE 2. Number and percentage of lifeguards at a hotel indoor waterpark resort who reported work-related symptoms,* by symptom and level of hotel occupancy† — Ohio, 2007

Symptom	High occupancy day 1 (n = 14) No.	(%)	High occupancy day 2 (n = 29) No.	(%)	Low occupancy day (n = 27) No.	(%)
Cough§	9	(64)	16	(55)	6	(22)
Eye irritation	9	(64)	20	(69)	9	(33)
Nose irritation	4	(29)	10	(34)	4	(15)
Wheezing§	1	(7)	7	(24)	2	(7)
Shortness of breath§	2	(14)	6	(21)	4	(15)
Chest tightness§	3	(21)	5	(17)	0	
Sore throat	6	(43)	2	(7)	4	(15)
Blurry or foggy vision	—¶		9	(31)	0	
Blue-gray vision	—¶		3	(10)	1	(4)
Halo vision	—¶		3	(10)	0	

* Symptoms experienced at work, starting at beginning, middle, or end of shift.
† High occupancy (more than 1,000 guests) versus low occupancy (fewer than 100 guests). Because no direct counting of bathers was possible, the number of persons booked at the hotel (i.e., hotel occupancy) was used as a proxy for bather load.
§ Adjusted for smoking status.
¶ This information was not collected on the initial version of the questionnaire and therefore is missing for this day.

Water chemistry tests at the waterpark met state standards. However, review of the ventilation and water system designs identified several areas of concern. In the children's pool water system, the spray features drew water directly from the surge tank, bypassing the filtration and chemical treatment system. In

addition, the ventilation system might not have provided sufficient air movement and distribution to guarantee adequate capture and removal of air contaminants, including trichloramine, at the pool surface and deck levels. Concerns also included the high placement of air supply and return ducts. Furthermore, recirculation of air during winter months might have resulted in increased concentrations of airborne contaminants, including trichloramine. The ventilation system recirculates up to 33% of indoor air when outdoor temperatures fall below 40°F (4°C), which occurred in January and February 2007. NIOSH recommended that the indoor waterpark modify its water and ventilation systems to address the identified design concerns that could help reduce the amount of airborne contaminants, including trichloramine. Subsequently, substantial ventilation system modifications were made by repositioning air supply and return ducts closer to the pool deck.

Reported by: *D Stansbury, MPH, C Yeager, Warren County Combined Health District, Ohio. L Chen, MS, C Mueller, MS, Div of Surveillance, Hazard Evaluations, and Field Studies, KH Dunn, MS, D Almaguer, MS, J Ernst, Div of Applied Research and Technology, National Institute for Occupational Safety and Health; C Otto, MPA, Div of Emergency and Environmental Health Svcs, National Center for Environmental Health; B Dang, MD, F Gong, PhD, EIS officers, CDC.*

Editorial Note: Chloramines are disinfection by-products formed when chlorine combines with nitrogen-containing compounds such as sweat and urine. They include monochloramine, dichloramine, and trichloramine. Trichloramine is the main chloramine compound present above chlorinated water surfaces (*3*) and has been suspected as the cause of outbreaks of eye and respiratory irritation at indoor pools (*4,5*). Increased bather load has been associated with increased trichloramine levels (*6*), most likely because of increased nitrogen compounds from bathers. Other factors affecting airborne trichloramine concentration include water chemistry, air recirculation, and aerosolization of water contaminants from splashing and spraying (*1,7*). This investigation identified airborne trichloramine exposure as the likely cause of ocular and respiratory symptoms experienced by lifeguards and patrons. This conclusion is supported by the detection of trichloramine at or exceeding levels known to cause irritation symptoms, the significant excess of work-related symptoms among lifeguards compared with unexposed hotel employees, and the significant excess of work-related cough and eye irritation among lifeguards on high occupancy days. In March, when the resort began circulating outside air into the waterpark, the number of reported symptoms decreased markedly.

Trichloramine is a strong mucous membrane irritant (*8*) and has been associated with eye and respiratory tract irritation and asthma in swimmers and pool attendants (*7*). One study found that nonswimmers did not report symptoms until the trichloramine concentration reached 0.5 mg/m^3, and all nonswimmers reported symptoms at 0.7 mg/m^3 (*1*). The World Health Organization recommends an airborne trichloramine concentration of 0.5 mg/m^3 as a provisional value (*9*). Currently, no NIOSH or Occupational Safety and Health Administration (OSHA) occupational exposure limits exist for airborne trichloramine.

The findings in this report are subject to at least three limitations. First, the chloramine analytical methods used by NIOSH are still in development, and limitations exist in quantifying trichloramine at low concentrations (*2*). Second, personal samplers for trichloramine could not be placed on lifeguards because the sampling equipment could interfere with rescue duties or get wet and malfunction. This limited the ability to evaluate the association between trichloramine concentrations and symptoms. Finally, ventilation measurements using standard airflow evaluation techniques, such as smoke visualization and tracer gas testing, were difficult given the large size of the waterpark. Instead, ventilation system designs were reviewed and compared with relevant standards and guidelines.

Indoor waterparks have extensive splash features that introduce potentially more risk for recreational water–related illness than typical indoor pools. These complex environments require a holistic approach to reduce symptoms caused by the aerosolization of water contaminants. Means of controlling contaminant production include increasing fresh water dilution, keeping combined chlorine levels as low as possible, and reducing activation time of splash features. In addition, proper ventilation design can provide adequate air movement and contaminant capture (*10*).

The first hotel indoor waterpark resort opened in the United States in 1994. By 2007, an estimated 184 facilities had been established. This industry is fast growing, and clinicians, public health officials, managers, and employees need to be aware of the risks and understand the importance of controlling contaminant production and proper ventilation design in reducing irritation symptoms.

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References

1. Hery M, Hecht G, Gerber JM, Gendre JC, Hubert G, Rebuffaud J. Exposure to chloramines in the atmosphere of indoor swimming pools. Ann Occup Hyg 1995;39:427–39.

2. Chen L, Dang B, Mueller C, et al. Health hazard evaluation report: investigation of employee symptoms at an indoor waterpark. Cincinnati, OH: US Department of Health and Human Services, CDC, National Institute for Occupational Safety and Health: 2008. Report no. HETA2007-0163-3062. Available at http://www.cdc.gov/niosh/hhe/reports/pdfs/2007-0163-3062.pdf.
3. Holzwarth G, Balmer RG, Soni L. The fate of chlorine and chloramines in cooling towers. Water Res 1984;18:1421–7.
4. Bowen AB, Kile JC, Otto C, et al. Outbreaks of short-incubation ocular and respiratory illness following exposure to indoor swimming pools. Env Health Pers 2007;115:267–71.
5. Kaydos-Daniels SC, Beach MJ, Shwe T, Magri J, Bixler D. Health effects associated with indoor swimming pools: a suspected toxic chloramine exposure. Public Health 2008;122:195–200.
6. Jacobs JH, Spaan S, van Rooy GB, et al. Exposure to trichloramine and respiratory symptoms in indoor swimming pool workers. Eur Respir J 2007;29:690–8.
7. Massin N, Bohadana AB, Wild P, Hery M, Toamain JP, Hubert G. Respiratory symptoms and bronchial responsiveness in lifeguards exposed to nitrogen trichloride in indoor swimming pools. Occup Environ Med 1998;55:258–63.
8. Barbee SJ, Thackara JW, Rinehart WE. Acute inhalation toxicology of nitrogen trichloride. Am Ind Hyg Assoc J 1983;44:145–6.
9. World Health Organization. Guidelines for safe recreational water environments. Volume 2: swimming pools and similar environments. Geneva, Switzerland: World Health Organization; 2006. Available at http://www.who.int/water_sanitation_health/bathing/srwe2full.pdf.
10. American Society of Heating, Refrigerating, and Air-Conditioning Engineers. Heating, ventilating, and air-conditioning applications. ASHRAE handbook. Atlanta, GA: American Society of Heating, Refrigerating, and Air-Conditioning Engineers; 2007.

Multistate Outbreak of *Salmonella* Infections Associated with Peanut Butter and Peanut Butter–Containing Products — United States, 2008–2009

On January 29, this report was posted as an MMWR Early Release *on the* MMWR *website* (http://www.cdc.gov/mmwr).

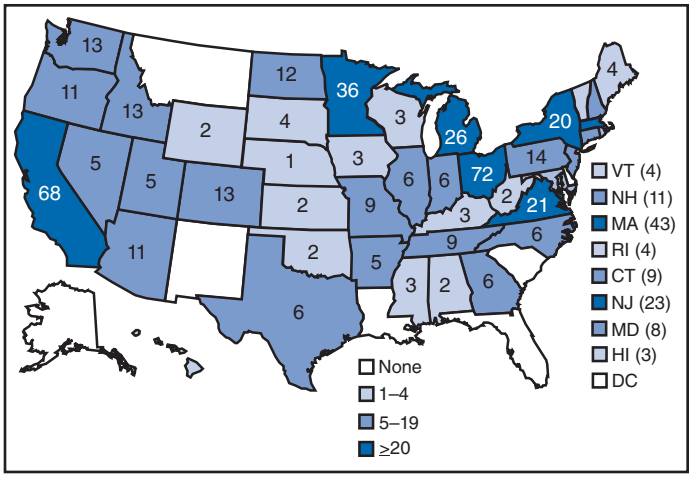
On November 25, 2008, an epidemiologic assessment began of a growing cluster of *Salmonella* serotype Typhimurium isolates that shared the same pulsed-field gel electrophoresis (PFGE) pattern in PulseNet.* As of January 28, 2009, 529 persons from 43 states (Figure 1) and one person from Canada had been reported infected with the outbreak strain. This report is an interim summary of results from ongoing epidemiologic studies and recall and control activities by CDC, the Food and Drug Administration (FDA), and state and local public health agencies. Confirmed, reported onset of illness dates have ranged from September 1, 2008, to January 16, 2009. A total of 116 patients were reported hospitalized, and the infection might have contributed to eight deaths. Sequential case-control studies have indicated significant associations between illness and consumption of any peanut butter (matched odds ratio [mOR] = 2.53), and specific brands of prepackaged peanut butter crackers (mOR = 12.25), but no association with national brand jarred peanut butter sold in grocery stores. Epidemiologic and laboratory findings indicate that peanut butter and peanut paste produced at one plant are the source of the outbreak. These products also are ingredients in many foods produced and distributed by other companies. This outbreak highlights the complexities of "ingredient-driven" outbreaks and the importance of rapid outbreak detection and investigation. Consumers are advised to discard and not eat products that have been recalled (Box).

* The national molecular subtyping network for foodborne disease surveillance.

Initial Outbreak Investigation

On November 10, 2008, CDC's PulseNet staff noted a small and highly dispersed multistate cluster of 13 *S.* Typhimurium isolates with an unusual PFGE pattern (*Xba*I PFGE pattern JPXX01.1818) reported from 12 states. On November 25, CDC's OutbreakNet team, working with state and local partners, began an epidemiologic assessment of that cluster, which had increased to 35 isolates. On December 2, CDC and state and local partners began an assessment of a second cluster of 41 *S.* Typhimurium isolates. The PFGE patterns of the second cluster (*Xba*I pattern JPXX01.0459/JPXX01.1825) were very similar to the patterns in the first cluster and were first noted by

FIGURE 1. Number of laboratory-confirmed cases (N = 529)* of *Salmonella* Typhimurium infection with the outbreak strain associated with peanut butter and peanut butter–containing products — United States, 2008–2009



* Cases reported as of January 28, 2009. Cases reported in the previous 3 weeks might not yet be reported.

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National Black HIV/AIDS Awareness Day — February 7, 2009

February 7 is National Black HIV/AIDS Awareness Day, which seeks to increase awareness of the disproportionate effects of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) among blacks living in the United States. In 2006, blacks accounted for approximately 12% of the adolescent and adult U.S. population but 46.1% of the number estimated to be living with HIV (*1*). For 2006, estimates of HIV incidence show that blacks had the highest rates of new infections (115.7 per 100,000 population for males and 55.7 per 100,000 population for females) of any racial/ethnic population (*2*). Among black females, high-risk heterosexual contact accounted for 83% of the new infections. Among black males, male-to-male sexual contact accounted for 63% of the new infections (*3*).

In 2006, a higher percentage of blacks reported having been tested for HIV during the preceding 12 months than did Hispanics and whites (22% versus 13% and 8%, respectively) (*4*). Nonetheless, HIV testing should be promoted and increased among blacks because persons who are aware of their HIV infection are less likely to transmit it to others.

Information regarding National Black HIV/AIDS Awareness Day is available at http://www.cdc.gov/features/blackhivaidsawareness. Information regarding blacks and HIV/AIDS is available at http://www.cdc.gov/hiv/topics/aa/index.htm.

References

1. CDC. HIV prevalence estimates—United States, 2006. MMWR 2008;57:1073–6.
2. CDC. Subpopulation estimates from the HIV incidence surveillance system—United States, 2006. MMWR 2008;57:985–9.
3. CDC. Trends in HIV/AIDS diagnoses among men who have sex with men—33 states, 2001–2006. MMWR 2008;57:681–6.
4. CDC. Persons tested for HIV—United States. MMWR 2008;57:845–9.

HIV Infection Among Young Black Men Who Have Sex with Men — Jackson, Mississippi, 2006–2008

In the United States, black men who have sex with men (MSM) account for a disproportionate number of new cases of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (*1*). From 2001 to 2006, the number of HIV/AIDS cases among black MSM aged 13–24 years in 33 states increased 93% (*2*). In 2006, more new AIDS cases among black MSM were diagnosed in the South* than in all other U.S. census regions combined (*3*). In November 2007, the Mississippi State Department of Health (MSDH) reported to CDC an increase in the number of young black MSM who received diagnoses of HIV infection at a sexually transmitted disease (STD) clinic in Jackson, Mississippi. MSDH and CDC conducted a survey of 29 young black MSM in the three-county Jackson area who received diagnoses of HIV infection during January 2006–April 2008 to characterize risk behavior and HIV testing behavior. This report summarizes the results of that survey, which found that, during the 12 months before receiving their HIV infection diagnosis, 20 (69%) of the 29 participants had unprotected anal intercourse, but only

* Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

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