



Wisconsin Epi Express

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Program updates

New Vectorborne Program monthly newsletter

The Wisconsin Department of Health (DHS) Vectorborne Disease Program has started a monthly newsletter to inform partners about vector activity, vectorborne disease surveillance, new resources and tools, and other related program activities from Vectorborne Disease Program. The newsletter goes out to local and Tribal health agencies, local health department staff, nurses, and infection preventionists.

New varicella dashboard

The Immunization Program has developed a dashboard showing varicella (chickenpox) case counts by week, age, county, and region on the [varicella web page](#).

Updated Ebola and other viral hemorrhagic fever fact sheet

The [Ebola and other viral hemorrhagic fever \(VHF\) fact sheet](#) has been updated. The fact sheet is available in additional languages including Hmong, Spanish, and French.

Wisconsin Immunization Registry (WIR) and Wisconsin Blood Lead Registry (WBLR) upcoming changes

DHS is working with Strategic Solutions Group (SSG) to modernize the WIR and WBLR systems. This modernization effort will strengthen system performance, improve data quality, enhance security, support future public health needs and provide an opportunity to streamline both immunization and blood lead workflows. Providers will transition to the new system during spring of 2027. Find steps you can take to prepare for the update in our recent [data modernization messages](#).

Staff updates

BCD welcomes the following staff to their new positions!

Marie Nofodji Zomassi, HDAP/IAP Specialist, HIV Care Unit

Ryan Burbach, Respiratory Disease Epidemiologist, Vectorborne, Respiratory, and Invasive Diseases Unit

2025 statewide HIV surveillance data

By: Stephanie Luedtke, HIV Prevention Epidemiologist and Evaluation Coordinator and Yi Ou, HIV Surveillance Unit Supervisor

Introduction

HIV surveillance data are reported to the state by various reporting entities, including private or health care providers, public health labs, health care systems, and HIV testing sites. The HIV Surveillance Unit collects these reports for ongoing surveillance and analysis. These data inform HIV care and prevention programs in Wisconsin that improve the lives of people living with HIV and prevent HIV transmission.

New diagnoses

Since 1979, 11,969 Wisconsin residents were diagnosed with HIV. During 2025, 254 people were newly diagnosed with HIV in Wisconsin (Figure 1).

- A disproportionate number of new HIV diagnoses were reported among young cisgender men of color.
- Male-male sexual contact was the most commonly reported transmission mode for HIV.
- Approximately 84% of cases were linked to care services within one month of diagnosis.

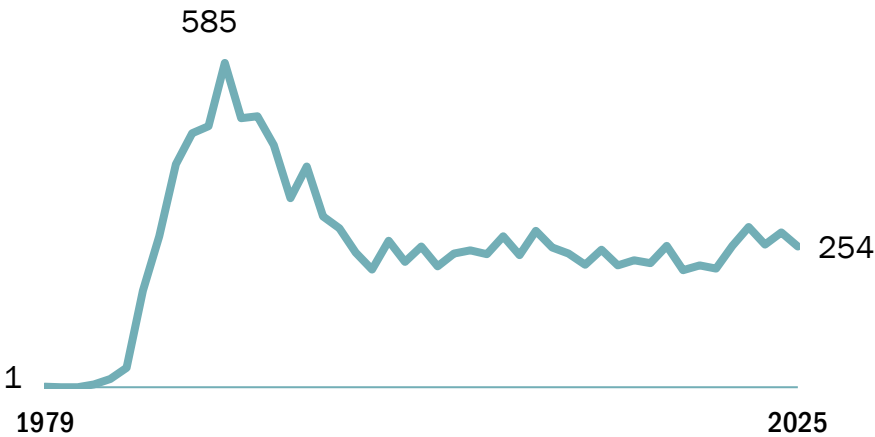


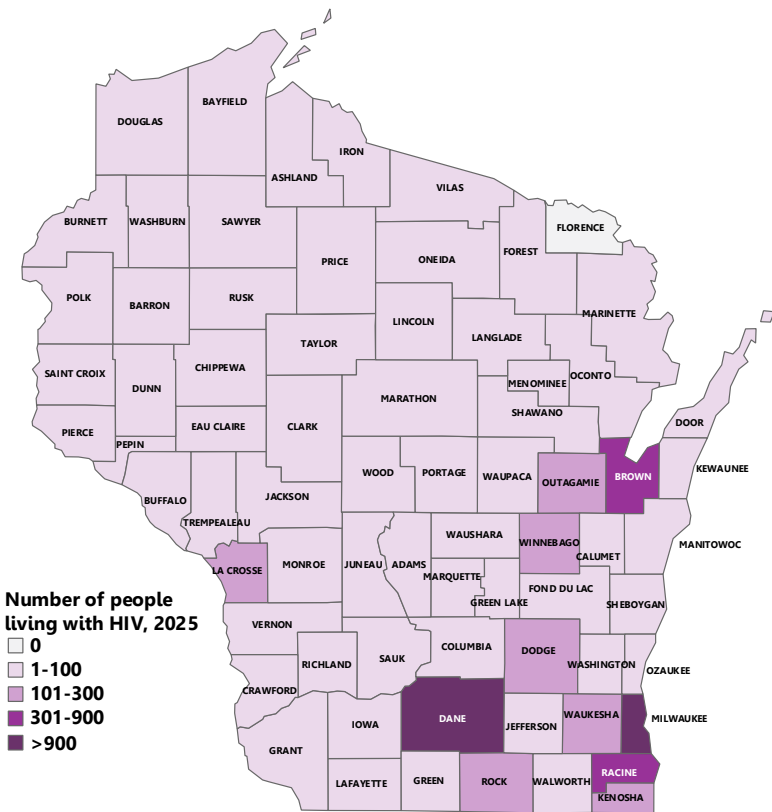
Figure 1 (above). Number of new HIV diagnoses, Wisconsin, 1979–2025.

Prevalence

A total of 7,963 people known to be living with HIV resided in Wisconsin at the end of 2025.

- The majority of people living with HIV resided in the southern and southeastern parts of the state in 2025 (Figure 2).
- During 2025, 79% of people living with HIV were virally suppressed (had less than 200 copies of HIV per milliliter of blood).
- Prevalent cases tended to be older than new diagnoses.

Figure 2 (left). Geographic distribution of people living with HIV, Wisconsin, 2025.



2025 statewide HIV surveillance data

By: Stephanie Luedtke, HIV Prevention Epidemiologist and Evaluation Coordinator and Yi Ou, HIV Surveillance Unit Supervisor

Stages of HIV

An acute HIV diagnosis occurs in the two to four weeks after HIV was acquired. People in the acute stage of HIV have a high viral load (a large amount of virus in the blood), which increases the risk of transmitting HIV to others. Rapid linkage of people with an acute HIV diagnosis to partner services ensures that exposed partners receive timely HIV testing.

A late HIV diagnosis occurs when a person living with HIV progresses to Stage 3 (AIDS) at the time of receiving their initial HIV diagnosis or within one year of their initial diagnosis. Without treatment, progression to Stage 3 typically occurs eight to 10 years after HIV was acquired. Stage 3 status is clinically defined by having a very low CD4 white blood cell count or a Stage 3-defining opportunistic infection. Early diagnosis and rapid access to HIV care can prevent progression to Stage 3, which optimizes health outcomes of people living with HIV and reduces the risk of transmitting HIV to others.

During 2025, 25 out of the total new HIV diagnoses in Wisconsin were considered acute diagnoses and 71 were considered late diagnoses. Almost 40% of people with a late HIV diagnosis were initially identified at an inpatient hospital. When the data were further broken down by region and stage of HIV at diagnosis, the western region of the state had 15 new diagnoses—67% were late HIV diagnoses and 0% were acute diagnoses (Figure 3).

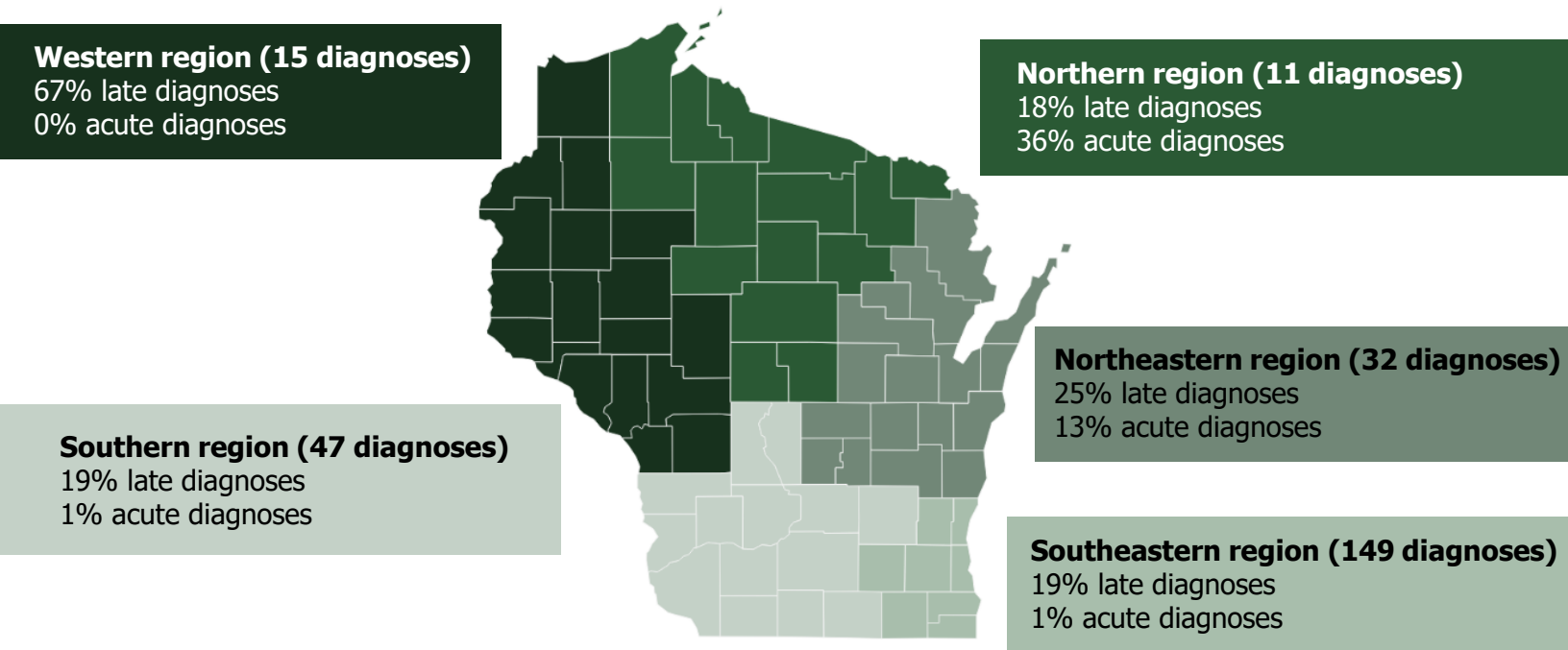


Figure 3. Percent of all new HIV diagnoses that were late* or acute diagnoses by region, Wisconsin, 2025.

*Those diagnosed with HIV during 2025 have not had one full year to evaluate progression to Stage 3. These late diagnosis data are provisional and should be interpreted with caution.

Additional information

For more data, see the [HIV Data web page](#). For questions, reach out to the HIV Surveillance Unit at DHSIHVSurveillance@dhs.wisconsin.gov.

Oral health infection control

By: Ashley O'Keefe, Infection Preventionist, and Linda Coakley, Infection Preventionist

Introduction

September is Dental Infection Control Awareness month! An important part of infection control in dental clinics is monitoring adherence to expected practices. Some examples of monitoring include environmental rounding and hand hygiene observations. To make monitoring easier, the Wisconsin Healthcare-Associated Infections (HAI) Prevention Program has created tools that can be used and modified to fit the needs of dental clinics.



Multidisciplinary Infection Prevention and Control Rounding Tool for Oral Health Care Settings

The clinic environment can serve as a reservoir for a variety of pathogens that can cause adverse outcomes for patients. The infection control officer and other staff can reduce this risk by monitoring the environment and implementing infection control measures as needed. The [Multidisciplinary Infection Prevention and Control Rounding Tool for Oral Health Care Settings \(Word\)](#) is designed to help assess the clinic environment for infection control gaps and prioritize corrective measures and follow-up. The tool can be easily modified to more closely align with clinic-specific policies as necessary. It is recommended to perform rounding at least quarterly and involve other leaders and frontline staff in the assessment.

Hand Hygiene Observations Template for Oral Health Settings

Hand hygiene protects both health care personnel and patients. The [Hand Hygiene Observations Template for Oral Health Settings \(Excel\)](#) tool is designed to make monitoring hand hygiene compliance easier. It includes a template for observing hand hygiene practices as well as tables for logging the data. The tables automatically convert hand hygiene data into easy-to-read graphs that visualize hand hygiene compliance data over time, by staff type, or by moments for hand hygiene opportunity. If a dental clinic has multiple locations, the tool also allows users to compare hand hygiene compliance from one location to the next.

Resources

The HAI Prevention Program also offers free, consultative, non-regulatory, proactive clinic walkthroughs to help clinics improve their infection prevention practices. To learn more about dental infection prevention or schedule a clinic walkthrough with our dental infection preventionists, please visit the [HAI Oral Health web page](#).

Contact

The HAI Prevention Program is here to support you! If you'd like help getting started with monitoring infection prevention practices, please reach out to DHSWIHAIPreventionProgram@dhs.wisconsin.gov.

Wisconsin student immunization waivers

By: Laura Gregor, Vaccine Preventable Diseases Epidemiologist

Background

Wisconsin’s [student immunization law](#) permits health, religious, and personal conviction waivers that parents may claim for one or more required immunizations. The immunization program collects aggregated student waiver data on the [annual school immunization assessment \(PDF\)](#). The percentage of students with any waiver has been increasing steadily in Wisconsin since the 1985–1986 school year, when less than one percent of students had a waiver.

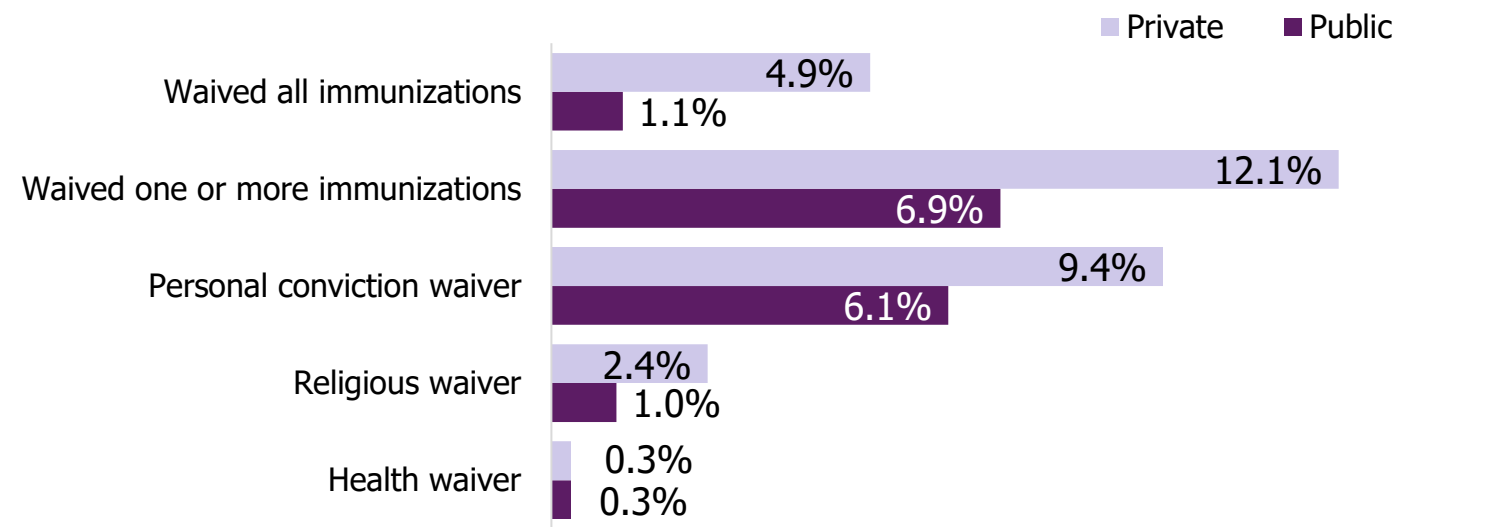
Statewide, during the 2025–2026 school year, 7.6% of students had a waiver for one or more immunizations, surpassing last year’s record of 6.7%. While the percentage of students with a health or religious waiver has remained relatively steady, 6.5% of students had a personal conviction waiver for the 2025–2026 school year—a record high. Statewide, 1.6% of students waived all immunizations.

Previous statewide school immunization analyses have not compared waiver trends by school type (public vs. private) and urbanicity (urban vs. rural).

Waiver trends by school type and urbanicity

This analysis examined annual school immunization assessment waiver data by school type (Figure 1) and urbanicity (Figure 2). Urban and rural counties were determined using the [Federal Office of Rural Health Policy \(FORHP\) 2020+](#) classification. The results suggest striking public/private and urban/rural disparities.

Figure 1: Compared to public schools, private schools reported a higher proportion of students in nearly every waiver category.

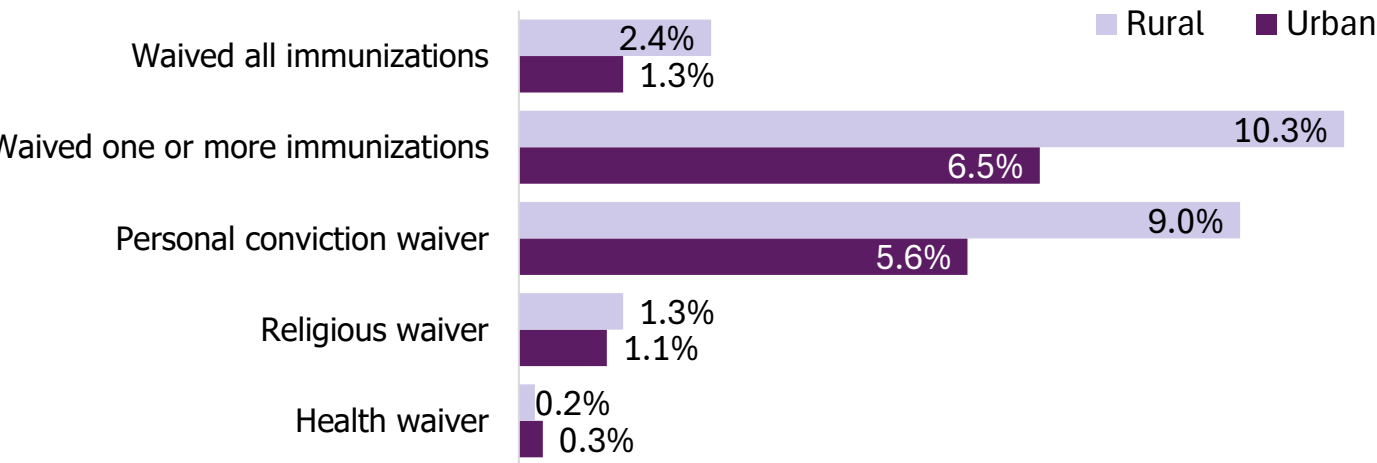


The proportion of students having a health waiver was identical for both public and private schools (0.3%). However, private schools reported 12.1% of students with a waiver for one or more immunizations, compared to 6.9% of students reported by public schools. Likewise, private schools reported 9.4% of students with a personal conviction waiver, compared to 6.1% of public school students. Of particular concern was that 4.9% of private school students waived all immunizations, compared to 1.1% of public school students. This means that nearly 5% of private school students have no documented protection in the event of a vaccine-preventable disease outbreak.

Wisconsin student immunization waivers

By: Laura Gregor, Vaccine Preventable Diseases Epidemiologist

Figure 2: Compared to schools in urban counties (FORHP 2020+), rural schools reported a higher proportion of students in nearly every waiver category.



Similarly, schools in rural counties reported a higher proportion of students in nearly every waiver category, compared to schools in urban counties. Of note, 10.3% of students in rural schools had a waiver for one or more immunizations compared to 6.5% of students in urban schools. In rural schools, 9.0% of students had a personal conviction waiver versus 5.6% of students in urban schools. While a higher proportion of students in rural schools waived all immunizations (2.4%) compared to students in urban schools (1.3%), the difference was less pronounced.

Takeaways

This analysis indicates that waiver rates are disproportionately higher among private schools and schools in rural counties. These trends may signal a higher proportion of vaccine-hesitant parents in the private school system and rural parts of the state; however, the proportion of students with waivers, particularly personal conviction waivers, are still very high among public schools and schools in urban counties as well. Lowering the percentage of students with waivers will require a localized, community-based approach to connect with all parents and address possible concerns with immunizations.

Limitations

Parents provide student immunization records to schools. Schools then aggregate this information and report to state and local public health departments during the fall of every school year. The Wisconsin Department of Health Services does not have the ability to verify the accuracy of the enrollment or coverage data that was submitted by schools. In addition, private and rural schools account for a lower share of Wisconsin students compared to public and urban schools and therefore may be more sensitive to small numerator and denominator changes.

Resources

[Wisconsin Student Immunization Requirements](#)

[Wisconsin School Immunization Assessment Data, P-01892 \(Excel\)](#)

Contact us

For questions regarding Wisconsin’s school immunization requirements, reach out to DHSImmProgram@dhs.wisconsin.gov

Communicable disease case counts

This table includes **preliminary** case counts for reportable conditions for the current year-to-date (YTD) and the previous year and YTD. Preliminary and YTD case counts are not included for hepatitis B, hepatitis C, and HIV. Annual communicable disease surveillance data for these reportable conditions (as well as hepatitis B, hepatitis C, and HIV) from 2010–2024 are available on the interactive [Wisconsin Communicable Disease Surveillance Data dashboard](#).

Visit the [Wisconsin Department of Health Services \(DHS\) Disease Reporting page](#) for more information about disease reporting.

*Case counts are considered preliminary and subject to change. YTD case counts are through **September 30**.

Disease	2026 YTD	2025 YTD	2025 Total
Enteric/gastrointestinal			
Campylobacteriosis ²	1,245	1,365	1,775
Cholera ^{1,2}	0	0	0
Cryptosporidiosis ²	441	420	505
Cyclosporiasis ²	303	65	65
<i>E. coli</i> , Enteropathogenic ²	1,378	1,752	2,229
<i>E. coli</i> , Enterotoxigenic ²	316	404	507
<i>E. coli</i> , Shiga toxin-producing (STEC) ²	466	409	530
Giardiasis ²	324	415	515
Hemolytic Uremic Syndrome (HUS) ²	1	4	4
Listeriosis ²	20	19	23
Salmonellosis ²	970	875	1,116
Shigellosis / <i>E. coli</i> , Enteroinvasive ²	135	136	172
Typhoid and Paratyphoid Fever ²	9	3	3
Vibriosis (Non-Cholera) ²	39	42	49
Yersiniosis ²	153	175	211
Healthcare associated			
<i>Candida auris</i> , Clinical	20	24	32
<i>Candida auris</i> , Colonization	13	11	15
Carbapenemase-producing Organism, Clinical	73	93	124
Carbapenemase-producing Organism, Colonization	23	17	33
Vancomycin Intermediate/Resistant <i>Staphylococcus aureus</i>	0	2	2
Invasive bacteria			
Group A Streptococcal Invasive Disease ²	323	299	390
Group B Streptococcal Invasive Disease ²	510	506	671
Rheumatic Fever	0	0	0
Toxic Shock Syndrome, Staphylococcal	2	0	1
Toxic Shock Syndrome, Streptococcal	0	2	2

Communicable disease case counts

Disease	2026 YTD	2025 YTD	2025 Total
Mycotic (Fungal)			
Blastomycosis ²	3	15	18
Coccidioidomycosis ¹	1	27	28
Histoplasmosis ²	0	3	3
Respiratory			
Please refer to the respiratory virus data webpage for statewide and regional interactive data visualizations.			
COVID-19, Pediatric Mortality	1	1	2
COVID-19-associated Hospitalization ²	2,103	3,183	4,158
Influenza, Novel ²	0	0	0
Influenza, Pediatric Mortality	0	4	5
Influenza-associated Hospitalization ²	3,127	6,166	8,086
Legionellosis ²	154	174	210
Respiratory Syncytial Virus (RSV), Pediatric Mortality	0	1	1
Respiratory Syncytial Virus (RSV)-associated Hospitalization ²	2,215	2,065	2,235
Tuberculosis (TB)	41	50	64
Sexually transmitted			
Chlamydia (<i>Chlamydia trachomatis</i> Infection)	16,010	16,520	21,968
Gonorrhea (<i>Neisseria gonorrhoeae</i> Infection)	4,328	4,190	5,572
Sexually Transmitted Pelvic Inflammatory Disease	42	18	30
Syphilis	478	1,001	1,266
Syphilis, Congenital	4	18	22
Vaccine preventable			
Diphtheria	0	0	0
<i>Haemophilus influenzae</i> Invasive Disease ²	85	105	156
Measles (Rubeola) ²	243	36	36
Meningococcal Disease ²	2	7	8
Mumps	1	6	6
Pertussis (Whooping Cough)	203	659	778
Poliomyelitis	0	0	0
Rubella	0	0	0
<i>Streptococcus pneumoniae</i> Invasive Disease ²	349	443	586
Tetanus	1	2	2
Varicella (Chickenpox)	118	145	177

Communicable disease case counts

Disease	2026 YTD	2025 YTD	2025 Total
Vectorborne			
Anaplasmosis ²	603	969	1,076
Babesiosis ²	124	152	165
<i>Borrelia miyamotoi</i> Infection	14	13	14
Chikungunya Virus Infection	0	1	5
Dengue Virus Infection ¹	5	14	19
Eastern Equine Encephalitis Virus Infection	0	0	0
<i>Ehrlichia</i> Infection (species undetermined) ²	26	56	64
<i>Ehrlichia chaffeensis</i> Infection ²	4	9	9
<i>Ehrlichia ewingii</i> Infection ²	0	2	2
<i>Ehrlichia muris euclairensis</i> Infection ²	4	11	13
Jamestown Canyon Virus Infection	2	7	7
La Crosse Virus Infection	2	0	0
Lyme Disease (<i>B. burgdorferi</i>) ²	6,926	7,635	8,930
Lyme Disease (<i>B. mayonii</i>) ²	1	1	1
Malaria ¹	6	12	14
Powassan Virus Infection	7	17	18
Spotted Fever Group Rickettsiosis ²	5	8	10
St. Louis Virus Infection	0	0	0
Typhus Fever Group Rickettsiosis	1	2	2
West Nile Virus Infection	4	27	27
Yellow Fever ¹	0	0	0
Zika Virus Infection ¹	0	1	1
Zoonotic			
Brucellosis	0	0	0
Hantavirus Infection	0	1	1
Leptospirosis	0	0	0
Lymphocytic Choriomeningitis Virus Infection	0	0	0
Psittacosis	0	0	0
Q Fever, Acute	0	2	2
Q Fever, Chronic	1	3	3
Rabies (Human)	0	0	0
Toxoplasmosis	-	-	-

Communicable disease case counts

Disease	2026 YTD	2025 YTD	2025 Total
Zoonotic (continued)			
Trichinellosis	0	0	0
Tularemia	5	5	5
Other			
Acute Flaccid Myelitis (AFM)	0	0	0
Amebic Keratitis	2	3	4
Botulism, Infant	1	2	4
Botulism, Non-infant	0	1	1
Cronobacter, Invasive Infection, Infant	0	0	0
Free-Living Ameba Infection	0	1	1
Hepatitis A ²	2	0	0
Hansen's Disease/Leprosy	5	12	15
Mpox ²	5	5	6
Multisystem Inflammatory Syndrome in Children (MIS-C)	0	0	0
Non-tuberculous Mycobacteriosis	1,031	1,111	1,457
Primary Amebic Meningoencephalitis	0	0	0
Prion Disease	1	13	19

¹ Denotes diseases where all cases in Wisconsin residents are travel-associated. No local transmission occurs.

² DHS collects standardized industry and occupation (I/O) information in the Wisconsin Electronic Disease Surveillance System (WEDSS) for these conditions, which is summarized in the [I/O Reports](#) (login is required).

Data source: The data summarized on this report are obtained from the [Wisconsin Electronic Disease Surveillance System \(WEDSS\)](#). WEDSS is a secure, web-based system designed to facilitate reporting, investigation, and surveillance of communicable diseases in Wisconsin. Most data are collected through routine, passive surveillance. The WEDSS reporting network is made up of institutions that treat patients or test specimens, including physicians, infection preventionists, laboratorians, and other health care providers.

Case definitions and reportable conditions: This table summarizes the burden of reportable communicable diseases meeting case definitions established by the Wisconsin Department of Health Services (DHS) and, when also nationally notifiable, the [CDC \(Centers for Disease Control and Prevention\)](#) and the [Council of State and Territorial Epidemiologists \(CSTE\)](#). Wisconsin-specific case definitions can be found in guidance available on the DHS website for each disease and on the [DHS Disease Reporting webpage](#).

Enumerated year: For most diseases, cases are enumerated and displayed based on the date of illness onset. For cases without an illness onset date reported in WEDSS, the date of specimen collection, test result, or report date, whichever is earliest, is used to enumerate the case. For the following diseases, cases are enumerated using a different method than previously described. For TB cases, the case year is determined by date of a confirmatory diagnostic test. For prion disease cases, the case year is determined based on the date of death. For invasive bacterial diseases, meningococcal disease, invasive *Haemophilus influenzae*, invasive *Streptococcus pneumoniae*, and group A and B streptococcal invasive diseases, the date of first positive specimen collection is used. This table uses calendar year for annual case counts and does not use the [MMWR year](#), which is the standard for data displayed by the CDC.

Data shown are provisional and subject to change: Some examples of corrections or updates that affect presented data would include the delayed submission of a disease report, updating an onset date, correction to laboratory results, or correction of a patient's address to a different state. There may also be small differences between data summarized on this table compared to reports released by disease programs. There are multiple factors that can influence data discrepancies or differences in case counts. For example, factors include if programs use different case classification filters (such as confirmed cases only); if different dates are used for enumeration; if data are extracted at different timepoints; if the data source is different than WEDSS (for example, hospital discharge or vital records data); or if provisional data are displayed.