CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

December 6, 1996 / Vol. 45 / No. 48

MMWR™
MORBIDITY AND MORTALITY WEEKLY REPORT

National Drunk and Drugged Driving Prevention Month — December 1996

Persons who drive while impaired by alcohol or other drugs are a public health hazard to themselves and to others. During 1995, alcohol-related motor-vehicle crashes resulted in 17,274 deaths in the United States; intoxication rates in fatal crashes were highest for persons aged 21–24 years (*1*). Alcohol-related traffic crashes remain a leading cause of death for teenagers and young adults.

The injuries, disabilities, deaths, and economic and social costs associated with impaired driving are enormous and preventable. December has been designated National Drunk and Drugged Driving Prevention Month by the National Drunk and Drugged Driving Prevention Month Coalition, a nationwide public/private sector coalition for the prevention of crashes related to impaired driving. Additional information about National Drunk and Drugged Driving Prevention Month is available from the Impaired Driving Division, Office of Traffic Injury Control Programs (NTS-11), National Highway Traffic Safety Administration, 400 7th Street, SW, Washington, DC 20590, telephone (202) 366-9581.

Reference

1. National Highway Traffic Safety Administration. Traffic safety facts, 1995: alcohol. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, National Center for Statistics and Analysis, Research, and Development, 1996.

Involvement by Young Drivers in Fatal Motor-Vehicle Crashes — United States, 1988–1995

Motor-vehicle crashes (MVCs) are the leading cause of death for persons aged 15–20 years in the United States (*1*). Although the 11.9 million young drivers aged 15–20 years constituted only 6.7% of the total number of licensed drivers in the United States during 1995, they represented a disproportionate 14% of all drivers involved in fatal MVCs. In addition, adjusting for the number of miles driven, rates of fatal crashes were higher for young drivers than for drivers in any other age group (e.g., the rate for 16-year-olds was 18 times that for persons aged 30–34 years) (*2*). This report summarizes trends in involvement in fatal MVCs by drivers aged 15–20 years during 1988–

Fatal Motor-Vehicle Crashes — Continued

1995; these findings document an overall decline in involvement by young drivers in fatal crashes in the United States.

This analysis used data from the Fatal Accident Reporting System of the National Highway Traffic Safety Administration (NHTSA). A driver was defined as an operator of a moving motor vehicle. A fatal MVC was a crash in which at least one person, who may or may not have been the driver, died. An alcohol-involved crash was one in which the driver had a blood alcohol concentration (BAC) of ≥0.01 g/dL. NHTSA uses statistical models to estimate BACs for drivers and pedestrians where BAC results are not available (*3*). Nighttime crashes were crashes that occurred from 9 p.m. to 5 a.m. Protective device use was defined as use of a safety belt or a motorcycle helmet.

During 1988–1995, a total of 68,206 fatal crashes involved young drivers (Table 1). Of these, 50,744 (74.4%) of the young drivers were male; 18,599 (27.3%) had BACs ≥0.01 g/dL, including 12,048 (64.8%) who had BACs ≥0.1 g/dL (i.e., legally intoxicated in most states). Overall, 27,144 (39.8%) of these crashes occurred during nighttime hours, and 36,655 (53.7%) young drivers were not using protective devices at the time of the crash. The proportion of fatal nighttime crashes and the proportion of alcohol-involved crashes increased with driver age. Drivers aged 15–17 years were less likely to be involved in fatal crashes at night and less likely to have BACs ≥0.01 g/dL than were drivers aged 18–20 years. Rates of fatal crashes were highest for persons aged 18–20 years and lowest for those aged 15 years (Table 1). Drivers aged 15 years were less likely to be using protective devices when involved in a fatal crash than were young drivers of other ages.

During 1988–1995, involvement by young drivers in fatal alcohol-involved crashes and crashes in which the driver was not using protective devices declined for each age. Involvement in nighttime fatal crashes declined for young persons of all ages, except those aged 15 years, from 1994 to 1995.

Reported by: Div of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC.

Editorial Note: The findings in this report document an overall decline in involvement by young drivers in fatal crashes in the United States during 1988–1995. However, because this analysis examined only fatal crashes, the findings do not indicate the total level of involvement by young drivers in MVCs. In 1995, approximately 2 million nonfatal MVCs involved drivers aged ≤20 years (*4*).

Despite the decline in fatal MVCs, rates for fatal crash involvement continue to be highest among young drivers when adjusted for the number of miles driven. Factors associated with MVCs among young drivers include risk-taking behavior and lack of driving experience (*5*). Specific risk factors that increase the likelihood of involvement by a young driver in an MVC include alcohol use, low use of protective devices, and driving at night. For drivers aged 18–20 years, the increasing number of miles driven and increasing access to alcohol also increase their risk for an MVC (*2,6*).

NHTSA has recommended that states implement and enforce graduated driver licensing systems (GDLSs) to reduce the involvement of young drivers in MVCs (*7*). The GDLS is a public health intervention that enables young drivers to acquire driving experience in low-risk settings and exposes beginning drivers incrementally to more challenging driving experiences (see box). Although the GDLS has reduced crashes 5%–16% for young drivers in the United States (*7*), most states have implemented only parts of the recommended GDLS. Ten states (California, Colorado, Florida, Ken-

TABLE 1. Number and rate* of young drivers involved in fatal† motor-vehicle crashes, by age of driver and year — United States, 1988–1995

Age group (yrs)	1988		1989		1990		1991		1992		1993		1994		1995		Total	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate§	No.	Rate
15	244	7.3	229	7.0	231	6.9	218	6.6	211	6.1	228	6.5	245	6.8	255	6.7	**1,861**	**6.8**
16	1,300	36.7	1,242	37.0	1,116	34.0	1,088	32.4	1,044	31.5	1,109	31.9	1,162	33.0	1,315	36.2	**9,376**	**34.1**
17	1,928	49.2	1,663	45.9	1,535	44.7	1,344	40.0	1,389	40.3	1,317	38.7	1,503	42.2	1,427	39.6	**12,106**	**42.7**
18	2,376	60.2	2,217	57.1	2,022	56.2	1,777	52.6	1,585	47.9	1,637	48.2	1,666	51.7	1,740	49.6	**15,020**	**53.0**
19	2,320	57.9	2,310	57.5	2,183	53.3	1,900	50.0	1,553	43.4	1,662	47.4	1,733	48.3	1,626	45.9	**15,287**	**50.7**
20	2,247	59.2	2,010	51.6	1,965	48.6	1,893	46.7	1,621	42.9	1,531	43.0	1,659	47.6	1,630	45.7	**14,556**	**48.2**
Total	**10,415**	**46.2**	**9,671**	**43.9**	**9,052**	**41.5**	**8,220**	**38.7**	**7,403**	**35.5**	**7,484**	**35.9**	**7,968**	**37.8**	**7,993**	**36.9**	**68,206**	**39.6**

* Per 100,000 age-specific population.
† The driver may or may not have been killed in the crash.
§ Numbers based on 1995 intercensal estimates.

Fatal Motor-Vehicle Crashes — Continued

Selected Components of the Graduated Driver Licensing System Recommended by the National Highway Traffic Safety Administration

Level	Restrictions	Requirements
Learner's	• Zero alcohol tolerance • Driver must be supervised at all times by a parent, guardian, or person aged ≥21 years who is a licensed driver • All vehicle occupants must wear safety belts • Driver limited regarding speed, type of road, and number of passengers	Must remain crash- and conviction-free for at least 6 consecutive months
Intermediate	• Zero alcohol tolerance • Cannot drive during restricted hours (e.g., 10 p.m.–5 a.m.) unless supervised by a parent, guardian, or person aged ≥21 years who is a licensed driver • All vehicle occupants must wear safety belts	Must remain crash- and conviction-free for at least 12 consecutive months
Unrestricted	• Zero alcohol tolerance at age <21 years	

tucky, Maryland, Massachusetts, New York, Pennsylvania, West Virginia, and Wisconsin) have a three-stage licensing system that includes many of the recommended components of the GDLS; four states (Illinois, New Jersey, Oregon, and Vermont) have two stages of licensing that include several of the recommended components (*8*). In September 1996, the Michigan state legislature enacted the first complete GDLS, which will become operational in April 1997.

In the absence of state legislation, parents can implement their own form of graduated licensing. For example, parents can require that their children always wear safety belts, that for an appropriate length of time they drive only with an adult present, that they conform to parental rules regarding passengers, and that they drive only during daylight hours.

The findings in this report can be used by states and other agencies in planning and evaluating interventions to decrease MVCs involving young drivers. In addition, these findings can assist in measuring progress toward the national health objectives for the year 2000 (*9*), which include increasing the use of safety belts and helmets (objectives 9.12 and 9.14), decreasing alcohol-involved MVCs (objective 9.23), and increasing to 35 the number of states having a GDLS for drivers and riders aged <18 years (objective 9.26).

References

1. Singh GK, Mathews TJ, Clarke SC, Yannicos T, Smith BL. Annual summary of births, marriages, divorces, and deaths: United States, 1994. Hyattsville, Maryland: US Department of Health and Human Services, National Center for Health Statistics, CDC, 1995 (Monthly vital statistics report; vol 43, no. 13).

Fatal Motor-Vehicle Crashes — Continued

2. Cerrelli EC. Research note: crash data and rates for age-sex groups of drivers, 1994. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 1995.
3. Klein TM. A method of estimating posterior BAC distributions for persons involved in fatal traffic accidents: final report. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 1986; report no. DOT-HS-807-094.
4. National Highway Traffic Safety Administration. Traffic safety facts, 1995: a compilation of motor vehicle crash data from the Fatal Accident Reporting System and the General Estimates System. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 1996; report no. DOT-HS-808-471.
5. Shope JT, Waller PF, Lang SW. Correlates of high-risk driving behavior among high school seniors by gender. In: 40th Annual proceedings of the Association for the Advancement of Automotive Medicine, 1996. Des Plaines, Illinois: Association for the Advancement of Automotive Medicine, 1996.
6. Preusser DF, Williams AF. Sales of alcohol to underage purchasers in three New York counties and Washington, DC. J Public Health Policy 1992;13:306–17.
7. National Highway Traffic Safety Administration. Graduated driver licensing system for young novice drivers. Guidelines for motor vehicle administrators. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 1996; report no. DOT-HS-808-331.
8. Williams AF, Weinberg K, Fields M, Ferguson SA. Current requirements for getting a driver's license in the United States. Arlington, Virginia: Insurance Institute for Highway Safety, 1995.
9. Public Health Service. Healthy people 2000: midcourse review and 1995 revisions. Washington, DC: US Department of Health and Human Services, Public Health Service, 1995.

Update: Respiratory Syncytial Virus Activity — United States, 1996–97 Season

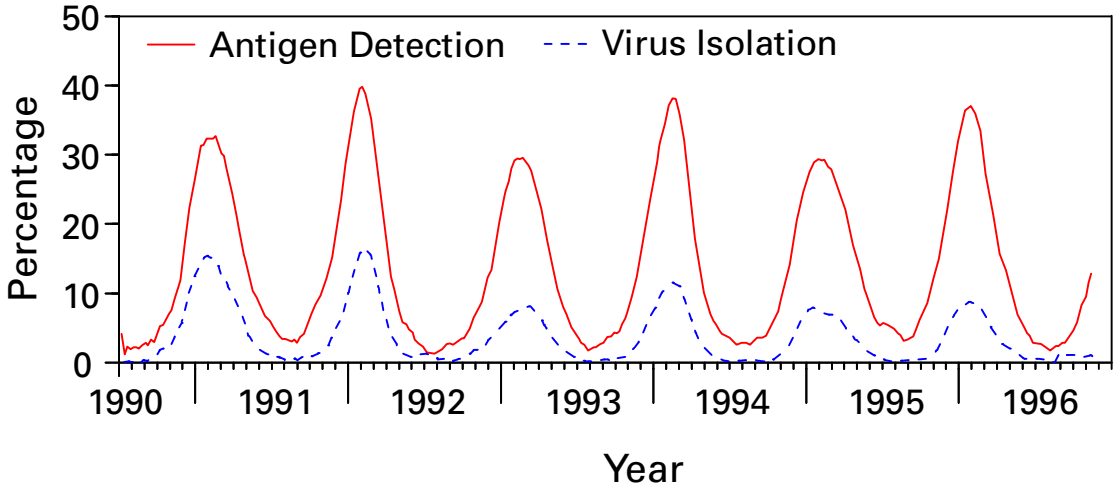
Respiratory syncytial virus (RSV), a common cause of winter outbreaks of acute respiratory disease, results in an estimated 90,000 hospitalizations and 4500 deaths each year from lower respiratory tract disease in both infants and young children in the United States (*1*). Outbreaks occur annually throughout the country (*2*). RSV activity in the United States is monitored by the National Respiratory and Enteric Virus Surveillance System (NREVSS), a voluntary, laboratory-based system. This report summarizes trends in RSV from the NREVSS from July 1, 1990, through June 28, 1996, and presents provisional surveillance results for June 29–November 29, 1996. These data indicate onset of widespread RSV activity for the 1996–97 season.

Since July 1, 1990, a total of 98 hospital-based and public health laboratories in 47 states have participated in the NREVSS and have reported weekly to CDC the number of specimens tested for RSV by the antigen-detection and virus-isolation methods and the number of positive results. Widespread RSV activity is defined by the NREVSS as the first of two consecutive weeks during which at least half of the participating laboratories report any RSV detections. This definition generally indicates a mean percentage of specimens positive by antigen detection in excess of 10%.

During the previous six seasons, from July 1990 through June 1996, onset of widespread RSV activity began in November and continued for a mean of 22 weeks until April (Figure 1). In most parts of the 48 contiguous states, activity peaked each year in January or February; however, in the Southeast, activity peaked as early as November or December (*3*). For the reporting period June 29–November 29, 1996, a total of

Respiratory Syncytial Virus — Continued

FIGURE 1. Percentage* of specimens positive for respiratory syncytial virus, by method of confirmation and week — United States, July 1, 1990–November 29, 1996



*Laboratory group mean, "smoothed" using a 7-week running mean.

75 laboratories in 45 states reported results of testing for RSV. Since the week ending November 22, more than half of the participating laboratories reported detections of RSV on a weekly basis, indicating onset of widespread RSV activity for the 1996–97 season.

Reported by: National Respiratory and Enteric Virus Surveillance System collaborating laboratories. Respiratory and Enterovirus Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: During the RSV season, health-care providers should consider the role of RSV as a cause of acute respiratory disease in both children and adults. Most severe manifestations of infection with RSV (e.g., pneumonia and bronchiolitis) occur in infants aged 2–6 months; however, children of any age with underlying cardiac or pulmonary disease or who are immunocompromised are at risk for serious complications from this infection. Because natural infection with RSV provides limited protective immunity, RSV causes repeated symptomatic infections throughout life. In adults, RSV usually causes upper respiratory tract manifestations but may cause lower respiratory tract disease—especially in the elderly and in immunocompromised persons (*4–6*). Infection in immunocompromised persons can be associated with high death rates (*6*).

RSV is a common, but preventable, cause of nosocomially acquired infection; the risk for nosocomial transmission increases during community outbreaks. Sources for nosocomially acquired infection include infected patients, staff, visitors, or contaminated fomites. Nosocomial outbreaks or transmission of RSV can be controlled with strict attention to contact-isolation procedures (*7*). In addition, chemotherapy with ribavirin may be considered for some patients (e.g., those at high risk for severe complications or who are seriously ill with this infection) (*8*); respiratory syncytial virus immune globulin intravenous (human) for high-risk patients was licensed for use in January 1996 (*9*). Vaccines for RSV are being developed, but none have been demonstrated to be safe and efficacious (*10*).

Respiratory Syncytial Virus — Continued

References

1. Institute of Medicine. Appendix N: prospects for immunizing against respiratory syncytial virus. In: Institute of Medicine. New vaccine development: establishing priorities. Vol 1: diseases of importance in the United States. Washington, DC: National Academy Press, 1985:397–409.
2. Gilchrist S, Török TJ, Gary HE Jr, Alexander JP, Anderson LJ. National surveillance for respiratory syncytial virus, United States, 1985–1990. J Infect Dis 1994;170:986–90.
3. Török TJ, Clarke MJ, Holman RC, Anderson LJ. Temporal and spatial trends in respiratory syncytial virus activity in the United States, 1990–1996 [Abstract]. In: RSV after 40 years: an anniversary symposium (Charleston, South Carolina, November 9–12, 1996).
4. Dowell SF, Anderson LJ, Gary HE Jr, et al. Respiratory syncytial virus is an important cause of community-acquired lower respiratory infection among hospitalized adults. J Infect Dis 1996;174:456–62.
5. Falsey AR, Cunningham CK, Barker WH, et al. Respiratory syncytial virus and influenza A infections in the hospitalized elderly. J Infect Dis 1995;172:389–94.
6. Whimbey E, Couch RB, Englund JA, et al. Respiratory syncytial virus pneumonia in hospitalized adult patients with leukemia. Clin Infect Dis 1995;21:376–9.
7. CDC. Guideline for prevention of nosocomial pneumonia. Respir Care 1994;39:1191–236.
8. Committee on Infectious Diseases, American Academy of Pediatrics. Reassessment of the indications for ribavirin therapy in respiratory syncytial virus infections. Pediatrics 1996;97: 137–40.
9. Groothuis JR, Simoes EA, Levin MJ, et al. Prophylactic administration of respiratory syncytial virus immune globulin to high-risk infants and young children. N Engl J Med 1993;329:1524–30.
10. Murphy BR, Hall SL, Kulkarni AB, et al. An update on approaches to the development of respiratory syncytial virus (RSV) and parainfluenza virus type 3 (PIV3) vaccines. Virus Res 1994;32:13–36.

Progress Toward Poliomyelitis Eradication — Eastern Africa, 1988–1995

In 1988, the World Health Assembly established the goal of eradicating poliomyelitis by the year 2000 (*1*). Commitment to this goal and to the strategies that have proven effective in other regions (*2,3*) was reaffirmed in 1995 by the African Regional Health Committee and in 1996 by heads of state attending the Organization of African Unity Summit. These strategies include 1) achieving and maintaining high vaccination coverage among children aged <1 year with at least three doses of oral poliovirus vaccine (OPV) through routine vaccination services; 2) establishing effective epidemiologic and laboratory surveillance systems, with examination of stool specimens from suspected cases of polio; and 3) providing supplemental vaccination through National Immunization Days (NIDs)* to interrupt wild poliovirus transmission. This report summarizes progress toward polio eradication since 1988 in the seven countries (Burundi, Eritrea, Kenya, Rwanda, Tanzania, Uganda, and Zambia) of the Eastern Africa Epidemiological Block (EAEB) of the African Region (AFR) of the World Health Organization (WHO) (Figure 1).† Implementation of these polio-

*Nationwide mass campaigns over a short period (days to weeks), in which two doses of OPV are administered to all children in the target age group (usually aged <5 years), regardless of previous vaccination history, with an interval of 4–6 weeks between doses.

†Although located in eastern Africa, Djibouti, Somalia, and Sudan are part of the Eastern Mediterranean Region (EMR) of the World Health Organization, and progress in the EMR was summarized previously (*4,5*). In addition, Ethiopia is considered by the AFR as one of four large African countries in especially difficult circumstances and will be reported on separately.

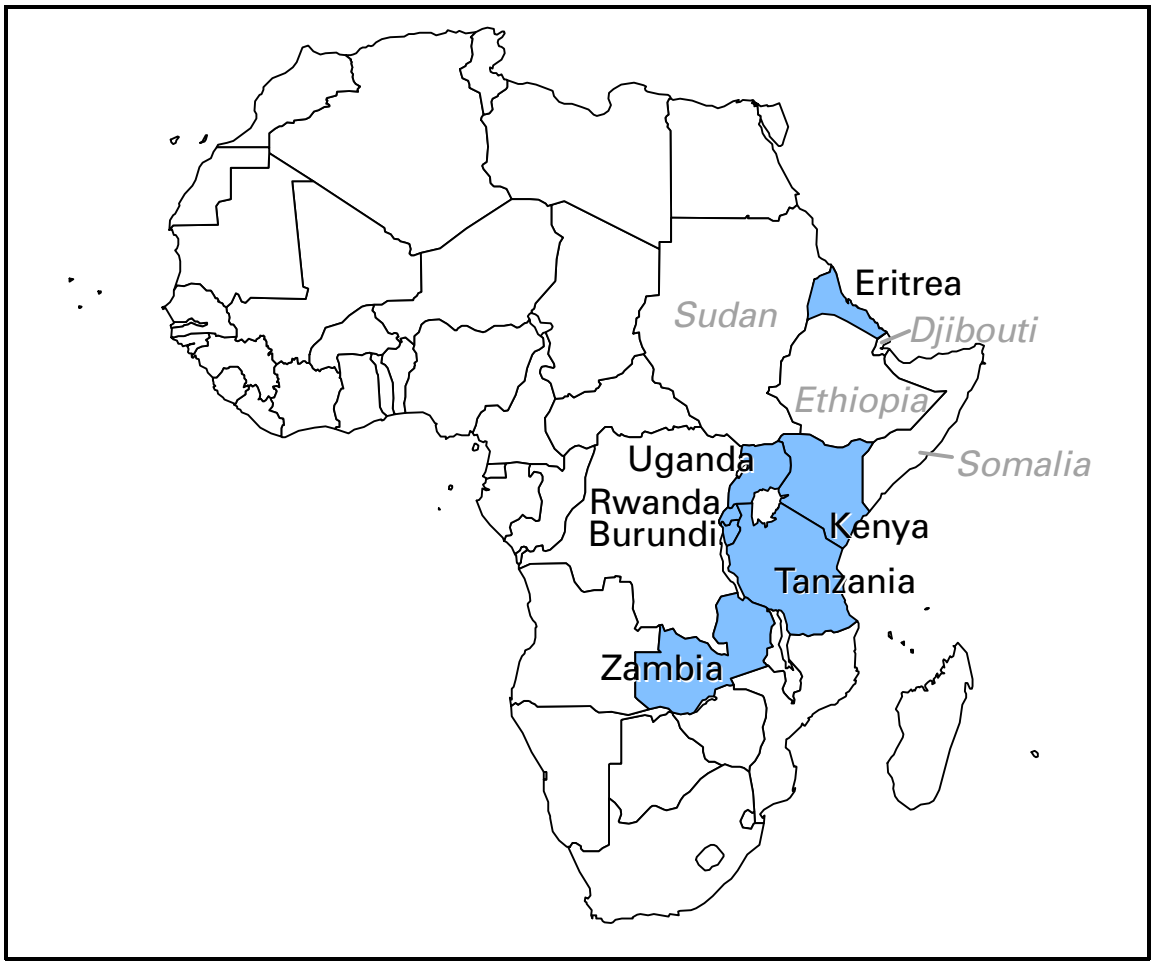
Polio Eradication — Continued

eradication strategies is proceeding rapidly; however, overall surveillance capacity in the EAEB is not yet adequate and requires strengthening.

In 1993, all seven EAEB countries were classified by the World Bank as being among the 42 countries with "low income economies," and four of the seven were among the 10 poorest countries in the world (*6*). In the EAEB countries during 1991, annual gross national products ranged from $100 to $420 per capita (median: $210 per capita), the infant mortality rate ranged from 67 to 135 infant deaths per 1000 live-born infants (median: 115 per 1000), and life expectancy at birth ranged from 46 to 59 years (median: 48 years) (*6,7*). The estimated population of the EAEB in 1994 was 103 million persons, approximately 20% of the total population of the AFR.

All countries of the EAEB have initiated substantial efforts to enhance surveillance for polio. To improve the efficiency and timeliness of surveillance, EAEB countries are developing nationwide systems to immediately report all cases of acute flaccid paralysis (AFP) or "suspected poliomyelitis" to district health offices and to identify geo-

FIGURE 1. Location of the Eastern Africa Epidemiological Block* — African Region (AFR) of the World Health Organization



*Although located in eastern Africa, Djibouti, Somalia, and Sudan are part of the Eastern Mediterranean Region (EMR) of the World Health Organization, and progress in the EMR was summarized previously (*4,5*). In addition, Ethiopia is considered by the AFR as one of four large African countries in especially difficult circumstances and will be reported on separately.

Polio Eradication — Continued

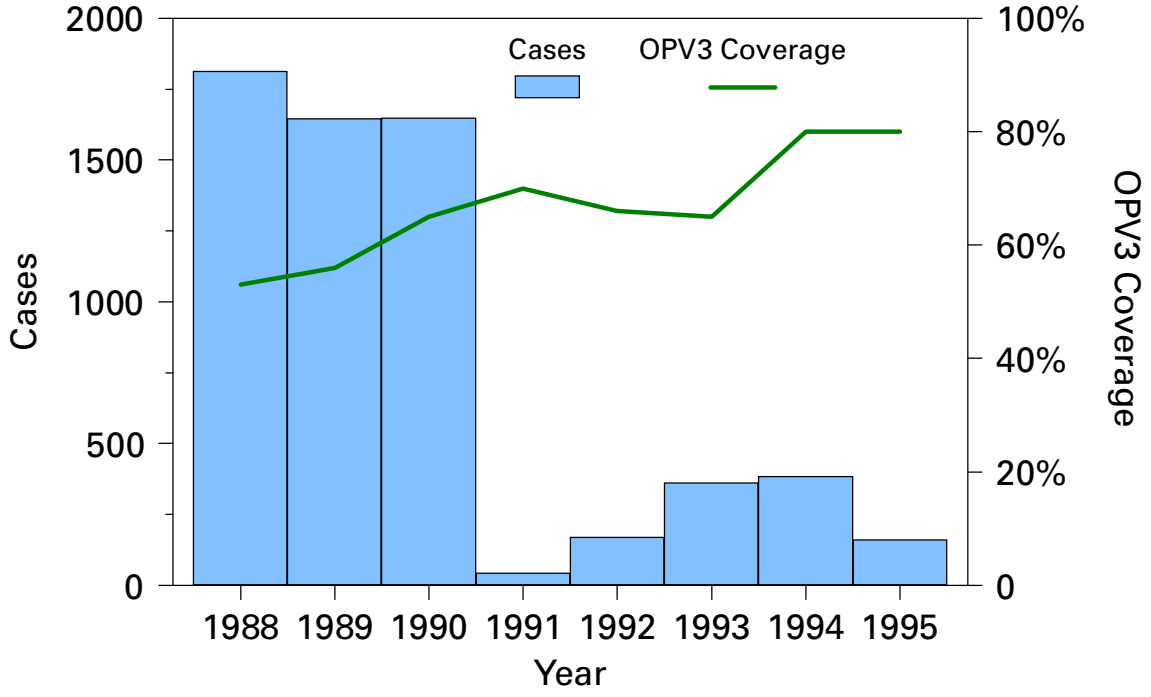
graphic areas in which polio remains endemic or focal transmission is occurring. AFP or suspected polio cases are investigated within 48 hours, and a detailed history and two stool specimens are collected from the patient for examination for poliovirus. EAEB countries also are changing their routine reporting systems to include AFP or suspected poliomyelitis and are adopting and distributing the standard WHO case definition for AFP.[§]

During 1988–1995, the annual incidence of polio in the EAEB declined 91%, from 1813 cases to 160 cases—reflecting, in part, the reporting by Kenya during 1988–1990 of previous cases of residual paralysis and other diseases as polio (Figure 2). The increase in the number of cases reported in the EAEB during 1992 and 1993 resulted in part from the initiation of polio reporting by Eritrea in 1993 (1 year after gaining its independence): Eritrea reported zero cases in 1993 and 23 cases in 1994.

Surveillance for AFP with laboratory examination of stool specimens to isolate poliovirus was initiated in Rwanda, Tanzania, Uganda, and Zambia in 1994, and in Kenya in 1995. In Eritrea, initiation of AFP surveillance with case investigations is planned for early 1997; AFP cases are not investigated in Burundi. In 1995, a total of 113 AFP cases were reported in the EAEB, and stool specimens were collected and examined for 97 cases. Wild poliovirus was isolated from 15 case-patients: three in Tanzania, five in Uganda, and seven in Zambia. WHO-sponsored national polio reference laboratories are fully functional in Kenya, Uganda, and Zambia, and Tanzania is

[§]AFP is defined as acute (i.e., rapid progression), flaccid (i.e., floppy) paralysis, including Guillain-Barré syndrome, in a child aged <15 years or any paralytic illness at any age when polio is suspected.

FIGURE 2. Number of reported cases of poliomyelitis and coverage with three doses of oral poliovirus vaccine (OPV3), by year — Eastern Africa Epidemiological Block, African Region of the World Health Organization, 1988–1995



Polio Eradication — Continued

planning to establish a laboratory. These laboratories have the capacity to isolate and type polioviruses and identify other enteroviruses from stool specimens. An indicator of the quality of surveillance for polio is the rate of nonpolio AFP reported through the surveillance system—a rate of ≥1 case per 100,000 children aged <15 years indicates adequate completeness of reporting to the system (*8*). Only Zambia has achieved a national nonpolio AFP reporting rate >1 per 100,000, although reporting is not uniform throughout the country.

During 1988–1995, coverage with three doses of OPV among children aged 1 year increased from 53% to 80% in EAEB countries (Figure 2). In 1995, reported OPV coverage was 90% in Rwanda, 84% in Kenya, 82% in Tanzania and Zambia, 79% in Uganda, 62% in Burundi, and 45% in Eritrea. Although civil unrest in Rwanda resulted in disruption of vaccination services and health-care reporting systems in 1994, vaccination coverage increased to 83% in 1995—the highest level since 1983. Although Burundi had achieved 87% vaccination coverage in 1992, coverage declined to 64% in 1993 and to 48% in 1994; coverage increased to 62% in 1995, but civil unrest during 1996 could again result in disrupted vaccination services. In Eritrea, coverage increased from 1993 (when reporting of OPV coverage was initiated) through 1994; in 1993 and 1994, coverage levels were 28% and 36%, respectively.

In 1996, Kenya, Rwanda, Tanzania, and Zambia conducted NIDs, achieving average coverage levels for the two rounds of 80%, 58%, 100%, and 87%, respectively. Kenya and Tanzania held their NIDs on the same days in August and September. Burundi conducted three 10-day mass-vaccination cycles during the first half of 1996, administering OPV and other routine childhood vaccines to all children aged <1 year; however, no data are available to WHO about the number of doses administered and the coverage level attained. In October and November, Eritrea conducted "Sub-National Immunization Days" (SNIDs), administering vaccines only at health centers and outreach posts that already provided routine vaccination services (i.e., fixed sites), and achieved national OPV coverage levels of 61% and 72%. Because only an estimated 50% of the children in Eritrea live within 2.4 miles (5 km) of the fixed sites, the first round was considered highly successful. Uganda is planning its first round of NIDs for December 1996. All seven EAEB countries are planning to conduct NIDs in 1997; Kenya, Tanzania, and Uganda are planning to conduct their rounds concurrently.

Reported by: Ministry of Health, Burundi. Ministry of Health, Eritrea. Ministry of Health, Kenya. Ministry of Health, Rwanda. Ministry of Health, Tanzania. Ministry of Health, Uganda. Ministry of Health, Zambia. Expanded Program on Immunization, Regional Office for Africa, Brazzaville, Congo; Global Program for Vaccines and Immunization, World Health Organization, Geneva, Switzerland. Respiratory and Enterovirus Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Polio Eradication Activity, National Immunization Program, CDC.

Editorial Note: Despite multiple barriers (e.g., poverty and poorly developed infrastructure—especially for transportation, communication, and electricity), the countries in the EAEB have made substantial progress toward polio eradication; if efforts and progress can be sustained, these countries should be polio-free by the year 2000 (*7,9*). Factors accounting for progress in the EAEB include 1) well-established national vaccination programs with substantial experience in cold-chain management and vaccine delivery; 2) widespread knowledge and acceptance by the public of routine vaccination services; 3) the capacities of the district health departments in most EAEB countries to maintain effective surveillance for polio and ensure the success of NIDs; 4) efforts to educate parents about the importance of vaccinations and the need for

Polio Eradication — Continued

their children to receive supplemental doses of OPV; and 5) the political commitment of the heads of state, local leaders, and community organizations.

For progress to continue toward polio eradication in the EAEB, polio-eradication activities and resources must be used to strengthen primary health care and the integration of health activities while still achieving vaccination program goals. For example, NIDs may divert efforts from other priority health problems and even interfere with routine preventive services. However, reports from EAEB countries that conducted NIDs in 1996 also indicated several benefits of NIDs, including improved planning capacities of district health departments, improved budgeting through more accurate estimation of the costs of vaccination services, the development of new national and local private-sector partners participating in the funding and delivery of vaccination services, enhancement of the vaccine cold chain, increased community participation in social mobilization and the provision of vaccination services, and improved surveillance for vaccine-preventable diseases.

Despite efforts to strengthen polio surveillance, overall surveillance capacities in EAEB countries are not yet adequate to document eradication of polio in the EAEB. However, by the end of 1997, all countries in the EAEB are expected to have initiated AFP surveillance, and most should have attained a level of surveillance adequate to meet or exceed globally established indicators of performance. Sustained external political and financial support¶ also will be essential to ensure that the goal of polio eradication is achieved in countries of the EAEB.

References

1. World Health Assembly. Global eradication of poliomyelitis by the year 2000: resolution of the 41st World Health Assembly. Geneva, Switzerland: World Health Organization, 1988. (Resolution WHA41.28).
2. World Health Organization. Global eradication of poliomyelitis by the year 2000. Wkly Epidemiol Rec 1988;63:161–2.
3. Regional Committee for Africa. Expanded Program on Immunization: disease control goals, the countdown has started — resolutions of the 45th Regional Committee for Africa. Brazzaville, Congo: World Health Organization, 1995 (Resolution AFR/RC45/R5).
4. CDC. Implementation of health initiatives during a cease-fire—Sudan, 1995. MMWR 1995;44:433–6.
5. CDC. Progress toward poliomyelitis eradication—Eastern Mediterranean Region, 1988–1994. MMWR 1995;44:809–11,817–8.
6. World Bank. World development report, 1993: investing in health. New York: Oxford University Press, 1993.
7. Klaucke DN, Lobanov A, Okwo-Bele JM, Barakamfitiye D. Status of polio eradication in the seven countries of the Eastern Africa Epidemiological Block. J Infect Dis 1997 (in press).
8. Hull HF, Ward NA, Milstien JB, de Quadros C. Paralytic poliomyelitis: seasoned strategies, disappearing disease. Lancet 1994;343:1331–7.
9. Okwo-Bele JM, Lobanov A, Biellik R, et al. Overview of poliomyelitis in the African region and current regional plan of action. J Infect Dis 1997 (in press).

¶Support is provided by a coalition of organizations that include WHO, the United Nations Children's Fund (UNICEF), other bilateral and multilateral organizations, and Rotary International.

Erratum: Vol. 45, No. 47

In the article "Accessibility to Minors of Cigarettes from Vending Machines—Broward County, Florida, 1996," on page 1038, percentages were incorrect in the second sentence of the first paragraph of the editorial note. The sentence should have read "These success rates were lower than those reported in surveys conducted in Massachusetts and Minnesota (42% and 48%, respectively) (*2,3*)."

Alcohol Involvement in Fatal Motor-Vehicle Crashes — United States, 1994–1995

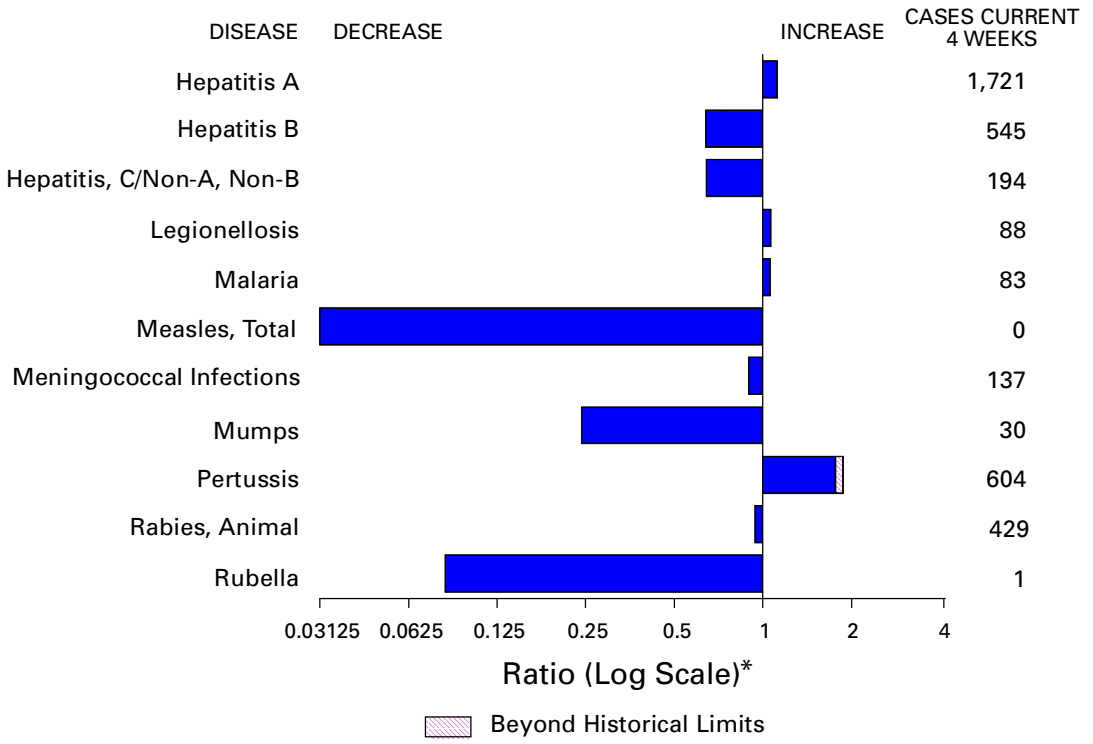
The figure on page 1067 compares alcohol involvement in fatal motor-vehicle crashes for 1994 and 1995. A fatal crash is considered alcohol-related by the National Highway Traffic Safety Administration (NHTSA) if either a driver or nonoccupant (e.g., pedestrian) had a blood alcohol concentration (BAC) of ≥0.01 g/dL in a police-reported traffic crash. Because BACs are not available for all persons in fatal crashes, NHTSA estimates the number of alcohol-related traffic fatalities based on a discriminant analysis of information from all cases for which driver or nonoccupant BAC data are available (*1*).

Overall, the number of alcohol-related traffic fatalities increased 4.1% from 1994 to 1995; for BACs of 0.01 g/dL–0.09 g/dL, the increase was 6.5%, for BACs ≥0.10 g/dL (the legal limit of intoxication in most states), the increase was 3.4%.

Reference

1. Klein TM. A method of estimating posterior BAC distributions for persons involved in fatal traffic accidents: final report. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 1986; report no. DOT-HS-807-094.

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending November 30, 1996, with historical data — United States



*Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — provisional cases of selected notifiable diseases, United States, cumulative, week ending November 30, 1996 (48th Week)

	Cum. 1996		Cum. 1996
Anthrax	-	Plague	5
Brucellosis	84	Poliomyelitis, paralytic¶	-
Cholera	3	Psittacosis	41
Congenital rubella syndrome	1	Rabies, human	1
Cryptosporidiosis*	2,145	Rocky Mountain spotted fever (RMSF)	672
Diphtheria	1	Streptococcal toxic-shock syndrome*	15
Encephalitis: California*	107	Syphilis, congenital**	225
eastern equine*	2	Tetanus	32
St. Louis*	1	Toxic-shock syndrome	122
western equine*	-	Trichinosis	17
Hansen Disease	99	Typhoid fever	334
Hantavirus pulmonary syndrome*†	19	Yellow fever††	1
HIV infection, pediatric*§	242		

-: no reported cases
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§ Updated monthly to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention (NCHSTP), last update November 26, 1996.
¶ Three suspected cases of polio with onset in 1996 has been reported to date.
**Updated quarterly from reports to the Division of STD Prevention, NCHSTP.
†† This fatal case of yellow fever is the first occurrence of this disease reported in the United States since 1924. The infection is presumed to have been acquired in Brazil.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 30, 1996, and December 2, 1995 (48th Week)

Reporting Area	AIDS*		Chlamydia	*Escherichia coli* O157:H7		Gonorrhea		Hepatitis C/NA,NB		Legionellosis	
				NETSS†	PHLIS§						
	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1996	Cum. 1996	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995
UNITED STATES	62,258	65,519	348,471	2,562	1,533	274,806	362,305	3,039	3,719	945	1,055
NEW ENGLAND	2,551	3,112	15,406	330	194	6,564	7,099	105	114	71	34
Maine	42	82	864	22	-	53	86	-	-	3	6
N.H.	85	85	397	40	39	80	103	8	12	5	2
Vt.	19	28	U	35	32	43	60	36	13	4	-
Mass.	1,249	1,337	6,374	148	123	2,031	2,532	55	82	29	21
R.I.	167	211	1,706	15	-	462	501	6	7	30	5
Conn.	989	1,369	6,065	70	-	3,895	3,817	-	-	N	N
MID. ATLANTIC	17,328	17,632	42,344	215	43	33,302	41,779	281	449	220	188
Upstate N.Y.	2,385	2,122	N	142	16	6,223	8,899	217	235	69	52
N.Y. City	9,497	9,214	18,756	15	-	10,373	15,705	1	1	10	5
N.J.	3,353	4,150	6,900	58	5	5,037	5,395	-	174	14	32
Pa.	2,093	2,146	16,688	N	22	11,669	11,780	63	39	127	99
E.N. CENTRAL	4,733	4,912	73,731	557	415	51,324	72,540	418	323	275	318
Ohio	1,058	1,008	16,057	165	101	11,550	21,972	33	15	105	142
Ind.	548	494	8,884	83	54	5,886	8,677	8	14	41	73
Ill.	2,084	2,048	21,774	211	128	16,127	19,069	65	78	9	35
Mich.	788	1,032	18,606	98	70	13,633	16,796	312	216	96	32
Wis.	255	330	8,410	N	62	4,128	6,026	-	-	24	36
W.N. CENTRAL	1,443	1,537	25,364	568	343	11,550	18,269	126	84	61	74
Minn.	270	345	2,702	258	224	U	2,638	4	4	10	6
Iowa	82	94	3,960	122	88	1,077	1,431	55	13	10	21
Mo.	749	711	11,071	68	-	7,588	10,547	40	21	18	16
N. Dak.	11	5	2	16	15	-	32	-	5	-	3
S. Dak.	12	17	1,360	24	-	168	212	-	1	3	3
Nebr.	94	101	2,096	50	4	790	977	8	23	15	17
Kans.	225	264	4,173	30	12	1,927	2,432	19	17	5	8
S. ATLANTIC	15,559	16,602	50,963	132	69	89,004	100,689	232	225	145	158
Del.	264	278	1,148	2	2	1,349	2,079	1	-	11	2
Md.	2,164	2,398	6,359	N	8	13,474	12,828	5	7	29	25
D.C.	1,196	977	N	-	-	4,075	4,408	-	-	8	5
Va.	1,097	1,397	10,798	N	34	8,428	9,887	16	18	23	21
W. Va.	112	114	1	N	3	512	598	9	44	1	4
N.C.	830	951	-	44	15	17,257	21,574	46	58	12	31
S.C.	808	870	-	12	7	10,415	11,502	30	19	6	30
Ga.	2,293	2,171	11,198	30	-	16,686	18,799	U	15	3	14
Fla.	6,795	7,446	21,459	32	-	16,808	19,014	125	64	52	26
E.S. CENTRAL	2,089	2,085	29,172	74	61	32,225	37,463	534	923	48	52
Ky.	362	266	6,174	14	10	3,895	4,399	28	30	9	10
Tenn.	743	840	12,291	33	48	10,982	12,827	371	891	20	24
Ala.	569	560	7,760	15	3	12,446	15,351	9	2	4	6
Miss.	415	419	U	12	-	4,902	4,886	126	U	15	12
W.S. CENTRAL	6,313	5,611	33,666	72	13	26,083	49,481	426	328	19	22
Ark.	247	243	-	13	4	2,772	5,338	15	7	2	6
La.	1,375	965	6,790	6	4	7,514	9,881	196	182	2	3
Okla.	245	257	6,762	12	1	4,422	5,298	69	51	5	5
Tex.	4,446	4,146	20,114	41	4	11,375	28,964	146	88	10	8
MOUNTAIN	1,801	2,068	15,815	213	103	6,376	8,728	525	438	51	110
Mont.	34	22	-	25	-	34	65	19	14	1	4
Idaho	37	43	1,399	38	13	93	133	95	47	-	2
Wyo.	6	17	539	11	9	35	49	175	178	7	12
Colo.	463	629	U	80	43	1,077	2,619	59	61	9	39
N. Mex.	153	155	3,655	11	-	856	983	67	51	2	5
Ariz.	535	632	6,578	N	26	3,196	3,448	70	54	20	12
Utah	178	143	1,413	32	-	261	255	22	11	6	16
Nev.	395	427	2,231	16	12	824	1,176	18	22	6	20
PACIFIC	10,440	11,960	62,010	401	292	18,378	26,257	392	835	55	99
Wash.	642	848	8,428	146	126	1,867	2,558	50	209	6	21
Oreg.	439	425	4,849	91	59	582	764	9	37	1	-
Calif.	9,160	10,405	45,897	160	97	15,093	21,804	132	483	42	73
Alaska	30	62	1,186	4	2	404	615	3	2	1	-
Hawaii	169	220	1,650	N	8	432	516	198	104	5	5
Guam	4	-	168	N	-	31	91	1	6	2	1
P.R.	2,170	2,181	N	18	U	349	549	75	203	-	-
V.I.	18	30	N	N	U	-	-	-	-	-	-
Amer. Samoa	-	-	-	N	U	-	36	-	-	-	-
C.N.M.I.	1	-	N	N	U	11	51	-	5	-	-

N: Not notifiable U: Unavailable -: no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands

*Updated monthly to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, last update November 26, 1996.

†National Electronic Telecommunications System for Surveillance.

§Public Health Laboratory Information System.

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending November 30, 1996, and December 2, 1995 (48th Week)

Reporting Area	Lyme Disease		Malaria		Meningococcal Disease		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal	
	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995
UNITED STATES	13,051	10,443	1,432	1,229	2,915	2,729	9,892	15,205	17,465	19,271	6,267	7,152
NEW ENGLAND	3,865	1,954	66	48	139	135	175	328	382	463	676	1,409
Maine	52	25	8	7	14	10	-	2	20	11	107	46
N.H.	46	26	3	2	7	23	1	1	14	17	51	142
Vt.	15	9	7	1	4	11	-	-	-	4	130	171
Mass.	332	142	22	18	57	42	75	64	190	259	105	394
R.I.	509	312	8	4	14	6	4	4	28	45	37	311
Conn.	2,911	1,440	18	16	43	43	95	257	130	127	246	345
MID. ATLANTIC	7,941	6,914	380	352	269	332	433	799	3,269	3,941	1,351	1,832
Upstate N.Y.	4,136	3,433	78	61	80	93	68	80	415	492	1,003	1,104
N.Y. City	318	426	207	190	37	51	120	349	1,698	2,162	-	-
N.J.	1,866	1,632	64	71	61	71	127	163	671	718	128	316
Pa.	1,621	1,423	31	30	91	117	118	207	485	569	220	412
E.N. CENTRAL	75	421	150	151	399	378	1,410	2,633	1,840	1,815	90	99
Ohio	48	29	13	11	145	109	512	851	288	254	13	12
Ind.	24	19	13	18	57	52	181	322	155	169	8	14
Ill.	3	18	70	74	111	96	384	985	956	943	24	15
Mich.	-	5	39	26	44	70	176	287	344	362	31	40
Wis.	U	350	15	22	42	51	157	188	97	87	14	18
W.N. CENTRAL	200	209	47	27	224	171	327	683	443	526	487	354
Minn.	108	121	21	6	25	26	51	41	99	130	27	28
Iowa	20	14	3	3	48	29	21	43	62	58	223	125
Mo.	31	46	10	8	93	65	211	561	183	205	18	30
N. Dak.	1	-	1	2	4	1	-	-	6	5	68	27
S. Dak.	-	-	-	2	10	9	-	-	17	22	113	96
Nebr.	5	6	3	3	20	17	12	12	21	21	5	5
Kans.	35	22	9	3	24	24	32	26	55	85	33	43
S. ATLANTIC	673	654	292	239	577	469	3,466	3,794	3,176	3,379	2,616	2,059
Del.	105	50	4	1	2	6	35	16	30	53	75	86
Md.	395	406	79	62	69	36	611	475	271	365	584	417
D.C.	3	3	7	16	10	8	127	98	121	96	10	11
Va.	48	53	55	54	56	60	363	561	282	283	570	422
W. Va.	11	23	5	4	14	8	3	10	50	66	95	111
N.C.	64	82	29	16	74	80	1,011	1,050	465	415	662	442
S.C.	6	17	12	3	58	56	361	541	298	294	86	120
Ga.	1	14	27	37	130	101	609	695	562	617	280	263
Fla.	40	6	74	46	164	114	346	348	1,097	1,190	254	187
E.S. CENTRAL	73	68	35	25	216	197	2,213	3,110	1,161	1,317	204	275
Ky.	25	14	7	3	28	44	148	169	215	286	39	28
Tenn.	20	28	14	10	59	76	788	837	349	402	82	93
Ala.	7	9	6	9	79	41	505	606	386	378	79	145
Miss.	21	17	8	3	50	36	772	1,498	211	251	4	9
W.S. CENTRAL	115	109	56	48	316	325	1,255	3,073	2,265	2,808	375	557
Ark.	24	9	-	2	34	33	131	460	177	217	28	46
La.	8	9	6	5	55	53	476	962	175	328	17	42
Okla.	22	45	-	1	37	39	171	180	156	330	32	28
Tex.	61	46	50	40	190	200	477	1,471	1,757	1,933	298	441
MOUNTAIN	7	12	57	60	164	191	129	191	572	621	145	172
Mont.	-	-	7	3	6	4	-	4	14	10	24	43
Idaho	1	-	-	1	23	12	4	-	7	14	-	3
Wyo.	2	3	7	-	3	8	2	1	6	4	30	26
Colo.	-	-	25	26	38	45	23	98	75	76	42	9
N. Mex.	1	1	2	6	26	34	1	9	75	71	6	6
Ariz.	-	1	7	12	40	57	79	44	232	307	32	56
Utah	1	1	5	6	16	15	2	4	51	38	4	15
Nev.	2	6	4	6	12	16	18	31	112	101	7	14
PACIFIC	102	102	349	279	611	531	484	594	4,357	4,401	323	395
Wash.	17	10	21	21	94	85	6	15	219	252	6	15
Oreg.	19	17	23	19	113	98	12	21	144	140	5	3
Calif.	65	75	293	225	388	332	464	556	3,751	3,765	304	370
Alaska	-	-	3	4	10	12	-	2	64	69	8	7
Hawaii	1	-	9	10	6	4	2	-	179	175	-	-
Guam	-	-	-	2	1	3	3	8	35	103	-	-
P.R.	-	-	-	1	5	23	124	265	63	162	41	38
V.I.	-	-	-	2	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	5	-	-
C.N.M.I.	-	-	-	1	-	-	1	9	-	36	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending November 30, 1996, and December 2, 1995 (48th Week)

Reporting Area	*H. influenzae*, invasive		Hepatitis (viral), by type				Measles (Rubeola)			
			A		B		Indigenous		Imported†	
	Cum. 1996*	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	1996	Cum. 1996	1996	Cum. 1996
UNITED STATES	903	1,033	26,458	27,826	9,163	9,157	-	415	-	51
NEW ENGLAND	28	38	390	295	180	215	-	11	-	4
Maine	-	3	22	30	2	12	-	-	-	-
N.H.	9	10	24	12	19	20	-	-	-	-
Vt.	1	2	10	5	11	6	-	1	-	1
Mass.	16	12	185	129	62	88	-	9	-	3
R.I.	2	5	22	34	10	8	-	-	-	-
Conn.	-	6	127	85	76	81	-	1	-	-
MID. ATLANTIC	130	156	1,738	1,789	1,320	1,353	-	23	-	5
Upstate N.Y.	10	39	405	449	307	351	-	-	-	-
N.Y. City	36	34	551	840	541	397	-	9	-	3
N.J.	56	27	335	284	227	343	-	3	-	-
Pa.	28	56	447	216	245	262	-	11	-	2
E.N. CENTRAL	158	174	2,232	2,994	913	1,022	-	6	-	7
Ohio	86	90	703	1,673	116	101	-	2	-	3
Ind.	15	20	341	175	137	210	-	-	-	-
Ill.	38	44	563	621	240	265	-	2	-	1
Mich.	11	18	462	345	355	373	-	-	-	3
Wis.	8	2	163	180	65	73	-	2	-	-
W.N. CENTRAL	43	78	2,428	1,789	490	591	-	20	-	3
Minn.	25	42	129	173	59	61	-	16	-	2
Iowa	7	3	326	83	77	46	-	-	-	1
Mo.	8	26	1,230	1,229	269	400	-	3	-	-
N. Dak.	-	-	137	23	2	4	-	-	-	-
S. Dak.	1	1	42	79	5	2	-	-	-	-
Nebr.	1	3	210	49	47	32	-	-	-	-
Kans.	1	3	354	153	31	46	-	1	-	-
S. ATLANTIC	181	200	1,386	1,076	1,456	1,202	-	5	-	9
Del.	2	-	21	9	7	8	-	1	-	-
Md.	59	63	235	202	281	239	-	-	-	2
D.C.	6	-	36	25	31	21	-	1	-	-
Va.	9	28	173	202	129	105	-	-	-	3
W. Va.	10	8	15	24	30	52	-	-	-	-
N.C.	25	28	167	103	316	286	-	3	-	1
S.C.	5	3	50	44	94	49	-	-	-	-
Ga.	39	63	150	54	32	62	-	-	-	2
Fla.	26	7	539	413	536	380	-	-	-	1
E.S. CENTRAL	26	11	1,172	1,973	815	773	-	2	-	-
Ky.	4	5	42	42	60	64	-	-	-	-
Tenn.	12	-	742	1,648	466	606	-	2	-	-
Ala.	9	5	184	80	71	103	-	-	-	-
Miss.	1	1	204	203	218	U	-	-	-	-
W.S. CENTRAL	37	62	5,460	4,133	1,201	1,271	-	26	-	2
Ark.	-	6	484	577	75	68	-	-	-	-
La.	4	1	177	151	144	221	-	-	-	-
Okla.	29	23	2,272	1,187	59	156	-	-	-	-
Tex.	4	32	2,527	2,218	923	826	-	26	-	2
MOUNTAIN	93	111	4,119	4,036	1,049	798	-	153	-	5
Mont.	-	1	110	163	15	22	-	-	-	-
Idaho	1	4	226	324	86	95	-	1	-	-
Wyo.	35	9	33	101	44	26	-	1	-	-
Colo.	15	16	475	475	128	127	-	4	-	3
N. Mex.	10	14	333	762	381	288	-	17	-	-
Ariz.	15	27	1,589	1,270	222	114	-	8	-	-
Utah	9	11	976	650	95	68	-	117	-	2
Nev.	8	29	377	291	78	58	-	5	-	-
PACIFIC	207	203	7,533	9,741	1,739	1,932	-	169	-	16
Wash.	4	9	676	802	98	184	-	51	-	-
Oreg.	27	26	798	2,571	113	113	-	10	-	1
Calif.	171	163	5,923	6,158	1,498	1,595	-	38	-	8
Alaska	2	1	42	47	18	11	-	63	-	-
Hawaii	3	4	94	163	12	29	-	7	-	7
Guam	-	-	2	8	-	5	U	-	U	-
P.R.	1	3	135	104	357	609	-	8	-	-
V.I.	-	-	-	8	-	15	-	-	-	-
Amer. Samoa	-	-	-	6	-	-	U	-	U	-
C.N.M.I.	10	11	1	24	5	22	U	-	U	-

N: Not notifiable U: Unavailable -: no reported cases

*Of 215 cases among children aged <5 years, serotype was reported for 54 and of those, 19 were type b.

†For imported measles, cases include only those resulting from importation from other countries.

TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending November 30, 1996, and December 2, 1995 (48th Week)

Reporting Area	Measles (Rubeola), cont'd. Total		Mumps			Pertussis			Rubella		
	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995
UNITED STATES	466	293	11	602	795	174	5,497	4,219	-	202	117
NEW ENGLAND	15	11	-	2	12	43	1,228	655	-	27	49
Maine	-	-	-	-	4	-	20	44	-	-	-
N.H.	-	-	-	-	1	9	143	51	-	-	1
Vt.	2	-	-	-	-	5	178	73	-	2	-
Mass.	12	4	-	2	3	24	820	455	-	21	9
R.I.	-	5	-	-	1	2	32	4	-	-	-
Conn.	1	2	-	-	3	3	35	28	-	4	39
MID. ATLANTIC	28	12	1	84	115	79	598	380	-	13	15
Upstate N.Y.	-	1	-	25	25	67	382	200	-	5	4
N.Y. City	12	5	-	17	16	-	48	52	-	5	8
N.J.	3	6	-	3	20	-	19	18	-	2	3
Pa.	13	-	1	39	54	12	149	110	-	1	-
E.N. CENTRAL	13	15	1	95	162	14	580	545	-	3	4
Ohio	5	2	1	42	51	12	267	152	-	-	-
Ind.	-	-	-	9	9	-	105	55	-	-	-
Ill.	3	2	-	20	47	2	154	112	-	1	-
Mich.	3	5	-	23	55	-	49	99	-	2	4
Wis.	2	6	-	1	-	-	5	127	-	-	-
W.N. CENTRAL	23	2	1	19	46	16	385	253	-	-	1
Minn.	18	-	-	6	8	12	303	125	-	-	-
Iowa	1	-	1	3	10	-	20	11	-	-	-
Mo.	3	1	-	7	23	4	44	61	-	-	-
N. Dak.	-	-	-	2	1	-	1	8	-	-	-
S. Dak.	-	-	-	-	-	-	4	12	-	-	-
Nebr.	-	-	-	-	4	-	9	14	-	-	-
Kans.	1	1	-	1	-	-	4	22	-	-	1
S. ATLANTIC	14	19	1	104	120	7	619	338	-	93	10
Del.	1	-	-	-	-	-	17	10	-	-	-
Md.	2	1	-	28	34	4	239	45	-	-	1
D.C.	1	-	-	1	-	-	4	6	-	2	-
Va.	3	-	-	16	25	-	98	31	-	2	-
W. Va.	-	-	-	-	-	-	2	-	-	-	-
N.C.	4	-	-	20	16	-	100	110	-	78	1
S.C.	-	-	-	7	11	2	44	27	-	1	-
Ga.	2	4	-	3	10	-	17	25	-	-	-
Fla.	1	14	1	29	24	1	98	84	-	10	8
E.S. CENTRAL	2	-	-	21	17	-	176	270	-	2	1
Ky.	-	-	-	-	-	-	122	25	-	-	-
Tenn.	2	-	-	3	5	-	21	207	-	-	1
Ala.	-	-	-	3	4	-	24	36	-	2	-
Miss.	-	-	-	15	8	-	9	2	N	N	N
W.S. CENTRAL	28	34	4	40	53	-	118	290	-	3	7
Ark.	-	2	-	2	7	-	13	39	-	-	-
La.	-	18	4	17	13	-	9	19	-	1	-
Okla.	-	-	-	1	-	-	19	31	-	-	-
Tex.	28	14	-	20	33	-	77	201	-	2	7
MOUNTAIN	158	70	-	22	30	6	404	616	-	6	4
Mont.	-	-	-	-	1	1	35	9	-	-	-
Idaho	1	2	-	-	3	-	101	105	-	2	-
Wyo.	1	-	-	1	-	-	8	1	-	-	-
Colo.	7	26	-	3	2	2	107	105	-	2	-
N. Mex.	17	31	N	N	N	-	61	138	-	-	-
Ariz.	8	10	-	1	2	-	29	153	-	1	3
Utah	119	-	-	2	11	-	22	27	-	-	1
Nev.	5	1	-	15	11	3	41	78	-	1	-
PACIFIC	185	130	3	215	240	9	1,389	872	-	55	26
Wash.	51	19	-	20	14	9	662	324	-	2	1
Oreg.	11	1	-	-	-	-	35	64	-	1	-
Calif.	46	108	3	163	204	-	660	425	-	49	20
Alaska	63	-	-	3	12	-	4	1	-	-	-
Hawaii	14	2	-	29	10	-	28	58	-	3	5
Guam	-	-	U	5	4	U	1	2	U	-	1
P.R.	8	3	-	1	2	-	1	2	-	-	-
V.I.	-	-	-	-	3	-	-	-	-	-	-
Amer. Samoa	-	-	U	-	-	U	-	-	U	-	-
C.N.M.I.	-	-	U	-	1	U	-	-	U	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE IV. Deaths in 121 U.S. cities,* week ending November 30, 1996 (48th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	>65	45-64	25-44	1-24	<1	
NEW ENGLAND	496	368	77	34	9	8	36
Boston, Mass.	123	86	22	10	4	1	3
Bridgeport, Conn.	26	21	4	1	-	-	9
Cambridge, Mass.	25	19	5	1	-	-	-
Fall River, Mass.	19	16	3	-	-	-	-
Hartford, Conn.	49	32	8	4	4	1	1
Lowell, Mass.	24	20	2	1	-	1	-
Lynn, Mass.	7	5	2	-	-	-	-
New Bedford, Mass.	22	18	2	2	-	-	1
New Haven, Conn.	32	21	4	6	-	1	1
Providence, R.I.	49	38	7	3	1	-	6
Somerville, Mass.	6	6	-	-	-	-	-
Springfield, Mass.	41	27	8	4	-	2	5
Waterbury, Conn.	21	17	4	-	-	-	5
Worcester, Mass.	52	42	6	2	-	2	5
MID. ATLANTIC	2,021	1,415	371	167	27	41	104
Albany, N.Y.	39	32	3	3	-	1	3
Allentown, Pa.	25	20	3	1	1	-	-
Buffalo, N.Y.	72	52	15	3	1	1	6
Camden, N.J.	25	15	7	2	1	-	-
Elizabeth, N.J.	15	11	3	-	-	1	-
Erie, Pa.§	40	37	2	1	-	-	4
Jersey City, N.J.	24	18	5	-	-	1	2
New York City, N.Y.	1,205	831	227	112	13	22	52
Newark, N.J.	43	19	11	6	3	4	1
Paterson, N.J.	18	13	3	1	-	1	1
Philadelphia, Pa.	200	128	45	18	5	4	10
Pittsburgh, Pa.§	38	25	8	1	1	3	1
Reading, Pa.	13	13	-	-	-	-	3
Rochester, N.Y.	76	55	13	7	-	1	5
Schenectady, N.Y.	26	19	4	2	1	-	-
Scranton, Pa.§	28	26	2	-	-	-	2
Syracuse, N.Y.	85	60	15	7	1	2	8
Trenton, N.J.	30	22	5	3	-	-	4
Utica, N.Y.	19	19	-	-	-	-	2
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,670	1,122	307	146	54	39	97
Akron, Ohio	37	24	10	3	-	-	-
Canton, Ohio	29	22	4	3	-	-	2
Chicago, Ill.	463	273	101	57	16	14	36
Cincinnati, Ohio	133	102	18	9	1	3	14
Cleveland, Ohio	114	79	24	8	2	1	2
Columbus, Ohio	154	108	29	7	4	6	6
Dayton, Ohio	74	52	12	7	1	2	1
Detroit, Mich.	129	85	22	16	4	2	4
Evansville, Ind.	26	18	4	3	1	-	-
Fort Wayne, Ind.	64	48	10	3	3	-	5
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	40	27	4	3	4	2	1
Indianapolis, Ind.	91	61	17	3	9	1	9
Madison, Wis.	U	U	U	U	U	U	U
Milwaukee, Wis.	73	57	9	4	-	3	4
Peoria, Ill.	24	15	5	3	1	-	-
Rockford, Ill.	31	20	4	6	-	1	1
South Bend, Ind.	39	31	4	2	1	1	2
Toledo, Ohio	118	75	26	7	7	3	9
Youngstown, Ohio	31	25	4	2	-	-	1
W.N. CENTRAL	521	379	85	24	6	21	46
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	21	16	4	1	-	-	1
Kansas City, Kans.	14	10	1	2	-	1	-
Kansas City, Mo.	107	74	13	5	2	7	7
Lincoln, Nebr.	23	17	4	1	-	1	2
Minneapolis, Minn.	122	87	24	7	-	4	14
Omaha, Nebr.	79	58	14	1	1	5	3
St. Louis, Mo.	66	49	12	2	1	2	14
St. Paul, Minn.	36	31	4	1	-	-	3
Wichita, Kans.	53	37	9	4	2	1	2
S. ATLANTIC	1,045	661	216	109	34	23	49
Atlanta, Ga.	89	48	21	12	6	2	2
Baltimore, Md.	219	138	47	24	4	4	21
Charlotte, N.C.	78	58	12	2	3	3	1
Jacksonville, Fla.	88	56	21	7	2	2	3
Miami, Fla.	115	69	20	20	6	-	1
Norfolk, Va.	38	29	6	2	1	-	3
Richmond, Va.	49	28	12	5	1	3	1
Savannah, Ga.	36	32	3	1	-	-	4
St. Petersburg, Fla.	42	28	8	3	-	3	1
Tampa, Fla.	137	97	25	11	3	1	8
Washington, D.C.	139	75	29	22	8	5	4
Wilmington, Del.	15	3	12	-	-	-	-
E.S. CENTRAL	649	428	146	50	19	6	43
Birmingham, Ala.	108	65	25	12	6	-	3
Chattanooga, Tenn.	73	48	16	4	3	2	4
Knoxville, Tenn.	76	56	13	5	2	-	7
Lexington, Ky.	53	40	8	3	1	1	5
Memphis, Tenn.	171	113	41	11	5	1	14
Mobile, Ala.	47	31	9	6	-	1	1
Montgomery, Ala.	27	19	7	1	-	-	2
Nashville, Tenn.	94	56	27	8	2	1	7
W.S. CENTRAL	996	675	170	100	27	21	59
Austin, Tex.	36	26	7	3	-	-	2
Baton Rouge, La.	34	27	3	2	-	2	-
Corpus Christi, Tex.	47	36	7	4	-	-	3
Dallas, Tex.	125	76	26	17	2	4	2
El Paso, Tex.	74	60	8	4	2	-	7
Ft. Worth, Tex.	51	38	7	5	-	1	2
Houston, Tex.	209	127	50	19	9	4	19
Little Rock, Ark.	47	29	8	5	3	2	5
New Orleans, La.	122	73	19	18	6	3	-
San Antonio, Tex.	125	90	16	12	4	3	9
Shreveport, La.	57	43	4	8	1	1	4
Tulsa, Okla.	69	50	15	3	-	1	6
MOUNTAIN	737	471	154	62	30	18	32
Albuquerque, N.M.	76	42	21	9	4	-	3
Colo. Springs, Colo.	U	U	U	U	U	U	U
Denver, Colo.	97	55	22	12	6	2	4
Las Vegas, Nev.	148	91	34	13	7	3	6
Ogden, Utah	27	21	4	2	-	-	2
Phoenix, Ariz.	155	93	34	9	11	8	7
Pueblo, Colo.	18	13	4	1	-	-	1
Salt Lake City, Utah	98	63	20	11	1	3	3
Tucson, Ariz.	118	93	15	5	1	2	6
PACIFIC	1,247	889	225	90	28	14	108
Berkeley, Calif.	15	11	1	2	1	-	-
Fresno, Calif.	55	35	11	6	1	1	3
Glendale, Calif.	8	7	1	-	-	-	1
Honolulu, Hawaii	66	42	19	-	3	2	5
Long Beach, Calif.	51	39	7	3	2	-	4
Los Angeles, Calif.	183	112	44	20	7	-	6
Pasadena, Calif.	27	22	2	2	1	-	3
Portland, Oreg.	116	83	18	12	2	1	5
Sacramento, Calif.	150	109	24	12	2	3	22
San Diego, Calif.	87	64	15	5	1	2	14
San Francisco, Calif.	88	61	16	8	2	1	12
San Jose, Calif.	140	102	28	6	2	2	13
Santa Cruz, Calif.	30	24	4	2	-	-	3
Seattle, Wash.	121	91	20	6	2	2	7
Spokane, Wash.	46	40	3	2	1	-	8
Tacoma, Wash.	64	47	12	4	1	-	2
TOTAL	9,382¶	6,408	1,751	782	234	191	574

U: Unavailable -: no reported cases

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

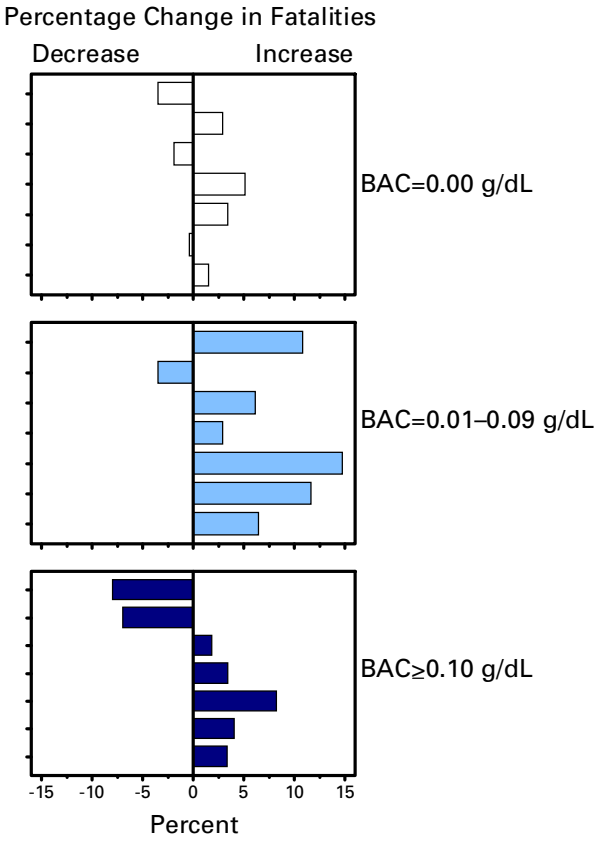
†Pneumonia and influenza.

§Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

Changes in the number and percentage of traffic fatalities (including drivers, occupants, and nonoccupants), by age group and highest blood alcohol concentration (BAC)* of driver† or nonoccupant in crashes — United States, 1994 and 1995

	No. Fatalities	
Age group (yrs)	**1994**	**1995**
<15§	2,270	2,191
15-20	3,896	4,014
21-24	1,878	1,843
25-34	3,092	3,253
35-64	7,030	7,279
≥65	5,918	5,896
Total¶	**24,084**	**24,476**
<15§	192	213
15-20	751	725
21-24	486	516
25-34	769	792
35-64	950	1,091
≥65	326	364
Total¶	**3,474**	**3,701**
<15§	423	389
15-20	1,592	1,481
21-24	1,871	1,907
25-34	3,732	3,862
35-64	4,750	5,146
≥65	702	731
Total¶	**13,070**	**13,516**



*BAC distributions are estimates for drivers and nonoccupants involved in fatal crashes. Fatalities include all occupants and nonoccupants who died within 30 days of a motor-vehicle crash on a public roadway and whose age was known.
†Driver may or may not have been killed.
§Although usually too young to drive legally, persons in this age group are included for completeness of the data set.
¶The number of fatalities for each BAC category is rounded to the nearest whole number.

Source: Fatal Accident Reporting System, National Highway Traffic Safety Administration.

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to *lists@list.cdc.gov*. The body content should read *subscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/* or from CDC's file transfer protocol server at *ftp.cdc.gov*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (404) 332-4555.

☆U.S. Government Printing Office: 1997-532-228/47042 Region IV