MMWR™
Morbidity and Mortality Weekly Report
Weekly June 25, 2004 / Vol. 53 / No. 24

National HIV Testing Day — June 27, 2004

National HIV Testing Day is June 27. This annual event is sponsored by the National Association of People with AIDS to encourage persons at risk for human immunodeficiency virus (HIV) infection to get tested and learn their status. This year's theme, "It's Better to Know," underscores the importance of being tested for HIV. An estimated 850,000–950,000 persons in the United States are HIV positive, and an estimated one in four are not aware of their infection (*1*). Persons who know they are infected can benefit from advances in medical care that can prolong their lives, and they can take action to prevent transmission to others.

HIV testing has become easier, more accessible, and less invasive in 2004. One antibody test can provide preliminary results in as little as 20 minutes and can be used in both medical and nonclinical settings (*2*). A new oral version of that test, approved by the Food and Drug Administration in April, will make getting tested even easier by eliminating the need for a finger-stick blood sample.

Additional information about where to get tested and local events being held to encourage testing among populations at greatest risk (e.g., non-Hispanic blacks, Hispanics, and men who have sex with men) is available at http://www.hivtest.org.

References

1. Fleming P, Byers RH, Sweeney PA, Daniels D, Karon JM, Janssen RS. HIV prevalence in the United States, 2000 [Abstract]. Presented at the 9th Conference on Retrovirus and Opportunistic Infections, Seattle, Washington, 2002.
2. CDC. Approval of a new rapid test for HIV antibody. MMWR 2002;51:1051–2.

Voluntary HIV Testing as Part of Routine Medical Care — Massachusetts, 2002

In 2003, CDC released *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. One of the four strategies of this initiative is to expand routine, voluntary human immunodeficiency virus (HIV) testing (*1*). This report describes the results of a state-funded program in Massachusetts that offered HIV counseling, testing, and referral (HIV CTR) to patients entering one of four hospital-associated urgent care centers. Among the 3,068 patients tested, the program identified an HIV seroprevalence of 2.0%. The findings underscore the effectiveness of routine HIV CTR in HIV case identification.

The Massachusetts Department of Public Health (MDPH) AIDS Bureau identified the 15 cities in Massachusetts with the highest HIV prevalence. On the basis of patient volume and existing HIV primary care services, four hospital-associated urgent care centers in these cities were selected for program implementation. The program, called "Think HIV," was designed to assist centers in routine HIV counseling and testing, facilitate patient follow-up for test results, and promote strategies for linkage to care. Patient privacy and the availability of adequate, expedient HIV care for those who tested positive were essential components of the program.

INSIDE

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The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2004;53:[inclusive page numbers].

After registration for urgent care, patients were offered the opportunity to speak with a "health educator," a certified counselor with case-management experience trained specifically in sexually transmitted diseases, hepatitis C, and HIV. Counselors were available weekdays and some weekends. Patients who agreed to speak with a health educator were told that voluntary, confidential HIV CTR was now offered routinely to urgent care patients. Patients who declined to speak with a health educator were asked about their reasons for refusal, and those who reported they were already known to be HIV-infected were asked if they were receiving HIV care; if not, they were linked to care.

Upon completion of counseling, confidential HIV tests were performed by using the oral swab, OraSure® HIV-1 antibody detection system (Epitope, Inc., Bethlehem, Pennsylvania). Patients were instructed to return to the urgent care center for test results 14 days later, when results were provided and posttest counseling was performed. Substantial efforts, including a minimum of four telephone calls and a follow-up letter, were made to locate all patients testing negative or positive who did not return for results. Additional efforts, including offering transportation vouchers and contacting homeless shelters, were made for persons testing positive who failed to return. At each center, an HIV intake nurse from an HIV outpatient clinic provided assistance to patients during posttest counseling, arranged follow-up HIV clinical care appointments, and often brought patients to their care appointments.

During 2002, the first year of the program, 10,352 patients were offered HIV counseling at the four centers, accounting for approximately 10%–15% of all patients entering these urgent care centers and a percentage determined by counselor capacity. Of the 10,352 patients offered HIV testing, 7,071 (68%) declined testing; 6,291 (89%) of these 7,071 were willing to answer inquiries about their refusal to undergo testing. The reasons given for testing refusal included one or more of the following: 1) did not feel at risk for HIV (2,974 [47%]), 2) tested for HIV before (2,624 [42%]), 3) felt too ill (686 [11%]), 4) testing takes too long (281 [4%]), 5) information too personal (120 [2%]), and 6) already known to be HIV-infected (86 [1%]). Of the 2,573 patients reporting previous HIV testing who also provided the dates of the test, 1,542 (60%) reported their tests were performed in 2002 (Table).

Among the 3,068 patients with completed test results, 60 were HIV-infected (HIV prevalence: 2.0%); of these, 49 (82%) returned for their results. Of the first 42 patients for whom linkage-to-care data were available, all 42 had at least one documented follow-up visit for HIV care. During the interview process, the program also identified six additional patients who reported they were known to be HIV-infected and who

TABLE. Number and percentage of patients* who accepted or declined human immunodeficiency virus (HIV) testing, by selected characteristics and test result — Massachusetts, 2002†

Characteristic	Tested positive		Tested negative		Not tested	
	No.	(%)	No.	(%)	No.	(%)
Sex						
Male	41	(68)	1,684	(56)	3,420	(49)
Female	19	(32)	1,317	(44)	3,626	(51)
Total	**60**	**(100)**	**3,008**	**(100)**	**7,071**	**(100)**
Race/Ethnicity						
White, non-Hispanic	2	(4)	632	(22)	2,160	(35)
Black, non-Hispanic	33	(56)	1,092	(38)	2,033	(33)
Hispanic	12	(20)	794	(28)	1,446	(23)
Haitian	6	(10)	151	(5)	203	(3)
Other	6	(10)	216	(7)	396	(6)
Education						
<High school	22	(37)	772	(26)	1,347	(22)
High school	24	(41)	1,194	(40)	2,447	(39)
>High school	13	(22)	1,029	(34)	2,448	(39)

* A total of 16 (<1%) patients had missing data for age, 32 (<1%) for sex, 957 (9%) for race/ethnicity, and 843 (8%) for education.
† Mean age was 35.5 years among persons testing positive, 33.6 years for those testing negative, and 33.1 years for those not tested.

described themselves as either not having a doctor or not being in care. These patients were referred for follow-up HIV care. Four of these six patients had confirmed attendance at their first HIV care appointment.

The program was funded by the MDPH AIDS Bureau. Overall, the cost of the program for the first 12 months was $349,400, which amounted to $7,100 for each of the 49 new HIV-infected patients told of their diagnosis or $5,800 for each of the 60 new cases identified.

Reported by: *RP Walensky, MD, Massachusetts General Hospital; KA Freedberg, MD, Harvard Medical School; E Losina, PhD, Boston Univ School of Public Health; PR Skolnik, MD, JM Hall, Boston Univ Medical Center; L Malatesta, MPH, GE Barton, CA O'Connor, MSN, JF McGuire, PhD, AIDS Bur, Massachusetts Dept of Public Health.*

Editorial Note: This report describes results of the Think HIV program in Massachusetts, which offered voluntary HIV CTR routinely to patients entering four urgent care centers. Because these centers did not previously have routine HIV CTR available, the majority of the 60 newly identified HIV patients likely would not have been identified until later in the course of their disease without the program. Health-care providers often discourage HIV testing in urgent care centers because of concerns regarding adequate training, pre- and post test counseling, and follow-up for patients testing HIV positive (*2*). Because many medically underserved patients at high risk for HIV use urgent care centers and emergency departments for their primary care, repeated opportunities for HIV diagnosis in these patients often are missed (*3*).

Simply making a diagnosis of HIV, however, does not ensure the individual and public health benefits of HIV care. Previous reports have indicated that a mean delay of entry into HIV care of 3 months occurs after HIV diagnosis, with 32% of patients delaying >2 years and 18% delaying >5 years (*4*). To combat this lag to care, the program emphasized a formal linkage-to-care mechanism. An identified intake nurse at each center confirmed that newly HIV-diagnosed patients had rapid, immediate communication with members of their future health-care team. Success with the linkage component of the program is evidenced by a first appointment attendance rate of 100%, compared with 34% in another urgent care routine testing program in Atlanta (*5*). Results from CDC's Antiretroviral Treatment and Access Study also demonstrated substantial improvements in entry into HIV care with the presence of HIV case-management personnel. Patients who had two to three visits with a case manager during a 3-month period attended more HIV care visits, compared with patients who did not have these encounters (*6*).

HIV testing as part of routine care has been delegated to primary care providers. In a 10- or 15-minute provider visit intended to cover many components of medical care, HIV CTR typically is not performed. By using counselors committed to this effort, the program had an estimated cost per new HIV patient identified of <$6,000, a figure that would be reduced with more streamlined pretest procedures of providing information about HIV testing (as recommended in CDC's *Advancing HIV Prevention* initiative) rather than the previously recommended extensive pretest counseling (*1*). Model-based cost-effectiveness analyses of routine HIV screening in primary care, outpatient, and inpatient settings have projected cost-effectiveness ratios of $22,000–$36,700 per quality-adjusted life year gained, which is more cost-effective than screening for colon cancer (*7–10*).

The findings in this report are subject to at least two limitations. First, although efforts were made to test all patients entering the urgent care centers, access to HIV testing was based on counselor availability. Second, centers with suspected high HIV prevalence were chosen, and results should not be generalized to all urgent care centers throughout the United States.

CDC's initiative *Advancing HIV Prevention: New Strategies for a Changing Epidemic* calls for including HIV testing as a routine part of medical care to increase the number of HIV-infected persons who are aware of their positive serostatus (*1*). The diagnosis of HIV in HIV-infected persons is a priority in the United States. Routine, voluntary HIV screening programs in urgent care centers in areas of high HIV prevalence are feasible and can be successful at diagnosing persons with HIV and linking them to appropriate HIV care. CDC is currently

funding such projects in out-patient care clinics and emergency departments in four states. In addition, CDC will be funding community-based organizations and health departments to assist with linkage and referrals in facilities in areas of high HIV prevalence and will evaluate the cost-effectiveness of this strategy.

References

1. CDC. Advancing HIV prevention: new strategies for a changing epidemic—United States, 2003. MMWR 2003;52:329–32.
2. Fincher-Mergi M, Cartone KJ, Mischler J, et al. Assessment of emergency department health care professionals' behaviors regarding HIV testing and referral for patients with STDs. AIDS Patient Care STDS 2002;16:549–53.
3. Liddicoat RV, Horton NJ, Urban R, et al. Assessing missed opportunities for HIV testing in medical settings. J Gen Intern Med 2004;19:349–56.
4. Samet JH, Freedberg KA, Stein MD, et al. Trillion virion delay: time from testing positive for HIV to presentation for primary care. Arch Intern Med 1998;158:734–40.
5. CDC. Routinely recommended HIV testing at an urban urgent-care clinic—Atlanta, Georgia, 2000. MMWR 2001;50:538–41.
6. Gardner LI, Metsch L, Loughlin A, et al. Initial results of the Antiretroviral Treatment Access Studies (ARTAS): efficacy of the case management trial [Abstract no. M3-B13-08]. Presented at the National HIV Prevention Conference, Atlanta, Georgia, 2003.
7. Phillips KA, Fernyak S. The cost-effectiveness of expanded HIV counseling and testing in primary care settings: a first look. AIDS 2000;14:2159–69.
8. Walensky RP, Weinstein MC, Kimmel AD, et al. Routine inpatient HIV testing: a clinical and economic evaluation of national guidelines [Abstract no. T3-E11-02]. Presented at the National HIV Prevention Conference, Atlanta, Georgia, 2003.
9. Paltiel A, Weinstein M, Kimmel A, et al. Expanded screening for HIV disease in the United States: clinical impact and cost-effectiveness [Abstract no. T3-E11-04]. Presented at the National HIV Prevention Conference, Atlanta, Georgia, 2003.
10. Frazier AL, Colditz GA, Fuchs CS, et al. Cost-effectiveness of screening for colorectal cancer in the general population. JAMA 2000;284:1954–61.

Acknowledgments

This report is based in part on contributions by HE Smith, Massachusetts General Hospital, the hospital staff, urgent care center staff, and HIV counselors at Boston Medical Center, Baystate Medical Center, Univ of Massachusetts Medical Center, Cambridge Hospital, Whidden Hospital, Boston; AIDS Bur, Partners/Fenway/Shattuck Center for AIDS Research, Massachusetts Dept of Public Health. National Institute of Allergy and Infectious Diseases, National Institute of Mental Health, National Institutes of Health.

Cancer Survivorship — United States, 1971–2001

Because of advances in early detection and treatment, cancer has become a curable disease for some and a chronic illness for others. Underscoring this change, persons with diagnoses of cancer increasingly are described as "cancer survivors" rather than "cancer victims" (*1,2*). Cancer survivors include all living persons who ever received a diagnosis of cancer (*1*). To highlight how the population of cancer survivors has changed in the United States, the National Cancer Institute and CDC studied cancer data collected during 1971–2001. This report summarizes the results of that study, which determined that the number of persons living with cancer increased from 3.0 million (1.5% of the U.S. population) in 1971 to 9.8 million (3.5%) in 2001. A national health objective for 2010 is to increase to 70% the proportion of cancer patients who are living ≥5 years after diagnosis (objective no. 3-15), an objective already achieved for children with cancer but not yet for adults. The growing number of persons living with cancer poses challenges for researchers to understand the physical, psychosocial, and economic effects of surviving cancer and for public health practitioners to develop evidence-based programs to promote the health and well-being of cancer survivors.

This report uses incidence and follow-up data from registries in the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute to estimate the number of persons alive after a diagnosis of cancer and to monitor the progress in cancer survivorship (*3*). In addition, survival rates for persons receiving a diagnosis of cancer during 1991–2000 were compared with those receiving a cancer diagnosis during 1974–1976, the earliest dates for which SEER maintained data on survival; data collection for SEER began on January 1, 1973. To overcome the limited duration of data collection in all but the Connecticut registry (which began collecting data in 1935), estimates were adjusted to obtain lifetime or complete counts by using a statistical model that accounts for cases diagnosed before the start of the SEER program (*4*). The estimated number of cancer survivors was calculated by using data from SEER-9 registries to estimate the proportion of persons, by age, sex, and race, who were alive on January 1, 2001, and had a diagnosis of cancer during 1975–2000, taking into account loss to follow-up (*4*). These estimates were projected to U.S. population estimates, and data for all races combined were estimated by summing the counts for whites/unknown, blacks, and other races (*5*). Finally, the number of persons with a diagnosis of cancer no matter how long since the diagnosis was 1) estimated by adjusting the limited-duration data based on statistical modeling of incidence and survival, controlling for age and sex (*6*), and 2) validated by using 1940–1997 data from the historical Connecticut registry.

For all cancers combined, the number of survivors in the United States has increased steadily during the last three

rec•om•men•da•tion: *n*

("rek-ə-mən-'dā-shən) 1 : something, such as a course of action, that is recommended; see also *MMWR*.

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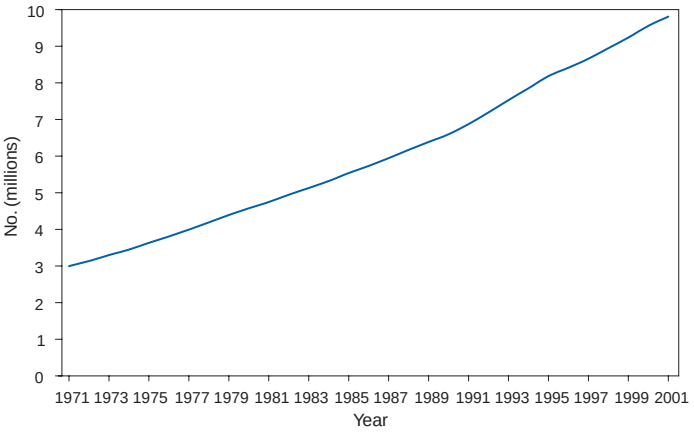
decades. In 1971, an estimated 3.0 million persons were living with cancer, representing approximately 1.5% of the population. In 2001, an estimated 9.8 million persons were cancer survivors, approximately 3.5% of the population (Figure 1). In the absence of other competing causes of death, an estimated 64% of adults whose cancer was diagnosed during 1995–2000 could expect to be alive 5 years after diagnosis, compared with 50% for those whose cancer was diagnosed during 1974–1976. Among children (i.e., persons aged ≤14 years), 79% of cancer survivors during 1991–2000 were expected to be alive at 5 years and approximately 75% at 10 years, compared with 56% expected to live ≥5 years after diagnosis during 1974–1976.

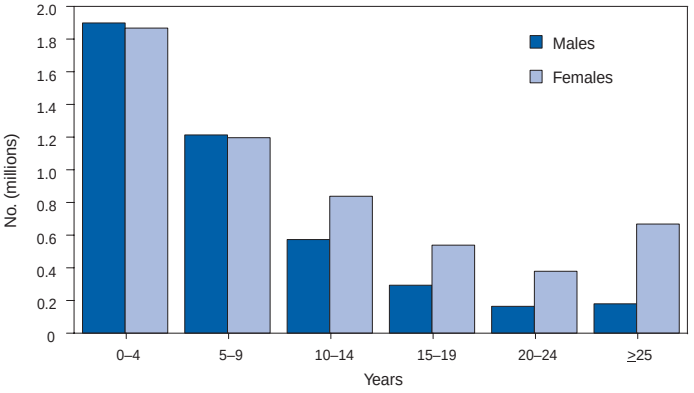
Among all cancer survivors in 2001, an estimated 14% had received a cancer diagnosis ≥20 years ago (Figure 2). More females than males were survivors, although more males than females received cancer diagnoses. In 2001, men had a higher proportion of lung cancer, for which survival chances are poor, whereas women had higher proportions of more readily detectable and treatable cancers (e.g., breast and gynecologic). Among cancer survivors in 2001, the most common primary cancer type was female breast cancer (22%), followed by prostate cancer (17%), colorectal cancer (11%), and gynecologic cancer (10%) (Figure 3). In 2001, an estimated 60% of all newly diagnosed cancers occurred among persons aged ≥65 years, who represented 61% of all cancer survivors. Thirty-three percent of cancer survivors were aged 40–64 years, 5% were aged 20–39 years, and <1% were aged ≤19 years.

FIGURE 1. Estimated number* of living persons who have ever received a cancer diagnosis, by year — United States, 1971–2001



* Estimated by applying U.S. populations to SEER-9 and historical Connecticut Tumor Registry data and adjusted to represent all cancer survivors. January 1 populations were based on average mid-year population estimates from the U.S. Census Bureau.

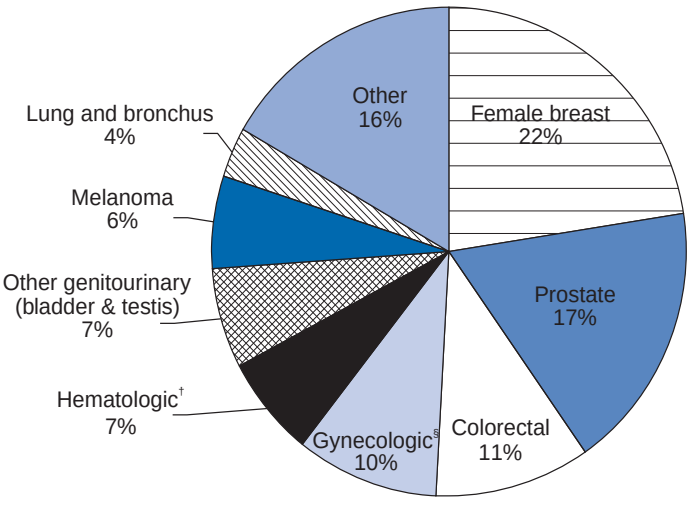
FIGURE 2. Number of cancer survivors, by sex and years after diagnosis — United States, 2001



Reported by: *J Rowland, PhD, A Mariotto, PhD, N Aziz, MD, G Tesauro, MSW, EJ Feuer, PhD, Div of Cancer Control and Population Sciences, National Cancer Institute. D Blackman, PhD, P Thompson, Div of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion; LA Pollack, MD, EIS Officer, CDC.*

Editorial Note: Increases in the number of persons surviving for longer periods after a diagnosis of cancer have resulted from 1) earlier diagnoses through increased screening, 2) more effective treatment, 3) prevention of secondary disease and cancer recurrence, and 4) decreases in mortality from other causes. This increase has led to a broader definition for cancer survivors. Cancer also is associated with aging. As the U.S. population ages, increased effort will likely be needed to plan for the care and optimal health of older persons, many of whom will become cancer survivors.

FIGURE 3. Distribution of primary cancers* among living persons who have ever received a cancer diagnosis — United States, 2001



* Only first (primary) cancer site counted.
† Hodgkin's disease, non-Hodgkin's lymphoma, and leukemia.
§ Cervix, corpus uteri, and ovarian.

The findings in this report are subject to at least four limitations. First, higher survival rates do not always result in lower cancer mortality rates (*7*); living longer with cancer might reflect how early the cancer was diagnosed rather than an improvement in outcome. Second, projection of race- and age-specific proportions from SEER to the U.S. population does not account for other prognostic factors (e.g., socioeconomic status and smoking). Third, persons with multiple tumors were categorized according to their first tumor; a person with melanoma and later breast cancer is counted as a survivor from melanoma but not from breast cancer. Estimators of the number of persons with cancer using different methods of counting multiple tumors are available (*5*). Finally, the estimates do not include broader health-status data that might indicate whether a survivor was cured, in active therapy, living with a chronic illness or disability, or dying from cancer. Methods that relate these factors to the trajectory of disease are being studied (*8,9*).

The findings raise critical issues for public health practitioners. A growing need exists to promote health, prevent secondary disease, and ensure the social, psychological, and economic well-being of long-term cancer survivors and their families. Public health initiatives typically have addressed the early detection and prevention of cancer, and the change in cancer survivorship in part reflects the success of these efforts. Acknowledging the growing numbers of cancer survivors, public health practitioners are expanding efforts to address cancer survivorship and transform research findings into practice. Public health organizations and their partners are developing programs to support survivors and their families across the continuum of cancer treatment, health promotion, and survival. Long-term surveillance that monitors the health and social well-being of survivors after 5 years could provide a knowledge base for cancer survivorship. Development of clinical guidelines could help health-care practitioners provide follow-up to survivors. Policymakers could be educated about economic concerns faced by survivors, such as employment and insurance discrimination.

The Office of Cancer Survivorship at the National Cancer Institute supports research that seeks to identify, examine, and prevent or control adverse long- and short-term effects associated with cancer. This office also disseminates information, such as the *Facing Forward Series* (available at http://www.cancer.gov/cancerinformation/life-after-treatment), to enhance the quality of life of survivors. CDC is supporting states and tribal organizations in developing and incorporating survivorship priorities into their comprehensive cancer-control plans. Advocacy organizations (e.g., Lance Armstrong Foundation and National Coalition for Cancer Survivorship) promote education, awareness, and community programs that offer innovative after-treatment services and support for survivors. Recommendations from these and other organizations are included in the recently published National Action Plan for Cancer Survivorship: Advancing Public Health Strategies (available at http://www.cdc.gov/cancer/survivorship/index.htm) (*2*), an Institute of Medicine report on *Childhood Cancer Survivorship* (*10*), and *Living Beyond Cancer: Finding a New Balance* from the President's Cancer Panel (available at http://pcp.cancer.gov). Recommendations include establishing a representative registry of survivors, continuing research on the chronic and late effects of cancer, exploring programs that enable survivors to access and navigate complex health-care systems and coordinate care, creating clinical guidelines for follow-up care, developing public education programs on survivorship, and evaluating the effects and outcomes of these efforts.

References

1. Aziz NM, Rowland JH. Trends and advances in cancer survivorship research: challenge and opportunity. Semin Radiat Oncol 2003;13:248–66.
2. CDC, Lance Armstrong Foundation. A national action plan for cancer survivorship: advancing public health strategies. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 2004. Available at http://www.cdc.gov/cancer/survivorship/overview.htm.
3. Surveillance, Epidemiology, and End Results (SEER) Program. SEERStat Database: incidence—SEER-9 regulations. Bethesda, Maryland: National Cancer Institute, Division of Cancer Control and Population Sciences, 2003. Available at http://www.seer.cancer.gov.
4. Feldman AR, Kessler L, Myers MH, Naughton MD. The prevalence of cancer: estimates based on the Connecticut Tumor Registry. N Engl J Med 1986;315:1394–7.
5. Reis LA, Eisner MP, Kosary CL, et al., eds. SEER cancer statistics review, 1975–2000. Bethesda, Maryland: National Cancer Institute, 2003.
6. Merrill RM, Capocaccia R, Feuer EJ, Mariotto A. Cancer prevalence estimates based on tumour registry data in the Surveillance, Epidemiology, and End Results (SEER) Program. Int J Epidemiol 2000;29:197–207.
7. Welch HG, Schwartz LM, Woloshin S. Are increasing 5-year survival rates evidence of success against cancer? JAMA 2000;283:2975–8.
8. Mariotto A, Warren JL, Knopf KB, Feuer EJ. The prevalence of colorectal cancer patients under care in the U.S. Cancer 2003;98:1253–61.
9. Phillips N, Coldman A, McBride ML. Estimating cancer prevalence using mixture models for cancer survival. Stat Med 2002;21:1257–70.
10. Hewitt M, Weiner SL, Simone JV, eds., National Research Council. Childhood cancer survivorship: improving care and quality of life. Washington, DC: Institute of Medicine, 2003.

Racial/Ethnic Trends in Fetal Mortality — United States, 1990–2000

Fetal deaths at ≥20 weeks' gestation account for 49% of all deaths that occur between the 20th week of pregnancy and the first year of life. Although the risk for fetal death has declined substantially since the 1950s, disparities in the risk

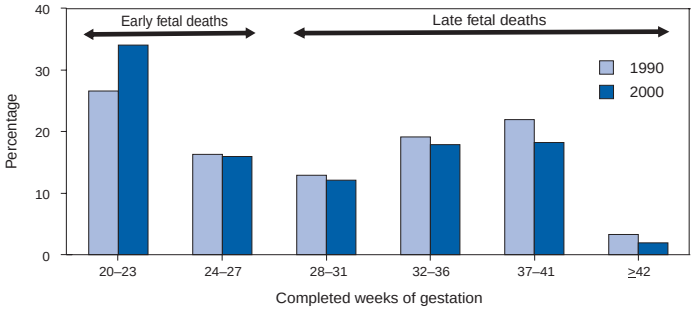
for fetal death by race/ethnicity exist (*1,2*). One of the national health objectives for 2010 is to reduce deaths among fetuses of ≥20 weeks' gestation to 4.1 deaths per 1,000 live births plus fetal deaths for all racial/ethnic populations (objective no. 16-1a) (*3*). To assess progress toward meeting this objective, CDC analyzed 1990–2000 data from the National Vital Statistics System (NVSS). The findings indicate substantial reductions in fetal deaths, primarily because of reductions in late fetal deaths (≥28 weeks' gestation) compared with early fetal deaths (20–27 weeks' gestation). Despite these reductions, racial/ethnic disparities in fetal deaths persist, particularly among non-Hispanic blacks. Prevention strategies should recognize fetal deaths as a public health problem, improve fetal death surveillance and reporting, target etiologic research, and educate practitioners in identifying women at risk.

During 1990–2000, NVSS data included all U.S. fetal deaths that were reported at ≥20 weeks' gestation. A fetal death was defined as an involuntary loss in which the fetus showed no evidence of life (i.e., no heartbeat or respiration) on delivery. Infant death was defined as the delivery of a live-born infant who subsequently died by age 1 year (*4*). Perinatal deaths included fetal and infant deaths (i.e., ≥20 weeks' gestation to age 1 year). The fetal mortality rate (FMR) was calculated as the number of fetal deaths in a specified group per 1,000 live births plus fetal deaths. Fetal deaths with presumed gestation of ≥20 weeks but with unknown specific gestational ages (2% of all fetal deaths at ≥20 weeks) were redistributed proportionately to calculate rates for early and late fetal deaths. Race/ethnicity was based on the self-reported race of the mother. Plurality (i.e., the number of fetuses delivered in a pregnancy) was categorized into deaths in singleton and multiple deliveries. All differences in mortality rates (based on Z scores) are statistically significant ($p<0.05$) unless otherwise noted.

In 1990, of 69,737 perinatal deaths reported, 29,345 (42%) were fetal deaths; of these, 12,554 were early fetal deaths, and 16,791 were late fetal deaths. In 2000, of 54,964 perinatal deaths reported, 27,003 (49%) were fetal deaths, including 13,497 early fetal deaths and 13,506 late fetal deaths. A comparison of fetal deaths in 1990 and 2000 by more detailed gestational age groups indicated a shift in the distribution toward deaths at earlier gestational ages (Figure). During 1990–2000, late fetal deaths decreased; however, early fetal deaths at 20–23 weeks increased from 27% to 34%.

During 1990–2000, FMR for all pluralities decreased 12%, from 7.5 per 1,000 live births plus fetal deaths to 6.6 (Table 1). However, contrasting trends were observed for early and late FMRs. Early FMRs increased slightly, from 3.2 to 3.3, whereas late FMRs declined 23%, from 4.3 to 3.3.

FIGURE. Percentage of fetal deaths, by gestational age and year — United States, 1990 and 2000



Among singleton deliveries (91% of all fetal deaths in 2000), FMRs decreased 13% overall (early FMR increased slightly, and late FMR decreased 22%). Among multiple deliveries, larger declines were observed; overall FMRs decreased 22% (early and late FMRs decreased 11% and 35%, respectively). Despite improvements in FMRs for multiple deliveries, in 2000, the risk for fetal mortality for multiples was approximately three times that for singletons (FMR =18.5 versus 6.2).

Declines in overall fetal mortality were observed for all groups except Asians/Pacific Islanders (A/PIs) (Table 2). FMRs declined 27% for American Indians/Alaska Natives (AI/ANs), 16% for Hispanics, 10% for non-Hispanic whites, and 5% for non-Hispanic blacks. Increases in early fetal mortality were observed for all groups except AI/ANs and A/PIs, whereas decreases in late fetal mortality were observed for all racial/ethnic populations.

Total, early, and late FMRs were substantially higher among non-Hispanic blacks in 1990 and 2000 than among other racial/ethnic populations. In 2000, FMR for non-Hispanic blacks was 12.1, compared with a total U.S. FMR of 6.6. The gap between FMRs for non-Hispanic blacks and other racial/ethnic populations remained wide during during 1990–2000; the FMR ratio between non-Hispanic blacks and the U.S. total was 1.7 for 1990 and 1.8 for 2000.

Reported by: *W Barfield, MD, Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; J Martin, MPH, D Hoyert, PhD, Div of Vital Statistics, National Center for Health Statistics, CDC.*

Editorial Note: The findings in this report indicate substantial declines in late fetal mortality for all populations (i.e., singleton and multiple deliveries in all racial/ethnic populations) during 1990–2000. The 23% decline observed in late fetal mortality is similar to that reported for neonatal mortality during the same period (*2*).

The findings also indicate that mortality among fetuses delivered at 20–27 weeks' gestation increased slightly during 1990–2000. This finding was consistent for all populations

TABLE 1. Fetal mortality rates*, by plurality† and year — United States, 1990–2000

Year	Singleton deliveries			Multiple deliveries			All pluralities		
	Total (≥20 weeks)	Early (20–27 weeks)	Late (≥28 weeks)	Total (≥20 weeks)	Early (20–27 weeks)	Late (≥28 weeks)	Total (≥20 weeks)	Early (20–27 weeks)	Late (≥28 weeks)
1990§	**7.1**	3.0	4.1	**23.7**	12.8	11.2	**7.5**	**3.2**	**4.3**
1991§	**6.9**	3.0	3.9	**23.4**	12.8	11.0	**7.3**	**3.2**	**4.1**
1992§	**7.0**	3.1	3.9	**23.7**	12.7	11.3	**7.4**	**3.3**	**4.1**
1993§	**6.8**	3.1	3.6	**21.3**	11.9	9.6	**7.1**	**3.4**	**3.8**
1994§	**6.6**	3.1	3.6	**21.0**	11.8	9.4	**7.0**	**3.3**	**3.7**
1995	**6.6**	3.1	3.5	**21.4**	12.7	8.9	**7.0**	**3.3**	**3.6**
1996	**6.5**	3.1	3.5	**20.6**	11.9	8.9	**6.9**	**3.3**	**3.6**
1997	**6.4**	3.0	3.4	**20.8**	12.0	9.0	**6.8**	**3.3**	**3.5**
1998	**6.3**	3.1	3.3	**19.1**	11.6	7.7	**6.7**	**3.3**	**3.4**
1999	**6.3**	3.1	3.2	**19.4**	11.9	7.8	**6.7**	**3.4**	**3.4**
2000	**6.2**	3.1	3.2	**18.5**	11.4	7.3	**6.6**	**3.3**	**3.3**

*Calculated as the number of fetal deaths in a specified group per 1,000 live births plus fetal deaths. Includes fetal deaths with stated or presumed gestations of ≥20 weeks.
† Defined as the number of fetuses delivered in a pregnancy (e.g., singleton or multiple deliveries).
§ Excludes data for Louisiana, which did not report plurality.

TABLE 2. Fetal mortality rates*, by race/ethnicity and year — United States, 1990–2000

Year	White, non-Hispanic			Black, non-Hispanic			Hispanic			Asian/ Pacific Islander			American Indian/ Alaska Native			All races/ ethnicities		
	Total (≥20 weeks)	Early (20–27 weeks)	Late (≥28 weeks)	Total (≥20 weeks)	Early (20–27 weeks)	Late (≥28 weeks)	Total (≥20 weeks)	Early (20–27 weeks)	Late (≥28 weeks)	Total (≥20 weeks)	Early (20–27 weeks)	Late (≥28 weeks)	Total (≥20 weeks)	Early (20–27 weeks)	Late (≥28 weeks)	Total (≥20 weeks)	Early (20–27 weeks)	Late (≥28 weeks)
1990†	**5.9**	2.4	3.5	**12.8**	6.3	6.4	**6.9**	2.4	4.5	**5.7**	2.3	3.4	**7.5**	2.9	4.7	**7.5**	**3.2**	**4.3**
1991†	**5.8**	2.4	3.4	**12.3**	6.1	6.1	**6.6**	2.4	4.2	**5.1**	2.0	3.2	**7.0**	2.6	4.4	**7.3**	**3.2**	**4.1**
1992§	**5.9**	2.5	3.4	**12.8**	6.6	6.2	**6.5**	2.5	4.0	**4.8**	2.1	2.7	**8.5**	2.8	5.8	**7.4**	**3.3**	**4.1**
1993¶	**5.7**	2.5	3.2	**12.4**	6.7	5.6	**6.1**	2.5	3.6	**5.1**	2.5	2.6	**6.4**	2.7	3.8	**7.1**	**3.4**	**3.8**
1994¶	**5.7**	2.6	3.1	**12.3**	6.6	5.6	**6.2**	2.5	3.7	**5.0**	2.2	2.8	**7.1**	2.7	4.4	**7.0**	**3.3**	**3.7**
1995**	**5.7**	2.6	3.1	**12.3**	6.8	5.5	**6.1**	2.6	3.5	**5.0**	2.2	2.8	**7.1**	2.8	4.4	**7.0**	**3.3**	**3.6**
1996**	**5.7**	2.6	3.1	**12.0**	6.6	5.3	**6.1**	2.6	3.4	**5.1**	2.4	2.8	**6.4**	2.7	3.8	**6.9**	**3.3**	**3.6**
1997**	**5.5**	2.5	3.0	**12.0**	6.7	5.3	**6.0**	2.7	3.4	**4.8**	2.3	2.5	**6.7**	2.4	4.4	**6.8**	**3.3**	**3.5**
1998††	**5.4**	2.5	2.9	**11.9**	6.6	5.2	**5.8**	2.5	3.2	**5.1**	2.7	2.4	**5.9**	2.4	3.4	**6.7**	**3.3**	**3.4**
1999§§	**5.4**	2.5	2.9	**12.3**	7.1	5.2	**5.9**	2.7	3.1	**5.4**	2.6	2.8	**6.1**	2.4	3.7	**6.7**	**3.4**	**3.4**
2000§§	**5.3**	2.5	2.8	**12.1**	6.8	5.2	**5.8**	2.7	3.1	**5.2**	2.4	2.8	**5.5**	2.5	3.0	**6.6**	**3.3**	**3.3**

* Calculated as the number of fetal deaths in a specified group per 1,000 live births plus fetal deaths. Includes fetal deaths with stated or presumed gestations of ≥20 weeks.
† Rates for non-Hispanic white, non-Hispanic black, and Hispanic exclude data for Louisiana, Maryland, Massachusetts, New Hampshire, Oklahoma, and Rhode Island, which did not report Hispanic origin.
§ Rates for non-Hispanic white, non-Hispanic black, and Hispanic exclude data for Louisiana, Maryland, Massachusetts, New Hampshire, and Oklahoma, which did not report Hispanic origin.
¶ Rates for non-Hispanic white, non-Hispanic black, and Hispanic exclude data for Louisiana, Maryland, Massachusetts, and Oklahoma, which did not report Hispanic origin.
** Rates for non-Hispanic white, non-Hispanic black, and Hispanic exclude data for Maryland, Massachusetts, and Oklahoma, which did not report Hispanic origin.
†† Rates for non-Hispanic white, non-Hispanic black, and Hispanic exclude data for Maryland, and Oklahoma, which did not report Hispanic origin.
§§ Rates for non-Hispanic white, non-Hispanic black, and Hispanic exclude data for Oklahoma, which did not report Hispanic origin.

except multiples and AI/ANs. To determine whether the lack of improvement in early fetal mortality was restricted to earlier and less viable gestations, FMRs were calculated separately for fetal deaths at 20–23 and 24–27 weeks. No improvement in FMRs was reported for either group. In contrast, outcomes among live-born infants delivered at 24–27 weeks have improved (*5*).

Trends in the risk for early and late fetal death suggest that changes in perinatal technologies (e.g., fetal imaging, prevention of perinatal infections, effective treatment of maternal medical conditions such as diabetes and chronic hypertension, and more aggressive management of labor and delivery) (*6*) might have had more of an impact on fetal survival at later rather than earlier gestational ages. In addition, rates of prenatal-care use increased substantially during the 1990s (*7*), and the subsequent improved access to care also might have had more impact on late rather than early fetal mortality (e.g., through the detection of maternal, fetal, or placental abnormalities that might lead to a live-born delivery). The lack of progress in reducing fetal mortality at earlier gestational ages might be related to 1) poor understanding of the factors associated with premature delivery and 2) limited understanding of the causes of fetal death and the role of maternal, fetal, and placental pathology (*8*).

Racial/ethnic disparities in fetal mortality persist. The risk for early fetal mortality among non-Hispanic blacks was more

than double that for other racial/ethnic populations; the risk for late fetal mortality for non-Hispanic blacks was approximately two thirds higher. Despite substantial reductions in late fetal mortality among non-Hispanic blacks during 1990–2000, greater reductions must occur during the next decade if the 2010 national health objective is to be achieved.

CDC, in conjunction with state partners, has revised the U.S. Standard Report of Fetal Death and is collaborating with the National Association for Public Health Statistics and Information Systems and the Social Security Administration to improve the quality of fetal death surveillance (*4,9*). Several states are linking additional data sources (e.g., maternal delivery and hospital records) to fetal death records to enhance understanding of the relationship between maternal disease and fetal death (*9*). The National Institutes of Child Health and Human Development recently established a national research agenda on stillbirths (fetal deaths at ≥20 weeks' gestation) (*8*) and granted awards to five sites to conduct population-based studies of stillbirths. The March of Dimes also has launched a 5-year national prematurity campaign focusing on education and research that includes fetal deaths (*10*).

The findings in this report are subject to at least two limitations. First, fetal deaths might be underreported, particularly at earlier gestational ages. Considerable variability was observed among reporting areas in the quality and completeness of data elements such as Hispanic ethnicity (*4*). The completeness of reporting of gestational age improved from 93.6% to 96.4% for all records during 1990–2000. Because reporting tends to be less complete at earlier gestational ages (*4*), the likely impact of this change, if any, would be to increase the number of early fetal deaths. Thus, the increase in early fetal mortality (but not overall mortality) might be less than reported here. Second, live-born infants who died shortly after birth, particularly infants born at early gestational ages or low birthweights, might have been misclassified as fetal deaths.

In the United States, the number of fetal deaths nearly equals that of infant deaths during the perinatal period. Mechanisms that contribute to fetal and infant deaths might be related in certain circumstances, but targeting infant deaths is insufficient to appropriately address adverse pregnancy outcomes. Prevention efforts must first acknowledge fetal deaths as a public health problem. Prevention strategies should begin with accurate surveillance and reporting of fetal death to provide researchers with population-based information that provides a better understanding of the factors associated with fetal death. Racial/ethnic disparities also must be addressed in research on fetal deaths, including preconceptional and maternal medical conditions, fetal and placental pathology, and social and environmental factors. These findings can be used by health-care professionals to 1) improve the identification of women at risk for fetal death and 2) educate practitioners on improving the health of women and their infants.

References

1. Barfield WD, Tomashek KM, Flowers LM, Iyasu S. Contribution of late fetal deaths to U.S. perinatal mortality rates, 1995–1998. Semin Perinatol 2002;26:17–24.
2. Fried VM, Prager K, MacKay AP, Xia H. Chartbook on Trends in the Health of Americans. Health, United States, 2003. Hyattsville, Maryland: U.S. Department of Health and Human Services, CDC, National Center for Health Statistics, 2003.
3. U.S. Department of Health and Human Services. Healthy People 2010, 2nd ed. Understanding and Improving Health and Objectives for Improving Health (2 vols.). Washington, DC: U.S. Department of Health and Human Services, 2000.
4. Martin JA, Hoyert DL. The national fetal death file. Semin Perinatol 2002;26:3–11.
5. Stevenson DK, Wright LL, Lemons JA, et al. Very low birth weight outcomes of the National Institute of Child Health and Human Development Neonatal Research Network, January 1993 through December 1994. Am J Obstet Gynecol 1998;179:1632–9.
6. Cnattingius S, Stephansson O. The epidemiology of stillbirth. Semin Perinatol 2002;26:25–30.
7. Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Munson ML. Births: final data for 2002. Hyattsville, Maryland: U.S. Department of Health and Human Services, CDC, National Center for Health Statistics, 2003; Natl Vital Stat Rep;52(10).
8. Hankins G, Willinger M, Spong CY. Introduction: stillbirth after 20 weeks. Semin Perinatol 2002;26:1–2.
9. National Association for Public Health Statistics and Information Systems. Vital records and statistics re-engineering. Available at http://www.naphsis.org/projects/index.asp?bid=393.
10. March of Dimes. Prematurity: the answers can't come soon enough. Available at http://www.marchofdimes.com/prematurity.

Progress Toward Global Eradication of Poliomyelitis, January 2003–April 2004

In 1988, the World Health Assembly (WHA) resolved to eradicate poliomyelitis globally (*1*). Since then, implementation of the eradication strategies reduced the number of countries with endemic polio from 125 in 1988 to six in 2003 (*2*). However, in 2003, an unprecedented 10 countries reported poliovirus importations, including eight in West and Central Africa (*3*), one in Southern Africa (Botswana), and one in the Middle East (Lebanon). This report describes progress made toward global polio eradication during January 2003–April 2004, outlines remaining challenges, and underscores the need for decisive action to interrupt transmission by the end of 2004 or early 2005.

Routine Vaccination

Worldwide, routine vaccination coverage among infants with 3 doses of oral poliovirus vaccine (OPV3) was estimated at 75% in 2002, compared with 75% in 2001 and 82% in 2000. Coverage varied among World Health Organization (WHO) regions, from 56% in the African Region to 93% in the European Region, with a range in country-level estimates from 25% to 99%. In countries with endemic polio, estimated OPV3 coverage in 2002 was as follows: Egypt, 97%; India, 70%; Pakistan, 63%; Afghanistan, 48%; Niger, 25%; and Nigeria, 25% (*4*).

Supplementary Immunization Activities (SIAs)

In 2003, increased SIAs reached 415 million children aged <5 years during 157 SIA rounds conducted in 55 countries. Countries with endemic polio conducted an increased number of national immunization days (NIDs)* and subnational immunization days (SNIDs)† during 2003: four NIDs and two SNIDs in India, four NIDs and four SNIDs in Pakistan, three NIDs and three SNIDs in Afghanistan, four NIDs and three SNIDs in Egypt, and three NIDs and two SNIDs in Niger. In Nigeria, SIAs were conducted in most states; however, SIAs were suspended in certain northern states (e.g., Kano) after March 2003 because of unfounded concerns about OPV safety. Synchronized NIDs were conducted in late 2003 in eight West and Central African countries affected by poliovirus importations, targeting approximately 25 million children aged <5 years.

Acute Flaccid Paralysis (AFP) Surveillance

AFP surveillance is established in all countries presently and previously endemic for polio. Two key performance indicators are monitored: 1) the rate of nonpolio AFP cases (target: one or more cases per 100,000 persons aged <15 years); and 2) the proportion of persons with AFP with adequate stool specimens (target: ≥80%).

Globally, the nonpolio AFP rate was 1.9 in 2003 (range by WHO region: 1.2–2.6). The annualized nonpolio AFP rate through April 2004 was 1.5 (range by WHO region: 0.8–2.7). The proportion of persons with adequate specimens for laboratory testing increased from 84% in 2002, to 86% in 2003, and 87% during January–April 2004 (Table). All countries with endemic polio achieved or maintained surveillance quality standards; however, analyses at the subnational level indicate gaps in surveillance.

A global network of 145 specialized laboratories supports surveillance activities by testing stool samples for the presence of poliovirus, determining whether the viruses are vaccine-related or wild, and conducting genomic sequencing. Approximately 70,000 stool samples were processed during 2003 in these WHO-accredited, national, regional, and global laboratories.

Wild Poliovirus (WPV) Incidence

The number of polio cases decreased from 1,918 in 2002, to 784 in 2003, and to 185 during January–April 2004§ (Figure). In 2002, a total of 1,600 cases (83% of all global cases) were detected in India; of these, 59% were in children from Muslim communities, which represent approximately 20% of the total population of India. In response to the 2002 epidemic, India intensified SIAs in 2003 and enhanced social mobilization activities to increase acceptance of OPV in all socioeconomic groups. The proportion of Muslim children receiving ≥3 doses of OPV, as assessed by surveillance data¶, increased from 61% to 85% during 2002–2003. Cases of polio in India decreased from 1,600 in 2002, to 225 cases in 2003, to eight cases during January–April 2004; a total of 77 cases were reported during January–April 2003.

In Pakistan, reported cases increased from 90 in 2002 to 103 in 2003. However, transmission during the peak season in the second half of 2003 was lower than in any previous year. Pakistan reported 12 cases during January–April 2004, compared with 23 during the same period in 2003. Afghanistan, which shares a cross-border reservoir of ongoing transmission with Pakistan, reported 10 cases in 2002, eight cases in 2003, and two cases in 2004.

Egypt intensified SIAs and increased the proportion of children receiving ≥5 doses of OPV from 74% to 89% during 2002–2003. One polio case was reported in 2003, compared with seven cases in 2002; the proportion of environmental samples positive for WPV declined from 57% in 2001 to 4% in 2003. No polio cases were reported during January–April 2004.

The number of reported cases increased substantially in Nigeria, from 202 in 2002, to 355 in 2003, to 133 in January–April 2004; a total of 32 cases were reported for the same period in 2003. In 2003, Nigeria reported the largest number of cases globally (*5*). Inadequate SIA coverage and suspension

* National or subnational mass campaigns during a limited number of days in which 2 doses of OPV are administered to all children (usually aged <5 years), regardless of previous vaccination history, with an interval of 4–6 weeks between doses

† Campaigns similar to NIDs but confined to certain parts of the country.

§ As of May 18, 2004.

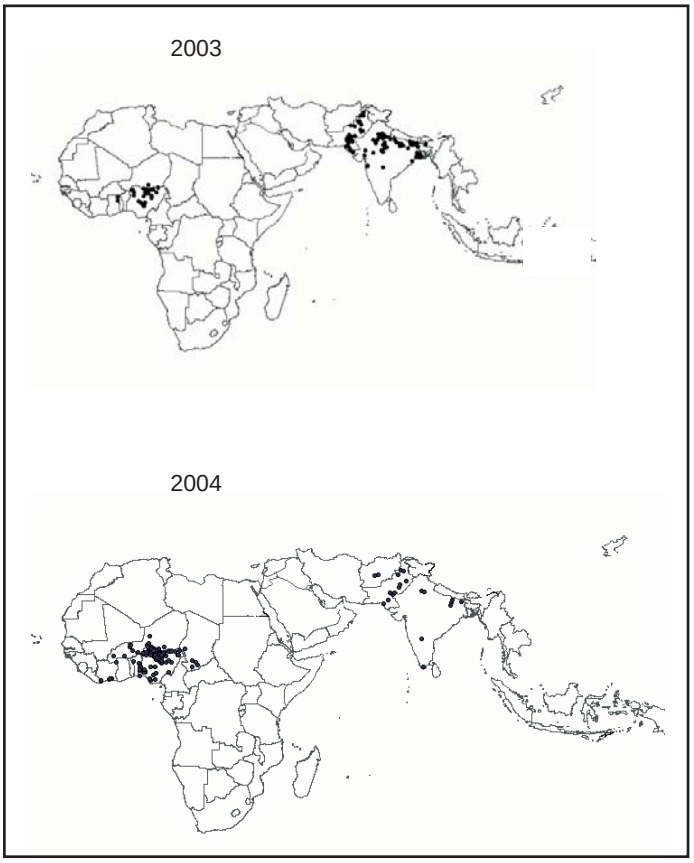
¶ National polio eradication programs analyze the OPV vaccination status (routine and supplemental doses) of children aged <5 years with nonpolio AFP as a proxy for OPV coverage in the general population.

TABLE. Acute flaccid paralysis (AFP) and poliomyelitis cases, by World Health Organization region and country, 2003 and 2004*

Region/Country†	No. reported AFP cases		Nonpolio AFP rate§		% persons with AFP with adequate specimens¶		Virus-confirmed cases			
							Total		January–April	
	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004
African	8,184	2,745	2.6	2.7	88	91	446	162	34	162
Nigeria	3,318	1,425	6.0	7.9	91	91	355	133	32	133
Niger	175	80	2.4	3.6	79	88	40	12	1	12
Eastern Mediterranean	5,294	1,798	2.4	2.3	90	90	113	15	24	15
Pakistan	2,270	742	3.0	2.8	90	90	103	12	23	12
Afghanistan	599	212	3.9	3.9	88	91	8	2	0	2
Egypt	608	268	2.5	2.7	93	94	1	1	0	1
South-East Asian	11,305	3,360	1.9	1.1	83	85	225	8	77	8
India	8,524	2,543	2.0	1.1	81	84	225	8	77	8
American	2,229	488	1.3	0.8	80	—	0	0	0	0
European	1,639	491	1.2	1.0	82	81	0	0	0	0
Western Pacific	6,397	1,313	1.4	0.9	88	85	0	0	0	0
Worldwide	**35,048**	**10,195**	**1.9**	**1.5**	**86**	**87**	**784**	**185**	**135**	**185**

* 2004 data are cases reported during January–April, as of May 18, 2004.
† Data presented only from countries with indigenous polio during 2003. Values do not add to regional and global totals.
§ Per 100,000 children aged <15 years; annualized for 2004.
¶ Two stool specimens collected at an interval of at least 24 hours within 14 days of paralysis onset and adequately shipped to the laboratory.

FIGURE. Number* and location of virus-confirmed poliomyelitis cases, January–April 2003 and January–April 2004†



* A total of 135 during January–April 2003 and 185 during January–April 2004.
† As of May 18, 2004.

of SIAs in some northern states resulted in intense poliovirus transmission in these areas. This led to the reemergence of polio in previously polio-free areas within Nigeria, and exportation of virus to eight previously polio-free countries in West and Central Africa.

The number of reported cases in Niger, which borders Nigeria, increased from three in 2002 to 40 in 2003. During January–April 2004, a total of 12 cases were reported, compared with one for the same period in 2003. Surveillance data indicate that <20% of target age children have received ≥3 doses of OPV, indicating poor quality of SIAs.

In 2003, a total of 51 cases of polio were reported from eight previously polio-free countries in West and Central Africa (Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Ghana, Ivory Coast, and Togo) (*3*). In 2004, a total of 17 cases have been reported from six of these countries and one in Southern Africa (Botswana).

Reported by: *Vaccines and Biologicals Dept, World Health Organization, Geneva, Switzerland. Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program, CDC.*

Editorial Note: Substantial progress toward polio eradication was made in 2003, particularly in the Asian and Northern African countries with endemic polio. Only six countries in the world had endemic polio in 2003, the lowest total ever, compared with seven in 2002. Somalia is no longer considered endemic after >1 year without detection of WPV. Egypt, India, and Pakistan recorded their lowest-ever levels of transmission during the second half of 2003, the peak season for poliovirus transmission; levels for January–April 2004 also were record lows.

The eradication initiative faced multiple unprecedented obstacles. In Nigeria, several states postponed or canceled SIAs beginning in mid-2003 because of rumors about the safety of OPV. The intense transmission in Nigeria jeopardizes the goal of interruption of poliovirus transmission globally by the end of 2004. For the first time ever, the number (10) of countries reporting poliovirus importations was greater than the number of countries (six) with endemic transmission. The additional control activities in countries with importations resulted in $25 million (U.S.) in unbudgeted costs in 2003.

An emergency meeting on polio eradication was convened in January 2004 in Geneva, Switzerland, to develop consensus on increased efforts toward interrupting WPV transmission. On behalf of their nations, health ministers from the affected countries and their polio eradication partners signed the Geneva Declaration to express renewed national and international commitment toward the eradication goal. To interrupt WPV transmission as quickly as possible, countries with endemic polio must intensify polio immunization campaigns throughout 2004, and surveillance standards must be achieved or maintained to ensure rapid detection and response to any importation of polio. On May 17, 2004, at the World Health Assembly, representatives of Afghanistan, Egypt, India, and Pakistan announced accelerated plans to respond to every new case with immediate and widespread vaccination campaigns. Emergency response campaigns in countries of West and Central Africa affected by importations should be extended throughout 2004 and 2005. At their May 2004 meeting, African Union health ministers decided that 22 West and Central African countries should launch emergency synchronized SIAs, targeting 74 million children. These activities will cost an additional $100 million (U.S.) during 2004–2005.

The world is almost polio-free. Substantial progress has been made in the majority of countries that remain endemic for polio, increasingly restricting WPV transmission. Governments, health-care workers, volunteers, and international polio partners in all countries where poliovirus is detected must continue to work together to achieve global polio eradication.

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 (WHA resolution no. 41.28).
2. World Health Organization. Global Polio Eradication Initiative Progress 2002. Geneva, Switzerland: World Health Organization, 2003.
3. CDC. Wild poliovirus importations—West and Central Africa, January 2003–March 2004. MMWR 2004;53:433–5.
4. World Health Organization. WHO-UNICEF estimates of routine immunization coverage. Geneva, Switzerland: World Health Organization, 2003.
5. CDC. Progress toward global poliomyelitis eradication—Nigeria, January 2003–March 2004. MMWR 2004;53:343–6.

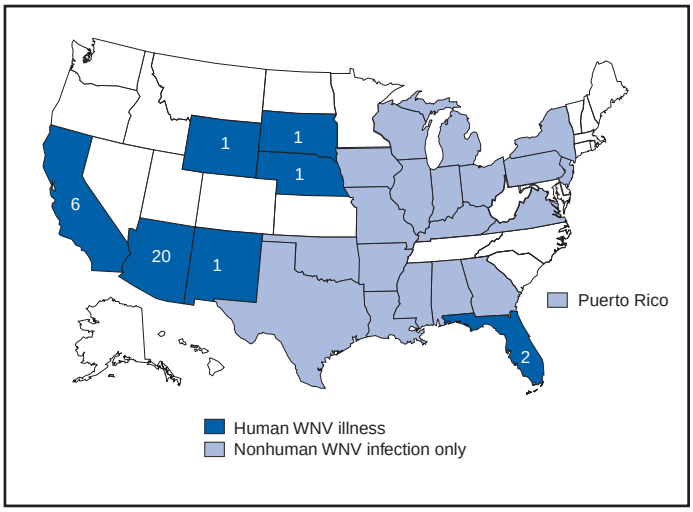
West Nile Virus Activity — United States, June 16–22, 2004

As of June 22, 2004, seven states reported a total of 32 human cases of West Nile virus (WNV) illness to CDC through ArboNET. Twenty cases were reported from Arizona, six cases from California, two cases from Florida, and one case each from Nebraska, New Mexico, South Dakota, and Wyoming (Figure). Twenty-three (72%) of the cases occurred in males; the median age of patients was 52 years (range: 9–78 years), and dates of illness onset ranged from May 8 to June 7. Sixteen (50%) of the patients had neuroinvasive WNV illness, 14 (44%) had West Nile fever, and two (6%) had clinically unspecified illness.

A total of 13 presumptive West Nile viremic blood donors have been reported to ArboNET. Of these, 12 were reported from Arizona, and one was reported from New Mexico. Of the 13 donors reported to ArboNET, one person aged 69 years subsequently had neuroinvasive illness, and three persons aged 22, 51, and 52 years had West Nile fever.

In addition, during 2004, a total of 616 dead corvids and 58 other dead birds with WNV infection have been reported from 20 states, and 17 WNV infections in horses have been reported from six states (Alabama, Arizona, Missouri, Oklahoma, Texas, and Virginia). WNV seroconversions have been reported in 65 sentinel chicken flocks from four states (Arizona, California, Florida, and Louisiana). One seropositive sentinel horse was reported from Puerto Rico. A total of 129 WNV-positive mosquito pools have been reported from eight states (Arizona, California, Illinois, Indiana, Louisiana, Missouri, Pennsylvania, and Texas).

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2004*



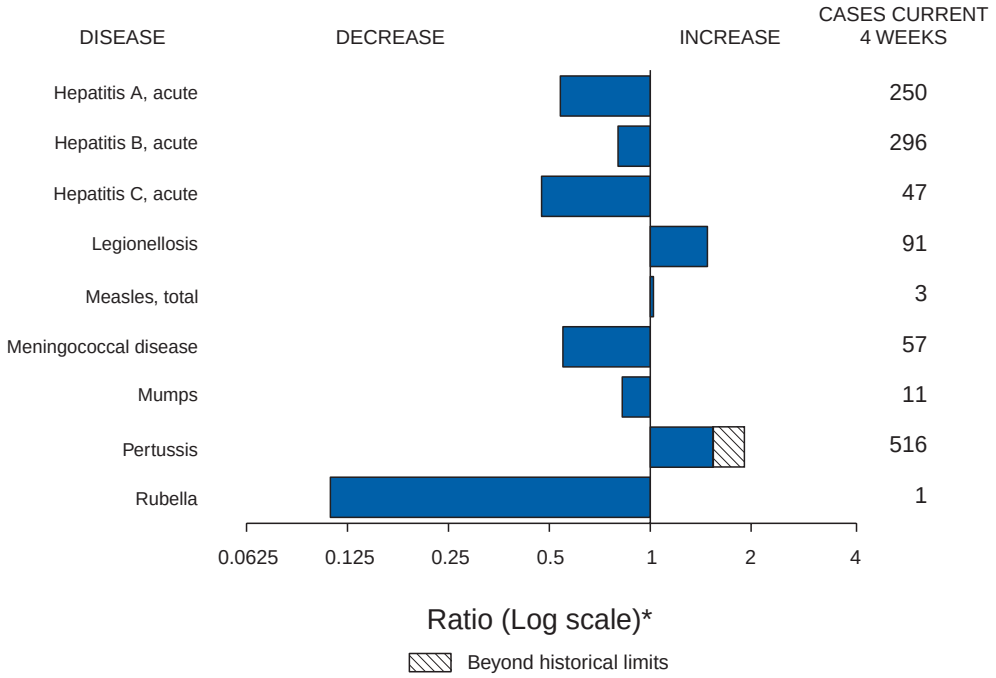
* As of 3 a.m., Mountain Standard Time, June 22, 2004.

Additional information about national WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and at http://westnilemaps.usgs.gov.

Erratum: Vol. 53, No. SS-2

In the *MMWR Surveillance Summaries*, "Youth Risk Behavior Surveillance—United States, 2003," two errors occurred. On page 27, the text should read, "Although the percentage of students enrolled in PE class remained constant during 1991–2003 (48.9%–55.7%), the percentage of students with daily PE attendance decreased significantly during 1991–1995 (41.6%–25.4%) and then remained stable during 1995–2003 (25.4%–28.4%)." On page 29, the text should read, "Nationwide, of persons aged 16–17 years, approximately 6% were not enrolled in a high school program and had not completed high school (*13*)."

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals June 19, 2004, with historical data



* 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 of provisional cases of selected notifiable diseases, United States, cumulative, week ending June 19, 2004 (24th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	Hemolytic uremic syndrome, postdiarrheal†	35	49
Botulism:	-	-	HIV infection, pediatric†§	78	102
foodborne	7	7	Measles, total	16¶	27**
infant	26	31	Mumps	90	111
other (wound & unspecified	4	10	Plague	-	1
Brucellosis†	47	41	Poliomyelitis, paralytic	-	-
Chancroid	14	28	Psittacosis†	3	5
Cholera	2	1	Q fever†	22	35
Cyclosporiasis†	59	24	Rabies, human	-	-
Diphtheria	-	-	Rubella	13	4
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	1
human granulocytic (HGE)†	41	50	SARS-associated coronavirus disease†††	-	7
human monocytic (HME)†	29	41	Smallpox†§§	-	NA
human, other and unspecified	1	8	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)†§§	4	NA
California serogroup viral†	-	-	Vancomycin-resistant (VRSA)†§§	1	1
eastern equine†	-	1	Streptococcal toxic-shock syndrome†	53	109
Powassan†	-	-	Tetanus	7	3
St. Louis†	-	3	Toxic-shock syndrome	49	68
western equine†	-	-	Trichinosis	3	-
Hansen disease (leprosy)†	36	35	Tularemia†	19	11
Hantavirus pulmonary syndrome†	7	12	Yellow fever	-	-

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update May 23, 2004.
¶ Of 16 cases reported, nine were indigenous, and seven were imported from another country.
** Of 27 cases reported, 19 were indigenous, and eight were imported from another country.
†† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (notifiable as of July 2003).
§§ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 19, 2004, and June 14, 2003 (24th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2004§	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	17,011	19,186	379,464	393,708	2,388	1,428	1,003	898	1	4
NEW ENGLAND	569	655	13,293	12,592	-	-	62	63	-	-
Maine	5	27	894	880	N	N	14	5	-	-
N.H.	23	15	705	722	-	-	14	10	-	-
Vt.	13	6	467	455	-	-	6	10	-	-
Mass.	150	277	6,336	4,791	-	-	17	26	-	-
R.I.	66	50	1,618	1,477	-	-	2	9	-	-
Conn.	312	280	3,273	4,267	N	N	9	3	-	-
MID. ATLANTIC	3,912	4,069	49,877	47,649	-	-	155	132	-	-
Upstate N.Y.	453	267	10,247	8,712	N	N	38	32	-	-
N.Y. City	2,154	1,974	14,234	15,788	-	-	36	48	-	-
N.J.	675	783	5,901	7,017	-	-	10	8	-	-
Pa.	630	1,045	19,495	16,132	N	N	71	44	-	-
E.N. CENTRAL	1,455	1,987	65,252	71,867	6	3	225	225	-	-
Ohio	237	302	16,740	19,407	-	-	62	32	-	-
Ind.	166	260	8,340	7,859	N	N	30	21	-	-
Ill.	700	960	16,335	22,444	-	-	13	36	-	-
Mich.	269	363	17,899	14,256	6	3	49	41	-	-
Wis.	83	102	5,938	7,901	-	-	71	95	-	-
W.N. CENTRAL	331	360	23,084	22,795	4	2	127	84	-	-
Minn.	81	73	4,093	4,962	N	N	49	37	-	-
Iowa	21	41	2,311	2,466	N	N	18	13	-	-
Mo.	135	180	9,134	8,276	3	1	19	8	-	-
N. Dak.	12	1	724	709	N	N	6	3	-	-
S. Dak.	5	6	1,148	1,127	-	-	16	17	-	-
Nebr.¶	18	24	2,345	1,988	1	1	7	3	-	-
Kans.	59	35	3,329	3,267	N	N	12	3	-	-
S. ATLANTIC	5,282	5,392	70,214	73,440	-	2	200	123	-	1
Del.	78	105	1,348	1,438	N	N	-	3	-	-
Md.	601	555	8,488	7,486	-	2	9	8	-	-
D.C.	308	595	1,508	1,551	-	-	3	1	-	-
Va.	288	477	9,935	8,602	-	-	23	12	-	-
W. Va.	30	41	1,180	1,163	N	N	2	2	-	-
N.C.	305	565	12,674	11,999	N	N	36	15	-	-
S.C.¶	329	326	7,047	6,277	-	-	9	2	-	-
Ga.	782	736	9,026	15,711	-	-	62	46	-	1
Fla.	2,561	1,992	19,008	19,213	N	N	56	34	-	-
E.S. CENTRAL	782	836	24,234	25,333	2	1	44	52	-	-
Ky.	71	78	2,500	3,771	N	N	14	10	-	-
Tenn.¶	326	373	10,272	8,910	N	N	12	18	-	-
Ala.	208	185	4,692	6,790	-	-	11	21	-	-
Miss.	177	200	6,770	5,862	2	1	7	3	-	-
W.S. CENTRAL	2,047	2,084	49,802	49,452	2	-	26	20	-	3
Ark.	87	63	3,634	3,397	1	-	8	3	-	-
La.	346	365	11,656	9,445	1	-	-	1	-	-
Okla.	90	91	4,996	5,001	N	N	9	4	-	-
Tex.	1,524	1,565	29,516	31,609	-	-	9	12	-	3
MOUNTAIN	571	717	18,971	23,496	1,573	942	52	40	1	-
Mont.	-	10	971	1,074	N	N	11	8	-	-
Idaho	3	13	1,344	1,124	N	N	4	7	-	-
Wyo.	6	5	491	462	-	-	2	1	-	-
Colo.	98	157	3,751	5,957	N	N	24	8	-	-
N. Mex.	91	51	2,586	3,458	9	3	2	3	-	-
Ariz.	208	337	6,357	6,960	1,523	918	7	2	1	-
Utah	34	32	1,501	1,706	12	3	1	8	-	-
Nev.	131	112	1,970	2,755	29	18	1	3	-	-
PACIFIC	2,062	3,086	64,737	67,084	801	478	112	159	-	-
Wash.	165	211	8,059	7,160	N	N	14	14	-	-
Oreg.	111	126	2,069	3,471	-	-	13	17	-	-
Calif.	1,731	2,691	51,765	52,224	801	478	84	128	-	-
Alaska	14	12	1,684	1,767	-	-	-	-	-	-
Hawaii	41	46	1,160	2,462	-	-	1	-	-	-
Guam	1	1	-	337	-	-	-	-	-	-
P.R.	209	514	1,002	1,069	N	N	N	N	-	-
V.I.	5	15	143	147	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	32	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update May 30, 2004.

¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 19, 2004, and June 14, 2003 (24th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	591	566	78	78	56	50	5,994	7,065	131,218	147,063
NEW ENGLAND	43	35	20	14	11	2	626	505	3,095	3,119
Maine	2	4	-	-	-	-	63	54	122	100
N.H.	6	7	4	1	-	-	15	20	56	53
Vt.	-	2	-	-	-	-	51	38	40	38
Mass.	16	11	2	6	11	2	296	243	1,459	1,175
R.I.	5	1	-	-	-	-	54	51	418	437
Conn.	14	10	14	7	-	-	147	99	1,000	1,316
MID. ATLANTIC	67	63	7	6	12	11	1,495	1,496	15,703	18,577
Upstate N.Y.	27	24	4	3	4	5	498	366	3,353	3,327
N.Y. City	8	3	-	-	-	-	459	536	4,544	6,038
N.J.	11	7	1	-	4	-	145	217	2,302	4,110
Pa.	21	29	2	3	4	6	393	377	5,504	5,102
E.N. CENTRAL	112	147	16	17	6	8	803	1,267	26,506	31,077
Ohio	26	35	4	10	6	8	327	357	7,952	9,982
Ind.	9	16	-	-	-	-	-	-	2,867	2,928
Ill.	23	26	-	1	-	-	84	389	6,884	9,602
Mich.	24	27	2	-	-	-	261	291	7,260	5,876
Wis.	30	43	10	6	-	-	131	230	1,543	2,689
W.N. CENTRAL	110	82	11	10	12	8	778	705	7,425	7,599
Minn.	30	30	5	7	2	-	276	257	1,517	1,221
Iowa	26	11	-	-	-	-	107	97	412	558
Mo.	20	24	6	1	4	1	200	204	3,712	3,890
N. Dak.	3	2	-	1	4	1	11	16	57	33
S. Dak.	5	4	-	-	-	-	28	21	125	85
Nebr.	14	5	-	1	-	-	58	53	468	641
Kans.	12	6	-	-	2	6	98	57	1,134	1,171
S. ATLANTIC	58	45	15	18	7	12	1,026	1,062	30,892	35,999
Del.	-	-	N	N	N	N	23	16	430	538
Md.	13	1	1	-	1	1	42	51	3,676	3,493
D.C.	1	1	-	-	-	-	27	17	1,034	1,131
Va.	7	17	6	3	-	-	165	131	3,991	3,990
W. Va.	1	1	-	-	-	-	12	14	361	389
N.C.	-	-	4	-	2	11	N	N	6,545	6,789
S.C.	3	-	-	-	-	-	27	57	3,253	3,622
Ga.	15	9	2	2	-	-	267	343	3,802	7,626
Fla.	18	16	2	13	4	-	463	433	7,800	8,421
E.S. CENTRAL	32	28	1	-	7	4	146	148	10,292	12,335
Ky.	11	9	1	-	4	4	N	N	1,091	1,593
Tenn.	7	11	-	-	3	-	70	66	3,676	3,629
Ala.	8	5	-	-	-	-	76	82	2,780	4,122
Miss.	6	3	-	-	-	-	-	-	2,745	2,991
W.S. CENTRAL	32	25	1	2	1	2	117	119	18,529	19,956
Ark.	7	3	-	-	-	-	52	64	1,772	1,832
La.	1	1	-	-	-	-	15	8	5,204	5,341
Okla.	5	4	-	-	-	-	50	47	2,090	1,914
Tex.	19	17	1	2	1	2	-	-	9,463	10,869
MOUNTAIN	52	60	6	9	-	3	532	549	4,491	4,916
Mont.	2	2	-	-	-	-	18	28	35	56
Idaho	14	17	3	5	-	-	75	71	35	35
Wyo.	-	2	1	-	-	-	7	7	26	24
Colo.	9	17	1	1	-	3	165	159	1,239	1,354
N. Mex.	4	1	-	3	-	-	29	23	313	562
Ariz.	7	11	N	N	N	N	80	90	1,748	1,820
Utah	9	7	-	-	-	-	117	117	222	158
Nev.	7	3	1	-	-	-	41	54	873	907
PACIFIC	85	81	1	2	-	-	471	1,214	14,285	13,485
Wash.	28	22	-	1	-	-	123	108	1,226	1,305
Oreg.	13	13	1	1	-	-	172	155	265	462
Calif.	37	45	-	-	-	-	112	871	12,257	10,974
Alaska	1	1	-	-	-	-	25	39	268	246
Hawaii	6	-	-	-	-	-	39	41	269	498
Guam	N	N	-	-	-	-	-	-	-	38
P.R.	-	1	-	-	-	-	11	77	91	124
V.I.	-	-	-	-	-	-	-	-	49	40
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	3	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 19, 2004, and June 14, 2003 (24th Week)*

Reporting area	*Haemophilus influenzae*, invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		A	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	936	904	9	12	48	64	101	110	2,478	2,862
NEW ENGLAND	84	62	1	1	4	5	3	3	432	127
Maine	7	2	-	-	-	-	-	1	9	4
N.H.	12	6	-	-	2	-	-	-	7	7
Vt.	5	6	-	-	-	-	1	-	6	4
Mass.	35	34	1	1	-	5	2	1	368	66
R.I.	3	3	-	-	-	-	-	1	10	11
Conn.	22	11	-	-	2	-	-	-	32	35
MID. ATLANTIC	203	173	-	-	3	2	28	26	285	615
Upstate N.Y.	66	61	-	-	3	2	4	7	38	49
N.Y. City	42	28	-	-	-	-	9	6	98	227
N.J.	37	38	-	-	-	-	3	7	57	101
Pa.	58	46	-	-	-	-	12	6	92	238
E.N. CENTRAL	139	151	-	1	10	3	19	30	220	271
Ohio	62	39	-	-	2	-	10	7	26	49
Ind.	29	23	-	-	4	-	1	2	15	20
Ill.	20	60	-	-	-	-	6	16	83	82
Mich.	12	11	-	1	4	3	1	-	78	91
Wis.	16	18	-	-	-	-	1	5	18	29
W.N. CENTRAL	55	63	2	-	3	6	4	6	89	76
Minn.	24	23	1	-	3	6	-	1	23	20
Iowa	1	-	1	-	-	-	-	-	25	15
Mo.	15	27	-	-	-	-	2	5	25	22
N. Dak.	3	2	-	-	-	-	-	-	1	-
S. Dak.	-	1	-	-	-	-	-	-	2	-
Nebr.	5	-	-	-	-	-	-	-	7	5
Kans.	7	10	-	-	-	-	2	-	6	14
S. ATLANTIC	227	174	-	-	12	7	20	11	474	637
Del.	8	-	-	-	-	-	2	-	4	4
Md.	36	41	-	-	2	4	1	-	68	60
D.C.	-	-	-	-	-	-	-	-	4	22
Va.	21	16	-	-	-	-	1	4	46	36
W. Va.	10	7	-	-	-	-	3	-	2	8
N.C.	30	14	-	-	4	-	-	-	33	33
S.C.	2	2	-	-	-	-	-	-	20	23
Ga.	61	36	-	-	-	-	12	4	174	254
Fla.	59	58	-	-	6	3	1	3	123	197
E.S. CENTRAL	37	43	-	1	-	2	7	4	79	79
Ky.	3	3	-	-	-	1	-	-	11	14
Tenn.	23	24	-	-	-	1	5	3	45	43
Ala.	11	16	-	1	-	-	2	1	6	11
Miss.	-	-	-	-	-	-	-	-	17	11
W.S. CENTRAL	36	46	1	1	4	6	1	3	195	295
Ark.	1	4	-	-	-	1	-	-	38	18
La.	7	15	-	-	-	2	1	3	11	25
Okla.	27	25	-	-	4	3	-	-	16	6
Tex.	1	2	1	1	-	-	-	-	130	246
MOUNTAIN	119	101	3	5	12	16	14	12	219	196
Mont.	-	-	-	-	-	-	-	-	4	2
Idaho	5	2	-	-	-	-	2	1	10	9
Wyo.	-	1	-	-	-	-	-	-	2	1
Colo.	27	17	-	-	-	-	3	4	21	27
N. Mex.	24	13	-	-	4	3	3	1	5	8
Ariz.	46	55	-	5	7	7	1	4	144	108
Utah	9	8	2	-	-	3	3	2	27	14
Nev.	8	5	1	-	1	3	2	-	6	27
PACIFIC	36	91	2	3	-	17	5	15	485	566
Wash.	3	3	2	-	-	2	1	1	29	30
Oreg.	23	23	-	-	-	-	1	2	36	30
Calif.	3	41	-	3	-	15	2	7	407	497
Alaska	2	18	-	-	-	-	1	5	4	5
Hawaii	5	6	-	-	-	-	-	-	9	4
Guam	-	-	-	-	-	-	-	-	-	1
P.R.	-	-	-	-	-	-	-	-	10	39
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 19, 2004, and June 14, 2003 (24th Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C							
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	2,674	3,068	546	500	499	541	207	241	3,841	4,447
NEW ENGLAND	151	154	3	2	12	17	10	11	434	562
Maine	1	1	-	-	-	-	2	1	53	-
N.H.	21	9	-	-	-	2	1	2	20	8
Vt.	1	2	1	2	1	1	-	-	12	6
Mass.	77	105	2	-	4	7	2	6	121	315
R.I.	3	4	-	-	2	1	1	-	43	109
Conn.	48	33	U	U	5	6	4	2	185	124
MID. ATLANTIC	441	386	57	57	124	112	44	44	2,872	3,210
Upstate N.Y.	42	33	6	7	28	33	16	8	1,008	966
N.Y. City	45	125	-	-	7	11	4	11	-	48
N.J.	221	102	-	-	27	11	10	9	694	924
Pa.	133	126	51	50	62	57	14	16	1,170	1,272
E.N. CENTRAL	227	227	32	75	117	127	30	29	67	191
Ohio	67	68	3	4	62	61	14	5	35	17
Ind.	8	10	2	3	10	8	5	1	2	5
Ill.	28	18	4	12	2	17	-	9	-	11
Mich.	124	106	23	53	41	31	10	10	5	-
Wis.	-	25	-	3	2	10	1	4	25	158
W.N. CENTRAL	190	131	190	114	11	24	5	8	67	53
Minn.	20	16	4	3	1	2	2	2	25	30
Iowa	9	4	-	-	2	5	1	-	9	8
Mo.	137	89	186	110	6	11	2	3	26	12
N. Dak.	1	-	-	-	1	1	-	-	-	-
S. Dak.	-	1	-	-	1	-	-	-	-	-
Nebr.	13	12	-	1	-	2	-	3	3	1
Kans.	10	9	-	-	-	3	-	-	4	2
S. ATLANTIC	850	795	91	77	123	142	32	53	325	318
Del.	16	4	-	-	3	2	N	N	35	61
Md.	69	52	8	5	19	27	4	5	199	199
D.C.	12	1	1	-	3	1	-	-	2	3
Va.	96	58	11	1	8	8	4	7	15	14
W. Va.	2	7	15	1	2	3	1	2	2	1
N.C.	80	76	6	5	15	12	8	9	45	20
S.C.	53	74	7	17	1	4	-	2	1	1
Ga.	274	248	6	6	14	15	6	16	2	9
Fla.	248	275	37	42	58	70	9	12	24	10
E.S. CENTRAL	189	196	54	41	21	35	14	9	23	23
Ky.	24	37	15	7	6	11	4	1	9	3
Tenn.	88	78	24	9	10	12	8	1	9	7
Ala.	31	37	1	5	5	10	1	5	1	1
Miss.	46	44	14	20	-	2	1	2	4	12
W.S. CENTRAL	84	510	66	90	31	27	15	28	10	51
Ark.	26	44	1	3	-	1	-	-	2	-
La.	29	70	37	52	2	1	1	1	1	6
Okla.	17	29	2	-	2	2	-	1	-	-
Tex.	12	367	26	35	27	23	14	26	7	45
MOUNTAIN	221	273	22	15	31	28	11	15	8	4
Mont.	1	8	2	1	1	1	-	1	-	-
Idaho	6	4	-	1	3	3	1	-	2	2
Wyo.	6	17	-	-	4	1	-	-	1	-
Colo.	21	43	4	4	4	5	3	6	-	-
N. Mex.	7	21	4	-	-	2	-	2	-	-
Ariz.	124	129	2	4	5	6	-	5	1	-
Utah	21	18	2	-	12	7	1	1	4	1
Nev.	35	33	8	5	2	3	6	-	-	1
PACIFIC	321	396	31	29	29	29	46	44	35	35
Wash.	26	30	10	10	5	3	6	3	3	-
Oreg.	46	63	8	4	N	N	4	2	16	8
Calif.	235	292	10	14	24	26	36	38	16	26
Alaska	12	3	-	-	-	-	-	-	-	1
Hawaii	2	8	3	1	-	-	-	1	N	N
Guam	-	3	-	1	-	-	-	-	-	-
P.R.	18	69	-	-	1	-	-	-	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 19, 2004, and June 14, 2003 (24th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	473	446	723	934	4,014	3,106	2,231	3,199	302	186
NEW ENGLAND	43	12	33	42	751	306	230	207	11	1
Maine	5	1	8	5	2	2	28	21	-	-
N.H.	-	2	3	3	20	18	8	10	-	-
Vt.	2	-	1	-	34	29	9	14	-	-
Mass.	21	9	19	26	674	236	95	78	10	1
R.I.	2	-	1	2	9	5	13	27	1	-
Conn.	13	-	1	6	12	16	77	57	-	-
MID. ATLANTIC	102	109	89	116	1,065	324	197	385	24	13
Upstate N.Y.	15	21	21	23	759	124	164	149	1	-
N.Y. City	44	56	14	29	68	49	4	4	4	4
N.J.	20	17	19	15	86	62	-	62	6	6
Pa.	23	15	35	49	152	89	29	170	13	3
E.N. CENTRAL	30	44	104	150	508	239	21	34	16	6
Ohio	11	7	43	39	192	107	8	12	9	3
Ind.	-	-	13	23	42	28	3	2	4	-
Ill.	2	22	9	44	43	18	8	5	-	2
Mich.	11	12	32	25	51	22	2	15	3	1
Wis.	6	3	7	19	180	64	-	-	-	-
W.N. CENTRAL	34	19	47	72	257	138	211	321	29	8
Minn.	16	11	13	16	51	47	23	12	-	-
Iowa	1	2	10	14	31	34	31	33	-	1
Mo.	7	1	11	29	138	28	8	3	23	6
N. Dak.	2	-	1	-	8	2	28	30	-	-
S. Dak.	1	1	1	1	9	2	10	70	-	-
Nebr.	2	-	2	5	3	2	53	64	5	1
Kans.	5	4	9	7	17	23	58	109	1	-
S. ATLANTIC	136	109	135	162	233	195	830	1,293	132	120
Del.	3	-	2	8	5	1	9	23	-	-
Md.	29	29	7	14	43	27	50	187	12	27
D.C.	7	6	4	3	2	-	-	-	-	-
Va.	11	7	9	11	57	33	213	248	1	1
W. Va.	-	4	4	1	4	5	32	37	-	-
N.C.	9	8	20	19	43	70	311	354	103	58
S.C.	7	2	12	14	26	9	61	84	8	8
Ga.	23	21	9	19	8	18	142	172	2	22
Fla.	47	32	68	73	45	32	12	188	6	4
E.S. CENTRAL	17	9	30	43	51	66	59	102	41	29
Ky.	1	1	3	8	11	15	11	16	-	-
Tenn.	3	4	10	10	28	34	20	73	21	18
Ala.	10	2	7	12	6	11	25	12	10	3
Miss.	3	2	10	13	6	6	3	1	10	8
W.S. CENTRAL	42	56	69	112	214	199	570	707	41	5
Ark.	6	3	12	10	9	11	27	25	19	-
La.	2	2	17	31	3	6	-	-	3	-
Okla.	2	2	4	8	14	14	64	118	19	2
Tex.	32	49	36	63	188	168	479	564	-	3
MOUNTAIN	15	15	33	50	465	487	43	55	4	4
Mont.	-	-	2	2	13	-	5	8	1	1
Idaho	1	1	4	6	17	18	-	1	1	1
Wyo.	-	-	2	2	3	119	-	1	-	2
Colo.	6	10	9	12	241	180	5	6	-	-
N. Mex.	1	-	4	5	54	25	-	3	-	-
Ariz.	2	2	6	19	95	85	33	33	1	-
Utah	3	1	3	-	32	44	-	2	1	-
Nev.	2	1	3	4	10	16	-	1	-	-
PACIFIC	54	73	183	187	470	1,152	70	95	4	-
Wash.	4	10	18	16	219	205	-	-	-	-
Oreg.	8	6	38	32	201	210	-	3	2	-
Calif.	41	55	122	128	35	730	62	87	2	-
Alaska	-	-	1	4	8	1	8	5	-	-
Hawaii	1	2	4	7	7	6	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	4	6	2	1	23	28	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 19, 2004, and June 14, 2003 (24th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive			
							Drug resistant, all ages		Age <5 years	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	10,703	13,225	4,153	10,193	2,536	3,411	1,263	1,188	294	387
NEW ENGLAND	601	664	107	122	119	321	15	62	7	1
Maine	34	40	2	4	5	19	2	-	1	-
N.H.	34	45	4	4	12	20	-	-	N	N
Vt.	21	22	2	5	6	14	7	6	1	1
Mass.	328	387	67	76	79	141	N	N	N	N
R.I.	48	34	8	3	17	5	6	8	5	-
Conn.	136	136	24	30	-	122	-	48	U	U
MID. ATLANTIC	1,582	1,654	548	1,049	411	593	89	77	60	57
Upstate N.Y.	400	338	269	136	139	210	41	37	43	41
N.Y. City	437	457	151	168	55	88	U	U	U	U
N.J.	243	296	78	185	79	124	-	-	2	2
Pa.	502	563	50	560	138	171	48	40	15	14
E.N. CENTRAL	1,553	1,847	344	855	520	853	292	264	88	177
Ohio	447	518	74	126	146	197	214	178	50	61
Ind.	158	190	84	54	63	72	78	86	21	16
Ill.	321	608	87	482	107	224	-	-	-	68
Mich.	335	279	50	127	177	248	N	N	N	N
Wis.	292	252	49	66	27	112	N	N	17	32
W.N. CENTRAL	900	745	168	318	183	204	122	9	34	40
Minn.	212	191	22	42	90	96	-	-	25	26
Iowa	183	136	34	22	N	N	N	N	N	N
Mo.	254	209	72	152	40	45	6	6	4	2
N. Dak.	15	16	1	4	8	8	-	3	1	2
S. Dak.	35	30	6	8	8	17	3	-	-	-
Nebr.	61	62	7	60	9	19	-	-	4	5
Kans.	140	101	26	30	28	19	113	-	N	N
S. ATLANTIC	2,644	3,064	1,228	3,155	509	559	586	620	10	6
Del.	16	38	3	134	2	6	4	1	N	N
Md.	239	320	50	237	106	146	-	4	-	-
D.C.	15	14	20	30	5	4	3	-	3	-
Va.	305	317	45	156	41	62	N	N	N	N
W. Va.	50	32	-	-	16	25	64	37	7	6
N.C.	340	419	137	355	73	59	N	N	U	U
S.C.	140	167	185	208	35	28	51	94	N	N
Ga.	407	473	263	684	107	119	130	148	N	N
Fla.	1,132	1,284	525	1,351	124	110	334	336	N	N
E.S. CENTRAL	707	828	247	462	128	111	74	86	-	-
Ky.	128	134	34	52	43	29	19	11	N	N
Tenn.	188	274	97	165	85	82	55	75	N	N
Ala.	210	212	89	150	-	-	-	-	N	N
Miss.	181	208	27	95	-	-	-	-	-	-
W.S. CENTRAL	1,040	1,535	1,011	2,841	136	158	31	50	64	65
Ark.	169	185	21	41	7	4	5	17	7	4
La.	148	261	98	229	1	1	26	33	8	14
Okla.	122	120	233	407	37	49	N	N	27	28
Tex.	601	969	659	2,164	91	104	N	N	22	19
MOUNTAIN	892	854	324	411	283	289	17	18	31	41
Mont.	59	45	4	2	-	1	-	-	-	-
Idaho	64	85	6	10	4	11	N	N	N	N
Wyo.	22	46	1	1	6	1	5	3	-	-
Colo.	200	216	53	65	75	81	-	-	28	38
N. Mex.	85	81	48	90	52	75	5	14	-	-
Ariz.	297	231	175	199	118	100	N	N	N	N
Utah	90	79	17	21	27	19	5	1	3	3
Nev.	75	71	20	23	1	1	2	-	-	-
PACIFIC	784	2,034	176	980	247	323	37	2	-	-
Wash.	187	233	45	83	34	29	-	-	N	N
Oreg.	165	187	30	47	N	N	N	N	N	N
Calif.	258	1,489	73	832	170	238	N	N	N	N
Alaska	33	41	4	4	-	-	-	-	N	N
Hawaii	141	84	24	14	43	56	37	2	-	-
Guam	-	19	-	20	-	-	-	-	-	-
P.R.	66	277	1	4	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	3	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 19, 2004, and June 14, 2003 (24th Week)*

Reporting area	Syphilis: Primary & secondary		Syphilis: Congenital		Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	3,154	3,246	143	211	3,402	5,340	112	135	8,796	9,061
NEW ENGLAND	71	97	1	-	156	174	13	13	565	1,996
Maine	-	4	-	-	-	10	-	-	175	615
N.H.	3	12	-	-	7	8	-	1	-	-
Vt.	-	-	-	-	-	5	-	-	390	427
Mass.	50	61	-	-	103	77	11	7	-	100
R.I.	9	11	-	-	11	25	1	2	-	3
Conn.	9	9	1	-	35	49	1	3	-	851
MID. ATLANTIC	465	364	25	33	855	972	28	23	34	10
Upstate N.Y.	41	15	1	3	103	103	2	3	-	-
N.Y. City	239	203	9	19	448	527	7	12	-	-
N.J.	77	73	15	11	170	176	9	7	-	-
Pa.	108	73	-	-	134	166	10	1	34	10
E.N. CENTRAL	336	451	33	38	486	497	5	16	4,055	3,526
Ohio	104	93	1	2	81	88	1	-	964	884
Ind.	25	21	8	7	60	54	-	4	-	-
Ill.	105	187	2	13	225	231	-	6	-	-
Mich.	92	139	22	16	91	96	3	6	2,752	2,102
Wis.	10	11	-	-	29	28	1	-	339	540
W.N. CENTRAL	63	87	-	4	168	215	2	3	115	37
Minn.	11	26	-	-	68	75	1	1	-	-
Iowa	4	7	-	-	15	11	-	1	N	N
Mo.	30	30	-	4	49	62	1	1	2	-
N. Dak.	-	-	-	-	3	-	-	-	70	37
S. Dak.	-	1	-	-	5	13	-	-	43	-
Nebr.	4	3	-	-	6	9	-	-	-	-
Kans.	14	20	-	-	22	45	-	-	-	-
S. ATLANTIC	851	859	17	44	795	975	19	26	1,354	1,241
Del.	3	4	1	-	-	-	-	-	4	13
Md.	169	129	2	7	110	94	3	7	-	-
D.C.	33	26	1	-	-	-	-	-	16	17
Va.	48	39	1	1	87	97	3	11	344	305
W. Va.	2	1	-	-	10	10	-	-	773	759
N.C.	69	77	3	9	96	106	3	4	N	N
S.C.	48	51	-	4	90	63	-	-	217	147
Ga.	137	229	-	11	11	234	8	2	-	-
Fla.	342	303	9	12	391	371	2	2	-	-
E.S. CENTRAL	169	156	6	7	262	295	4	2	2	-
Ky.	23	21	-	1	42	52	2	-	-	-
Tenn.	65	68	1	1	95	89	2	1	-	-
Ala.	68	56	3	4	92	109	-	1	-	-
Miss.	13	11	2	1	33	45	-	-	2	-
W.S. CENTRAL	501	375	22	32	300	876	7	7	1,160	1,953
Ark.	18	19	-	1	60	45	-	-	-	-
La.	97	51	-	-	-	-	-	-	34	9
Okla.	13	20	2	1	64	61	-	-	-	-
Tex.	373	285	20	30	176	770	7	7	1,126	1,944
MOUNTAIN	165	145	29	19	177	160	5	4	1,511	298
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	13	4	1	-	-	1	-	-	-	-
Wyo.	1	-	-	-	1	2	-	-	19	25
Colo.	10	19	-	3	42	39	1	3	1,132	-
N. Mex.	26	29	1	4	13	24	-	-	63	-
Ariz.	103	85	27	12	101	69	2	1	-	-
Utah	2	2	-	-	20	13	1	-	297	273
Nev.	10	6	-	-	-	12	1	-	-	-
PACIFIC	533	712	10	34	203	1,176	29	41	-	-
Wash.	43	34	-	-	105	106	2	2	-	-
Oreg.	9	18	-	-	34	47	1	2	-	-
Calif.	478	653	10	34	-	948	20	37	-	-
Alaska	-	1	-	-	13	28	-	-	-	-
Hawaii	3	6	-	-	51	47	6	-	-	-
Guam	-	1	-	-	-	27	-	-	-	81
P.R.	54	99	2	8	14	38	-	-	146	270
V.I.	4	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	10	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending June 19, 2004 (24th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	495	357	100	25	8	5	47
Boston, Mass.	124	86	30	5	2	1	15
Bridgeport, Conn.	32	24	6	2	-	-	2
Cambridge, Mass.	22	20	1	1	-	-	3
Fall River, Mass.	19	12	5	2	-	-	1
Hartford, Conn.	62	38	18	3	2	1	5
Lowell, Mass.	28	20	8	-	-	-	3
Lynn, Mass.	15	11	3	1	-	-	1
New Bedford, Mass.	33	30	2	1	-	-	6
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	47	36	7	1	2	1	-
Somerville, Mass.	2	2	-	-	-	-	-
Springfield, Mass.	36	24	5	5	1	1	3
Waterbury, Conn.	34	27	5	2	-	-	5
Worcester, Mass.	41	27	10	2	1	1	3
MID. ATLANTIC	2,255	1,524	471	159	60	39	161
Albany, N.Y.	41	30	6	1	1	3	2
Allentown, Pa.	18	14	1	2	1	-	-
Buffalo, N.Y.	90	69	17	2	1	1	11
Camden, N.J.	31	17	6	3	2	3	-
Elizabeth, N.J.	26	15	6	4	1	-	-
Erie, Pa.	44	37	5	1	1	-	3
Jersey City, N.J.	37	23	9	1	-	4	-
New York City, N.Y.	1,127	751	249	82	29	14	69
Newark, N.J.	66	34	17	6	6	3	3
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	377	230	88	40	13	6	26
Pittsburgh, Pa.§	21	15	3	2	-	1	2
Reading, Pa.	25	18	5	2	-	-	5
Rochester, N.Y.	119	91	22	5	1	-	18
Schenectady, N.Y.	21	17	2	1	1	-	4
Scranton, Pa.	34	27	5	2	-	-	2
Syracuse, N.Y.	96	72	15	2	3	4	12
Trenton, N.J.	28	19	9	-	-	-	-
Utica, N.Y.	20	15	3	2	-	-	2
Yonkers, N.Y.	34	30	3	1	-	-	2
E.N. CENTRAL	1,844	1,232	409	107	43	53	133
Akron, Ohio	56	28	19	7	-	2	3
Canton, Ohio	30	24	3	2	-	1	4
Chicago, Ill.	296	175	71	26	16	8	28
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	220	151	55	7	2	5	11
Columbus, Ohio	179	119	48	4	2	6	20
Dayton, Ohio	103	75	21	5	1	1	7
Detroit, Mich.	166	86	45	26	4	5	11
Evansville, Ind.	38	33	4	-	-	1	4
Fort Wayne, Ind.	55	38	8	4	2	3	3
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	52	35	11	-	3	3	10
Indianapolis, Ind.	183	121	43	7	4	8	7
Lansing, Mich.	41	31	10	-	-	-	2
Milwaukee, Wis.	120	87	27	4	2	-	8
Peoria, Ill.	60	41	13	1	1	4	2
Rockford, Ill.	46	36	3	4	1	2	6
South Bend, Ind.	48	43	4	1	-	-	-
Toledo, Ohio	103	74	19	5	2	3	6
Youngstown, Ohio	48	35	5	4	3	1	1
W.N. CENTRAL	640	420	135	51	17	17	59
Des Moines, Iowa	78	55	14	8	-	1	10
Duluth, Minn.	26	20	5	1	-	-	2
Kansas City, Kans.	30	18	8	2	1	1	8
Kansas City, Mo.	77	51	17	5	3	1	3
Lincoln, Nebr.	27	20	5	-	1	1	4
Minneapolis, Minn.	58	37	8	5	4	4	7
Omaha, Nebr.	73	52	16	2	2	1	9
St. Louis, Mo.	103	57	28	11	3	4	9
St. Paul, Minn.	65	48	10	6	1	-	2
Wichita, Kans.	103	62	24	11	2	4	5
S. ATLANTIC	1,247	785	293	95	42	32	57
Atlanta, Ga.	119	69	32	14	3	1	6
Baltimore, Md.	151	88	38	15	5	5	8
Charlotte, N.C.	102	64	19	8	3	8	4
Jacksonville, Fla.	143	86	43	7	4	3	6
Miami, Fla.	106	68	21	11	4	2	4
Norfolk, Va.	62	45	14	1	-	2	4
Richmond, Va.	40	18	11	7	3	1	1
Savannah, Ga.	59	40	14	2	1	2	4
St. Petersburg, Fla.	67	50	12	3	1	1	6
Tampa, Fla.	176	131	33	5	5	2	12
Washington, D.C.	200	112	51	20	12	5	2
Wilmington, Del.	22	14	5	2	1	-	-
E.S. CENTRAL	885	569	197	72	31	13	60
Birmingham, Ala.	175	104	43	16	4	5	20
Chattanooga, Tenn.	106	77	14	8	5	2	5
Knoxville, Tenn.	84	52	26	4	1	1	-
Lexington, Ky.	85	62	14	3	4	2	5
Memphis, Tenn.	167	99	45	12	10	1	11
Mobile, Ala.	76	50	15	8	3	-	4
Montgomery, Ala.	53	37	9	7	-	-	1
Nashville, Tenn.	139	88	31	14	4	2	14
W.S. CENTRAL	1,499	958	338	119	41	43	79
Austin, Tex.	82	47	25	7	1	2	7
Baton Rouge, La.	45	32	5	4	3	1	-
Corpus Christi, Tex.	69	50	13	3	2	1	9
Dallas, Tex.	223	140	48	21	7	7	10
El Paso, Tex.	75	44	16	6	2	7	4
Ft. Worth, Tex.	120	77	31	7	2	3	9
Houston, Tex.	343	197	89	30	13	14	11
Little Rock, Ark.	68	46	12	5	3	2	2
New Orleans, La.	45	28	12	5	-	-	-
San Antonio, Tex.	221	148	46	19	5	3	14
Shreveport, La.	64	43	18	1	2	-	4
Tulsa, Okla.	144	106	23	11	1	3	9
MOUNTAIN	895	616	176	55	28	20	59
Albuquerque, N.M.	127	93	18	10	5	1	8
Boise, Idaho	32	25	3	2	1	1	2
Colo. Springs, Colo.	72	49	16	2	4	1	4
Denver, Colo.	87	47	21	8	3	8	2
Las Vegas, Nev.	195	136	43	11	2	3	14
Ogden, Utah	33	25	6	2	-	-	1
Phoenix, Ariz.	50	28	13	6	3	-	5
Pueblo, Colo.	35	25	8	2	-	-	3
Salt Lake City, Utah	101	73	18	4	3	3	11
Tucson, Ariz.	163	115	30	8	7	3	9
PACIFIC	1,308	930	241	96	21	20	122
Berkeley, Calif.	11	9	1	-	-	1	5
Fresno, Calif.	80	56	17	4	2	1	3
Glendale, Calif.	10	7	1	1	-	1	1
Honolulu, Hawaii	91	63	20	6	-	2	7
Long Beach, Calif.	61	47	8	5	-	1	5
Los Angeles, Calif.	171	99	43	20	4	5	19
Pasadena, Calif.	28	20	6	1	-	1	2
Portland, Oreg.	114	85	18	9	2	-	7
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	181	131	26	16	7	1	16
San Francisco, Calif.	118	85	22	9	-	2	12
San Jose, Calif.	189	137	34	10	3	5	17
Santa Cruz, Calif.	29	21	6	1	1	-	1
Seattle, Wash.	86	70	9	6	1	-	14
Spokane, Wash.	48	37	9	2	-	-	5
Tacoma, Wash.	91	63	21	6	1	-	8
TOTAL	11,068¶	7,391	2,360	779	291	242	777

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. 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 this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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☆U.S. Government Printing Office: 2004-633-140/00024 Region IV ISSN: 0149-2195