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National Drunk and Drugged Driving Prevention Month — December 2004

December is National Drunk and Drugged Driving Prevention Month (3D Month), which is supported by public- and private-sector organizations devoted to preventing impaired-driving crashes. During 2003, alcohol-related motor-vehicle crashes accounted for nearly 40% of all traffic fatalities in the United States. Alcohol-related fatalities are those with any alcohol detected in blood specimens of drivers. During 1994–2003, the rate of fatalities in alcohol-related motor-vehicle crashes decreased 12%, from 6.7 to 5.9 per 100,000 population. A national health objective for 2010 is to reduce alcohol-related traffic fatalities to ≤4.0 per 100,000 population, a decline of 32% from 2003.

To achieve the national health objective, communities need comprehensive and effective strategies to prevent alcohol-impaired driving. CDC has determined that carefully planned and well-executed mass media campaigns that attain sufficient audience exposure and are implemented in conjunction with other ongoing prevention activities are effective in reducing alcohol-impaired driving. Six other interventions determined to be effective include 1) sobriety checkpoints, 2) 0.08g/dL blood alcohol concentration laws, 3) minimum legal drinking age laws, 4) zero-tolerance laws for young or inexperienced drivers, 5) school-based approaches to reduce riding with drinking drivers, and 6) some types of server-intervention training programs. Comprehensive approaches that implement several interventions simultaneously will further reduce alcohol-impaired driving.

The 3D Month program planner, which contains sample public service announcements, media tool kits, and program guidance for conducting 3D Month activities, is available at http://www.stopimpaireddriving.org.

Trends in Motorcycle Fatalities Associated with Alcohol-Impaired Driving — United States, 1983–2003

Motorcycles are the most dangerous type of motor vehicle to drive (*1*). These vehicles are involved in fatal crashes at a rate of 35.0 per 100 million miles of travel, compared with a rate of 1.7 per 100 million miles of travel for passenger cars. The National Highway Traffic Safety Administration (NHTSA) has reported increasing numbers of motorcycle deaths associated with alcohol-impaired driving in recent years, especially among persons aged ≥40 years (*2*). To determine trends by age group in motorcycle fatalities overall and in those involving alcohol impairment, CDC analyzed data from the NHTSA Fatality Analysis Reporting System (FARS) for 1983, 1993, and 2003. This report summarizes the results of that analysis, which indicated that, during 1983–2003, the overall prevalence of elevated blood alcohol concentrations (BACs) among motorcycle drivers who died in crashes declined; however, the peak rate of death among alcohol-impaired motorcycle drivers shifted from those aged 20–24 years to those aged 40–44 years. Strong enforcement of existing BAC laws, together with other public health interventions aimed at motorcyclists, might reduce the crash mortality rate, especially among older drivers.

FARS is an active, population-based surveillance system for motor-vehicle crashes that occur on public roadways in the United States and result in the death of an occupant or nonoccupant (e.g., pedestrian) within 30 days of the crash. FARS data are extracted primarily from law enforcement

INSIDE

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accident reports, which typically document driver BACs. However, for the approximately 35% of fatally injured drivers for whom BACs are unknown, NHTSA imputes BACs from driver and crash characteristics (*3*). For this analysis, a BAC level ≥0.08 g/dL, the legal limit in all states, was defined as alcohol impairment. This analysis was restricted to persons who died as a result of injuries sustained while driving a motorcycle or passenger car. The passenger car category does not include pickups, vans, or sport-utility vehicles. Rates were calculated by using U.S. census population estimates for 1983, 1993, and 2003 (*4*).

Overall, motorcycle mortality rates per 100,000 population declined from 1.6 in 1983 to 0.9 in 1993 and then increased to 1.2 in 2003. Most of the decline occurred among motorcyclists aged <30 years. For example, among drivers aged 20–24 years, the mortality rate declined from 5.0 in 1983 to 3.0 in 1993 and 2.4 in 2003, whereas among drivers aged 40–44 years, the mortality rate declined from 1.2 in 1983 to 1.0 in 1993 and then increased to 1.9 in 2003 (Figure). Among alcohol-impaired motorcycle drivers, the mortality rate was highest among persons aged 20–24 years in 1983 and among persons aged 40–44 years in 2003. In 1983, 8.2% of alcohol-impaired, fatally injured motorcycle drivers were aged ≥40 years; by 2003, 48.2% of such drivers were in this age group.

During 1983–2003, the overall proportion of both motorcycle and passenger-car drivers dying in crashes who were alcohol impaired declined (Table). Alcohol impairment occurred less often in automobile drivers of all ages in 2003 compared with 1983. This decrease also was observed among motorcycle drivers, except for persons aged 55–59 years, for whom the proportion with alcohol impairment increased from 16.7% in 1983 to 21.1% in 2003. In 2003, the proportion of fatally injured drivers with alcohol impairment was consistently lower among motorcycle drivers than among passenger-car drivers at each age through age 34 years. After age 34 years, however, higher proportions of motorcycle drivers than passenger-car drivers were alcohol-impaired.

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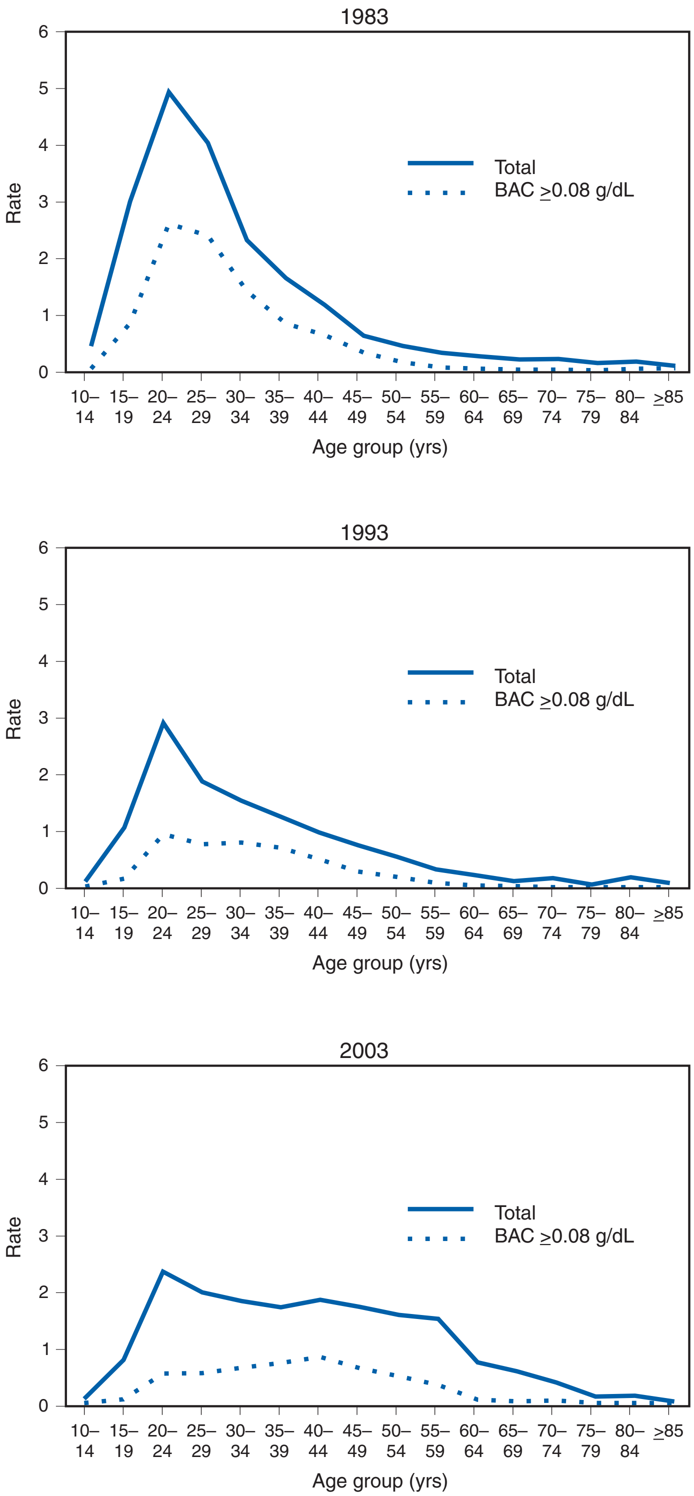
Editorial Note: Sales of new on-road motorcycles increased substantially from 1997 through 2003, from 247,000 to 648,000 units (*5*). This increase coincided with a 69.8% increase in the number of motorcyclist traffic fatalities during that period, from 2,116 in 1997 to 3,592 in 2003 (*6*). The increased number of motorcycles on the road probably contributed to the increase in the motorcycle mortality rate during 1993–2003. The mortality rate increase has been restricted to older motorcycle drivers.

FIGURE. Motorcycle fatality rates* for all drivers and drivers with blood alcohol concentrations (BACs) ≥0.08 g/dL, by age group — United States, 1983, 1993, and 2003



* Per 100,000 population.

TABLE. Percentage of drivers with blood alcohol concentrations ≥0.08 g/dL who died in fatal crashes, by age group* and vehicle type — United States, 1983, 1993, and 2003

Age group (yrs)	Vehicle type	Year 1983	1993	2003
15–19	Motorcycle	28.0	14.0	8.6
	Passenger car	47.2	22.7	23.5
20–24	Motorcycle	52.7	32.1	22.2
	Passenger car	61.0	47.8	43.6
25–29	Motorcycle	59.2	40.3	26.8
	Passenger car	62.6	51.6	46.2
30–34	Motorcycle	60.8	51.2	34.2
	Passenger car	59.3	51.3	44.8
35–39	Motorcycle	50.7	55.1	41.3
	Passenger car	56.0	48.2	40.9
40–44	Motorcycle	54.2	50.5	44.1
	Passenger car	44.8	42.4	37.1
45–49	Motorcycle	51.4	36.7	35.9
	Passenger car	40.5	31.2	35.1
50–54	Motorcycle	32.6	32.9	30.0
	Passenger car	38.9	26.3	26.5
55–59	Motorcycle	16.7	22.8	21.1
	Passenger car	32.4	26.5	20.8
All ages	**Motorcycle**	**48.6**	**38.5**	**29.5**
	Passenger car	**47.0**	**33.1**	**29.6**

* Percentages are unstable for persons aged ≥60 years because of the small number of crash-related deaths among this age group and therefore are not shown.

Although the proportion of alcohol-impaired motorcycle drivers in fatal crashes declined from 48.6% in 1983 to 29.5% in 2003, the decline has been comparatively small among motorcycle drivers aged ≥40 years. Mortality rates might be increasing among motorcycle drivers aged ≥40 years, not only because more persons in this age group are riding motorcycles, but also because older motorcycle drivers might now be more likely to consume alcohol before driving than younger motorcycle drivers. Older drivers might be more likely than younger drivers to limit their riding to recreational trips on weekends under circumstances that might involve alcohol consumption.

The findings in this report are subject to at least three limitations. First, because BAC levels were imputed for some cases, they must be considered estimates. Second, drinking drivers might be overrepresented among motorcycle drivers compared with passenger-car drivers because of other risk factors associated with drinking among motorcyclists. For example, motorcyclists who drink are also less likely to wear helmets (*2*), a factor that increases the risk for death in a motorcycle crash (*7*). Finally, because the number of motorcycle drivers in each age group is not known, age-specific rates cannot be calculated on the basis of the number of drivers in each age group nor on more sensitive measures (e.g., the number of miles of motorcycle travel by each age group).

Efforts to reduce alcohol consumption among motorcyclists should target older drivers. Several measures are effective in reducing the rate of alcohol-impaired driving (*8*). Certain measures, including sobriety checkpoints, enhanced enforcement of 0.08 g/dL BAC laws, and some types of server-intervention programs to reduce alcohol consumption in bars and restaurants, are most likely to impact motorcycle drivers aged ≥40 years. Laws setting a BAC limit of 0.08 g/dL for drivers have already been passed in all 50 states. Strong enforcement of these laws, together with other public health interventions aimed at motorcyclists, might help reduce the crash mortality rate, especially among older drivers. Because BAC levels less than the legal limit also adversely affect performance (*9*), drivers of all ages can help by avoiding the consumption of any alcohol before driving.

Acknowledgments

This report is based, in part, on contributions by T Lindsey, National Highway Traffic Safety Admin, Washington, DC.

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Diagnoses of HIV/AIDS — 32 States, 2000–2003

An estimated 850,000–950,000 persons in the United States are living with human immunodeficiency virus (HIV), including 180,000–280,000 who do not know they are infected (*1*). To examine trends of diagnoses for 2000–2003, CDC analyzed HIV and acquired immunodeficiency syndrome (AIDS) together as HIV/AIDS (i.e., HIV infection with or without AIDS), counted by the year of earliest reported diagnosis of HIV infection. From 2000 to 2003, in 32 states* that used confidential, name-based reporting of HIV and AIDS cases for ≥4 years, the overall annual rate of diagnosis of HIV/AIDS remained stable. However, rates among non-Hispanic black females were 19 times higher than rates among non-Hispanic white females, underscoring the need for continued emphasis on programs targeting females in racial/ethnic minority populations to reduce the number of cases of HIV/AIDS.

CDC surveillance reports of HIV/AIDS are limited to cases among residents of states and U.S. territories where surveillance for non-AIDS HIV infection is conducted by using the same confidential, name-based reporting approach as for AIDS case reporting (*2*). The number of states conducting HIV/AIDS surveillance in this manner has gradually increased, resulting in available data for a greater proportion of cases in the United States. Numbers of cases, age-adjusted rates, and associated confidence intervals (CIs) were calculated, adjusting for random variation, reporting delay, and missing information on HIV risk factors (e.g., men who have sex with men [MSM] and injection-drug use [IDU]) (*3,4*). Data from territories were not included in this analysis.

Cases were classified in the following hierarchy of transmission categories: MSM, IDU, both MSM and IDU, high-risk heterosexual contact (i.e., with someone of the opposite sex known to have HIV/AIDS or a risk factor [e.g., MSM or IDU] for HIV/AIDS), and all other HIV risk factors combined. Age-adjusted rates were calculated by the direct method, using the age distribution of the 2000 U.S. population as the standard. The statistical significance of differences between a pair of rates was assessed by the z test. To estimate the annual proportional change in a rate or number of diagnoses during 2000–2003, the logarithm of the rate or number was fit to a linear model. The significance of a trend was assessed by determining whether the 95% CI for the estimated annual proportional change included zero.

* Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

During 2000–2003, HIV/AIDS was diagnosed in 125,800 persons who resided in the 32 states. Of these persons, 35,241 (28.0%) were female (Table 1). Although non-Hispanic blacks constituted 13% of the population of the 32 states during these 4 years (*5*), they accounted for more than half (64,532 [51.3%]) of the HIV/AIDS diagnoses, including 68.8% of diagnoses among females and 44.5% of those among males. The remaining cases were among non-Hispanic whites (40,284 [32.0%]), Hispanics (18,642 [14.8%]), Asians/Pacific Islanders (799 [0.6%]), and American Indians/Alaska Natives (715 [0.6%]). Non-Hispanic blacks constituted 35.2% of cases in the MSM transmission category, 56.9% of cases in the IDU transmission category, 70.4% of cases in the high-risk heterosexual contact category, and 69.8% of cases of mother-to-child transmission. The transmission category with the largest proportion of males with HIV/AIDS was MSM (61.2%), followed by high-risk heterosexual contact (17.3%), and IDU (14.6%) (Table 1). The transmission category with the largest proportion of females with HIV/AIDS was high-risk heterosexual contact (77.7%), followed by IDU (19.4%). The proportional distribution of cases by transmission category varied by race/ethnicity (Table 2).

During 2000–2003, annual age-adjusted rates of HIV/AIDS diagnosis per 100,000 population changed little (Figure 1). Overall, the rate increased 1.0%, from 19.5 in 2000 to 19.7 in 2003. Further analyses indicated statistically significant ($p<0.05$) changes among certain populations. The rate among males increased 3.0% (from 27.9 to 28.8), and the rate among females decreased 3.7% (from 11.2 to 10.8). The rate among non-Hispanic white males increased 6.2% (from 14.3 to 15.2), and the rate among Asian/Pacific Islander males increased 39.7% (from 7.0 to 9.8); the rate among non-Hispanic black females decreased 6.0% (from 56.4 to 53.0). Trends in annual age-adjusted rates among other sex and racial/ethnic groups were not significant.

Rates among non-Hispanic black females were 19 times the rate among non-Hispanic white females, five times the rate among Hispanic females, and also higher than rates among males in any racial/ethnic population other than non-Hispanic blacks. Rates among non-Hispanic black males were

TABLE 1. Estimated number and percentage of persons with HIV/AIDS diagnosed, by sex and selected characteristics — 32 states*, 2000–2003

	Male		Female		Total†	
Characteristic	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Race/Ethnicity						
White, non-Hispanic	33,738	(37.3)	6,545	(18.6)	**40,284**	**(32.0)**
Black, non-Hispanic	40,278	(44.5)	24,254	(68.8)	**64,532**	**(51.3)**
Hispanic§	14,851	(16.4)	3,792	(10.8)	**18,642**	**(14.8)**
Asian/Pacific Islander	616	(0.7)	183	(0.5)	**799**	**(0.6)**
American Indian/Alaska Native	505	(0.6)	210	(0.6)	**715**	**(0.6)**
Unknown	570	(0.6)	257	(0.7)	**827**	**(0.7)**
Total†	**90,558**	**(100.0)**	**35,241**	**(100.0)**	**125,800**	**(100.0)**
Age group (yrs) at diagnosis						
<13	367	(0.4)	435	(1.2)	**802**	**(0.6)**
13–24	8677	(9.6)	5992	(17.0)	**14,669**	**(11.7)**
25–34	25,244	(27.9)	10,685	(30.3)	**35,930**	**(28.6)**
35–44	34,208	(37.8)	10,793	(30.6)	**45,001**	**(35.8)**
45–54	16,057	(17.7)	5,318	(15.1)	**21,375**	**(17.0)**
55–64	4644	(5.1)	1531	(4.4)	**6176**	**(4.9)**
≥65	1360	(1.5)	487	(1.4)	**1846**	**(1.5)**
Total†	**90,558**	**(100.0)**	**35,241**	**(100.0)**	**125,800**	**(100.0)**
Transmission category						
Men who have sex with men (MSM)	55,431	(61.2)	—	—	**55,431**	**(44.1)**
Injection-drug use (IDU)	13,235	(14.6)	6,847	(19.4)	**20,083**	**(16.0)**
Both MSM and IDU	5,145	(5.7)	—	—	**5,145**	**(4.1)**
High-risk heterosexual contact¶	15,711	(17.3)	27,387	(77.7)	**43,098**	**(34.3)**
Other**	1,036	(1.1)	1,007	(2.9)	**2,042**	**(1.6)**

* States with confidential, name-based reporting of HIV infection: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

† Totals include one person of unknown sex and also can differ from the apparent sums because of rounding of estimates that resulted from adjustments for reporting delay and missing risk factors.

§ Hispanics might be of any race.

¶ Sexual contact with someone of the opposite sex known to have HIV/AIDS or at least one of the following HIV risk factors: MSM, IDU, or hemophilia.

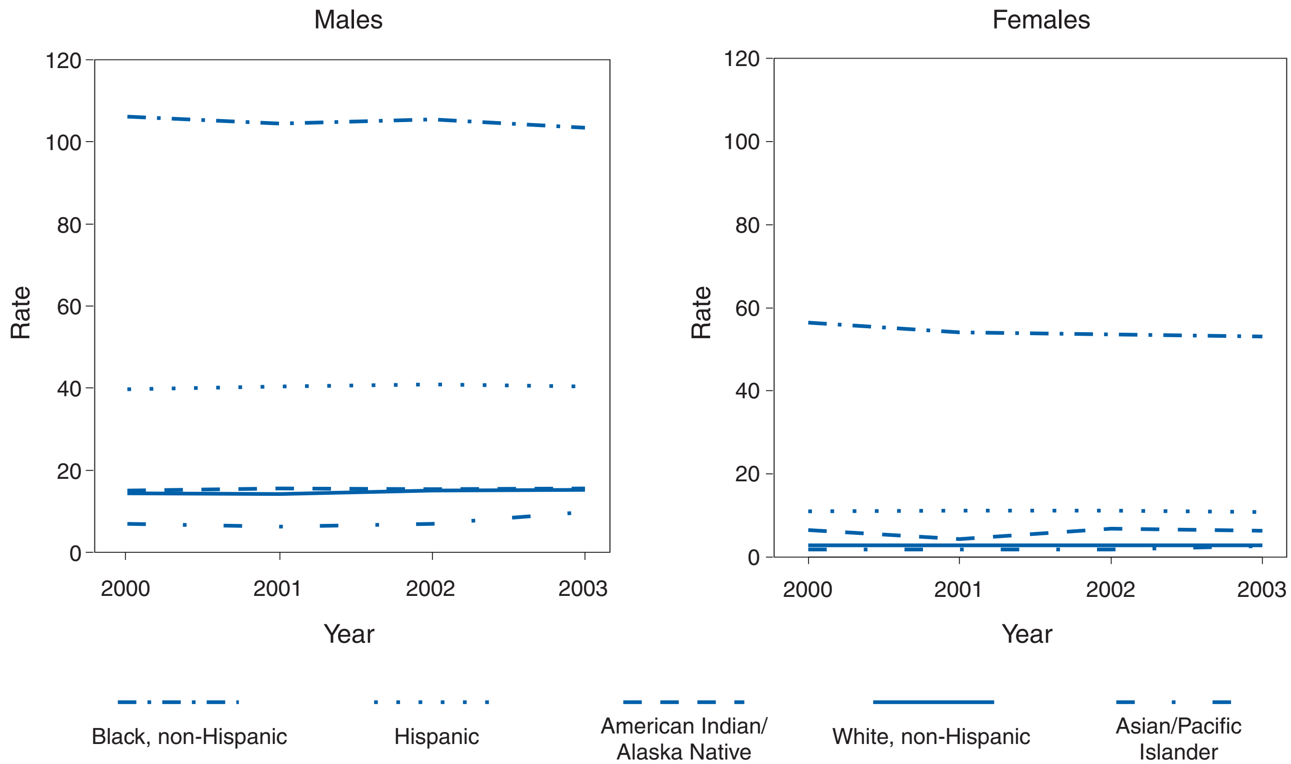
** Mother-to-child exposure, receipt of transfusion of blood, blood components, or blood products, receipt of organ or tissue transplant, artificial insemination, or unintentional occupational exposure to human blood or other body fluids.

TABLE 2. Estimated number and percentage of persons with HIV/AIDS diagnosed, by race/ethnicity, sex, and transmission category — 32 states*, 2000–2003

Transmission category	White, non-Hispanic No.	(%)	Black, non-Hispanic No.	(%)	Hispanic† No.	(%)	Asian/ Pacific Islander No.	(%)	American Indian/ Alaska Native No.	(%)
Male										
Men who have sex with men (MSM)	25,842	(76.6)	19,535	(48.5)	9,047	(60.9)	399	(64.8)	308	(60.9)
Injection-drug use (IDU)	3,264	(9.7)	7,372	(18.3)	2,362	(15.9)	74	(12.0)	76	(15.1)
Both MSM and IDU	2,251	(6.7)	2,018	(5.0)	753	(5.1)	25	(4.0)	55	(11.0)
High-risk heterosexual contact§	2,071	(6.1)	10,815	(26.8)	2,527	(17.0)	106	(17.3)	62	(12.2)
Other¶	310	(0.9)	537	(1.3)	162	(1.1)	12	(1.9)	4	(0.8)
Total	**33,738**	**(100.0)**	**40,278**	**(100.0)**	**14,851**	**(100.0)**	**616**	**(100.0)**	**505**	**(100.0)**
Female										
IDU	1,989	(30.4)	4,060	(16.7)	674	(17.8)	21	(11.4)	61	(29.1)
High-risk heterosexual contact§	4,390	(67.1)	19,510	(80.4)	2,982	(78.7)	153	(83.6)	146	(69.3)
Other¶	166	(2.5)	685	(2.8)	136	(3.6)	9	(5.0)	3	(1.6)
Total**	**6,545**	**(100.0)**	**24,254**	**(100.0)**	**3,792**	**(100.0)**	**183**	**(100.0)**	**210**	**(100.0)**

* States with confidential, name-based reporting of HIV infection: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.
† Hispanics might be of any race.
§ Sexual contact with someone of the opposite sex known to have HIV/AIDS or at least one of the following HIV risk factors: MSM, IDU, or hemophilia.
¶ Mother-to-child exposure, receipt of transfusion of blood, blood components, or blood products, receipt of organ or tissue transplant, artificial insemination, or unintentional occupational exposure to human blood or other body fluids.
** Totals include one person of unknown sex and also can differ from the apparent sums because of rounding of estimates that resulted from adjustments for reporting delay and missing risk factors.

FIGURE 1. Estimated annual age-adjusted rate of diagnosis of HIV/AIDS*, by sex and race/ethnicity — 32 states†, 2000–2003



* Diagnoses of HIV infection (with or without AIDS) per 100,000 population, adjusted for reporting delays and directly adjusted to the age distribution of the 2000 U.S. population.
† States with confidential, name-based reporting of HIV infection: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

seven times higher than those among non-Hispanic white males and three times higher than those among Hispanic males.

Statistically significant trends in the annual number of diagnoses included a 4.9% increase, from 2000 to 2003, among males (from 22,117 to 23,203). A 2.1% decrease among females (from 8,986 to 8,791) was not statistically significant. The increasing rate and number of diagnoses among males largely reflected the upward trend in the number of diagnoses associated with MSM, which increased 10.8% (Figure 2) from 13,099 to 14,510, consistent with the trend previously reported (*6*). The number of diagnoses associated with the combination of MSM and IDU decreased 10.3% (from 1,363 to 1,223).

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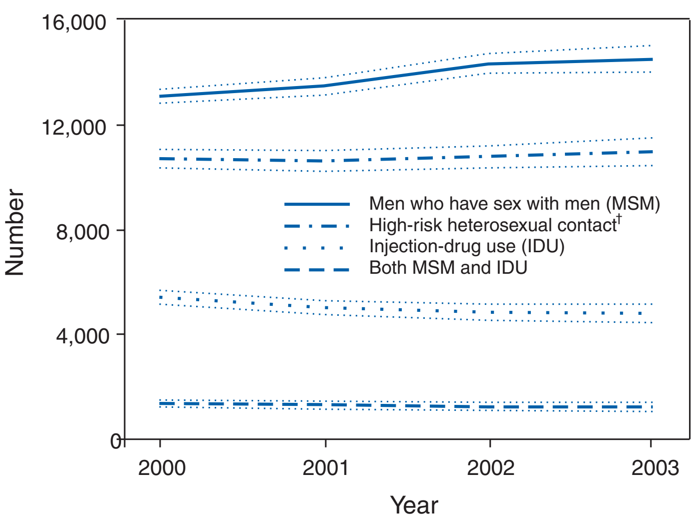
Editorial Note: The analysis of surveillance data for 2000–2003 reveals overall stable annual rates of HIV/AIDS diagnosis; these rates reflect the interaction between HIV incidence and HIV testing. CDC has determined that national HIV incidence has been stable since the early 1990s (*7*) and that 25% of those living with HIV do not know they are infected (*1*). The stable rates during 2000–2003 suggest that enhanced prevention efforts are needed to decrease HIV incidence and increase knowledge of HIV status. In 2003, CDC launched Advancing HIV Prevention (AHP), an initiative aimed at reducing barriers to early diagnosis of HIV and increasing access to quality medical care, treatment, and ongoing prevention services for HIV-infected persons (*8*). The availability of simple, rapid HIV tests, including those that use oral fluid, should increase testing opportunities for those at high risk for HIV; rapid testing was first implemented in U.S. prevention programs in late 2003. As part of AHP, CDC also encourages physicians to routinely provide prevention messages and screening for sexually transmitted diseases for their patients who are HIV positive (*9*). For those persons who have difficulty initiating and sustaining safer behaviors, more intensive interventions (e.g., individualized support and counseling through prevention case management or multisession behavioral interventions) might be beneficial.

FIGURE 2. Estimated annual number of HIV/AIDS diagnoses, by transmission category and year of diagnosis — 32 states*, 2000–2003



Note: Estimates are adjusted for reporting delays and redistribution of transmission category for cases without risk factor information. Confidence intervals are indicated by broken lines.

* Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

† Sexual contact with someone of the opposite sex known to have HIV/AIDS or at least one of the following HIV risk factors: MSM, IDU, or hemophilia.

Rates among non-Hispanic blacks, and to a lesser extent Hispanics, are substantially greater than rates among non-Hispanic whites in the United States. Race/ethnicity likely is associated with behavioral risk factors and underlying socioeconomic circumstances and barriers to risk reduction. To eliminate racial/ethnic disparities, opportunities for early diagnosis of HIV infection should be expanded. In addition, culturally sensitive prevention programs should be improved to promote avoidance of risk factors (e.g., by having only one sex partner of known infection status or abstaining from sex and illicit drug use) and to reduce the harm from risk factors (e.g., by using condoms correctly and consistently and by using aseptic practices to prevent transmission from IDU).

The findings in this report are subject to at least one limitation. Confidential, name-based HIV/AIDS surveillance was not conducted in all states and territories. The 32 states included in the analysis accounted for only 49% of the national total of AIDS diagnoses (excluding U.S. territories) during the same period and might not be nationally representative. Data from states with the highest AIDS morbidity in 2003 (e.g., California and New York) were not included. However, on the basis of national AIDS statistics with similar patterns, the racial/ethnic disparities in HIV/AIDS described in this report likely are indicative of substantial disparities nationwide (*10*).

In 2003, CDC reported a 17% increase in HIV/AIDS diagnoses in MSM, from 1999 to 2002, in 29 states; the largest increase occurred from 2001 to 2002. For this report, an 11% increase was observed in HIV/AIDS diagnoses in MSM from 2000 to 2003 in 32 states, with the largest increase occurring from 2001 to 2002. MSM continue to constitute a substantial proportion of HIV/AIDS cases. CDC funds prevention programs for MSM, including counseling and testing through community outreach. Effective behavioral interventions for MSM include conducting small group sessions on HIV transmission, training in how to negotiate risk reduction, such as condom use, and training of popular opinion leaders in how to promote risk reduction or elimination.

CDC also funds prevention activities for females that emphasize 1) better integration of testing, treatment, and prevention services for all females; 2) recognition of the relationship between drug use and sexual transmission of HIV; 3) research on effective female-controlled prevention methods for women unwilling or unable to negotiate condom use with a male partner; 4) and programs proven effective for changing risky behavior and sustaining those changes over time. CDC funds 104 community-based organizations involved in HIV/AIDS prevention, for which ≥15% of the target populations are females; 84% of these groups serve black females and 72% Hispanic females. Most of these prevention activities are funded through the Minority AIDS Initiative, a capacity-building initiative that supports implementation of effective prevention interventions among racial/ethnic minority populations. A sustained, comprehensive effort is required to reduce racial/ethnic disparities in HIV/AIDS diagnoses among females.

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Number of Persons Tested for HIV — United States, 2002

Strategies for preventing infection with human immunodeficiency virus (HIV) emphasize testing to identify infected persons and ensure access to appropriate medical care, treatment, and prevention services (*1*). To determine the number of persons who were tested for HIV during the preceding 12 months, CDC analyzed data from both the 2002 National Health Interview Survey (NHIS) and the 2002 Behavioral Risk Factor Surveillance System (BRFSS) survey. This report summarizes the results of these analyses, which indicated that, in 2002, approximately 10%–12% of persons aged 18–64 years in the United States reported being tested for HIV during the preceding 12 months, an estimated 16–22 million persons. Continued measurement of HIV testing by health surveys such as BRFSS and NHIS can be used in combination with program data and other surveys of populations at high risk to determine the impact of HIV strategies on increasing testing.

NHIS is a stratified, multistage probability sample survey representing the U.S. civilian, noninstitutionalized population (*2*). The estimates in this analysis were based on personal interviews with a nationally representative sample of 31,044 adults aged ≥18 years; the overall survey response rate was 74.3%.

BRFSS is an ongoing, state-based, random-digit–dialed telephone survey of the U.S. civilian, noninstitutionalized population aged ≥18 years (*3*). In 2002, the median state/area response rate was 58.3% (range: 42.2%–82.6%) (*4*). State data from BRFSS are often combined to produce national estimates. In 2002, a total of 188,952 adults aged 18–64 years were asked questions about HIV testing.

In both surveys respondents were asked whether they had ever been tested for HIV and, if "yes," the month and year of the most recent test; both surveys asked respondents to exclude tests that occurred through blood donations. Questions on NHIS used to estimate trends in the percentage tested during the preceding 12 months have changed over time. Neither survey asked about specific HIV-risk behaviors, but both asked respondents to state whether an identified risk category applied to them, without stating which category (Table 1). This analysis excluded HIV tests that were performed when persons donated blood. All other tests were counted, including those that were required (e.g., for employment, insurance, or military service) and those that were obtained to determine infection status. Persons with missing HIV testing data (about 4% of persons interviewed in the two surveys) were included in the denominator. Estimates were weighted for unequal selection probabilities and nonresponse. Statisti-

TABLE 1. Number and percentage of adults aged 18–64 years who reported having an HIV* test (excluding blood donation) during the preceding 12 months, by survey type, HIV-risk status, age group, and pregnancy status — National Health Interview Survey (NHIS) and Behavioral Risk Factor Surveillance System (BRFSS) survey, United States, 2002

Survey type/ Characteristic	No. surveyed	% tested	(95% CI†)	National estimate of no. persons tested (in 1,000s)	(95% CI)
NHIS					
Total	**25,184**	**10.0**	**(9.6–10.4)**	**17,279**	**(16,439–18,118)**
One or more HIV risk factors§					
Age group (yrs)					
18–24	88	28.8	(18.6–39.0)	186	(109–263)
25–44	450	25.0	(20.8–29.2)	661	(524–797)
45–64	216	10.4	(6.0–14.9)	133	(75–190)
Total	**754**	**21.5**	**(18.2–24.8)**	**979**	**(813–1,145)**
Pregnant women	372	48.4	(42.5–54.4)	1,211	(1,025–1,397)
BRFSS					
Total	**188,952**	**12.2**	**(12.0–12.5)**	**21,667**	**(21,155–22,178)**
One or more HIV risk factors¶					
Age group (yrs)					
18–24	1,335	35.4	(30.6–40.2)	778	(638–918)
25–44	2,844	25.0	(22.3–27.7)	757	(665–849)
45–64	1,241	15.0	(11.4–18.6)	167	(126–207)
Total	**5,420**	**26.8**	**(24.5–29.1)**	**1,702**	**(1,530–1,874)**
Pregnant women	2,592	54.0	(50.7–57.3)	1,392	(1,266–1,518)

* Human immunodeficiency virus.
† Confidence interval.
§ NHIS defined as 1) You have hemophilia and have received clotting factor concentrations; 2) You are a man who has had sex with other men, even just one time; 3) You have taken street drugs by needle, even just one time; 4) You have traded sex for money or drugs, even just one time; 5) You have tested positive for HIV (the virus that causes acquired immunodeficiency syndrome; or 6) You have had sex (even just one time) with someone who would answer yes to any of these statements.
¶ BRFSS defined as 1) You have used intravenous drugs in the preceding 12 months; 2) You have been treated for a sexually transmitted or venereal disease in the preceding 12 months; 3) You have given or received money or drugs in exchange for sex in the preceding 12 months; or 4) You had anal sex without a condom in the preceding 12 months.

cal software was used to adjust for the effects of the complex sampling design.

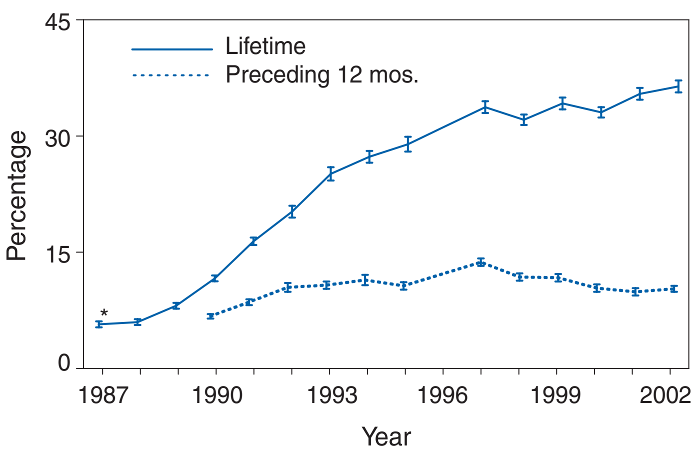
Results from NHIS indicated an increase in the percentage of respondents during 1987–2002 who had been tested during their lifetimes (Figure). In 2002, 37.8% of adults aged 18–64 years (95% confidence interval [CI] = 37.0%–38.6%) reported that they had been tested for HIV at least once in their lifetimes, compared with 5.7% in 1987 (CI = 5.3%–6.1%). In addition, in 2002, 10.0% of adults aged 18–64 years reported having been tested during the preceding 12 months, a percentage equivalent to an estimated 16–18 million persons tested nationally (Table 1). Persons tested during the preceding 12 months reported being tested, on average, 1.28 times (range: one to 24 times), a ratio equivalent to an estimated 21–24 million HIV tests per year for persons aged 18–64 years.

BRFSS data provided similar estimates of the percentages of persons tested. Results indicated that among adults aged 18–64 years, 43.5% (CI = 43.1%–43.9%) reported having been tested at least once in their lifetimes, and 12.2% reported having been tested during the preceding 12 months, a proportion equivalent to an estimated 21–22 million persons tested (Table 1).

In both surveys, greater percentages of pregnant women and persons at increased risk for HIV reported being tested during the preceding 12 months than other persons. According to NHIS and BRFSS data, approximately 48.4% and 54.0% of pregnant women, respectively, reported HIV tests. Among persons at increased risk for HIV, NHIS and BRFSS data indicated 21.5% and 26.8%, respectively, reported HIV tests (Table 1). Among those at increased risk, the percentage tested during the preceding 12 months was greater among younger age groups in both surveys. According to NHIS data, 28.8% of those aged 18–24 years were tested, compared with 10.4% of those aged 45–64 years; according to BRFSS data, 35.4% of those aged 18–24 years were tested, compared with 15.0% of those aged 45–64 years.

Data from the 2002 NHIS interviews regarding the most recent HIV tests indicated

FIGURE. Percentage of adults aged 18–64 years who reported having a human immunodeficiency virus test (excluding blood donations) during their lifetimes and the preceding 12 months, by year — National Health Interview Survey, United States, 1987–2002



* Confidence interval.

the majority of tests were obtained from physicians and health-maintenance organizations (43.5%) or hospitals (22.4%) (Table 2). Of 5.1% of tests reported as taking place "at home," 93.4% (CI = 88.2%–98.5%) were administered by a nurse or health-care worker. Testing sources that usually receive public funding (e.g., public health department clinics, family planning clinics, and prenatal clinics) accounted for 23.6% of tests during the preceding 12 months. Sources of HIV testing (Table 2) typically funded by CDC's HIV-prevention programs accounted for 17.3% of the tests, yielding an estimated 3.4 million to 4.3 million tests.

Reported by: *JE Anderson, PhD, Div of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention.*

Editorial Note: HIV testing is an integral part of current approaches to HIV prevention, which seek to expand testing practices, making HIV tests part of routine medical care and also more widely available outside of medical settings (*1*). However, as NHIS data indicate, the percentage of adults reporting new HIV tests each year has remained fairly constant at 10%–12% for more than a decade.

TABLE 2. Percentage and estimated number of HIV* tests conducted during the preceding 12 months among persons aged 18–64 years, by source of most recent test — National Health Interview Survey, United States, 2002

Source	% of tests	(95% CI†)	National estimate of no. tests (in 1,000s)	(95% CI)
Private doctor/health maintenance organization	43.5	(40.9–46.2)	9,647	(8,951–10,343)
Hospital, emergency department, outpatient clinic	22.4	(19.5–25.4)	4,969	(4,146–5,791)
Public source	23.6	(21.3–25.9)	5,220	(4,656–5,783)
Public health department clinic	6.2	(4.9–7.5)	1,375	(1,073–1,677)
AIDS clinic/counseling/testing site	5.2	(4.2–6.1)	1,149	(939–1,358)
Community health clinic	3.0	(2.1–3.8)	657	(467–847)
Sexually transmitted disease clinic	0.1	(0–0.2)	16	(0–35)
Family planning clinic	1.6	(1.0–2.2)	350	(224–476)
Prenatal clinic	0.7	(0.3–1.0)	153	(72–233)
Prison/Correctional facility	0.6	(0.2–1.0)	134	(55–214)
Drug treatment clinic	0.7	(0.2–1.1)	144	(40–249)
Military site	3.3	(2.0–4.6)	733	(447–1,018)
Immigration site	0.6	(0.3–1.0)	134	(55–212)
Other clinic	1.7	(1.1–2.2)	374	(250–498)
Other source				
Employer clinic	0.6	(0.3–0.9)	134	(72–196)
At home	5.1	(4.2–6.0)	1,131	(930–1,332)
Other location	4.8	(3.4–6.1)	1,058	(743–1,372)
Total	**100.0**		**22,158**	**(20,782–23,534)**
CDC-funded source§	17.3	(15.5–19.2)	3,843	(3,395–4,292)

* Human immunodeficiency virus.
† Confidence interval.
§ Includes HIV/AIDS counseling and testing center, community health clinic, sexually transmitted disease clinic, family planning clinic, prenatal clinic, drug treatment clinic, and public health department.

The findings in this report are subject to at least three limitations. First, persons aged <18 years and those not living in households were not interviewed. Second, because testing was self-reported and subject to recall bias, errors are possible in reporting whether tests occurred and the date and source of the tests. NHIS and BRFSS take steps to minimize the effects of these potential errors, including pretesting of questionnaires to ensure comprehension and accuracy of reporting and by using weighting factors to compensate for nonresponse. Finally, measures of behavioral or exposure HIV risk might not include all persons at increased risk and might include persons who are no longer at risk. Nevertheless, the indirect risk measures are associated with recent HIV testing. NHIS and BRFSS surveys yield similar results despite using different methodologies.

HIV-prevention strategies emphasize testing because many infected persons are unaware of their status or became aware late in their infection (*5,6*). Despite recommendations of universal voluntary testing during pregnancy, in recent years, an estimated 20%–40% of pregnant women were not tested (*7,8*). Persons who are at high priority for receiving HIV testing (e.g., those at increased risk or pregnant) reported testing at rates higher than the general population; however, many members of these priority groups were not tested during the preceding 12 months.

CDC's Advancing HIV Prevention initiative encourages testing for HIV by making voluntary testing a routine part of regular medical care, by offering rapid HIV testing in nonclinical settings (e.g., outreach into communities at high risk), and by making HIV testing part of the routine battery of prenatal tests for all pregnant women, unless declined (i.e., the "opt-out" approach). Continued surveys of HIV testing can help assess the success of these and other programs aimed at increasing the percentage of persons tested for HIV.

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Acute Flaccid Paralysis Surveillance Systems for Expansion to Other Diseases, 2003–2004

Since the 1988 World Health Assembly resolution to eradicate poliomyelitis, the number of countries where polio is endemic has decreased from 125 in 1988 to six at the end of 2003 (*1*). As part of the eradication strategy, a global surveillance system was established to 1) identify acute flaccid paralysis (AFP) cases in children aged ≤15 years and 2) deploy a network of accredited laboratories to perform virologic testing of stool specimens to determine whether the paralysis resulted from poliovirus infection. As AFP surveillance systems matured, countries increasingly applied AFP surveillance strategies and infrastructure to detect other diseases (*2*). This report describes the status of global AFP surveillance, including its expansion or use as a model in 131 (66%) of 198 countries for the reporting of measles and other vaccine-preventable diseases. As poliomyelitis is eradicated, AFP surveillance systems in these and other countries might be further expanded and adapted to improve the detection of and response to other diseases.

AFP Surveillance System

Any disease eradication initiative relies on sensitive and timely surveillance. Such surveillance is especially challenging for polio eradication, because only one of every 200 poliovirus infections results in clinically apparent paralytic disease. To ensure that paralytic polio cases will be detected if they occur, countries conduct surveillance for all AFP by using a standard case definition. All cases identified are tested to determine whether paralysis is caused by poliovirus infection. The quality of AFP surveillance is measured by using a standard definition for sensitivity and completeness, as follows: A rate of one or more nonpolio AFP cases per 100,000 population aged ≤15 years with timely collection of specimens indicates that surveillance is sensitive enough to detect polio and allows comparison of AFP reporting completeness among and within countries (Table).

As of the end of 2003, a total of 196 of 214 countries and territories operated AFP surveillance systems* and reported

* A total of 192 member states, one WHO associate, and 21 reporting entities report to WHO. Only 18 member states do not report AFP cases to WHO: Canada, Comoros, Denmark, Finland, France, Iceland, Japan, Luxembourg, Mauritius, Monaco, Netherlands, Reunion, San Marino, Saint Helena, Seychelles, Sweden, United Kingdom, and United States.

TABLE. Structure and performance of global acute flaccid paralysis (AFP) and measles surveillance systems, by World Health Organization (WHO) region, 2003

						Reported AFP and confirmed polio cases					Reported suspected and confirmed measles cases				
						No. and rate* of AFP cases (nonpolio AFP)		AFP with adequate† specimens tested				No. of clinically suspected cases tested		No. of laboratory-confirmed measles cases	
WHO region	No. of countries with AFP systems	No. of countries integrating AFP with measles/ neonatal tetanus reporting	No. of national and international staff members funded by polio partnership	No. of laboratories Poliovirus	No. of laboratories Measles	No.	Rate	No.	(%)	No. of laboratory-confirmed cases	No. of clinically suspected measles cases	No.	(%)	No.	(%)
Africa	46	28	780	16	34	8,181	2.6	7,199	(88)	446	262,314	14,583	(6)	3,543	(24)
Americas	44	44	1	9	178	2,229	1.3	1,805	(81)	0	34,766	33,028	(95)	105	—
Eastern Mediterranean	22	22	806	12	20	5,290	2.4	4,761	(90)	113	52,882	8,619	(16)	4,650	(54)
Europe	39	2	15	48	60	1,529	1.2	1,269	(83)	0	27,158§	7,904	(29)	737	(9)
Southeast Asia	11	10	1,087	16	16	11,289	1.9	9,369	(83)	225	83,862	1,083	(1)	506	(47)
Western Pacific	36	25	17	44	382	6,397	1.4	5,629	(88)	0	101,810	N/A		13,193	
WHO headquarters	—	—	45	—	—	—	—	—	—	—	—	—	—	—	—
Total	**198**	**131**	**2,752**	**145**	**690**	**34,915**		**30,032**	**(86)**	**784**	**562,792**	**65,217**		**22,734**	

* Annual number of nonpolio AFP cases per 100,000 population aged ≤15 years.
† Two specimens collected 24 hours apart within 14 days of onset of paralysis, arriving in the laboratory in good condition.
§ Expanded Program on Immunization monthly surveillance data.

data weekly to WHO. For many developed countries, the AFP surveillance system is integrated into existing disease surveillance systems. Countries with fewer public health resources receive external funding for polio eradication and to support a network of surveillance medical officers (SMOs). To promote quality AFP surveillance, SMOs maintain links to clinicians and the informal health sector (e.g., traditional healers, communities, and community informants).

AFP field activities are supported by a three-tiered global polio laboratory network that operates in all six WHO regions and consists of 145 laboratories: 123 at the national level, 15 regional reference laboratories, and seven global specialized laboratories (Figure) (*3*). Network laboratories process stool samples from AFP cases to perform virus isolation, serotyping, intratypic differentiation, and genomic sequencing. A WHO-sponsored laboratory accreditation program monitors laboratory performance; in 2003, AFP surveillance in all six WHO regions met or exceeded performance standards, and 96% of network laboratories were fully accredited by WHO. During 2003, approximately 35,000 AFP cases were reported globally, with adequate stool specimens tested in 86% of all AFP cases (Table).

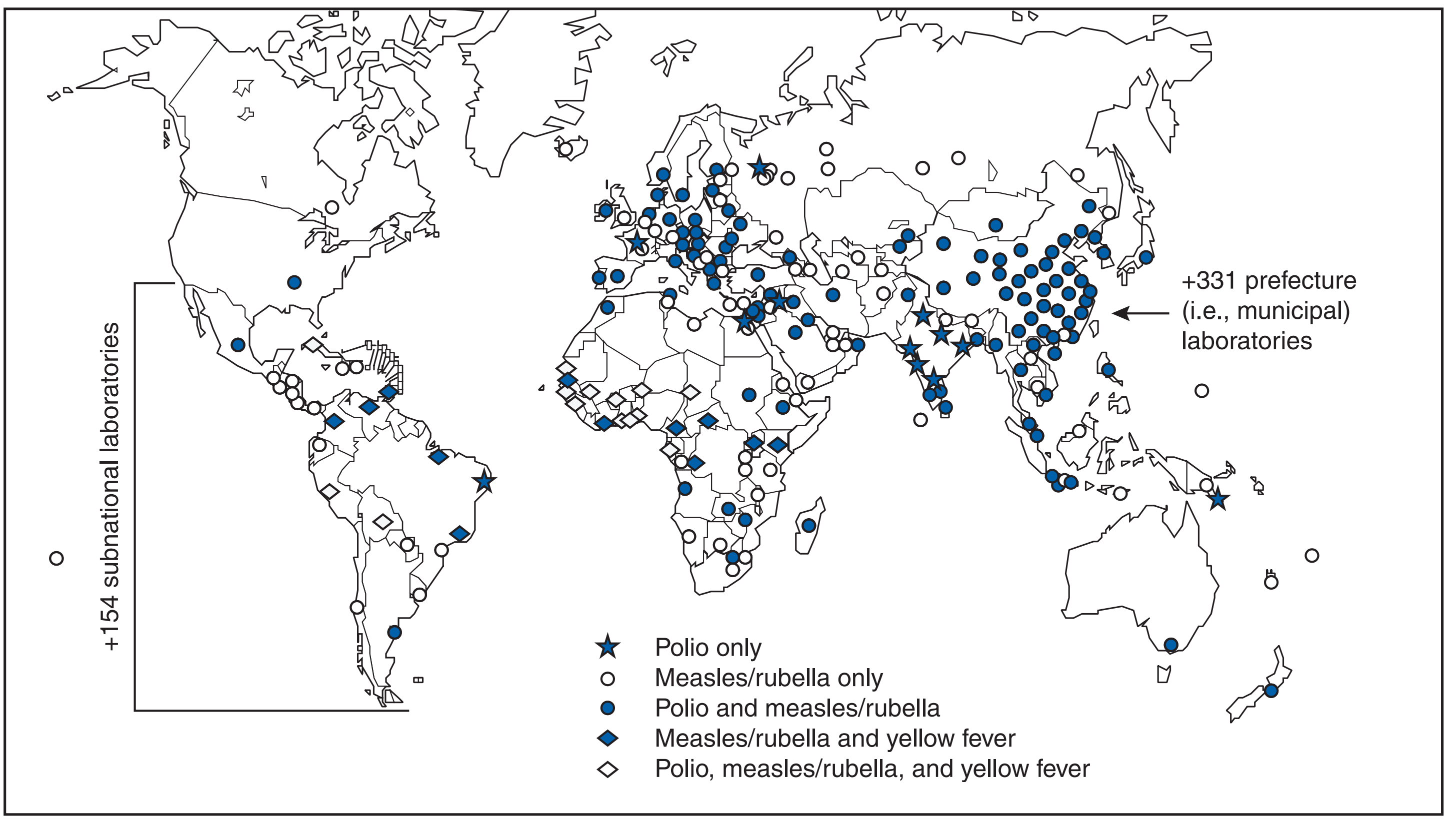
A WHO region is certified polio-free after a period of 3 years without isolation of wild poliovirus from an AFP case, in the presence of high-quality AFP surveillance[†]. Three of the six WHO regions have been certified as polio-free.

Expansion of Surveillance System

Measles. Globally, more than two thirds of countries with AFP surveillance have used that infrastructure, or applied it as a model, for measles surveillance (Table). As incidence of measles has declined to low levels, countries have shifted from aggregate measles reporting by age group to case-based reporting with laboratory confirmation. However, the extent of measles surveillance (i.e., as measured by the proportion of suspect cases that are tested) and the manner in which AFP strategies have been adapted for measles surveillance vary according to country resources and program goals (e.g., measles elimination versus mortality reduction) (Table).

[†] High-quality (i.e., certification-standard) AFP surveillance requires 1) detection of at least one case of nonpolio AFP per 100,000 population aged ≤15 years, 2) testing of two adequate stool specimens from at least 80% of AFP cases, and 3) testing of all specimens in WHO-accredited laboratories.

FIGURE. Global vaccine-preventable disease laboratory network — September 2004*



* The designation employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the secretariat of the World Health Organization concerning the legal status of any country, territory, city, or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Consisting of 690 laboratories, the global measles laboratory network (Figure) developed much like the global polio laboratory network (*4*). The network's primary roles are serologic confirmation of suspected measles cases and genetic characterization of measles viruses. Measles laboratories have used much of the polio laboratory infrastructure; they are often housed at the same institutions and use similar systems for specimen transport, data management, communication, and reporting of results. Most network laboratories routinely test measles-negative sera for rubella and processed approximately 65,000 serum specimens from suspected measles cases in 2003 (Table). Measles laboratories also perform serologic diagnosis of yellow fever in countries in the Africa and Americas regions where yellow fever is endemic (Figure).

In the Region of the Americas, the AFP surveillance system has been expanded or used as a model to fully implement case-based measles surveillance with laboratory confirmation of suspected cases. This approach has been instrumental in the successful interruption of endemic measles virus transmission (*5*). The system used in the Americas is now being expanded further to integrate rubella with measles surveillance in support of a regional goal to eliminate rubella and congenital rubella syndrome by 2010. In the Americas, in 2003, blood specimens were tested in 95% of suspected measles cases (Table). In other WHO regions, this proportion ranged from 1% to 29%.

In polio-free countries in the African, Southeast Asian, and Eastern Mediterranean regions, polio-funded SMOs have conducted measles surveillance activities. In addition, measles funds support approximately 80 international and national staff members (e.g., epidemiologists, surveillance officers, data managers, and laboratory coordinators) and fund diagnostic kits and laboratory equipment. Measles program activities, including surveillance, have been supported by the Measles Initiative, which is supported by an international coalition[§].

Other Diseases. In 57 countries, neonatal tetanus (NT) is a major public health problem, causing 14% of all neonatal deaths (*6*); however, current reporting captures <5% of NT cases. With expansion of AFP surveillance programs, in certain countries, SMOs now search for cases of NT and other diseases in addition to cases of AFP when they visit health centers and hospitals. This active search identifies areas with NT cases and enables prioritizing areas for intervention through vaccination and education.

In certain countries of the Africa Region, AFP surveillance provides a functional infrastructure, trained personnel, and other resources used to implement Integrated Disease Surveillance and Response (IDSR), a strategy adopted in 1998 by the Regional Committee of the WHO Regional Office for the Africa Region to strengthen all infectious disease surveillance activities, especially at the district level. This strategy includes integration of surveillance activities with laboratory support so that surveillance and laboratory data can be used to take specific and timely public health actions. As of June 2004, a total of 42 (91%) of 46 countries had completed surveillance assessments, 35 (76%) had adopted IDSR technical guidelines, and 44 (96%) countries had participated in a proficiency testing program through the National Public Health Laboratory in South Africa (*7*).

Expansion of AFP surveillance systems has increased the responsibilities of SMOs in dozens of countries. In 2003, SMOs and polio/measles laboratory workers assisted in the detection and investigation of outbreaks of severe acute respiratory syndrome (SARS), cholera, dengue, Rift Valley fever, shigellosis, hemorrhagic fevers, meningitis, and malaria. SMOs conducted field and case investigations, collected samples, shipped them to laboratories, and organized outbreak response measures in coordination with local and regional health authorities. Laboratory workers processed the samples and reported the results locally and to regional networks as needed.

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Editorial Note: Adoption of the global polio eradication goal in 1988 required implementation of AFP surveillance in all countries and territories, including areas affected by conflict and other obstacles. As the AFP surveillance system matured, countries and regions began to use this system to conduct surveillance for other diseases. At present, two thirds of countries with AFP systems have adapted their systems for surveillance of measles and other vaccine-preventable diseases.

The 2003 outbreak of SARS, the threat of influenza pandemics, and the importance of early detection of and response to outbreaks of other infectious diseases highlight the need for a more comprehensive global disease detection system. The urgent need for such a system is underscored by ongoing efforts to restructure the International Health Regulations (IHR) (*8*) as a framework for containment of global public health risks.

In resource-poor countries and areas of conflict, the AFP surveillance system often is the only method for early detection of diseases that are prone to epidemics. External technical and funding support for AFP surveillance is provided by the international polio partnership[¶]. During 2003, of the more

[§] Consisting of WHO, UNICEF, the United Nations Foundation, the American Red Cross, the International Federation of Red Cross/Red Crescent Societies, the Canadian International Development Agency, and CDC.

[¶] Led by Rotary International, WHO, UNICEF, and CDC.

than $98 million provided for AFP surveillance by the partnership, $47 million was used for surveillance activity costs (e.g., operation of the laboratory network, transportation, communication, and meetings), and $51 million was used to pay approximately 2,700 international and national staff members who supported and conducted AFP surveillance and vaccination activities (Table).

To date, diseases that have been successfully monitored by systems modeled after AFP and measles surveillance systems share common traits: well-defined case of syndromic presentation, relative ease of specimen collection for laboratory confirmation, strong international commitment and funding for control/elimination, and continued focus on using surveillance data for targeted control activities. The most obvious way to maintain and expand existing AFP and measles reporting systems is to phase in reporting of other diseases that support integration of surveillance activities. However, polio eradication must not be jeopardized by overburdening the systems.

AFP and measles surveillance systems have the potential to serve as a foundation for a global network of public health laboratories that conducts surveillance for other infectious diseases. Expansion of these systems might encourage development of additional partnerships for global disease detection that will also help maintain the quality of future AFP and measles surveillance.

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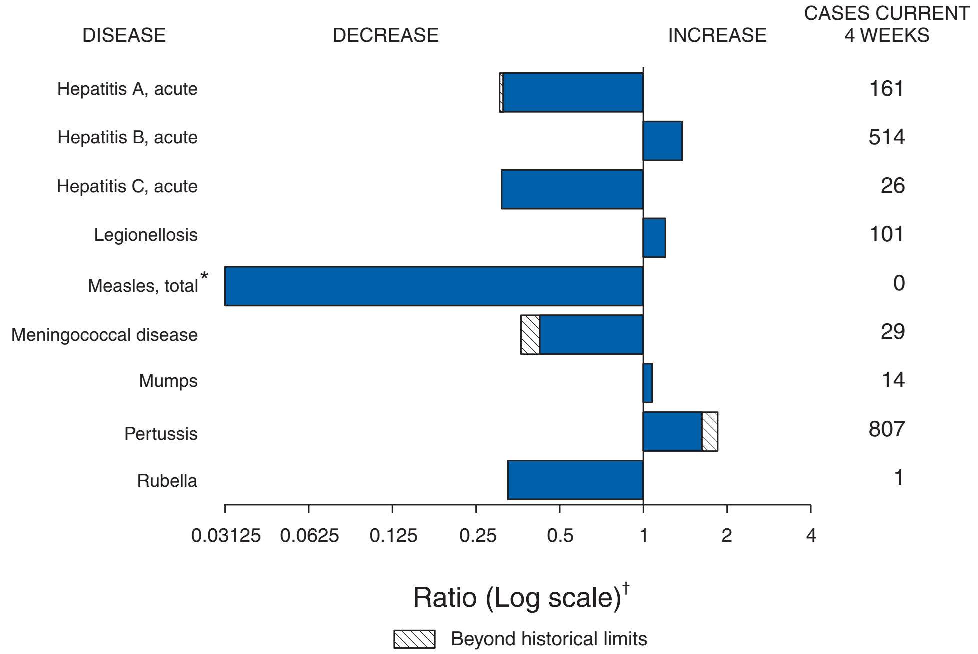
FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 27, 2004, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 47 of zero (0).
† 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 November 27, 2004 (47th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	HIV infection, pediatric†¶	140	185
Botulism:	-	-	Influenza-associated pediatric mortality**	-	NA
foodborne	12	12	Measles, total	24††	52§§
infant	67	67	Mumps	195	197
other (wound & unspecified)	9	27	Plague	1	1
Brucellosis†	104	92	Poliomyelitis, paralytic	-	-
Chancroid	34	52	Psittacosis†	9	12
Cholera	4	1	Q fever†	66	60
Cyclosporiasis†	206	66	Rabies, human	3	2
Diphtheria	-	1	Rubella	11	7
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	1
human granulocytic (HGE)†	309	295	SARS-associated coronavirus disease†**	-	8
human monocytic (HME)†	287	250	Smallpox†¶¶	-	NA
human, other and unspecified	32	45	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)†¶¶	-	NA
California serogroup viral†§	84	108	Vancomycin-resistant (VRSA)†¶¶	1	NA
eastern equine†§	4	13	Streptococcal toxic-shock syndrome†	91	142
Powassan†§	-	-	Tetanus	17	17
St. Louis†§	8	41	Toxic-shock syndrome	109	111
western equine†§	-	-	Trichinosis	5	4
Hansen disease (leprosy)†	74	73	Tularemia†	91	79
Hantavirus pulmonary syndrome†	19	21	Yellow fever	-	-
Hemolytic uremic syndrome, postdiarrheal†	130	157			

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 24, 2004.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 24 cases reported, 11 were indigenous, and 13 were imported from another country.
§§ Of 52 cases reported, 31 were indigenous, and 21 were imported from another country.
¶¶ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 27, 2004, and November 22, 2003 (47th 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	34,915	39,177	776,549	782,419	5,448	3,660	3,022	3,145	845	2,859
NEW ENGLAND	1,149	1,371	26,188	25,229	-	-	156	180	-	31
Maine	23	49	1,849	1,821	N	N	18	19	-	-
N.H.	41	36	1,522	1,431	-	-	30	22	-	2
Vt.	14	16	890	968	-	-	23	31	-	-
Mass.	435	598	11,882	10,060	-	-	54	75	-	12
R.I.	115	101	3,024	2,701	-	-	4	16	-	5
Conn.	521	571	7,021	8,248	N	N	27	17	-	12
MID. ATLANTIC	7,373	9,154	95,506	97,232	-	-	491	411	17	223
Upstate N.Y.	792	831	20,060	18,194	N	N	172	124	5	-
N.Y. City	4,086	5,089	29,309	31,464	-	-	101	114	2	57
N.J.	1,230	1,412	13,034	14,454	-	-	31	19	1	21
Pa.	1,265	1,822	33,103	33,120	N	N	187	154	9	145
E.N. CENTRAL	2,858	3,551	134,236	142,358	15	7	878	939	61	150
Ohio	561	718	32,017	38,789	N	N	211	155	11	84
Ind.	339	483	16,008	15,426	N	N	80	87	5	15
Ill.	1,279	1,597	38,080	43,515	-	-	87	95	28	30
Mich.	537	584	32,584	28,578	15	7	148	135	12	14
Wis.	142	169	15,547	16,050	-	-	352	467	5	7
W.N. CENTRAL	727	687	48,235	45,035	6	2	378	550	82	696
Minn.	193	140	8,795	9,620	N	N	125	145	13	48
Iowa	58	75	5,900	4,475	N	N	82	118	13	81
Mo.	307	320	18,809	16,575	3	1	66	48	26	39
N. Dak.	15	3	1,316	1,450	N	N	12	12	2	94
S. Dak.	8	10	2,237	2,319	-	-	37	39	6	151
Nebr.**	41	49	4,637	4,286	3	1	27	24	4	194
Kans.	105	90	6,541	6,310	N	N	29	164	18	89
S. ATLANTIC	11,003	10,791	151,066	147,336	-	5	480	351	56	191
Del.	137	199	2,658	2,720	N	N	-	4	-	12
Md.	1,292	1,437	17,060	15,044	-	5	21	25	7	49
D.C.	785	862	3,020	2,870	-	-	13	13	1	3
Va.	567	848	19,039	17,668	-	-	58	42	4	19
W. Va.	73	78	2,479	2,370	N	N	6	4	-	1
N.C.	1,031	990	24,943	23,668	N	N	75	45	3	16
S.C.**	641	738	17,693	13,074	-	-	15	8	-	3
Ga.	1,407	1,666	26,668	32,238	-	-	170	109	12	27
Fla.	5,070	3,973	37,506	37,684	N	N	122	101	29	61
E.S. CENTRAL	1,654	1,844	50,528	49,861	4	1	115	125	58	91
Ky.	215	198	5,333	7,292	N	N	43	24	1	11
Tenn.**	684	769	19,730	18,399	N	N	29	38	13	21
Ala.	388	442	9,882	12,997	-	-	20	53	13	25
Miss.	367	435	15,583	11,173	4	1	23	10	31	34
W.S. CENTRAL	4,027	4,431	93,424	96,658	2	-	69	111	189	604
Ark.	182	171	6,330	7,144	1	-	16	18	12	23
La.	812	521	20,017	18,351	1	-	3	4	68	96
Okla.	173	202	9,275	10,322	N	N	20	18	11	56
Tex.**	2,860	3,537	57,802	60,841	N	N	30	71	98	429
MOUNTAIN	1,294	1,370	43,943	44,005	3,548	2,187	154	125	232	871
Mont.	6	13	2,045	1,837	N	N	34	18	2	75
Idaho	16	24	2,555	2,211	N	N	27	26	-	-
Wyo.	15	6	976	871	2	1	3	5	2	92
Colo.	288	340	11,036	11,788	N	N	54	34	39	621
N. Mex.	169	98	5,139	6,686	20	9	12	11	30	74
Ariz.	496	576	14,279	12,061	3,434	2,134	17	6	128	7
Utah	55	60	3,145	3,365	35	9	5	17	6	-
Nev.	249	253	4,768	5,186	57	34	2	8	25	2
PACIFIC	4,830	5,978	133,423	134,705	1,873	1,458	301	353	150	2
Wash.	352	420	15,868	14,843	N	N	36	58	-	-
Oreg.	250	229	7,486	6,733	-	-	31	36	-	-
Calif.	4,061	5,214	102,328	104,807	1,873	1,458	232	258	150	2
Alaska	51	19	3,232	3,389	-	-	-	1	-	-
Hawaii	116	96	4,509	4,933	-	-	2	-	-	-
Guam	2	5	-	545	-	-	-	-	-	-
P.R.	617	940	3,131	2,406	N	N	N	N	-	-
V.I.	17	33	272	377	-	-	-	-	-	-
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 weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 31, 2004.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 27, 2004, and November 22, 2003 (47th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC) O157:H7 Cum. 2004	O157:H7 Cum. 2003	Shiga toxin positive, serogroup non-O157 Cum. 2004	Shiga toxin positive, serogroup non-O157 Cum. 2003	Shiga toxin positive, not serogrouped Cum. 2004	Shiga toxin positive, not serogrouped Cum. 2003	Giardiasis Cum. 2004	Giardiasis Cum. 2003	Gonorrhea Cum. 2004	Gonorrhea Cum. 2003
UNITED STATES	2,233	2,424	245	226	160	142	16,396	17,386	275,940	299,306
NEW ENGLAND	150	142	41	42	16	13	1,548	1,475	6,077	6,601
Maine	10	10	-	3	-	-	115	170	198	200
N.H.	21	18	5	3	-	-	44	38	112	114
Vt.	12	16	-	-	-	-	155	113	76	81
Mass.	65	63	10	8	16	13	681	765	2,794	2,641
R.I.	9	1	1	-	-	-	107	106	754	865
Conn.	33	34	25	28	-	-	446	283	2,143	2,700
MID. ATLANTIC	268	234	56	23	28	33	3,428	3,448	30,890	37,270
Upstate N.Y.	120	87	41	12	13	17	1,265	951	6,496	7,132
N.Y. City	35	7	-	-	-	-	864	1,099	9,402	12,306
N.J.	44	31	4	2	5	-	365	468	5,255	7,261
Pa.	69	109	11	9	10	16	934	930	9,737	10,571
E.N. CENTRAL	404	546	37	30	28	19	2,357	2,994	57,043	63,514
Ohio	94	127	9	16	20	19	727	830	16,557	20,520
Ind.	51	79	-	-	-	-	-	-	5,878	6,044
Ill.	64	120	2	2	1	-	475	862	16,868	19,580
Mich.	83	88	9	-	7	-	681	721	13,719	12,267
Wis.	112	132	17	12	-	-	474	581	4,021	5,103
W.N. CENTRAL	468	431	37	51	17	20	1,948	1,923	15,256	15,795
Minn.	111	128	18	21	1	1	752	735	2,640	2,764
Iowa	121	102	-	-	-	-	278	253	1,042	1,097
Mo.	84	79	13	17	7	1	496	480	8,081	7,880
N. Dak.	15	13	-	4	7	8	22	39	89	91
S. Dak.	31	28	2	4	-	-	58	73	253	198
Nebr.	67	48	4	5	-	-	146	135	940	1,444
Kans.	39	33	-	-	2	10	196	208	2,211	2,321
S. ATLANTIC	158	136	38	44	60	40	2,446	2,491	68,553	73,631
Del.	2	11	N	N	N	N	39	45	803	1,032
Md.	20	13	5	3	4	1	119	110	7,282	7,117
D.C.	1	1	-	-	-	-	60	47	2,268	2,271
Va.	35	36	17	13	-	-	482	327	7,546	8,198
W. Va.	2	5	-	-	-	-	40	40	814	775
N.C.	-	-	-	-	44	32	N	N	13,152	13,764
S.C.	7	2	-	-	-	-	52	128	8,628	7,684
Ga.	21	26	9	7	-	-	649	779	11,811	16,013
Fla.	70	42	7	21	12	7	1,005	1,015	16,249	16,777
E.S. CENTRAL	88	78	4	2	9	6	336	363	21,902	25,078
Ky.	25	25	2	2	6	6	N	N	2,388	3,268
Tenn.	31	33	2	-	3	-	157	168	7,467	7,663
Ala.	23	16	-	-	-	-	179	195	6,060	8,365
Miss.	9	4	-	-	-	-	-	-	5,987	5,782
W.S. CENTRAL	66	91	2	4	2	4	299	277	36,466	40,060
Ark.	14	12	1	-	-	-	116	139	3,174	3,829
La.	4	3	-	-	-	-	46	13	9,551	10,588
Okla.	17	28	-	-	-	-	137	125	3,948	4,237
Tex.	31	48	1	4	2	4	N	N	19,793	21,406
MOUNTAIN	235	303	29	26	-	7	1,395	1,468	9,521	9,452
Mont.	16	16	-	-	-	-	76	101	62	103
Idaho	50	78	16	15	-	-	181	187	88	65
Wyo.	9	4	5	1	-	-	22	21	58	39
Colo.	50	64	2	4	-	7	480	420	2,432	2,582
N. Mex.	9	13	2	5	-	-	62	49	736	1,056
Ariz.	25	37	N	N	N	N	165	225	3,482	3,332
Utah	49	68	3	-	-	-	301	333	485	356
Nev.	27	23	1	1	-	-	108	132	2,178	1,919
PACIFIC	396	463	1	4	-	-	2,639	2,947	30,232	27,905
Wash.	139	111	-	1	-	-	356	335	2,481	2,459
Oreg.	66	100	1	3	-	-	411	379	1,116	898
Calif.	180	239	-	-	-	-	1,718	2,069	25,093	22,920
Alaska	1	5	-	-	-	-	84	83	467	507
Hawaii	10	8	-	-	-	-	70	81	1,075	1,121
Guam	N	N	-	-	-	-	-	2	-	63
P.R.	1	2	-	-	-	-	119	314	226	249
V.I.	-	-	-	-	-	-	-	-	80	82
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 November 27, 2004, and November 22, 2003 (47th Week)*

Reporting area	*Haemophilus influenzae*, invasive — All ages, All serotypes Cum. 2004	Cum. 2003	Age <5 years — Serotype b Cum. 2004	Cum. 2003	Non-serotype b Cum. 2004	Cum. 2003	Unknown serotype Cum. 2004	Cum. 2003	Hepatitis (viral, acute), by type — A Cum. 2004	Cum. 2003
UNITED STATES	1,606	1,665	14	25	96	100	148	180	5,105	6,849
NEW ENGLAND	142	130	1	2	6	5	4	3	930	298
Maine	12	4	-	-	-	-	-	1	11	16
N.H.	18	12	-	1	2	-	1	-	26	17
Vt.	8	8	-	-	-	-	1	-	8	6
Mass.	53	61	1	1	-	5	2	1	799	168
R.I.	6	9	-	-	1	-	-	1	21	15
Conn.	45	36	-	-	3	-	-	-	65	76
MID. ATLANTIC	357	350	1	3	5	3	36	45	620	1,679
Upstate N.Y.	114	123	1	3	5	3	5	9	103	123
N.Y. City	73	62	-	-	-	-	14	11	240	420
N.J.	67	66	-	-	-	-	4	11	133	195
Pa.	103	99	-	-	-	-	13	14	144	941
E.N. CENTRAL	247	273	1	3	6	5	35	47	497	630
Ohio	95	64	1	-	2	-	15	11	47	155
Ind.	48	42	-	-	4	-	1	5	93	62
Ill.	50	100	-	-	-	-	11	21	171	174
Mich.	20	23	-	3	-	5	6	1	135	195
Wis.	34	44	-	-	-	-	2	9	51	44
W.N. CENTRAL	99	104	2	2	3	7	12	12	159	166
Minn.	43	45	1	2	3	7	1	2	32	44
Iowa	1	-	1	-	-	-	-	-	50	27
Mo.	35	37	-	-	-	-	7	9	40	56
N. Dak.	4	4	-	-	-	-	-	-	1	1
S. Dak.	-	1	-	-	-	-	-	-	3	-
Nebr.	9	2	-	-	-	-	2	-	10	12
Kans.	7	15	-	-	-	-	2	1	23	26
S. ATLANTIC	363	370	1	2	22	17	25	23	930	1,590
Del.	-	-	-	-	-	-	-	-	5	8
Md.	56	89	-	1	5	8	-	1	101	170
D.C.	-	1	-	-	-	-	-	-	7	43
Va.	35	52	-	-	-	-	1	6	122	93
W. Va.	15	15	-	-	1	-	3	-	6	14
N.C.	54	36	1	-	6	3	1	2	99	98
S.C.	4	6	-	-	-	-	-	2	24	35
Ga.	93	67	-	-	-	-	17	7	297	749
Fla.	106	104	-	1	10	6	3	5	269	380
E.S. CENTRAL	65	75	1	1	2	3	9	8	140	250
Ky.	11	6	-	-	2	2	1	-	29	31
Tenn.	38	46	-	-	-	1	6	5	80	181
Ala.	13	21	1	1	-	-	2	3	8	23
Miss.	3	2	-	-	-	-	-	-	23	15
W.S. CENTRAL	67	73	1	2	8	10	2	4	503	636
Ark.	3	6	-	-	-	1	1	-	56	32
La.	11	21	-	-	-	2	1	4	50	45
Okla.	52	43	-	-	8	7	-	-	20	21
Tex.	1	3	1	2	-	-	-	-	377	538
MOUNTAIN	175	156	4	6	25	23	18	16	417	427
Mont.	-	-	-	-	-	-	-	-	6	8
Idaho	5	4	-	-	-	-	2	1	21	17
Wyo.	1	2	-	-	1	-	-	-	5	1
Colo.	44	35	-	-	-	-	5	6	49	62
N. Mex.	35	17	1	-	7	4	5	1	20	21
Ariz.	61	76	-	6	12	10	2	4	255	234
Utah	16	12	2	-	2	5	3	4	48	35
Nev.	13	10	1	-	3	4	1	-	13	49
PACIFIC	91	134	2	4	19	27	7	22	909	1,173
Wash.	3	11	2	-	-	7	1	3	57	65
Oreg.	42	34	-	-	-	-	3	3	61	56
Calif.	34	57	-	4	19	20	1	10	761	1,031
Alaska	4	19	-	-	-	-	1	6	5	9
Hawaii	8	13	-	-	-	-	1	-	25	12
Guam	-	-	-	-	-	-	-	-	-	2
P.R.	-	1	-	-	-	-	-	1	24	75
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 November 27, 2004, and November 22, 2003 (47th Week)*

	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C							
Reporting area	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	5,960	6,381	759	975	1,692	1,956	586	603	16,179	18,777
NEW ENGLAND	337	328	13	8	55	112	40	47	2,514	3,678
Maine	2	1	-	-	-	2	7	7	53	152
N.H.	37	17	-	-	10	9	3	4	202	155
Vt.	5	4	8	8	6	6	2	1	47	43
Mass.	196	201	4	-	9	54	11	17	907	1,498
R.I.	5	18	-	-	15	15	1	-	197	564
Conn.	92	87	1	-	15	26	16	18	1,108	1,266
MID. ATLANTIC	1,136	688	134	120	491	567	138	122	10,822	12,401
Upstate N.Y.	82	86	15	15	105	139	44	33	3,674	4,113
N.Y. City	103	174	-	-	52	68	19	23	-	202
N.J.	679	170	-	-	92	85	23	22	3,018	2,792
Pa.	272	258	119	105	242	275	52	44	4,130	5,294
E.N. CENTRAL	501	473	110	134	450	412	91	81	808	895
Ohio	109	125	6	9	207	213	39	23	68	66
Ind.	39	34	9	8	72	27	16	8	18	21
Ill.	71	64	12	21	20	45	5	21	1	70
Mich.	250	206	83	91	136	109	26	19	34	9
Wis.	32	44	-	5	15	18	5	10	687	729
W.N. CENTRAL	289	305	49	232	55	64	20	16	566	399
Minn.	46	32	17	8	7	3	6	5	459	277
Iowa	14	13	-	1	6	9	3	-	44	49
Mo.	174	214	32	221	29	32	7	6	52	66
N. Dak.	4	2	-	-	2	1	-	-	-	-
S. Dak.	-	2	-	-	4	2	1	-	-	1
Nebr.	36	26	-	2	4	6	3	4	8	2
Kans.	15	16	-	-	3	11	-	1	3	4
S. ATLANTIC	1,710	1,831	147	137	357	493	104	121	1,272	1,141
Del.	28	11	-	-	12	26	N	N	137	201
Md.	151	122	16	9	71	128	16	24	737	672
D.C.	19	12	3	-	9	19	-	1	10	10
Va.	243	167	16	7	49	88	17	9	166	87
W. Va.	38	37	23	4	9	17	4	6	27	22
N.C.	171	148	11	11	37	36	24	16	112	95
S.C.	68	147	6	24	4	7	3	5	12	9
Ga.	532	614	15	13	36	34	14	30	13	10
Fla.	460	573	57	69	130	138	26	30	58	35
E.S. CENTRAL	387	426	87	82	86	96	21	29	46	60
Ky.	63	69	23	19	39	40	4	8	15	15
Tenn.	174	180	35	18	33	32	10	8	17	16
Ala.	64	90	5	6	11	19	5	11	3	8
Miss.	86	87	24	39	3	5	2	2	11	21
W.S. CENTRAL	546	1,050	115	150	56	72	27	49	31	90
Ark.	69	76	3	3	-	2	2	1	8	-
La.	59	110	67	98	4	1	3	4	4	6
Okla.	47	53	3	2	5	7	-	3	-	-
Tex.	371	811	42	47	47	62	22	41	19	84
MOUNTAIN	468	507	35	47	77	66	25	31	30	14
Mont.	2	16	2	2	2	4	-	2	-	-
Idaho	10	8	-	1	9	3	1	2	6	3
Wyo.	7	29	2	-	5	2	-	-	3	2
Colo.	56	74	-	12	19	12	12	9	-	-
N. Mex.	12	32	7	-	4	3	1	2	1	1
Ariz.	265	227	6	7	11	11	-	10	6	3
Utah	48	44	5	-	23	22	3	2	14	2
Nev.	68	77	13	25	4	9	8	4	-	3
PACIFIC	586	773	69	65	65	74	120	107	90	99
Wash.	48	68	21	18	10	10	9	7	13	3
Oreg.	99	104	14	14	N	N	6	5	32	15
Calif.	413	572	28	30	54	63	101	90	43	78
Alaska	15	5	-	-	1	-	-	-	2	3
Hawaii	11	24	6	3	-	1	4	5	N	N
Guam	-	9	-	5	-	1	-	-	-	-
P.R.	51	120	-	-	2	-	-	-	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 November 27, 2004, and November 22, 2003 (47th 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	1,157	1,207	1,136	1,475	15,206	8,749	5,055	6,339	1,358	858
NEW ENGLAND	68	59	64	69	1,515	1,537	623	558	19	8
Maine	6	2	9	6	4	12	41	64	-	-
N.H.	5	6	7	5	90	91	29	26	-	-
Vt.	4	2	3	3	71	61	35	30	1	-
Mass.	34	29	33	42	1,300	1,287	273	203	15	8
R.I.	4	2	2	2	38	20	35	64	1	-
Conn.	15	18	10	11	12	66	210	171	2	-
MID. ATLANTIC	305	332	139	179	2,540	1,096	529	854	91	40
Upstate N.Y.	48	54	33	45	1,728	546	488	395	4	-
N.Y. City	158	177	24	39	154	134	12	6	20	13
N.J.	55	60	31	25	215	159	-	62	33	16
Pa.	44	41	51	70	443	257	29	391	34	11
E.N. CENTRAL	98	101	160	232	4,669	1,028	153	163	25	21
Ohio	28	21	65	53	551	253	74	52	13	9
Ind.	17	4	24	40	232	60	10	27	6	1
Ill.	23	42	12	70	461	88	49	24	2	5
Mich.	20	23	45	42	277	115	16	46	4	6
Wis.	10	11	14	27	3,148	512	4	14	-	-
W.N. CENTRAL	63	45	82	117	1,851	428	458	606	124	62
Minn.	25	20	23	26	437	141	84	38	4	1
Iowa	4	6	17	25	189	143	101	99	1	2
Mo.	19	6	19	46	295	79	58	40	97	49
N. Dak.	3	1	2	1	717	7	57	54	-	-
S. Dak.	1	3	2	1	43	5	10	126	4	5
Nebr.	4	-	4	7	50	13	53	95	18	4
Kans.	7	9	15	11	120	40	95	154	-	1
S. ATLANTIC	309	295	196	246	609	630	1,781	2,481	694	504
Del.	6	2	3	8	8	9	9	58	4	1
Md.	71	67	10	26	117	81	292	330	70	105
D.C.	13	14	4	5	5	3	-	-	-	1
Va.	52	36	20	24	196	91	447	483	31	31
W. Va.	2	4	5	6	18	19	59	81	5	5
N.C.	19	21	28	32	79	118	549	742	484	252
S.C.	9	4	11	21	45	179	125	223	17	33
Ga.	50	63	15	29	19	29	298	376	63	64
Fla.	87	84	100	95	122	101	2	188	20	12
E.S. CENTRAL	28	27	59	82	255	145	132	203	172	123
Ky.	4	8	11	18	67	45	22	37	2	3
Tenn.	7	5	15	25	135	68	36	100	88	66
Ala.	12	7	16	20	38	18	63	62	47	21
Miss.	5	7	17	19	15	14	11	4	35	33
W.S. CENTRAL	92	121	105	166	710	701	999	1,080	203	90
Ark.	7	4	16	14	69	44	47	25	125	33
La.	5	4	34	38	11	10	-	5	5	1
Okla.	7	4	10	17	33	85	99	185	71	42
Tex.	73	109	45	97	597	562	853	865	2	14
MOUNTAIN	46	40	59	84	1,497	944	209	173	25	9
Mont.	-	-	3	5	52	5	25	20	3	1
Idaho	1	1	7	7	37	74	8	15	4	2
Wyo.	-	1	3	2	30	124	6	6	5	2
Colo.	15	21	15	22	835	337	43	38	1	2
N. Mex.	4	3	7	10	130	68	5	5	2	1
Ariz.	13	7	12	29	204	181	109	70	2	-
Utah	8	5	5	1	170	120	10	14	8	1
Nev.	5	2	7	8	39	35	3	5	-	-
PACIFIC	148	187	272	300	1,560	2,240	171	221	5	1
Wash.	17	25	30	31	686	699	-	-	-	-
Oreg.	16	9	54	52	400	420	6	6	3	-
Calif.	110	146	178	198	441	1,044	157	206	2	1
Alaska	2	1	3	7	11	66	8	9	-	-
Hawaii	3	6	7	12	22	11	-	-	-	-
Guam	-	1	-	-	-	1	-	-	-	-
P.R.	-	2	8	11	6	4	56	66	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 November 27, 2004, and November 22, 2003 (47th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive: Drug resistant, all ages		*Streptococcus pneumoniae*, invasive: 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	35,992	39,321	10,747	21,168	4,030	5,151	1,854	1,795	637	638
NEW ENGLAND	1,840	1,944	265	315	162	426	60	94	60	9
Maine	80	126	5	6	8	27	2	-	3	-
N.H.	129	131	8	8	18	29	-	-	N	N
Vt.	57	66	3	7	8	19	8	6	3	5
Mass.	1,052	1,133	166	211	107	187	31	N	47	N
R.I.	108	122	18	19	21	15	19	10	7	4
Conn.	414	366	65	64	-	149	-	78	U	U
MID. ATLANTIC	5,012	4,515	1,048	2,195	649	874	124	120	109	89
Upstate N.Y.	1,153	1,066	395	514	212	331	51	65	78	67
N.Y. City	1,101	1,236	344	388	92	136	U	U	U	U
N.J.	872	773	213	334	145	161	-	-	6	2
Pa.	1,886	1,440	96	959	200	246	73	55	25	20
E.N. CENTRAL	4,419	5,186	999	1,698	787	1,193	440	394	158	281
Ohio	1,126	1,250	155	277	209	277	306	253	73	90
Ind.	532	509	189	155	93	111	134	141	39	27
Ill.	1,221	1,818	298	916	161	311	-	-	7	113
Mich.	796	730	200	229	275	338	N	N	N	N
Wis.	744	879	157	121	49	156	N	N	39	51
W.N. CENTRAL	2,210	2,286	396	737	279	307	18	18	98	68
Minn.	570	515	63	96	138	145	-	-	65	47
Iowa	408	358	62	81	N	N	N	N	N	N
Mo.	564	835	152	342	57	71	13	14	13	3
N. Dak.	41	36	3	9	12	16	-	3	4	7
S. Dak.	112	112	10	16	17	22	5	1	-	-
Nebr.	172	158	33	86	14	25	-	-	6	5
Kans.	343	272	73	107	41	28	N	N	10	6
S. ATLANTIC	10,090	10,007	2,420	6,224	776	840	902	957	53	18
Del.	81	96	6	161	3	6	4	1	N	N
Md.	758	782	139	542	153	204	-	25	39	-
D.C.	58	43	37	72	10	9	6	-	3	7
Va.	1,111	987	151	406	68	94	N	N	N	N
W. Va.	219	119	9	-	23	33	99	67	11	11
N.C.	1,527	1,228	341	923	118	100	N	N	U	U
S.C.	774	745	278	469	37	38	69	131	N	N
Ga.	1,705	1,894	577	1,105	156	165	207	214	N	N
Fla.	3,857	4,113	882	2,546	208	191	517	519	N	N
E.S. CENTRAL	2,355	2,725	736	940	189	185	123	130	5	-
Ky.	321	363	71	122	57	44	29	17	N	N
Tenn.	523	702	327	339	132	141	93	113	N	N
Ala.	684	710	291	311	-	-	-	-	N	N
Miss.	827	950	47	168	-	-	1	-	5	-
W.S. CENTRAL	3,036	5,668	2,428	5,442	228	257	58	70	113	108
Ark.	532	761	74	100	16	6	10	20	8	7
La.	723	817	252	429	2	1	48	50	25	21
Okla.	367	438	432	785	60	81	N	N	43	52
Tex.	1,414	3,652	1,670	4,128	150	169	N	N	37	28
MOUNTAIN	2,213	2,076	769	1,154	465	483	36	8	39	65
Mont.	179	105	4	2	-	1	-	-	-	-
Idaho	145	168	13	29	9	18	N	N	N	N
Wyo.	49	73	5	8	8	2	10	7	-	-
Colo.	505	455	146	300	126	126	-	-	36	49
N. Mex.	247	269	114	244	70	109	5	-	-	11
Ariz.	702	635	389	463	210	193	N	N	N	N
Utah	232	204	47	46	39	32	19	1	3	5
Nev.	154	167	51	62	3	2	2	-	-	-
PACIFIC	4,817	4,914	1,686	2,463	495	586	93	4	2	-
Wash.	525	522	101	151	53	74	-	-	N	N
Oreg.	377	395	69	206	N	N	N	N	N	N
Calif.	3,526	3,699	1,466	2,051	329	385	N	N	N	N
Alaska	55	90	6	11	-	-	-	-	N	N
Hawaii	334	208	44	44	113	127	93	4	2	-
Guam	-	43	-	34	-	-	-	-	-	-
P.R.	272	657	8	27	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.

* 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 November 27, 2004, and November 22, 2003 (47th Week)*

Reporting area	Syphilis: Primary & secondary Cum. 2004	Syphilis: Primary & secondary Cum. 2003	Syphilis: Congenital Cum. 2004	Syphilis: Congenital Cum. 2003	Tuberculosis Cum. 2004	Tuberculosis Cum. 2003	Typhoid fever Cum. 2004	Typhoid fever Cum. 2003	Varicella (Chickenpox) Cum. 2004	Varicella (Chickenpox) Cum. 2003
UNITED STATES	6,614	6,377	295	396	9,682	11,232	256	330	15,949	15,336
NEW ENGLAND	164	192	5	1	339	376	20	27	607	2,996
Maine	2	8	-	-	-	19	-	-	180	774
N.H.	4	17	3	-	14	13	-	3	-	-
Vt.	-	1	-	-	-	9	-	-	427	721
Mass.	105	121	-	-	221	198	14	15	-	147
R.I.	22	20	1	-	30	43	1	2	-	5
Conn.	31	25	1	1	74	94	5	7	-	1,349
MID. ATLANTIC	865	797	38	59	1,824	2,005	58	75	80	38
Upstate N.Y.	86	40	4	9	251	265	8	12	-	-
N.Y. City	540	455	14	31	901	1,027	20	35	-	-
N.J.	128	162	19	19	382	399	15	21	-	-
Pa.	111	140	1	-	290	314	15	7	80	38
E.N. CENTRAL	778	816	55	71	1,053	1,058	17	32	5,404	5,345
Ohio	208	184	1	3	178	181	5	2	1,260	1,105
Ind.	50	43	9	14	113	118	-	4	61	-
Ill.	328	344	14	20	473	506	-	16	1	-
Mich.	163	229	31	33	208	193	10	10	3,690	3,361
Wis.	29	16	-	1	81	60	2	-	392	879
W.N. CENTRAL	134	137	5	5	396	426	9	6	130	74
Minn.	15	41	1	-	159	175	5	2	-	-
Iowa	5	8	-	-	33	30	-	2	N	N
Mo.	85	56	2	4	102	104	2	1	5	-
N. Dak.	-	2	-	-	4	4	-	-	82	74
S. Dak.	-	2	-	-	8	16	-	-	43	-
Nebr.	6	5	-	1	32	24	2	1	-	-
Kans.	23	23	2	-	58	73	-	-	-	-
S. ATLANTIC	1,732	1,672	46	77	2,068	2,283	44	51	1,965	1,998
Del.	8	6	1	-	-	23	-	-	4	29
Md.	316	281	7	12	220	220	11	9	-	1
D.C.	85	46	1	-	69	-	-	-	23	27
Va.	92	74	3	1	229	235	10	14	487	483
W. Va.	2	2	-	-	19	20	-	-	1,197	1,224
N.C.	170	140	10	16	274	285	8	9	N	N
S.C.	101	91	7	14	163	145	-	-	254	234
Ga.	304	449	1	13	326	470	5	6	-	-
Fla.	654	583	16	21	768	885	10	13	-	-
E.S. CENTRAL	354	292	19	12	484	625	7	6	-	-
Ky.	44	31	1	1	103	112	3	1	-	-
Tenn.	116	122	8	2	195	208	4	2	-	-
Ala.	147	106	8	7	153	205	-	3	-	-
Miss.	47	33	2	2	33	100	-	-	-	-
W.S. CENTRAL	1,063	851	48	72	1,006	1,636	19	30	5,413	4,308
Ark.	38	45	-	2	102	86	-	-	-	-
La.	252	159	-	1	-	-	-	-	49	16
Okla.	24	58	2	1	138	133	1	1	-	-
Tex.	749	589	46	68	766	1,417	18	29	5,364	4,292
MOUNTAIN	327	291	48	32	438	410	7	6	2,350	577
Mont.	-	-	-	-	4	5	-	-	-	-
Idaho	22	11	2	2	4	8	-	1	-	-
Wyo.	3	-	-	-	4	4	-	-	53	46
Colo.	38	34	-	3	95	97	2	3	1,790	-
N. Mex.	54	59	1	9	18	43	-	-	95	3
Ariz.	169	165	45	18	197	196	2	2	-	-
Utah	7	11	-	-	36	35	1	-	412	528
Nev.	34	11	-	-	80	22	2	-	-	-
PACIFIC	1,197	1,329	31	67	2,074	2,413	75	97	-	-
Wash.	127	74	-	-	203	219	6	3	-	-
Oreg.	25	42	-	-	74	98	2	4	-	-
Calif.	1,037	1,203	30	65	1,665	1,943	61	89	-	-
Alaska	1	1	-	-	35	52	-	-	-	-
Hawaii	7	9	1	2	97	101	6	1	-	-
Guam	-	1	-	-	-	48	-	-	-	143
P.R.	151	184	5	14	84	100	-	-	265	556
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 November 27, 2004 (47th Week)

Reporting Area	All causes, by age (years)						
	All Ages	≥65	45–64	25–44	1–24	<1	P&I[†] Total
NEW ENGLAND	213	153	42	11	5	2	21
Boston, Mass.	U	U	U	U	U	U	U
Bridgeport, Conn.	29	23	2	3	1	-	7
Cambridge, Mass.	11	6	4	-	1	-	1
Fall River, Mass.	17	15	2	-	-	-	1
Hartford, Conn.	48	34	10	1	2	1	4
Lowell, Mass.	11	8	3	-	-	-	2
Lynn, Mass.	14	12	1	1	-	-	1
New Bedford, Mass.	U	U	U	U	U	U	U
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	9	6	3	-	-	-	-
Springfield, Mass.	27	20	5	2	-	-	1
Waterbury, Conn.	U	U	U	U	U	U	U
Worcester, Mass.	47	29	12	4	1	1	4
MID. ATLANTIC	1,495	1,046	329	74	20	25	91
Albany, N.Y.	37	26	7	1	1	2	4
Allentown, Pa.	14	9	5	-	-	-	1
Buffalo, N.Y.	73	50	18	2	1	2	14
Camden, N.J.	U	U	U	U	U	U	U
Elizabeth, N.J.	U	U	U	U	U	U	U
Erie, Pa.	32	24	8	-	-	-	2
Jersey City, N.J.	19	6	10	3	-	-	-
New York City, N.Y.	863	597	197	46	13	9	42
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	221	153	44	10	2	12	7
Pittsburgh, Pa.[§]	16	9	4	3	-	-	1
Reading, Pa.	U	U	U	U	U	U	U
Rochester, N.Y.	96	84	9	3	-	-	11
Schenectady, N.Y.	U	U	U	U	U	U	U
Scranton, Pa.	26	19	6	1	-	-	1
Syracuse, N.Y.	80	60	15	4	1	-	8
Trenton, N.J.	18	9	6	1	2	-	-
Utica, N.Y.	U	U	U	U	U	U	U
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	764	560	131	49	14	10	47
Akron, Ohio	U	U	U	U	U	U	U
Canton, Ohio	40	29	9	2	-	-	1
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	72	49	11	8	2	2	2
Cleveland, Ohio	U	U	U	U	U	U	U
Columbus, Ohio	153	99	29	17	4	4	6
Dayton, Ohio	86	72	9	5	-	-	6
Detroit, Mich.	U	U	U	U	U	U	U
Evansville, Ind.	26	20	4	-	-	2	3
Fort Wayne, Ind.	70	57	8	2	2	1	3
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	31	21	6	3	1	-	5
Indianapolis, Ind.	U	U	U	U	U	U	U
Lansing, Mich.	39	33	5	1	-	-	2
Milwaukee, Wis.	64	46	16	2	-	-	5
Peoria, Ill.	30	24	5	-	-	1	1
Rockford, Ill.	35	26	8	1	-	-	3
South Bend, Ind.	U	U	U	U	U	U	U
Toledo, Ohio	68	44	12	7	5	-	2
Youngstown, Ohio	50	40	9	1	-	-	8
W.N. CENTRAL	419	289	83	26	8	10	24
Des Moines, Iowa	91	69	15	4	2	1	6
Duluth, Minn.	24	18	5	1	-	-	6
Kansas City, Kans.	U	U	U	U	U	U	U
Kansas City, Mo.	69	46	12	5	3	3	1
Lincoln, Nebr.	26	23	3	-	-	-	1
Minneapolis, Minn.	28	20	4	3	-	1	3
Omaha, Nebr.	51	37	6	5	1	2	4
St. Louis, Mo.	90	48	28	8	1	2	2
St. Paul, Minn.	40	28	10	-	1	1	1
Wichita, Kans.	U	U	U	U	U	U	U

Reporting Area	All causes, by age (years)						
	All Ages	≥65	45–64	25–44	1–24	<1	P&I[†] Total
S. ATLANTIC	540	325	142	40	20	12	24
Atlanta, Ga.	125	75	28	10	7	5	7
Baltimore, Md.	164	94	48	15	3	3	9
Charlotte, N.C.	U	U	U	U	U	U	U
Jacksonville, Fla.	U	U	U	U	U	U	U
Miami, Fla.	U	U	U	U	U	U	U
Norfolk, Va.	28	20	6	1	1	-	2
Richmond, Va.	37	18	14	3	1	1	4
Savannah, Ga.	26	14	7	3	1	1	-
St. Petersburg, Fla.	35	15	13	2	4	1	-
Tampa, Fla.	116	82	24	6	3	1	2
Washington, D.C.	U	U	U	U	U	U	U
Wilmington, Del.	9	7	2	-	-	-	-
E.S. CENTRAL	358	219	92	21	13	13	29
Birmingham, Ala.	110	63	32	4	2	9	9
Chattanooga, Tenn.	61	44	12	4	1	-	6
Knoxville, Tenn.	U	U	U	U	U	U	U
Lexington, Ky.	47	30	10	4	3	-	5
Memphis, Tenn.	U	U	U	U	U	U	U
Mobile, Ala.	31	20	6	3	2	-	1
Montgomery, Ala.	20	9	8	-	1	2	1
Nashville, Tenn.	89	53	24	6	4	2	7
W.S. CENTRAL	820	512	196	62	21	29	49
Austin, Tex.	43	33	7	2	-	1	3
Baton Rouge, La.	U	U	U	U	U	U	U
Corpus Christi, Tex.	26	17	8	-	-	1	1
Dallas, Tex.	128	71	31	17	5	4	6
El Paso, Tex.	U	U	U	U	U	U	U
Ft. Worth, Tex.	83	55	20	3	1	4	1
Houston, Tex.	237	138	48	24	10	17	20
Little Rock, Ark.	35	20	15	-	-	-	2
New Orleans, La.	46	29	14	3	-	-	-
San Antonio, Tex.	111	68	30	7	4	2	6
Shreveport, La.	29	19	8	2	-	-	2
Tulsa, Okla.	82	62	15	4	1	-	8
MOUNTAIN	962	642	223	65	17	15	61
Albuquerque, N.M.	81	46	22	10	1	2	7
Boise, Idaho	37	26	9	1	-	1	1
Colo. Springs, Colo.	35	20	10	1	1	3	-
Denver, Colo.	90	59	19	5	2	5	8
Las Vegas, Nev.	232	147	59	20	6	-	12
Ogden, Utah	26	19	4	2	1	-	6
Phoenix, Ariz.	248	186	48	10	1	3	14
Pueblo, Colo.	29	19	6	4	-	-	2
Salt Lake City, Utah	75	47	19	7	2	-	3
Tucson, Ariz.	109	73	27	5	3	1	8
PACIFIC	650	442	145	42	12	8	47
Berkeley, Calif.	10	7	3	-	-	-	3
Fresno, Calif.	90	59	22	6	3	-	5
Glendale, Calif.	4	3	1	-	-	-	-
Honolulu, Hawaii	55	41	9	3	2	-	1
Long Beach, Calif.	54	39	12	2	1	-	8
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	118	75	29	9	4	-	5
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	102	63	21	11	1	6	5
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	10	8	2	-	-	-	1
Seattle, Wash.	88	58	23	6	1	-	9
Spokane, Wash.	47	33	11	2	-	1	3
Tacoma, Wash.	72	56	12	3	-	1	7
TOTAL	6,221[¶]	4,188	1,383	390	130	124	393

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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