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National HIV Testing Day — June 27, 2011

June 27 is National HIV Testing Day, which promotes testing as an important strategy to prevent and treat human immunodeficiency virus (HIV) infection. Persons who learn that they have HIV can receive appropriate treatment, monitoring, and health care, and in doing so, delay disease progression, extend their lives, and reduce the chance that they will transmit the virus to others. To increase HIV testing, improve awareness of HIV status, and enable earlier diagnosis of HIV infection, CDC recommends that all persons aged 13–64 years be screened for HIV in health-care settings with prevalence of undiagnosed HIV infection ≥0.1% (*1*). CDC also recommends that persons with increased risk for HIV be retested at least annually.

At the end of 2008, approximately 20% of the estimated 1.2 million persons living with HIV were undiagnosed and unaware of their infection (*2*). In 2008, an estimated 33% of all HIV diagnoses were late diagnoses, often made after persons had already developed acquired immunodeficiency syndrome (AIDS) (*3*). Also, a recent study of men who have sex with men found a 6.9% prevalence of new infections among those who had tested negative during the preceding year (*4*). These findings indicate the continuing importance of getting tested for HIV, and for persons at higher risk for HIV, getting retested at least annually.

Information about HIV testing is available at http://www.cdc.gov/features/hivtesting and http://www.hivtest.org.

References

1. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55 (No. RR-14).
2. CDC. HIV surveillance—United States, 1981–2008. MMWR 2011; 60:689–93.
3. CDC. HIV/AIDS surveillance report, 2009. Vol. 21. Atlanta, GA: US Department of Health and Human Services, CDC; 2011.
4. CDC. HIV testing among men who have sex with men—21 cities, United States, 2008. MMWR 2011;60:694–9.

Results of the Expanded HIV Testing Initiative — 25 Jurisdictions, United States, 2007–2010

Approximately 20% of the estimated 1.2 million persons living with human immunodeficiency virus (HIV) infection in the United States at the end of 2008 were not aware of their infection (*1*). Testing, diagnosis, medical care, treatment with highly active antiretroviral therapy (HAART), and access to prevention services soon after HIV infection can prevent morbidity and mortality and reduce a person's risk for transmitting HIV (*2–6*). In 2006, CDC recommended screening patients aged 13–64 years for HIV infection in health-care settings that have a prevalence of undiagnosed HIV infection of ≥0.1% (*7*). In October 2007, CDC initiated the Expanded HIV Testing Initiative (ETI), through which it funded 25 health departments to facilitate HIV screening and increase diagnoses of HIV infections and linkage to care among populations disproportionately affected by HIV, especially non-Hispanic blacks. This report describes the results of that effort. Annual progress reports designed to provide data specific to ETI indicated that 2,786,739 HIV tests were conducted, of which 29,503 (1.1%) were positive and 18,432 (0.7%) resulted in new HIV diagnoses. Blacks accounted for 1,411,780 (60%) of tests and 11,638 (70%) of new HIV diagnoses. Clinical settings comprised at least 75% of the 1,331 testing venues and accounted for 90% of all tests and 81% of all new HIV diagnoses. Based on follow-up data available for 16,885 persons with new HIV diagnoses, 12,711 (75.3%) were linked successfully to HIV primary care. Through expanded HIV testing activities, substantial numbers of persons previously

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unaware of their HIV infection were identified and linked to care. Health departments should continue to partner with clinical-care providers to provide routine HIV screening, especially in populations disproportionately affected by HIV.

In October 2007, CDC launched ETI to supplement existing HIV testing efforts and improve the availability and accessibility of HIV testing services, facilitate adoption of HIV screening in health-care settings, and increase identification of undiagnosed HIV infection in populations disproportionately affected by HIV, particularly blacks. During the 3-year program period, CDC provided an additional $111 million to health departments in 25 U.S. jurisdictions* that had reported 140 or more AIDS diagnoses among blacks in 2005. Health departments were required to focus at least 80% of their activities on promoting opt-out HIV screening in high-morbidity clinical settings; they had the option of directing up to 20% of their efforts toward supporting innovative methods to increase targeted HIV testing among high-risk populations (e.g., social networking approaches to increase testing among men who have sex with men). In addition, health departments had to ensure that all persons newly diagnosed with HIV† through ETI received their HIV tests results, were linked to medical care,§ and were referred for partner services. Semiannually, health departments used progress report forms developed by CDC to report ETI-specific activities and outcomes, including the number of HIV tests and the venues in which tests were conducted, basic demographic information about test recipients, the number of confirmed new and previously diagnosed HIV infections identified, and the proportions of persons with new HIV diagnoses successfully linked to medical care and referred to partner services.

During October 2007–September 2010, a total of 2,786,739 HIV tests were conducted, of which 29,503 (1.1%) were positive for HIV infection. Among persons who were HIV-infected, 18,432 (62%) were unaware of their infection. Among 17,247 persons with new HIV diagnoses for whom some follow-up data were available, 15,737 (91%) received their test results, 12,711 (75%) were linked to care, and 14,234 (83%) were referred to partner services (Table 1). Compared with nonclinical settings, more persons who were tested in clinical settings received their test results (93% versus 84%) and were linked to care (78% versus 63%).

* Among the 25 jurisdictions, 23 (California; Los Angeles County, California; Chicago, Illinois; Connecticut; Florida; Maryland; Georgia; Louisiana; Massachusetts; Michigan; Missouri; New Jersey; New York; New York City, New York; North Carolina; Ohio; Pennsylvania; Philadelphia, Pennsylvania; South Carolina; Tennessee; Houston, Texas; Virginia; and District of Columbia) were funded for the full 3 years of the initiative. An additional two jurisdictions (Texas and Mississippi) received 2 years of funding, beginning in year 2 of the initiative.

† Persons were defined as being newly diagnosed with HIV based on the absence of evidence to the contrary. Operationally, this means that 1) during the testing encounter, the person indicated that he or she had not previously received a diagnosis of HIV infection and 2) the health department had no record of a previous diagnosis in its HIV surveillance system.

§ In the context of ETI, "linked to medical care" was defined as having attended a first appointment at an HIV care clinic.

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TABLE 1. Number and percentage of human immunodeficiency virus (HIV) tests conducted, new positive test results identified, and selected outcomes, by setting — 25 jurisdictions,* United States, October 2007–September 2010

		New positive test results		Received test results (n = 17,247)†		Linked to medical care (n = 16,885)†		Referred to partner services (n = 17,149)†	
Setting	HIV tests	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Clinical	2,519,917	15,478	(0.6)	13,484	(93)	10,861	(78)	12,031	(83)
Nonclinical	266,822	2,954	(1.1)	2,253	(84)	1,850	(63)	2,203	(82)
Total	**2,786,739**	**18,432**	**(0.7)**	**15,737**	**(91)**	**12,711**	**(75)**	**14,234**	**(83)**

* California; Los Angeles County, California; Chicago, Illinois; Connecticut; Florida; Maryland; Georgia; Louisiana; Massachusetts; Michigan; Mississippi; Missouri; New Jersey; New York; New York City, New York; North Carolina; Ohio; Pennsylvania; Philadelphia, Pennsylvania; South Carolina; Tennessee; Texas; Houston, Texas; Virginia; and District of Columbia.
† Does not equal total because of missing data.

Men accounted for 55% of all tests and 72% of new HIV diagnoses; their test positivity rate was more than twice that among women (0.9% versus 0.4%) (Table 2). Non-Hispanic blacks, compared with non-Hispanic whites and Hispanics, accounted for approximately three times as many tests (60% versus 18% and 16% respectively) and approximately five times as many new HIV diagnoses (70% versus 14% and 12%, respectively). Similarly, the test positivity rate among blacks (0.8%) was 1.6 times that among whites (0.5%) and Hispanics (0.5%).

By the third year of the program, 1,331 venues were funded by health departments through ETI to conduct HIV testing. In total, 90% of tests were conducted in clinical settings, and 10% in nonclinical settings. Emergency departments (EDs), which accounted for 8% of the testing venues, performed 30% of all tests and identified 32% of all new HIV diagnoses (Table 3). Sexually transmitted disease (STD) clinics accounted for 21% of testing venues, 21% of all tests, and 20% of new HIV diagnoses. Substance abuse clinics, although accounting for 6% of all testing venues, accounted for 0.9% of tests and new HIV diagnoses. Community-based organizations (CBOs), which performed targeted testing based on risk and accounted for the majority of tests performed in nonclinical settings, accounted for a larger share of new diagnoses (11%) than tests performed (6%) or testing venues (7%). CBOs also produced the highest test positivity rate for new HIV diagnoses (1.2%), but the largest numbers of new diagnoses came from clinical settings, where lower test positivity rates (e.g., 0.8% for EDs and 0.6% for STD clinics) were offset by the larger numbers of persons screened.

Reported by

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Editorial Note

Historically, HIV testing often has been targeted based on individual risk factors. However, the demographic evolution of the U.S. HIV epidemic over the course of 30 years has gradually diminished the effectiveness of using risk-based testing to identify many HIV-infected persons who are unaware of their infections. CDC has responded to the shifting contours of the epidemic by recommending routine HIV screening for persons aged 13–64 years, and the data in this report indicate that screening according to CDC's recommendations identifies a substantial number of persons infected with HIV. During the 3-year course of ETI, 18,432 persons were newly diagnosed with HIV through ETI, and the majority of these new diagnoses came from clinical settings. In general, the number of tests conducted and new HIV infections identified in a particular venue type were strongly aligned, and the yield of new HIV diagnoses exceeded CDC's recommended screening threshold (0.1% undiagnosed prevalence) in every clinical venue in which expanded screening was implemented.

CDC encouraged participating health departments to use locally available epidemiologic data to identify and solicit participation from clinical venues that served high-prevalence communities or substantial numbers of persons from populations disproportionately affected by HIV, particularly blacks. By directing support for screening programs to sites where the yield of new diagnoses likely would represent a good return on investment, health departments were able to maximize the public health value of CDC funds. This is consistent with the venue-based perspective taken in CDC's 2006 HIV screening recommendations, which indicate that routine screening is not warranted in settings where the prevalence of undiagnosed HIV infection is found to be <0.1% (*7*).

The continued success of HIV screening efforts in healthcare settings requires the development, implementation, and maintenance of sustainable practices, including integrated staffing models, absorption of screening into an organization's clinical flow, and supportive reimbursement policies and rates that value HIV screening in a manner similar to

TABLE 2. Number and percentage of human immunodeficiency virus (HIV) tests conducted and new positive test results identified, by sex and race/ethnicity — 25 jurisdictions,* United States, October 2007–September 2010

Characteristic	HIV tests		New positive test results		
	No.	(%)	No.	(%)	Rate
Sex					
Male	1,324,353	(54.7)	12,179	(72.0)	0.9
Female	1,089,486	(45.0)	4,528	(26.8)	0.4
Transgender	3,621	(0.1)	88	(0.5)	2.4
Unknown	3,796	(0.2)	114	(0.7)	3.0
Race/Ethnicity					
Hispanic	386,319	(16.4)	1,936	(11.6)	0.5
American Indian/Alaska Native, non-Hispanic	9,686	(0.4)	43	(0.3)	0.4
Asian, non-Hispanic	28,763	(1.2)	87	(0.5)	0.3
Black, non-Hispanic	1,411,780	(59.9)	11,638	(69.7)	0.8
Native Hawaiian/Pacific Islander, non-Hispanic	4,229	(0.2)	87	(0.5)	2.1
White, non-Hispanic	432,414	(18.3)	2,281	(13.7)	0.5
Multiple race	16,329	(0.7)	134	(0.8)	0.8
Unknown	68,290	(2.9)	496	(3.0)	0.7
Total†	**2,786,739**	—	**18,432**	—	**0.7**

* California; Los Angeles County, California; Chicago, Illinois; Connecticut; Florida; Maryland; Georgia; Louisiana; Massachusetts; Michigan; Mississippi; Missouri; New Jersey; New York; New York City, New York; North Carolina; Ohio; Pennsylvania; Philadelphia, Pennsylvania; South Carolina; Tennessee; Texas; Houston, Texas; Virginia; and District of Columbia.
† Categories do not sum to total because of missing data.

TABLE 3. Number and percentage of human immunodeficiency virus (HIV) tests conducted and new positive test results identified, by type of venue — 25 jurisdictions,* United States, October 2007–September 2010

Type of venue	Venues†		HIV tests		New positive test results		
	No.	(%)	No.	(%)	No.	(%)	Rate
Emergency departments	108	(8.1)	766,393	(29.9)	5,408	(32.3)	0.7
Inpatient medical units	26	(2.0)	37,709	(1.5)	118	(0.7)	0.3
Urgent-care clinics	5	(0.4)	9,662	(0.4)	82	(0.5)	0.8
STD clinics	281	(21.1)	524,593	(20.5)	3,302	(19.7)	0.6
Correctional health facilities	183	(13.7)	383,620	(15.0)	2,312	(13.8)	0.6
Substance abuse treatment centers	76	(5.7)	23,912	(0.9)	146	(0.9)	0.6
TB clinics	49	(3.7)	17,143	(0.7)	60	(0.4)	0.3
Community health centers	270	(20.3)	431,278	(16.8)	2,061	(12.3)	0.5
Community-based organizations	98	(7.4)	162,785	(6.4)	1,880	(11.2)	1.2
Other§	235	(17.7)	205,029	(8.0)	1,365	(8.2)	0.7
Total¶	**1,331**	**(100.0)**	**2,786,739**	—	**18,432**	—	**0.7**

Abbreviations: STD = sexually transmitted disease; TB = tuberculosis.
* California; Los Angeles County, California; Chicago, Illinois; Connecticut; Florida; Maryland; Georgia; Louisiana; Massachusetts; Michigan; Mississippi; Missouri; New Jersey; New York; New York City, New York; North Carolina; Ohio; Pennsylvania; Philadelphia, Pennsylvania; South Carolina; Tennessee; Texas; Houston, Texas; Virginia; and District of Columbia.
† Includes data for the 3rd year of the program
§ Includes primary-care clinics, targeted HIV testing events, university health centers, local health department outreach events, mobile medical units, field-based testing, syringe exchange programs, family planning clinics, anonymous test sites, public health clinics, shelters/transitional housing, and detention centers.
¶ Categories do not sum to total because of missing data.

other commonly accepted screening tests (e.g., cholesterol screening). The successful development and diffusion of such integrated screening models under ETI, in conjunction with an increased emphasis on coverage for prevention services, might increase the availability and efficiency of HIV screening in health-care settings.

The findings in this report are subject to at least two limitations. First, health departments collected information on testing events, not persons tested. Thus, the number of persons tested through ETI might be lower than that indicated by the total number of tests conducted because some persons might have been tested more than once. Second, health departments reported data in aggregate rather than at the level of an individual test event or client. Therefore, it is not possible to link individual demographic or outcome variables to determine, for example, whether newly diagnosed persons who were referred for partner services also were more likely to be successfully linked to care, or whether blacks with newly diagnosed HIV infections were more or less likely than persons of other races/ethnicities to be linked to care.

Detailed data collection is not consistent with routine screening activities, so CDC did not mandate collection of data (e.g., individual behavioral risk) that, although important, would have imposed substantial additional burden on clinical staff members implementing routine HIV screening activities. Instead, CDC limited the data it required health departments to submit to those basic demographic and outcome data necessary to ensure program integrity and assess performance against critical program objectives. Consequently, ETI raises a number of important questions that might warrant special studies in the future, including whether persons who already were aware of their HIV infection at the time of testing also were currently in care and, if not, what proportion of persons with previously diagnosed HIV infections were reengaged in care as a consequence of HIV screening efforts in health-care settings.

The National HIV/AIDS Strategy outlines goals to reduce HIV incidence, improve access to care and health outcomes for persons living with HIV, and reduce HIV-related health disparities and inequities (*8*). Specific objectives include increasing the proportion of persons living with HIV who are aware of their serostatus from 79% to 90% and increasing the proportion of persons with newly diagnosed HIV infections who are linked to clinical care within 3 months of their HIV diagnosis from 65% to 85% (*8*). CDC's experience through ETI suggests that to meet those goals, health departments, clinical-care providers, and CBOs should continue to forge partnerships that advance implementation of routine HIV screening in clinical venues and targeted testing in community settings, particularly those that serve populations disproportionately affected by HIV, and ensure that persons newly diagnosed with HIV through such screening activities are effectively linked to care.

Ultimately, achieving the broader National HIV/AIDS Strategy prevention goals of reducing HIV incidence and transmission will require more than strengthening mechanisms for identifying persons with undiagnosed HIV infection and linking these persons to care. Persons with HIV must enter and progress along a spectrum of care to reduce their risk for transmission: ETI focused on the first two elements of this spectrum (diagnosis and linkage to care). However, for efforts like ETI to translate into better individual and population-level outcomes, persons infected with HIV must be engaged and retained in care, receive and adhere to effective treatment with HAART to maximize viral load suppression, and have access to ongoing prevention and support services, including risk-reduction counseling and other evidence-based behavioral interventions, partner services, substance use and mental health treatment, and case management. At present, attrition is substantial, such that only an estimated 19% of the HIV-infected population has achieved viral load suppression (*9*). To improve outcomes across this spectrum, CDC is working with its grantees, partners, and other federal agencies (e.g., the Health Resources and Services Administration) to develop, evaluate, and support the infrastructure and strategies needed to create a seamless integration of prevention, care, case management, and social services for persons living with HIV.

What is already known about this topic?

In the United States, approximately 20% of persons with human immunodeficiency virus (HIV) infection are unaware of their infections and therefore do not access medical care and prevention services that can prevent morbidity and mortality and reduce further HIV transmission. Often, persons with HIV infection visit health-care settings years before receiving a diagnosis but are not tested for HIV because neither these persons nor their health-care providers recognize that they are at risk for HIV infection.

What is added by this report?

CDC's Expanded HIV Testing Initiative, launched in 2007, represents the first national effort to promote routine HIV screening in various clinical and nonclinical venues. During October 2007–September 2010, a total of 2,786,739 tests were conducted, and 18,432 HIV infections were newly diagnosed; clinical settings accounted for 90% of all tests and 81% of all new HIV diagnoses.

What are the implications for public health practice?

Expanding opportunities for HIV testing, particularly in health-care settings, can lead to the diagnosis of a substantial number of new infections, which can lead to reduced morbidity, mortality, and transmission. To meet national goals for reducing the number of HIV-infected persons who are unaware of their serostatus, health departments should continue to partner with clinical-care providers to expand implementation of routine HIV screening in health-care settings, especially in populations disproportionately affected by HIV.

References

1. CDC. HIV surveillance—United States, 1981–2008. MMWR 2011;60:689–93.
2. Palella FJ, Deloria-Knoll M, Chmiel JS, et al. Survival benefit of initiating antiretroviral therapy in HIV-infected persons in different CD4+ cell strata. Ann Intern Med 2003;138:620–6.
3. Antiretroviral Therapy Cohort Collaboration. Life expectancy of individuals on combination antiretroviral therapy in high-income countries: a collaborative analysis of 14 cohort studies. Lancet 2008;372:293–9.
4. Marks G, Crepaz N, Senterfitt JW, Janssen RS. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. J Acquir Immune Defic Syndr 2005;39:446–53.
5. Donnell D, Baeten JM, Kiarie J, et al. Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis. Lancet 2010;375:2092–8.

6. National Institute of Allergy and Infectious Diseases. Treating HIV-infected people with antiretrovirals protects partners from infection: findings result from NIH-funded international study. Bethesda, Maryland: US Department of Health and Human Services, National Institutes of Health, National Institute of Allergy and Infectious Diseases; 2011. Available at http://www.niaid.nih.gov/news/newsreleases/2011/pages/hptn052.aspx. Accessed June 17, 2011.
7. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55(No. RR-14).
8. Office of National AIDS Policy. National HIV/AIDS Strategy. Washington, DC: Office of National AIDS Policy; 2010. Available at http://www.whitehouse.gov/administration/eop/onap/nhas. Accessed June 17, 2011.
9. Gardner EM, McLees MP, Steiner JF, Del Rio C, Burman WJ. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. Clin Infect Dis 2011; 52:793–800.

HIV Screening of Male Inmates During Prison Intake Medical Evaluation — Washington, 2006–2010

Since 2006, CDC has recommended routine, opt-out human immunodeficiency virus (HIV) screening for patients in health-care settings with a prevalence of undiagnosed HIV infection of ≥0.1% (*1,2*). Before September 2007, the Washington State Department of Corrections (WADOC) only provided HIV testing to inmates on request. In September 2007, WADOC began routine HIV opt-in screening in which inmates were notified that HIV screening would be performed during the prison intake medical evaluation if they consented. In March 2010, WADOC switched to a routine opt-out HIV screening model in which inmates are notified that HIV screening will be performed unless they decline. To assess the proportion of inmates screened and the number of infections diagnosed during the use of the three HIV testing policies, WADOC reviewed HIV testing data for male inmates undergoing intake medical evaluation during January 2006–December 2010. From January 1, 2006, to August 31, 2007, 5% of 12,202 incoming inmates were tested for HIV at their request during the intake medical evaluation, and three (0.50%) of those tested had newly diagnosed HIV infection. From September 1, 2007, to March 15, 2010, 72% of 16,908 inmates agreed to opt-in HIV screening, and 13 (0.11%) tested positive for HIV. From March 16, 2010, to December 31, 2010, 90% of 5,168 inmates agreed to opt-out HIV screening, and six (0.13%) tested positive for HIV. Compared with routine opt-in HIV screening, opt-out HIV screening was associated with a greater proportion of inmates tested, without decreasing the rate of case detection.

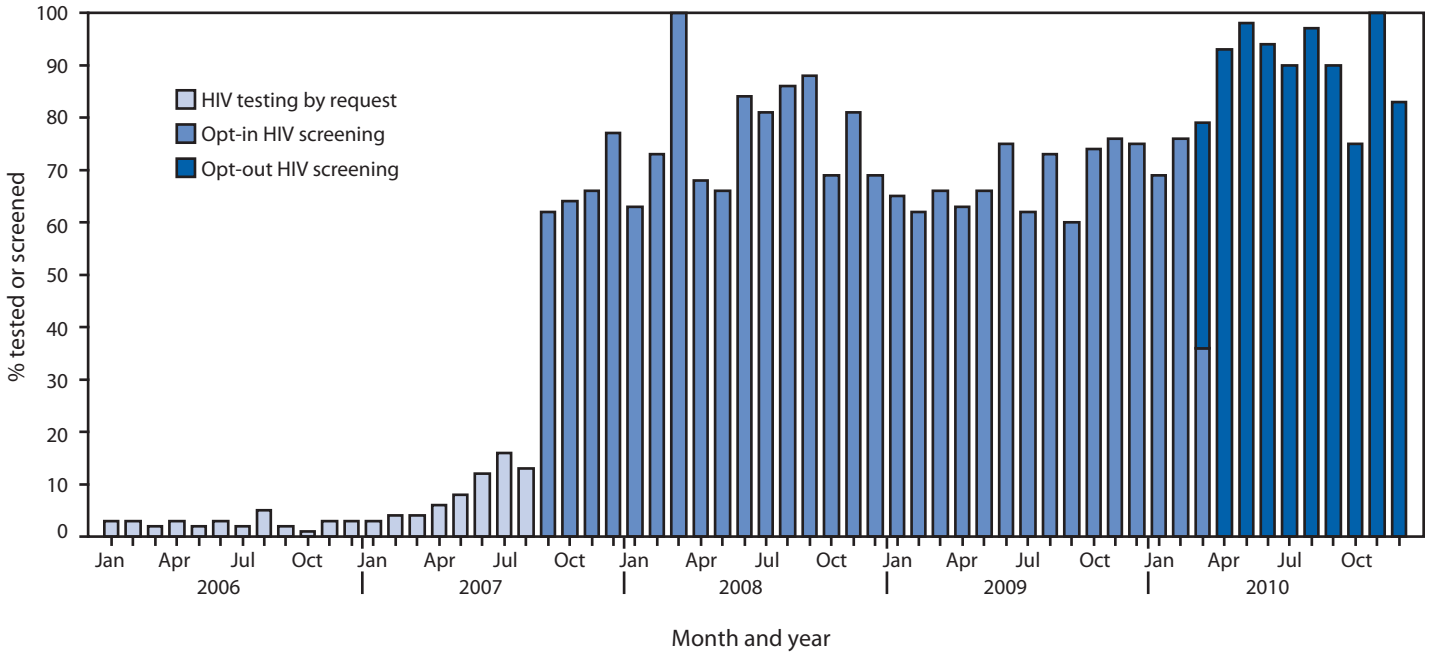
WADOC is a state prison system with 12 facilities for men and a daily male inmate population of approximately 15,000. Approximately 6,700 inmates are admitted each year, and a similar number released. The WADOC centralized reception center for men provides all incoming inmates with a medical evaluation within 14 days of arrival. The WADOC HIV testing program uses a conventional, laboratory-based enzyme immunoassay/Western blot algorithm on blood specimens (*3*). Based on serial, blinded seroprevalence studies, the prevalence of HIV infection in the male inmate population in WADOC has remained stable over the past decade at 0.6%–0.7% (M. Courogen, Washington State Department of Health [WADOH] personal communication, 2011). Oral informed consent is obtained before HIV testing, results are available in 7–14 days, and persons with a confirmed HIV-positive result are notified of their infection. Persons with HIV infection are reported to WADOH, provided HIV prevention counseling at WADOC, referred to specialized HIV care within the correctional facility, and linked to community health care on release.

Before September 2007, WADOC provided HIV testing only on request, if clinically indicated, or by court order. In September 2007, WADOC began to implement routine opt-in HIV testing, whereby nurses would routinely offer HIV testing to male inmates not known by WADOC to be HIV-infected during the intake medical evaluation, and inmates would provide their consent for the HIV test to be conducted. The infection control nurse promoted testing by telling inmates who initially declined testing that an HIV test could be performed at the same time they had blood drawn for routine syphilis screening. In mid-March 2010, WADOC began routine opt-out HIV testing during the intake medical evaluation. With the opt-out strategy, the infection control nurse informed incoming inmates not known by WADOC to be HIV-infected that an HIV test would be included among the standard screening tests unless they declined.

To determine how policy changes affected the proportion of inmates receiving HIV testing and the yield of newly identified HIV cases, WADOC reviewed its program data on HIV tests conducted from January 2006 through December 2010. A newly diagnosed case of HIV infection was defined as a confirmed diagnosis of HIV in a person at WADOC who had no record in WADOH HIV surveillance data of a previous positive HIV test result. Since implementation of routine (opt-in and opt-out) HIV screening, WADOC has conducted 16,820 HIV tests among 22,076 admissions; 19 (0.11%) tests were positive, resulting in five to six new HIV diagnoses per year. All inmates with newly diagnosed HIV infection were notified of their HIV diagnosis while still incarcerated, except one who was notified by the local health department following release.

The calculated annual number of tests performed increased with each change in testing strategy within WADOC, from 360 with testing on request, to 4,780 with opt-in screening, to 5,899 with opt-out screening. During the 20-month period in which HIV testing was available on request, an average of 5% of incoming inmates were tested each month within WADOC. During the 30.5-month period in which opt-in testing was in effect, approximately 72% of incoming inmates were tested. During the initial 9.5 months of the opt-out testing approach, 90% of incoming inmates were screened for HIV, demonstrating that an opt-out HIV testing strategy can increase acceptance of routine HIV testing (Figure).

FIGURE. Percentage of male inmates tested or screened for human immunodeficiency virus (HIV) infection during prison intake medical evaluation, by type of screening — Washington, January 2006–December 2010



The number of newly diagnosed cases detected per year also increased. Among the 604 HIV tests conducted on request before September 2007, three inmates were identified as having newly diagnosed HIV infection, a rate of 1.8 new HIV diagnoses per year. During the 30.5 month opt-in testing period, 13 inmates were identified as having newly diagnosed HIV infection, a rate of 5.1 new diagnoses per year. During the 9.5 months of opt-out testing, six inmates were identified as having newly diagnosed HIV infection, a rate of 7.6 new diagnoses per year.

Among the 19 inmates whose HIV infection was newly diagnosed during implementation of the opt-in and opt-out screening strategies, the mean CD4 cell count at the time of diagnosis was 422 cells/mm^3 (range: 71–898 cells/mm^3); nine had a CD4 cell count <500 cells/mm^3, and three had a count <200 cells/mm^3. The average age of the 19 inmates was 35 years (range: 20–58 years); three (16%) were American Indians/Alaska Natives, one (5%) was Hispanic, five (26%) were non-Hispanic black, and 10 (53%) were non-Hispanic white. Heterosexual sex was reported by eight (42%) inmates, six (32%) reported injection-drug use, four (21%) reported sex with men, and one (5%) reported both injection-drug use and sex with men.

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Editorial Note

Persons with HIV infection who are not aware of their infection are approximately three times more likely to transmit HIV than are persons who are aware of their infection (*4*). Routine HIV screening in correctional institutions can help identify cases of HIV infection, especially among persons who might not seek HIV testing in their community (*5*). In this report, inmate acceptance of HIV testing increased following changes to the WADOC testing policy. HIV testing increased from 5% to 72% to 90% when the testing policy was changed from on request to opt-in to opt-out. An opt-out approach helps destigmatize HIV testing (*6*).

Routine HIV screening (opt-in and opt-out) detected 19 new cases of HIV infection during a 40-month period. The opt-out testing approach was the most effective at case detection. Even in low-prevalence correctional settings such as WADOC, an opt-out HIV testing approach can identify persons with HIV infection and provide opportunities to link them to health care and treatment.

Racial and ethnic minorities are incarcerated at a higher rate than whites in the United States, and they are disproportionately infected with HIV (*7,8*). This also is true for the WADOC male inmate population. Compared with the general prison population in WADOC (blacks 19.2%, American Indians/

What is already known on this topic?

Routine human immunodeficiency virus (HIV) screening increases the proportion of patients tested in medical settings and can result in detection of undiagnosed HIV infection.

What is added by this report?

Compared with opt-in screening, an opt-out policy for screening inmates for HIV infection during intake medical evaluation increased the proportion of inmates tested from 72% to 90%, whereas the percentage testing positive remained similar (0.11% versus 0.13%).

What are the implications for public health practice?

Routinely offering opt-out HIV screening to all inmates during the prison medical intake evaluation can increase HIV case identification, even in low-prevalence settings.

Alaska Natives 4.4%), blacks and American Indians/Alaska Natives were overrepresented among inmates who had newly diagnosed HIV infection (26% and 16%, respectively) (*9*).

In this analysis, 42% of the 19 male inmates who had newly diagnosed HIV infection identified heterosexual contact as their only risk factor for HIV acquisition. This finding is similar to those of prior studies of HIV testing in correctional facilities (*10*), and supports the CDC recommendation that all inmates be provided opt-out HIV screening during their intake medical evaluation to maximize case detection and help prevent HIV transmission. Some HIV risk behaviors (e.g., male-to-male sex and injection-drug use) might have been underreported because inmates might have been reluctant to disclose these socially stigmatizing behaviors. However, the findings in this report emphasize the importance of not relying on risk-based testing.

The findings in this report are subject to at least one additional limitation. The reported newly diagnosed infections do not account for inmates who previously tested HIV-positive but who had no record of HIV infection in the WADOH surveillance system, resulting in a potential overestimation of new cases detected.

The results of this study, together with published guidance from CDC (*2*), can be useful in developing and implementing comprehensive HIV services for prison inmates. Routine opt-out HIV testing in prisons potentially can increase diagnoses of HIV infection, thereby improving health outcomes of persons with HIV infection and preventing new cases of HIV infection within the United States, especially among persons who might be less likely to access traditional community-based testing services.

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References

1. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55 (No. RR-14).
2. CDC. HIV testing implementation guidance for correctional settings. Atlanta, GA: US Department of Health and Human Services, CDC; 2009. Available at http://www.cdc.gov/hiv/topics/testing/resources/guidelines/correctional-settings. Accessed June 21, 2010.
3. CDC. Revised guidelines for HIV counseling, testing, and referral. MMWR 2001;50(No. RR-19).
4. Marks G, Crepaz N, Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS 2006;20:1447–50.
5. Desai AA, Latt AT, Spaulding A, Rich JD, Flanigan TP. The importance of routine HIV testing in the incarcerated population: the Rhode Island experience. AIDS Educ Prev 2002;14(5 Suppl B):45–52.
6. Young SD, Monin B, Owens D. Opt-out testing for stigmatized diseases: A social psychological approach to understanding the potential effect of recommendations for routine HIV testing. Health Psychol 2009;28: 675–81.
7. Sabol WJ, Minton TD, Harrison PM. Prison and jail inmates at midyear 2006. Washington, DC: Office of Justice Programs, US Department of Justice; 2007. Bureau of Justice Statistics Bulletin NCJ 217675. Available at http://bjs.ojp.usdoj.gov/content/pub/pdf/pjim06.pdf. Accessed June 15, 2011.
8. CDC. HIV prevalence estimates—United States, 2006. MMWR 2008;57:1073–6.
9. Washington State Department of Corrections. Quarterly fact card, December 31, 2010. Olympia, WA: Washington State Department of Corrections; 2010. Available at http://www.doc.wa.gov/aboutdoc/docs/msfactcard.pdf. Accessed May 24, 2011.
10. MacGowan R, Margolis A, Richardson-Moore A, et al. Voluntary rapid human immunodeficiency virus (HIV) testing in jails. Sex Transm Dis 2009;36(2 Suppl):S9–13.

Ten Great Public Health Achievements — Worldwide, 2001–2010

Worldwide, a child born in 1955 had an average life expectancy at birth of only 48 years (*1*). By 2000, the average life expectancy at birth had increased to 66 years and, if past trends continue, is projected to rise to 73 years by 2025 (*1*). These improvements in longevity have resulted from improved living conditions overall, advances in medical science, and a number of population-level interventions. However, major disparities persist. During the past decade, in low-income countries, average life expectancy at birth increased from 55 to 57 years (3.6%), while increasing from 78 to 80 years (2.6%) in high-income countries (*2*). Analogous to the recent *MMWR* report highlighting 10 public health achievements that occurred in the United States over the first 10 years of the new century, this report describes global public health achievements during the same period (*3*). Experts in global public health were asked to nominate noteworthy public health achievements that occurred outside of the United States during 2001–2010. From them, 10 have been summarized in this report. As with the previous report, the 10 global public health achievements are not ranked in any order. Additional information regarding these achievements is available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6019a5_addinfo.htm.

Reductions in Child Mortality

Child mortality, a key measurement of United Nations Millennium Development Goal 4, is defined as deaths in children aged <5 years and serves as a major indicator of a nation's health and development, tracking health services and outcomes as well as important social and economic indicators. Currently, an estimated 8.1 million children die each year before reaching their fifth birthday, a decrease of approximately 2 million during the past decade. From 77 deaths per 1,000 live births in 2000, the child mortality rate declined to 62 per 1,000 in 2009. The annual rate of decline in the child mortality rate has increased substantially, from 1.3% per year in the 1990s to 2.2% since 2000. Approximately 99% of all childhood deaths occur in low-income and middle-income countries, with 49% occurring in sub-Saharan Africa and 33% in southern Asia.

Approximately 68% of deaths among children aged <5 years are attributable to infectious diseases, most notably diarrhea, pneumonia, malaria, and acquired immunodeficiency syndrome (AIDS). Undernutrition contributes to at least one third of all childhood deaths, usually in interaction with infectious causes. The vast majority of gains in child survival have been accomplished through scale-up of interventions such as immunization, micronutrient supplementation, access to safe water, insecticide-treated bednets, oral rehydration therapy, antibiotics, antimalarial therapy, and antiretroviral therapies. Increased financial resources, strong partnerships, intensified country support, and innovations in service delivery approaches have made these gains possible. Because of the success in reducing the number of deaths caused by infection, 41% of childhood deaths now occur among neonates; leading causes of neonatal death are preterm birth complications, birth asphyxia, and sepsis (*4*).

Vaccine-Preventable Diseases

Expanded vaccination coverage is one of the most cost-effective ways to advance global welfare (*5*). In the first decade of the 21st century, an estimated 2.5 million deaths were prevented each year among children aged <5 years through the use of measles, polio, and diphtheria-tetanus-pertussis vaccines. Expanded coverage with measles vaccine resulted in a 78% decline in measles mortality from 2000 to 2008, averting an estimated 12.7 million deaths. Polio eradication efforts decreased the number of countries with endemic disease from 20 to four, with fewer than 1,500 cases reported in 2010. Global coverage with the third dose of diphtheria-tetanus-pertussis vaccine (a performance measure for vaccination programs) increased from 74% to 82%. Newer vaccines, including hepatitis B vaccine and *Haemophilus influenzae* type B (Hib) vaccine also are now widely used in national immunization programs globally. The number of countries using hepatitis B vaccine increased from 107 in 2000, to 178 in 2009; with global vaccination coverage of 70% achieved by the end of the decade, at least 700,000 deaths from cirrhosis and liver cancer are expected to be averted in each annual birth cohort in these 178 countries. During 2000–2009, the number of countries using Hib vaccine worldwide increased from 62 to 161; the resulting global coverage of 38% prevented an estimated 130,000 pneumonia and meningitis deaths annually among children aged <5 years.

Studies of disease burden and vaccine efficacy and creation of innovative financing mechanisms accelerated development and use in developing countries of vaccines licensed during the decade. As a result, new and underutilized vaccines for global use (i.e., pneumococcal conjugate [PCV], rotavirus, and rubella vaccines), and vaccines recommended for introduction in certain regions or in countries where certain criteria are met (e.g., Japanese encephalitis, human papillomavirus, meningococcal group A conjugate, and typhoid vaccines) are expected to be available around the world much more quickly than they have been in the past. By the end of 2009, 44 countries

had introduced PCV (11% of the global birth cohort), 23 had introduced rotavirus vaccine (11% of the global birth cohort), and 130 had introduced rubella vaccine (42% of the global birth cohort). Substantial work remains for these vaccines to be more widely introduced in developing countries.

Access to Safe Water and Sanitation

Water-related diseases, principally the 2.5 billion cases of diarrhea that occur annually, are the second leading cause of childhood mortality worldwide (*6*). Diarrhea, almost 90% of which is related to inadequate water, sanitation, and hygiene (WASH), kills 1.5 million children aged <5 years annually, more children than AIDS, malaria, and measles combined (*6*). From 2000 to 2008, the world's population increased from 6.1 billion to 6.7 billion, while the proportion of the world's population with access to improved drinking water sources increased from 83% to 87% (covering an additional 800 million persons), and the proportion with access to improved sanitation increased from 58% to 61% (covering an additional 570 million persons) (*7*). These gains were made through WASH initiatives to increase water and sanitation coverage and promote hygienic behaviors (e.g., handwashing), as well as through maintaining existing services.

During the previous century, in Europe, North America, and Japan, drinking water treatment virtually eliminated waterborne diseases such as cholera and typhoid (*8,9*). More recently, although improved WASH access has resulted in significant progress in controlling water-related disease in certain countries (e.g., Mexico and Chile), neglect of WASH infrastructure has contributed to large, deadly, waterborne outbreaks in others (e.g., cholera in Zimbabwe) (*10*). Continued improvements in global WASH coverage require intensifying current efforts, including long-term, multisectoral commitment to constructing and maintaining water and sanitation systems, behavior change promotion, and WASH-related disease surveillance.

Malaria Prevention and Control

Malaria is the fifth leading cause of death from infectious disease worldwide and the second leading cause in Africa, after human immunodeficiency virus/(HIV)/AIDS (*11*). The Roll Back Malaria partnership launched in 1998 is a coordinated response to malaria (additional information available at http://www.rollbackmalaria.org). During 2003–2010, financial assistance to malaria-endemic countries increased from approximately $100 million annually to nearly $1.8 billion annually, enabling increased coverage with insecticide-treated bednets, indoor residual spraying, rapid diagnosis and prompt treatment with artemisinin combination therapy, and intermittent preventive treatment during pregnancy (*12*). As a result, in sub-Saharan Africa, household ownership of insecticide-treated bednets increased from 3% in 2000 to 42% in 2009, protecting approximately 75% of the at-risk population. Protection with indoor residual spraying increased from 13 million households in 2005 to 75 million in 2009. Over the course of the past decade, the estimated number of malaria cases worldwide peaked at 244 million in 2005 but declined to 225 million in 2009. This decline was associated with a 21% decrease in estimated global malaria deaths, from approximately 985,000 in 2000 to 781,000 in 2009.

Prevention and Control of HIV/AIDS

The HIV epidemic continues to be a major global health challenge, with an estimated 33.3 million persons living with HIV at the end of 2009, compared with 28.6 million in 2001 (*13*). In 2009, 68% of persons living with HIV (22.5 million) were in sub-Saharan Africa (*13*). Despite this increase, the number of new infections annually has declined from an estimated 3.1 million in 2001 to 2.6 million in 2009. A decline also has been observed in the estimated number of AIDS-related deaths worldwide, from a peak of 2.1 million in 2004 to an estimated 1.8 million deaths in 2009 (*13*). Public health interventions possibly contributing to decreasing global HIV incidence have included the expansion of programs for provider-initiated HIV testing and counseling, prevention of mother-to-child HIV transmission, which covered an estimated 53% of pregnancies in HIV-positive mothers in 2009 (*14*), expanded availability and use of condoms and sterile injection equipment, improved blood safety, and antiretroviral therapy (ART). The scale-up of these interventions, including the provision of ART to 5.25 million persons in low-income and middle-income countries in 2009, has been concurrent with the decline in mortality (*15*). By averting new infections and offering improved health and longer lives to those already infected, these programs have enabled millions to contribute productively to families, communities, and economies.

Tuberculosis Control

During the past decade, 81 million new tuberculosis (TB) cases and 10 million deaths from TB occurred, largely in sub-Saharan Africa and Asia (*16*). In 1995, the World Health Organization (WHO) published its directly observed therapy, short-course (DOTS) strategy for TB control, focusing on finding and successfully treating TB cases with standardized regimens and rigorous treatment and program monitoring (*16,17*). Since 1995, DOTS has resulted in 41 million cases cured and 6 million deaths prevented (*16*). Since 2000, case detection and treatment success rates each have risen nearly 20%, with incidence and prevalence declining in every region. The world is on track to reduce TB mortality to 50% of 1990 levels by 2015 (*16*). DOTS also is cost effective: in sub-Saharan

Africa, implementation of DOTS at a cost of $12 billion (U.S.) would produce $129 billion in economic benefits to the region in 10 years (*18*).

Despite these successes, HIV-related and multidrug-resistant TB threaten to undermine progress, and TB incidence is declining, but slowly. HIV infection is the primary reason for failure to meet TB control targets in settings with high HIV prevalence, and TB is a major cause of death among persons living with HIV/AIDS. Interventions such as initiation of antiretroviral therapy in TB patients coinfected with HIV can decrease mortality. To address the threat of multidrug-resistant TB, DOTS-Plus strategies, which incorporate practical steps to improve infection control and special guidance on use and quality control of second-line drugs, have been implemented in countries with a high prevalence of this disease (*18*).

Control of Neglected Tropical Diseases

Neglected tropical diseases affect approximately 1 billion persons worldwide. Three of these diseases have been targeted for elimination or eradication: dracunculiasis (Guinea worm disease), onchocerciasis (river blindness) in the Americas, and lymphatic filariasis. Of these programs, those targeting dracunculiasis and onchocerciasis in the Americas are on the verge of success. In 1986, an estimated 3.5 million cases of dracunculiasis occurred in 20 countries. Using filters, safe water sources, larvicide, and most importantly, health education to encourage water filtration and prevention of water contamination, dracunculiasis transmission has been interrupted in all but four countries (Southern Sudan, Mali, Ethiopia, and Ghana), with most remaining cases in Southern Sudan. With only 1,797 cases reported in 2010, including 10 cases from an outbreak in Chad, the goal of eradication in 2012 is within reach.

The Onchocerciasis Elimination Program in the Americas began in 1992 to use mass drug administration to reduce blindness from onchocerciasis among the 500,000 persons at risk in six countries. By 2010, new cases of onchocercal blindness were eliminated in all 13 regional foci, and *Onchocerca volvulus* transmission was interrupted completely in eight of these. The goal is to eliminate transmission in all foci in the Americas by 2012.

In 2000, 1.34 billion persons in 72 countries were at risk for lymphatic filariasis and required mass drug administration, and 120 million were infected. With elimination targeted for 2020, the Global Programme to Eliminate Lymphatic Filariasis, begun in 2000, has delivered approximately 3 billion courses of antifilarial treatment at a cost of $0.05–$0.50 per person. Nine of the 72 countries have reached the WHO target for stopping mass drug administration. During 2000–2007, the program prevented infection in an estimated 6.6 million newborns, prevented disease in 9.5 million persons, and averted 32 million disability-adjusted life years.

Tobacco Control

In 2000, 4.8 million premature deaths were attributable to tobacco use (*19*). By the end of the decade, that number had risen to 5.4 million (*20*). In 2003, commitments were made through the WHO Framework Convention on Tobacco Control (WHO FCTC), WHO's first global health treaty, which was adopted by 168 countries by 2010 (*21*) and four more by June 2011. In addition, WHO developed a package of strategies called MPOWER (monitor tobacco use, protect from tobacco smoke, offer help to quit, warn about the dangers, enforce marketing bans, and raise taxes on tobacco) to support WHO FCTC (*20*). By 2010, 163 countries had completed youth surveys, and 14 had completed adult surveys as part of the Global Tobacco Surveillance System (*22*). Survey findings enable countries to track tobacco use and respond with interventions such as price increases; smoke-free policies; bans on tobacco advertising, promotion, and sponsorship; and tobacco-related health information provided via mass media campaigns and graphic health warnings (*20*).

Smoke-free environments, a component of WHO FCTC and MPOWER, protect persons from tobacco smoke. The U.S. Surgeon General's report conclusion that no safe level of exposure to tobacco smoke exists (*23*) and studies showing that smoke-free laws do not harm businesses have heightened worldwide interest in smoke-free policies. By the end of the decade, about half of the world's population was protected in health-care and educational facilities, although only about 5% of persons were protected by laws encompassing all public places (*24*). The total global population covered by comprehensive smoke-free laws increased from 3.1% in 2007 to 5.4% in 2008, providing protection for an additional 154 million persons (*24*).

Increased Awareness and Response for Improving Global Road Safety

Since 2000, when the International Federation of the Red Cross *International Disasters Report* raised an alarm regarding the worldwide impact of road traffic injuries, significant progress has been made in establishing a global response strategy (*25,26*). In 2001, WHO launched a 5-year plan to improve global road safety; in 2004, along with the World Bank, WHO issued the *World Report on Road Traffic Injury Prevention* (*26*). From 2001 to 2009, the number of annual traffic-related fatalities in the European Union declined 36%, from 55,700 to 34,900 (*27*). The largest declines in the traffic-related mortality rates from 2000 to 2009 were observed in

Spain and Portugal; rates decreased 59.2% in Spain, from 14.5 deaths per 100,000 population to 5.9, and 47% in Portugal, from 12.9 to 6.8 (*28*).

Despite such advances in road safety in developed countries, approximately 1.3 million persons die on the world's roads each year (3,000 every day), and this number is projected to double by 2030. Much of the projected worldwide increase is expected to come from low-income and middle income countries, which already account for 90% of global road deaths despite having less than half of the world's vehicles, and where the number of autos in use in rapidly emerging economies is expected to expand sixfold by 2018, potentially without corresponding improvements in road infrastructure or traffic safety. The Commission for Global Road Safety issued recommendations in 2006 and 2010, further raising the profile of global road traffic injuries and culminating in 2009 with adoption of a United Nations General Assembly resolution proclaiming the period 2011–2020 as the Decade of Action for Road Safety (*29,30*). The resolution established a 2020 goal of stabilizing and then reducing the forecasted growth of road traffic fatalities around the world by increasing road safety activities, including improved road and vehicle design, speed control, seat belt and helmet use, improved public transport, reduced alcohol-impaired driving, and more effective care of the injured at the national, regional, and global levels. If this goal is achieved, over the decade it could save 5 million lives and $3 trillion and prevent 50 million serious injuries.

Improved Preparedness and Response to Global Health Threats

Pandemic diseases and emerging diseases such as AIDS, severe acute respiratory syndrome, and influenza continue to cause fear, economic instability, severe illness, and premature death. In the past decade, the public health community has improved preparedness for and detection of pandemic threats and is now responding more effectively than before. The 2005 International Health Regulations, which entered into force in 2007, have modernized the international legal framework to improve systematic preparedness and response to pandemic and other emerging public health threats. Use of the Internet and other media for public health surveillance has expanded, and the Global Public Health Information Network, CDC's Global Disease Detection Operations Center (GDDOC), additional international influenza response networks, and other systems routinely detect and respond to clusters of unusual disease earlier than traditional surveillance. Laboratory and epidemiologic capacity also has improved. For example, since 2006, GDDOC worked with ministries of health to add availability of 185 new diagnostic tests in 59 countries, enabling these countries to conduct tests for pathogens they could not previously perform. Since 2000, a total of 21 new Field Epidemiology Training Programs have been established, three of which are now self-sustained. From 2000 to 2010, these new programs graduated approximately 500 epidemiologists. Cooperative agreements with ministries of health, regional training conducted in collaboration with WHO and other international organizations, and vital public health work to reduce transmission at the animal-human interface also have contributed to reducing the risk of influenza pandemics.

As a result of these and other efforts, the global response to the 2009 influenza A (H1N1) pandemic, which affected more than 214 countries and territories, was the most rapid and effective response to an influenza pandemic in history. The pandemic virus was rapidly identified and characterized. Epidemiologic investigations were conducted to characterize the severity and risk groups, and surveillance data were used to estimate the burden of disease and guide the response in real time. Within weeks of detecting the pandemic virus, diagnostic reagents were provided to laboratories in 146 countries, and laboratory and clinical training was provided, in collaboration with partners, to more than 6,100 health professionals in 34 countries. A vaccine was developed within 20 weeks of virus detection, and through an international donation program, made available to 86 countries. The lessons and experiences of the 2009 H1N1 response continue to inform preparedness efforts for future influenza pandemics as well as future public health emergencies.

Conclusion

During the previous century, great progress was made in raising life expectancy and reducing mortality among infants and young children through improvements in living conditions and activities to combat major infectious causes of death. Collectively, interventions such as those described in this report have contributed to the shifts in major causes of death observed in the new century, with chronic, noninfectious causes increasingly prevalent not only in affluent countries, but also in lower-income and middle-income countries. Noncommunicable diseases and health conditions are expected to account for an estimated 75% of all deaths worldwide by the year 2030 (*31*). The achievements described in this report demonstrate the capacity of public health agencies to harness and adapt the scientific, technical, legal, and political resources necessary to respond effectively to the problems at hand. This capacity will be tested in the years ahead as public health agencies continue to address communicable diseases while responding to the increasing prevalence of cardiovascular disease, diabetes, cancer, and other noncommunicable conditions and injuries that will require innovative responses to ensure significant public health achievements in the future.

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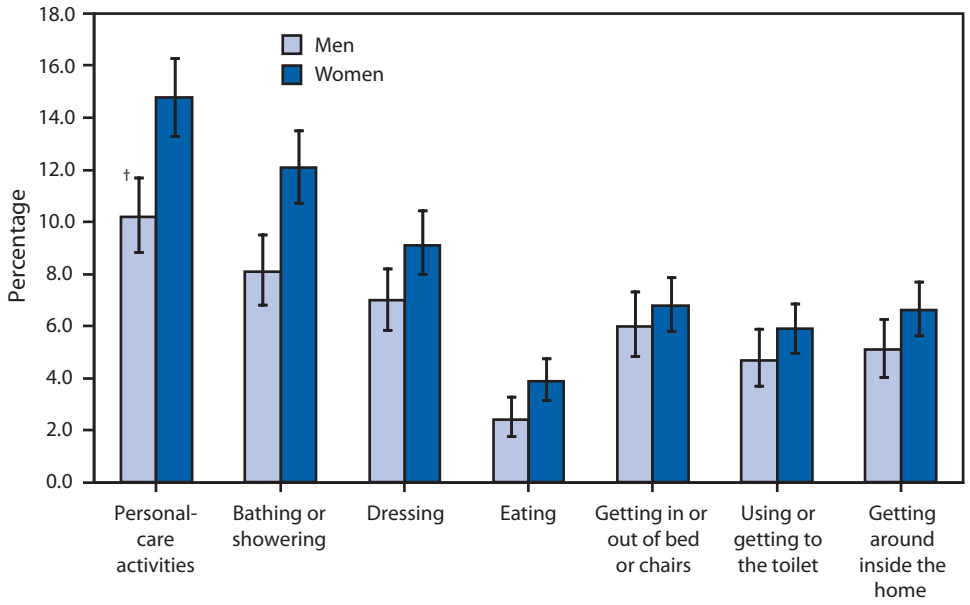
References

1. World Health Organization. The world health report 1998—life in the 21st century: a vision for all. Geneva, Switzerland: World Health Organization; 1998. Available at http://www.who.int/whr/1998/en/whr98_en.pdf. Accessed June 17, 2011.
2. World Health Organization. World health statistics 2010. Geneva, Switzerland; 2010. Available at http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf. Accessed June 17, 2011.
3. CDC. Ten great public health achievements—United States, 2001–2010. MMWR 2011;60:619–23.
4. You D, Jones G, Wardlaw T. Levels and trends in child mortality: estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation. New York, NY: United Nations Children's Fund (UNICEF); 2010.
5. Copenhagen Consensus Center. Copenhagen consensus 2008. Fredriksberg, Denmark: Copenhagen Consensus Center; 2008. Available at http://www.copenhagenconsensus.com/home.aspx. Accessed June 17, 2011.
6. The United Nations Children's Fund (UNICEF)/World Health Organization. Diarrhoea: why children are still dying and what can be done. Geneva, Switzerland: UNICEF/World Health Organization; 2009. Available at http://whqlibdoc.who.int/publications/2009/9789241598415_eng.pdf. Accessed June 17, 2011.
7. World Health Organization/The United Nations Children's Fund (UNICEF). Progress on sanitation and drinking-water: 2010 update. Geneva, Switzerland: World Health Organization/UNICEF; 2010.
8. Japanese Ministry of Health and Welfare. A 50-year history of the Ministry of Health and Welfare. Japan: Editorial Board of the Fifty-Year History of the Ministry of Health and Welfare; 1988.
9. Cutler D, Miller G. The role of public health improvements in health advances: the twentieth-century United States. Demography 2005; 42:1–22.
10. Sepulveda J, Valdespino JL, Garcia-Garcia L. Cholera in Mexico: the paradoxical benefits of the last pandemic. Int J Infect Dis 2006;10:4–13.
11. World Health Organization. Global burden of disease estimates. Geneva, Switzerland: World Health Organization; 2002.
12. World Health Organization. World malaria report, 2010. Geneva, Switzerland: World Health Organization; 2010. Available at http://www.who.int/malaria/world_malaria_report_2010/en/index.html. Accessed June 17, 2011.
13. Joint United Nations Programme on HIV/AIDS (UNAIDS). Global report: UNAIDS report on the global AIDS epidemic 2010. Geneva, Switzerland: UNAIDS; 2010. Available at http://www.unaids.org/globalreport/global_report.htm. Accessed June 17, 2011.
14. Joint United Nations Programme on HIV/AIDS (UNAIDS). Countdown to zero: global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. Geneva, Switzerland: UNAIDS; 2011. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_jc2137_global-plan-elimination-hiv-children_en-1.pdf. Accessed June 20, 2011.
15. World Health Oranization. Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector. Geneva, Switzerland: World Health Organization; 2010. Available at http://whqlibdoc.who.int/publications/2010/9789241500395_eng.pdf. Accessed June 17, 2011.
16. World Health Organization. WHO report 2010: global tuberculosis control. Geneva, Switzerland: World Health Organization; 2010. Available at http://www.who.int/tb/publications/global_report/en. Accessed June 17, 2011.
17. World Health Organization/Stop TB Partnership. The global plan to stop TB 2011–2015. Geneva, Switzerland: World Health Organization/Stop TB Partnership; 2010. Available at http://www.stoptb.org/global/plan. Accessed June 17, 2011.
18. The World Bank. Economic benefit of tuberculosis control. Washington, DC: The World Bank; 2007. Policy research working paper 4295.
19. Jha P, Chaloupka F, eds. Tobaco control in developing countries. New York, NY: Oxford University Press; 2000.
20. World Health Organization. WHO report on the global tobacco epidemic, 2008: the MPOWER package. Geneva, Switzerland: World Health Organization; 2011. Available at http://www.who.int/tobacco/mpower/2008/en/index.html. Accessed May 19, 2011.
21. World Health Organization. WHO Framework Convention on Tobacco Control. Geneva, Switzerland: World Health Organization; 2011. Available at http://www.who.int/tobacco/wntd/2011/announcement/en/index.html. Accessed May 19, 2011.
22. CDC. Global youth tobacco surveillance, 2000–2007. MMWR 2008; 57(No. SS-01).
23. US Department of Health and Human Services. The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services; 2006.
24. World Health Organization. WHO report on the global tobacco epidemic, 2009: implementing smoke-free environments. Geneva, Switzerland: World Health Organization; 2009. Available at http://www.who.int/tobacco/mpower/2009/en/index.html. Accessed May 22, 2011.
25. International Federation of Red Cross and Red Crescent Societies. World disasters report 2000. Geneva, Switzerland: International Federation of Red Cross and Red Crescent Societies; 2000.
26. Peden M, Scurfield R, Sleet DA, et al. World report on road traffic injury prevention. Geneva, Switzerland: World Health Organization; 2004.
27. European Transport Safety Council. Road safety target in sight: making up for lost time. Brussels, Belgium: European Transport Safety Council; 2010. Available at http://www.etsc.eu/documents/ETSC%20PIN%20Report%202010.pdf. Accessed June 17, 2011.
28. International Traffic Safety Data & Analysis Group. IRTAD road safety 2010. Available at http://www.internationaltransportforum.org/irtad/pdf/10irtadreport.pdf. Accessed June 17, 2011.
29. Commission for Global Road Safety. Make roads safe: a new priority for sustainable development. London, UK: Commission for Global Road Safety; 2006. Available at http://www.makeroadssafe.org/publications/documents/mrs_report_2007.pdf. Accessed June 17, 2011.
30. Commission for Global Road Safety. Make roads safe: a decade of action for road safety. London, UK: Commission for Global Road Safety; 2009. Available at http://www.makeroadssafe.org/publications/documents/decade_of_action_report_lr.pdf. Accessed June 17, 2011.
31. World Health Organization. World health statistics 2008. Geneva, Switzerland: World Health Organization; 2008. Available at http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf. Accessed June 17, 2011.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Noninstitutionalized Adults Aged ≥80 Years Who Need Help with Personal Care,* by Sex — United States, 2008–2009



* Estimates are based on household interviews of a sample of the civilian, noninstitutionalized U.S. population aged ≥80 years. Adults living in long-term care institutions (e.g., assisted living facilities, nursing homes for the elderly, or hospitals for the chronically ill or the physically or intellectually disabled) or correctional facilities are excluded from the sample. Data on personal-care activities are based on responses to the question, "Because of a physical, mental, or emotional problem, [do you/does anyone in the family] need the help of other persons with personal care needs, such as eating, bathing, dressing, or getting around inside the home?" Respondents who answered affirmatively were then asked, in separate questions, if the person in question needed help with 1) bathing or showering; 2) dressing; 3) eating; 4) getting in or out of bed or chairs; 5) using the toilet, including getting to the toilet; or 6) getting around inside the home. Persons with unknown information regarding personal-care activities were excluded from the denominators.

† 95% confidence interval.

Among noninstitutionalized adults aged ≥80 years, women were more likely than men to need the help of another person with personal-care activities (14.8% versus 10.2%). In particular, women were more likely than men to need help when bathing or showering (12.1% versus 8.1%), dressing (9.1% versus 7.0%), and eating (3.9% versus 2.4%).

Source: National Health Interview Survey, 2008–2009. Available at http://www.cdc.gov/nchs/nhis.htm.

Notifiable Diseases and Mortality Tables

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending June 18, 2011 (24th week)*

Disease	Current week	Cum 2011	5-year weekly average†	Total cases reported for previous years					States reporting cases during current week (No.)
				2010	2009	2008	2007	2006	
Anthrax	—	—	—	—	1	—	1	1	
Arboviral diseases§,¶:									
California serogroup virus disease	—	—	1	75	55	62	55	67	
Eastern equine encephalitis virus disease	—	—	0	10	4	4	4	8	
Powassan virus disease	—	—	0	8	6	2	7	1	
St. Louis encephalitis virus disease	—	—	0	10	12	13	9	10	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Babesiosis	5	27	2	NN	NN	NN	NN	NN	NY (4), PA (1)
Botulism, total	—	35	3	112	118	145	144	165	
foodborne	—	5	0	7	10	17	32	20	
infant	—	25	2	80	83	109	85	97	
other (wound and unspecified)	—	5	1	25	25	19	27	48	
Brucellosis	1	30	2	114	115	80	131	121	NE (1)
Chancroid	—	11	0	30	28	25	23	33	
Cholera	—	18	0	13	10	5	7	9	
Cyclosporiasis§	2	55	5	179	141	139	93	137	DE (1), WA (1)
Diphtheria	—	—	—	—	—	—	—	—	
Haemophilus influenzae,** invasive disease (age <5 yrs):									
serotype b	—	2	0	23	35	30	22	29	
nonserotype b	1	53	4	197	236	244	199	175	MD (1)
unknown serotype	5	120	3	223	178	163	180	179	MI (1), NE (1), FL (2), AZ (1)
Hansen disease§	—	21	2	97	103	80	101	66	
Hantavirus pulmonary syndrome§	—	6	1	20	20	18	32	40	
Hemolytic uremic syndrome, postdiarrheal§	2	40	6	266	242	330	292	288	NY (1), AR (1)
Influenza-associated pediatric mortality§,††	2	106	2	61	358	90	77	43	CA (2)
Listeriosis	6	185	15	820	851	759	808	884	NY (2), WV (1), NC (1), CA (2)
Measles§§	4	118	3	63	71	140	43	55	NYC (2), UT (1), WA (1)
Meningococcal disease, invasive¶¶:									
A, C, Y, and W-135	2	93	5	280	301	330	325	318	NC (1), SC (1)
serogroup B	—	52	3	135	174	188	167	193	
other serogroup	—	5	1	12	23	38	35	32	
unknown serogroup	8	230	10	406	482	616	550	651	NE (1), FL (3), AL (1), CA (3)
Novel influenza A virus infections***	—	1	0	4	43,774	2	4	NN	
Plague	—	1	0	2	8	3	7	17	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Polio virus Infection, nonparalytic§	—	—	—	—	—	—	—	NN	
Psittacosis§	—	1	0	4	9	8	12	21	
Q fever, total§	1	29	4	131	113	120	171	169	
acute	—	18	2	106	93	106	—	—	
chronic	1	11	0	25	20	14	—	—	WA (1)
Rabies, human	—	1	0	2	4	2	1	3	
Rubella†††	—	3	0	6	3	16	12	11	
Rubella, congenital syndrome	—	—	0	—	2	—	—	1	
SARS-CoV§	—	—	—	—	—	—	—	—	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	57	2	148	161	157	132	125	
Syphilis, congenital (age <1 yr)§§§	—	67	7	372	423	431	430	349	
Tetanus	—	3	0	10	18	19	28	41	
Toxic-shock syndrome (staphylococcal)§	—	38	2	82	74	71	92	101	
Trichinellosis	—	7	0	7	13	39	5	15	
Tularemia	3	22	5	124	93	123	137	95	SD (1), OK (1), CA (1)
Typhoid fever	10	148	6	468	397	449	434	353	FL (1), CA (9)
Vancomycin-intermediate *Staphylococcus aureus*§	—	25	1	91	78	63	37	6	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	2	1	—	2	1	
Vibriosis (noncholera *Vibrio* species infections)§	6	150	10	848	789	588	549	NN	MD (1), FL (4), CA (1)
Viral hemorrhagic fever¶¶¶	—	—	—	1	NN	NN	NN	NN	
Yellow fever	—	—	—	—	—	—	—	—	

See Table 1 footnotes on next page.

TABLE I. (*Continued*) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending June 18, 2011 (24th week)*

—: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts.

* Case counts for reporting years 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf.

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/5yearweeklyaverage.pdf.

§ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table except starting in 2007 for the arboviral diseases, STD data, TB data, and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/osels/ph_surveillance/nndss/phs/infdis.htm.

¶ Includes both neuroinvasive and nonneuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.

** Data for H. influenzae (all ages, all serotypes) are available in Table II.

†† Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Since October 3, 2010, 110 influenza-associated pediatric deaths occurring during the 2010-11 influenza season have been reported.

§§ Of the four measles cases reported for the current week, one was imported and three were indigenous.

¶¶ Data for meningococcal disease (all serogroups) are available in Table II.

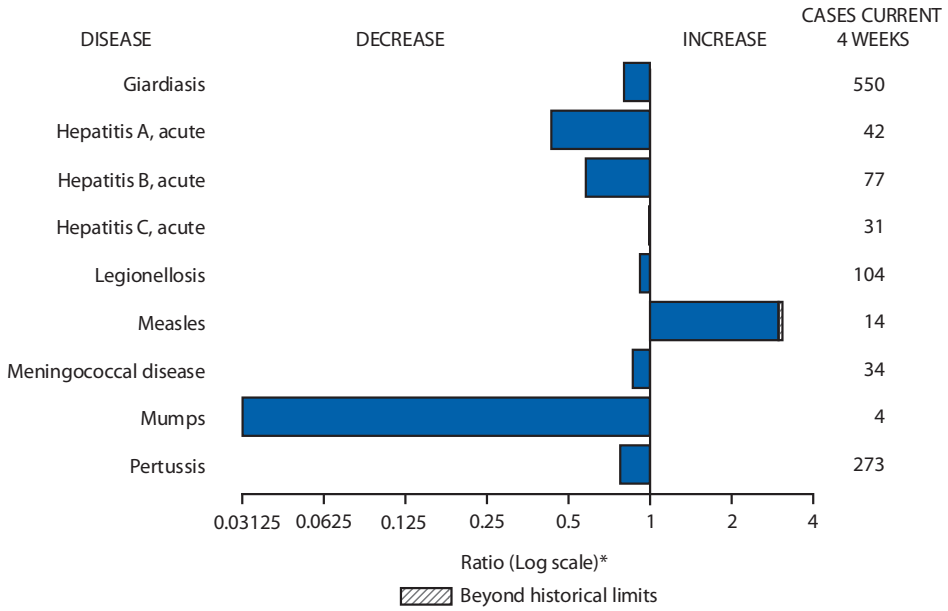
*** CDC discontinued reporting of individual confirmed and probable cases of 2009 pandemic influenza A (H1N1) virus infections on July 24, 2009. During 2009, four cases of human infection with novel influenza A viruses, different from the 2009 pandemic influenza A (H1N1) strain, were reported to CDC. The four cases of novel influenza A virus infection reported to CDC during 2010, and the one case reported during 2011, were identified as swine influenza A (H3N2) virus and are unrelated to the 2009 pandemic influenza A (H1N1) virus. Total case counts for 2009 were provided by the Influenza Division, National Center for Immunization and Respiratory Diseases (NCIRD).

††† No rubella cases were reported for the current week.

§§§ Updated weekly from reports to the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

¶¶¶ There was one case of viral hemorrhagic fever reported during week 12 of 2010. The one case report was confirmed as lassa fever. See Table II for dengue hemorrhagic fever.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals June 18, 2011, 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.

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TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	*Chlamydia trachomatis* infection					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	11,452	25,617	31,143	578,132	590,006	79	0	567	7,220	NN	42	105	374	1,791	2,769
New England	481	837	2,043	18,789	18,103	—	0	1	1	NN	—	5	27	88	229
Connecticut	—	234	1,557	3,479	4,272	—	0	0	—	NN	—	0	22	22	77
Maine†	—	55	100	1,215	1,150	—	0	0	—	NN	—	0	7	3	26
Massachusetts	342	404	861	10,143	9,461	—	0	0	—	NN	—	2	9	32	56
New Hampshire	36	53	81	1,331	1,038	—	0	1	1	NN	—	1	3	11	32
Rhode Island†	78	67	154	1,948	1,627	—	0	0	—	NN	—	0	2	1	9
Vermont†	25	26	84	673	555	—	0	0	—	NN	—	1	5	19	29
Mid. Atlantic	1,668	3,318	5,069	74,848	77,556	—	0	1	2	NN	8	15	38	276	270
New Jersey	69	485	684	9,892	12,156	—	0	0	—	NN	—	1	4	18	13
New York (Upstate)	754	713	2,099	16,402	14,897	—	0	0	—	NN	2	4	13	59	57
New York City	241	1,145	2,612	25,132	29,030	—	0	0	—	NN	—	2	6	23	28
Pennsylvania	604	953	1,222	23,422	21,473	—	0	1	2	NN	6	8	26	176	172
E.N. Central	966	4,034	7,039	88,055	92,380	—	0	3	21	NN	3	24	137	417	730
Illinois	33	1,123	1,320	21,208	27,433	—	0	0	—	NN	—	1	21	4	88
Indiana	258	451	3,376	12,637	7,804	—	0	0	—	NN	—	4	15	41	115
Michigan	518	942	1,397	21,766	23,372	—	0	3	14	NN	3	5	18	103	136
Ohio	—	1,000	1,138	22,417	23,438	—	0	3	7	NN	—	7	24	143	165
Wisconsin	157	467	559	10,027	10,333	—	0	0	—	NN	—	8	65	126	226
W.N. Central	507	1,433	1,627	31,941	33,285	—	0	1	1	NN	8	12	99	144	434
Iowa	14	207	240	4,672	4,966	—	0	0	—	NN	—	3	25	21	93
Kansas	—	187	287	4,135	4,524	—	0	0	—	NN	—	1	6	3	39
Minnesota	—	291	355	5,399	7,123	—	0	0	—	NN	—	2	22	—	132
Missouri	394	524	766	12,722	11,863	—	0	0	—	NN	5	3	29	51	68
Nebraska†	78	102	218	2,813	2,351	—	0	1	1	NN	3	3	26	52	47
North Dakota	—	40	90	664	1,016	—	0	0	—	NN	—	0	9	7	11
South Dakota	21	64	93	1,536	1,442	—	0	0	—	NN	—	1	6	10	44
S. Atlantic	3,031	5,109	6,526	123,412	118,904	—	0	2	3	NN	10	18	53	333	421
Delaware	108	83	220	2,064	2,019	—	0	0	—	NN	—	0	1	3	3
District of Columbia	—	105	180	1,947	2,520	—	0	0	—	NN	—	0	1	3	2
Florida	685	1,485	1,706	34,584	34,474	—	0	0	—	NN	2	6	19	88	162
Georgia	317	902	2,384	22,599	20,750	—	0	0	—	NN	4	5	11	116	134
Maryland†	—	476	1,125	9,196	10,786	—	0	2	3	NN	1	1	3	21	15
North Carolina	715	747	1,477	21,275	20,958	—	0	0	—	NN	—	0	17	23	35
South Carolina†	622	531	946	13,581	11,767	—	0	0	—	NN	—	2	8	43	22
Virginia†	584	662	970	16,309	13,949	—	0	0	—	NN	—	1	9	25	42
West Virginia	—	77	121	1,857	1,681	—	0	0	—	NN	3	0	5	11	6
E.S. Central	1,088	1,828	3,315	41,525	41,570	—	0	0	—	NN	2	4	19	64	83
Alabama†	—	547	1,564	11,414	11,458	—	0	0	—	NN	—	1	13	8	34
Kentucky	274	268	2,352	7,421	7,174	—	0	0	—	NN	—	1	6	19	26
Mississippi	558	392	780	9,061	10,370	—	0	0	—	NN	—	0	2	11	5
Tennessee†	256	587	795	13,629	12,568	—	0	0	—	NN	2	1	5	26	18
W.S. Central	972	3,294	4,723	73,403	83,103	—	0	1	1	NN	2	6	33	86	139
Arkansas†	275	307	440	7,504	7,069	—	0	0	—	NN	—	0	3	7	15
Louisiana	448	320	1,052	4,813	13,663	—	0	1	1	NN	—	0	6	10	19
Oklahoma	249	228	1,371	5,319	6,048	—	0	0	—	NN	—	0	8	—	26
Texas†	—	2,369	3,107	55,767	56,323	—	0	0	—	NN	2	4	24	69	79
Mountain	823	1,679	2,155	37,510	37,886	67	0	429	5,718	NN	4	10	30	190	220
Arizona	115	511	678	9,794	12,397	65	0	425	5,635	NN	—	1	3	14	14
Colorado	382	410	849	11,511	8,788	—	0	0	—	NN	3	2	10	53	54
Idaho†	—	70	199	1,403	1,752	—	0	0	—	NN	1	2	7	37	40
Montana†	—	63	88	1,534	1,413	—	0	1	2	NN	—	1	5	24	27
Nevada†	219	194	380	4,942	4,634	2	0	4	42	NN	—	0	7	3	6
New Mexico†	56	203	1,183	4,543	4,852	—	0	4	30	NN	—	2	12	39	40
Utah	51	128	175	2,945	3,073	—	0	2	6	NN	—	1	5	13	27
Wyoming†	—	38	90	838	977	—	0	2	3	NN	—	0	3	7	12
Pacific	1,916	3,758	6,559	88,649	87,219	12	0	143	1,473	NN	5	11	27	193	243
Alaska	—	116	157	2,568	2,862	—	0	0	—	NN	—	0	3	5	2
California	1,309	2,867	5,763	67,892	66,029	12	0	143	1,472	NN	5	6	19	116	139
Hawaii	—	108	141	2,292	2,917	—	0	0	—	NN	—	0	0	—	1
Oregon	276	240	524	6,299	5,551	—	0	1	1	NN	—	3	13	68	68
Washington	331	412	520	9,598	9,860	—	0	0	—	NN	—	1	9	4	33
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	NN	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	NN	—	—	—	—	—
Guam	—	9	44	189	88	—	0	0	—	NN	—	0	0	—	—
Puerto Rico	—	105	349	2,677	2,931	—	0	0	—	NN	N	0	0	N	N
U.S. Virgin Islands	—	14	27	328	256	—	0	0	—	NN	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	Dengue Virus Infection									
	Dengue Fever†					Dengue Hemorrhagic Fever§				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max		
United States	—	4	52	30	130	—	0	2	—	3
New England	—	0	3	1	1	—	0	0	—	—
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine¶	—	0	2	—	1	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	1	—	—	—	0	0	—	—
Vermont¶	—	0	1	1	—	—	0	0	—	—
Mid. Atlantic	—	1	25	8	43	—	0	1	—	2
New Jersey	—	0	5	—	4	—	0	0	—	—
New York (Upstate)	—	0	5	—	5	—	0	1	—	1
New York City	—	0	17	—	29	—	0	1	—	1
Pennsylvania	—	0	3	8	5	—	0	0	—	—
E.N. Central	—	0	5	5	11	—	0	1	—	—
Illinois	—	0	1	2	—	—	0	0	—	—
Indiana	—	0	2	1	3	—	0	0	—	—
Michigan	—	0	2	—	2	—	0	0	—	—
Ohio	—	0	2	—	5	—	0	0	—	—
Wisconsin	—	0	2	2	1	—	0	1	—	—
W.N. Central	—	0	6	—	8	—	0	1	—	—
Iowa	—	0	1	—	—	—	0	0	—	—
Kansas	—	0	1	—	—	—	0	0	—	—
Minnesota	—	0	1	—	7	—	0	0	—	—
Missouri	—	0	0	—	—	—	0	0	—	—
Nebraska¶	—	0	6	—	—	—	0	0	—	—
North Dakota	—	0	0	—	1	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	1	—	—
S. Atlantic	—	1	19	10	51	—	0	1	—	1
Delaware	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	1	14	9	41	—	0	1	—	1
Georgia	—	0	2	—	4	—	0	0	—	—
Maryland¶	—	0	0	—	—	—	0	0	—	—
North Carolina	—	0	2	1	—	—	0	0	—	—
South Carolina¶	—	0	3	—	2	—	0	0	—	—
Virginia¶	—	0	3	—	3	—	0	0	—	—
West Virginia	—	0	1	—	1	—	0	0	—	—
E.S. Central	—	0	2	—	—	—	0	0	—	—
Alabama¶	—	0	2	—	—	—	0	0	—	—
Kentucky	—	0	1	—	—	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee¶	—	0	1	—	—	—	0	0	—	—
W.S. Central	—	0	1	—	—	—	0	1	—	—
Arkansas¶	—	0	0	—	—	—	0	1	—	—
Louisiana	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	1	—	—	—	0	0	—	—
Texas¶	—	0	1	—	—	—	0	0	—	—
Mountain	—	0	2	1	3	—	0	0	—	—
Arizona	—	0	2	1	1	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—
Idaho¶	—	0	1	—	—	—	0	0	—	—
Montana¶	—	0	1	—	—	—	0	0	—	—
Nevada¶	—	0	1	—	1	—	0	0	—	—
New Mexico¶	—	0	0	—	1	—	0	0	—	—
Utah	—	0	0	—	—	—	0	0	—	—
Wyoming¶	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	7	5	13	—	0	0	—	—
Alaska	—	0	0	—	1	—	0	0	—	—
California	—	0	5	2	9	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—
Washington	—	0	2	3	3	—	0	0	—	—
Territories										
American Samoa	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	38	454	237	2,276	—	1	20	1	68
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Dengue Fever includes cases that meet criteria for Dengue Fever with hemorrhage, other clinical and unknown case classifications.
§ DHF includes cases that meet criteria for dengue shock syndrome (DSS), a more severe form of DHF.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	Ehrlichiosis/Anaplasmosis†														
	Ehrlichia chaffeensis					*Anaplasma phagocytophilum*					Undetermined				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	8	6	109	104	215	12	16	145	60	620	2	1	13	24	36
New England	—	0	2	2	3	—	1	9	10	43	—	0	0	—	2
Connecticut	—	0	0	—	—	—	0	6	—	14	—	0	0	—	—
Maine§	—	0	1	1	2	—	0	2	6	9	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	1	1	1	—	0	2	4	8	—	0	0	—	2
Rhode Island§	—	0	1	—	—	—	0	6	—	11	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	1	—	1	—	0	0	—	—
Mid. Atlantic	2	1	8	10	33	8	4	17	21	65	—	0	2	1	6
New Jersey	—	0	6	—	26	—	0	6	—	34	—	0	1	—	1
New York (Upstate)	2	0	7	6	6	8	3	14	19	30	—	0	2	1	4
New York City	—	0	2	4	—	—	0	3	2	1	—	0	0	—	—
Pennsylvania	—	0	1	—	1	—	0	1	—	—	—	0	1	—	1
E.N. Central	—	0	4	7	18	—	2	45	3	205	—	0	6	8	17
Illinois	—	0	2	4	8	—	0	2	—	1	—	0	1	1	3
Indiana	—	0	0	—	—	—	0	0	—	—	—	0	3	5	6
Michigan	—	0	1	1	—	—	0	1	—	1	—	0	1	1	—
Ohio	—	0	3	2	1	—	0	1	1	—	—	0	0	—	—
Wisconsin	—	0	2	—	9	—	2	45	2	203	—	0	3	1	8
W.N. Central	2	1	13	27	46	1	2	77	6	281	1	0	11	9	2
Iowa	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Kansas	—	0	2	1	2	—	0	1	—	—	—	0	0	—	—
Minnesota	—	0	12	—	—	—	2	75	1	279	—	0	11	—	—
Missouri	2	0	13	26	44	1	0	2	5	2	1	0	3	8	2
Nebraska§	—	0	1	—	—	—	0	0	—	—	—	0	1	1	—
North Dakota	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
South Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
S. Atlantic	2	3	18	45	81	3	1	7	16	21	1	0	1	2	—
Delaware	—	0	2	6	8	—	0	1	—	1	—	0	0	—	—
District of Columbia	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Florida	2	0	3	10	4	2	0	1	4	1	—	0	0	—	—
Georgia	—	0	3	5	13	1	0	1	5	1	1	0	1	1	—
Maryland§	—	0	3	5	6	—	0	2	—	7	—	0	1	—	—
North Carolina	—	0	13	7	29	—	0	4	6	9	—	0	0	—	—
South Carolina§	—	0	1	—	2	—	0	1	—	—	—	0	0	—	—
Virginia§	—	1	8	12	18	—	0	2	1	2	—	0	1	1	—
West Virginia	—	0	1	—	1	—	0	0	—	—	—	0	0	—	—
E.S. Central	2	0	11	13	25	—	0	2	4	5	—	0	1	1	7
Alabama§	—	0	3	—	4	—	0	2	2	1	N	0	0	N	N
Kentucky	—	0	2	3	3	—	0	0	—	—	—	0	0	—	1
Mississippi	—	0	1	—	1	—	0	1	—	1	—	0	0	—	1
Tennessee§	2	0	7	10	17	—	0	2	2	3	—	0	1	1	5
W.S. Central	—	0	87	—	8	—	0	9	—	—	—	0	1	—	—
Arkansas§	—	0	5	—	—	—	0	2	—	—	—	0	0	—	—
Louisiana	—	0	0	—	1	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	82	—	6	—	0	7	—	—	—	0	0	—	—
Texas§	—	0	1	—	1	—	0	1	—	—	—	0	1	—	—
Mountain	—	0	0	—	—	—	0	0	—	—	—	0	1	2	—
Arizona	—	0	0	—	—	—	0	0	—	—	—	0	1	2	—
Colorado	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Idaho§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Montana§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Nevada§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
New Mexico§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Utah	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Wyoming§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	1	—	1	—	0	0	—	—	—	0	1	1	2
Alaska	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
California	—	0	1	—	1	—	0	0	—	—	—	0	1	1	2
Hawaii	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Oregon	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Puerto Rico	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Cumulative total *E. ewingii* cases reported for year 2010 = 10, and 1 case reported for 2011.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive† All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	143	341	549	5,665	8,000	2,673	5,885	7,484	128,063	135,957	31	61	141	1,508	1,537
New England	3	26	55	413	681	53	100	206	2,136	2,434	—	4	9	84	87
Connecticut	—	5	12	85	126	—	41	150	823	1,142	—	0	6	21	18
Maine§	3	3	11	49	77	—	2	7	63	95	—	0	2	11	5
Massachusetts	—	13	25	176	293	39	48	80	1,039	977	—	2	6	37	46
New Hampshire	—	2	10	33	78	5	2	7	61	70	—	0	2	8	7
Rhode Island§	—	1	7	7	34	3	5	15	127	122	—	0	2	3	7
Vermont§	—	3	10	63	73	6	0	8	23	28	—	0	3	4	4
Mid. Atlantic	18	62	106	1,152	1,334	321	717	1,121	16,072	15,477	11	11	32	311	291
New Jersey	—	8	22	127	179	8	117	172	2,514	2,604	—	2	7	53	49
New York (Upstate)	15	22	72	392	454	105	114	271	2,524	2,328	5	3	18	82	78
New York City	—	17	30	337	376	57	239	497	5,247	5,401	—	2	5	50	51
Pennsylvania	3	15	27	296	325	151	260	364	5,787	5,144	6	4	11	126	113
E.N. Central	5	52	99	902	1,382	228	1,055	2,091	22,952	24,768	2	11	19	271	242
Illinois	—	10	31	160	312	2	297	369	5,268	6,744	1	3	9	73	85
Indiana	—	7	15	95	157	52	113	1,018	3,233	2,195	—	2	7	49	52
Michigan	2	11	25	190	297	134	248	490	5,489	6,426	1	1	4	29	19
Ohio	—	17	29	326	372	—	320	383	6,933	7,285	—	3	7	82	54
Wisconsin	3	8	35	131	244	40	98	130	2,029	2,118	—	2	5	38	32
W.N. Central	16	28	73	395	825	136	298	363	6,571	6,414	2	4	10	73	111
Iowa	4	5	12	101	117	4	36	57	844	776	—	0	0	—	1
Kansas	—	2	10	34	101	—	39	62	811	925	—	0	2	7	12
Minnesota	—	9	33	—	313	—	38	62	715	978	—	0	5	—	41
Missouri	7	8	26	145	158	113	144	181	3,330	2,984	1	1	5	39	40
Nebraska§	5	4	9	76	83	18	24	49	551	518	1	0	3	19	9
North Dakota	—	0	12	12	10	—	3	11	61	82	—	0	6	7	8
South Dakota	—	2	5	27	43	1	12	20	259	151	—	0	1	1	—
S. Atlantic	45	66	127	1,150	1,628	980	1,469	1,862	32,849	35,127	9	15	30	383	383
Delaware	—	0	5	10	14	19	17	48	423	456	—	0	2	3	4
District of Columbia	—	1	5	11	26	—	38	70	718	934	—	0	0	—	—
Florida	15	34	75	498	867	224	379	486	8,771	9,161	4	5	12	137	100
Georgia	22	15	51	373	311	169	313	874	6,944	7,011	—	3	7	75	89
Maryland§	2	4	10	95	145	—	127	246	2,291	3,087	4	1	4	32	27
North Carolina	N	0	0	N	N	273	257	490	6,903	6,945	—	2	9	40	54
South Carolina§	1	2	9	45	54	203	161	257	3,859	3,536	—	1	5	35	51
Virginia§	1	8	32	97	195	92	121	185	2,573	3,786	1	1	8	52	47
West Virginia	4	0	8	21	16	—	14	26	367	211	—	0	9	9	11
E.S. Central	3	4	11	68	69	301	495	1,007	10,956	11,180	2	3	10	103	98
Alabama§	3	4	11	68	69	—	160	406	3,432	3,341	—	1	4	31	17
Kentucky	N	0	0	N	N	65	73	712	1,942	1,818	—	1	4	14	16
Mississippi	N	0	0	N	N	159	115	216	2,390	2,863	—	0	2	10	9
Tennessee§	N	0	0	N	N	77	142	194	3,192	3,158	2	1	5	48	56
W.S. Central	1	5	17	69	147	282	855	1,664	18,346	22,235	—	2	26	63	74
Arkansas§	1	2	9	39	41	88	101	138	2,268	2,079	—	0	3	14	11
Louisiana	—	3	12	30	62	72	99	509	1,221	3,911	—	0	4	22	18
Oklahoma	—	0	5	—	44	122	78	332	1,562	1,735	—	1	19	26	40
Texas§	N	0	0	N	N	—	598	867	13,295	14,510	—	0	4	1	5
Mountain	14	28	58	460	730	93	189	255	4,174	4,303	5	5	12	142	176
Arizona	2	3	8	54	65	26	63	92	1,356	1,499	1	2	6	60	67
Colorado	11	12	27	219	310	32	48	92	1,010	1,214	3	1	5	34	46
Idaho§	1	3	9	56	98	—	2	14	48	50	1	0	2	8	10
Montana§	—	1	6	21	57	—	1	5	41	54	—	0	1	2	2
Nevada§	—	1	11	32	25	29	33	103	917	821	—	0	2	9	5
New Mexico§	—	2	6	24	37	4	28	98	688	477	—	1	4	21	22
Utah	—	4	13	42	117	2	4	10	95	169	—	0	3	8	19
Wyoming§	—	0	5	12	21	—	0	3	19	19	—	0	1	—	5
Pacific	38	51	129	1,056	1,204	279	624	807	14,007	14,019	—	3	10	78	75
Alaska	—	2	6	29	40	—	21	34	432	640	—	0	2	8	12
California	33	33	68	727	741	243	508	695	11,526	11,375	—	0	6	11	14
Hawaii	—	1	4	14	25	—	14	26	292	319	—	0	3	14	11
Oregon	—	8	20	156	218	7	23	40	560	472	—	1	6	44	34
Washington	5	9	57	130	180	29	57	86	1,197	1,213	—	0	2	1	4
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	1	—	0	5	6	8	—	0	0	—	—
Puerto Rico	—	1	7	10	38	—	6	12	163	134	—	0	0	—	1
U.S. Virgin Islands	—	0	0	—	—	—	3	7	49	56	—	0	0	—	—

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† Data for H. influenzae (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	Hepatitis (viral, acute), by type														
	A					B					C				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	12	24	74	440	705	15	58	167	952	1,447	11	17	39	399	364
New England	—	1	6	12	58	—	0	5	21	29	1	1	4	22	31
Connecticut	—	0	4	5	13	—	0	4	7	8	—	0	3	14	17
Maine†	—	0	1	1	4	—	0	2	5	9	1	0	2	5	2
Massachusetts	—	0	5	3	35	—	0	3	8	7	—	0	1	1	12
New Hampshire	—	0	1	—	—	—	0	1	1	4	N	0	0	N	N
Rhode Island†	—	0	1	1	6	U	0	0	U	U	U	0	0	U	U
Vermont†	—	0	1	2	—	—	0	1	—	1	—	0	1	2	—
Mid. Atlantic	5	4	12	88	114	—	5	11	117	147	—	1	6	30	47
New Jersey	—	1	4	10	32	—	1	4	23	40	—	0	4	—	9
New York (Upstate)	5	1	4	25	25	—	1	9	22	24	—	1	4	17	24
New York City	—	1	6	28	33	—	1	5	34	46	—	0	1	—	1
Pennsylvania	—	1	3	25	24	—	1	4	38	37	—	0	2	13	13
E.N. Central	1	4	9	79	81	1	7	23	121	238	1	3	11	87	45
Illinois	—	1	3	13	21	—	2	7	33	56	—	0	1	1	—
Indiana	—	0	3	10	9	—	1	6	13	33	—	0	5	32	17
Michigan	1	1	5	31	27	1	2	5	38	62	1	1	7	51	21
Ohio	—	1	5	22	15	—	1	16	25	59	—	0	1	2	4
Wisconsin	—	0	2	3	9	—	1	3	12	28	—	0	1	1	3
W.N. Central	—	1	25	16	23	—	2	16	55	60	—	0	6	2	6
Iowa	—	0	3	1	4	—	0	1	4	10	—	0	0	—	—
Kansas	—	0	2	3	7	—	0	2	6	4	—	0	1	2	—
Minnesota	—	0	22	2	1	—	0	15	2	2	—	0	6	—	3
Missouri	—	0	1	5	9	—	1	4	36	34	—	0	1	—	2
Nebraska†	—	0	4	3	2	—	0	3	6	9	—	0	1	—	1
North Dakota	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	2	2	—	—	0	1	1	1	—	0	0	—	—
S. Atlantic	1	5	14	101	150	5	14	33	267	409	7	4	10	97	83
Delaware	—	0	1	1	5	—	0	1	—	17	U	0	0	U	U
District of Columbia	—	0	0	—	1	—	0	0	—	3	—	0	0	—	2
Florida	1	2	7	38	55	2	4	11	93	144	3	1	5	24	23
Georgia	—	1	4	25	14	—	2	8	42	88	2	1	3	15	10
Maryland†	—	0	2	10	12	1	1	4	26	29	2	0	2	15	12
North Carolina	—	0	4	8	28	2	2	16	60	34	—	1	7	26	23
South Carolina†	—	0	2	4	18	—	1	4	13	24	—	0	1	—	—
Virginia†	—	1	6	11	16	—	1	7	28	40	—	0	2	8	7
West Virginia	—	0	5	4	1	—	0	18	5	30	—	0	5	9	6
E.S. Central	1	0	6	17	19	2	8	14	173	143	1	3	8	73	64
Alabama†	—	0	2	—	4	—	1	4	33	28	—	0	1	3	2
Kentucky	—	0	6	3	9	—	3	8	55	48	—	2	6	34	44
Mississippi	—	0	1	2	1	—	1	3	15	16	U	0	0	U	U
Tennessee†	1	0	5	12	5	2	3	8	70	51	1	1	5	36	18
W.S. Central	3	2	15	41	67	6	9	67	113	221	—	2	11	41	29
Arkansas†	—	0	1	—	—	—	1	4	19	33	—	0	1	—	—
Louisiana	—	0	1	1	5	—	1	4	18	23	—	0	2	4	1
Oklahoma	—	0	4	1	1	5	1	16	25	33	—	1	10	21	11
Texas†	3	2	11	39	61	1	4	45	51	132	—	0	3	16	17
Mountain	—	2	8	31	82	1	2	7	34	62	—	1	4	19	27
Arizona	—	0	4	8	38	—	0	2	11	13	U	0	0	U	U
Colorado	—	0	2	8	19	—	0	5	3	17	—	0	3	2	8
Idaho†	—	0	2	4	4	—	0	1	2	4	—	0	2	6	7
Montana†	—	0	1	2	4	—	0	0	—	—	—	0	1	2	—
Nevada†	—	0	3	4	6	1	1	3	15	20	—	0	2	6	2
New Mexico†	—	0	1	3	3	—	0	2	2	2	—	0	1	2	7
Utah	—	0	2	—	5	—	0	1	1	6	—	0	2	—	3
Wyoming†	—	0	3	2	3	—	0	1	—	—	—	0	1	1	—
Pacific	1	3	15	55	111	—	4	25	51	138	1	1	12	28	32
Alaska	—	0	1	1	—	—	0	1	2	1	U	0	1	U	U
California	—	2	15	35	87	—	2	22	20	96	—	0	4	8	14
Hawaii	—	0	2	4	5	—	0	1	4	3	U	0	0	U	U
Oregon	—	0	2	5	9	—	0	3	14	22	—	0	3	9	8
Washington	1	0	2	10	10	—	1	4	11	16	1	0	5	11	10
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	5	8	12	—	1	8	28	22	—	0	7	10	21
Puerto Rico	—	0	2	2	9	—	0	3	2	12	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	Legionellosis					Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	17	46	128	809	1,122	283	263	1,828	4,537	10,452	13	27	114	448	594
New England	—	4	16	38	71	5	70	503	711	3,638	—	1	20	16	39
Connecticut	—	1	6	10	12	—	27	213	358	1,386	—	0	20	—	2
Maine†	—	0	3	3	3	3	9	62	93	160	—	0	1	2	3
Massachusetts	—	1	10	17	40	—	14	223	94	1,418	—	0	4	9	27
New Hampshire	—	0	5	3	4	—	12	69	108	583	—	0	2	2	1
Rhode Island†	—	0	4	1	10	—	1	40	4	25	—	0	4	—	5
Vermont†	—	0	2	4	2	2	5	28	54	66	—	0	1	3	1
Mid. Atlantic	6	13	53	176	260	237	136	662	2,559	3,474	2	9	22	101	195
New Jersey	—	1	18	1	44	—	37	234	609	1,570	—	1	6	8	44
New York (Upstate)	5	5	19	79	70	114	36	159	516	633	1	1	6	17	30
New York City	—	2	17	28	52	—	7	31	2	266	—	4	13	53	92
Pennsylvania	1	5	19	68	94	123	60	279	1,432	1,005	1	1	4	23	29
E.N. Central	1	9	44	145	208	—	21	373	324	1,296	—	3	9	50	56
Illinois	—	1	14	15	44	—	1	17	7	46	—	1	6	18	22
Indiana	—	1	6	25	17	—	0	7	10	38	—	0	2	5	7
Michigan	1	3	20	32	37	—	1	14	11	15	—	0	4	8	6
Ohio	—	4	15	73	85	—	0	9	7	10	—	1	5	18	17
Wisconsin	—	0	5	—	25	—	18	345	289	1,187	—	0	2	1	4
W.N. Central	1	2	9	26	49	—	6	188	6	686	1	1	45	6	25
Iowa	—	0	2	4	3	—	0	10	4	34	—	0	2	2	6
Kansas	—	0	2	2	6	—	0	1	1	7	—	0	2	2	3
Minnesota	—	0	8	—	15	—	3	181	—	641	—	0	45	—	3
Missouri	1	0	5	18	15	—	0	1	—	1	—	0	3	—	3
Nebraska†	—	0	1	—	4	—	0	2	1	3	1	0	1	2	8
North Dakota	—	0	1	1	2	—	0	10	—	—	—	0	1	—	—
South Dakota	—	0	2	1	4	—	0	1	—	—	—	0	1	—	2
S. Atlantic	6	9	22	162	232	39	55	178	840	1,213	7	7	41	155	159
Delaware	—	0	3	3	8	7	10	32	246	308	—	0	1	2	2
District of Columbia	—	0	3	4	12	—	1	5	8	12	—	0	1	5	7
Florida	3	3	9	69	71	6	1	8	29	23	3	2	7	41	50
Georgia	—	1	4	9	33	—	0	2	3	4	1	1	7	30	27
Maryland†	1	1	6	25	49	13	16	103	279	539	3	1	21	34	26
North Carolina	1	1	6	22	22	—	1	9	18	32	—	0	13	13	18
South Carolina†	—	0	2	5	6	—	0	3	4	16	—	0	1	1	3
Virginia†	—	1	9	20	26	11	19	82	236	265	—	1	5	29	26
West Virginia	1	0	2	5	5	2	0	29	17	14	—	0	1	—	—
E.S. Central	1	2	9	63	61	—	0	4	13	23	—	0	3	11	11
Alabama†	—	0	2	10	6	—	0	2	5	—	—	0	1	3	2
Kentucky	1	0	4	12	10	—	0	1	—	2	—	0	1	4	3
Mississippi	—	0	2	6	8	—	0	0	—	—	—	0	2	1	—
Tennessee†	—	1	7	35	37	—	0	4	8	21	—	0	2	3	6
W.S. Central	—	3	13	34	49	—	1	29	16	41	1	1	18	21	33
Arkansas†	—	0	2	3	9	—	0	0	—	—	1	0	1	2	1
Louisiana	—	0	3	6	2	—	0	1	—	—	—	0	1	—	1
Oklahoma	—	0	2	2	6	—	0	0	—	—	—	0	1	2	3
Texas†	—	2	11	23	32	—	1	29	16	41	—	1	17	17	28
Mountain	1	2	10	39	72	—	0	3	4	6	1	1	4	25	25
Arizona	1	1	7	15	20	—	0	1	3	1	1	0	4	14	10
Colorado	—	0	2	4	16	—	0	1	—	—	—	0	3	5	9
Idaho†	—	0	1	2	1	—	0	2	—	2	—	0	1	1	—
Montana†	—	0	1	—	3	—	0	1	—	—	—	0	1	—	1
Nevada†	—	0	2	8	14	—	0	1	—	—	—	0	2	3	2
New Mexico†	—	0	2	2	2	—	0	2	1	1	—	0	1	2	—
Utah	—	0	2	7	13	—	0	1	—	2	—	0	0	—	3
Wyoming†	—	0	2	1	3	—	0	0	—	—	—	0	0	—	—
Pacific	1	5	21	126	120	2	3	11	64	75	1	4	10	63	51
Alaska	—	0	2	—	—	—	0	1	—	2	—	0	2	3	2
California	—	4	15	112	107	2	2	9	46	49	—	2	10	46	31
Hawaii	—	0	1	1	1	N	0	0	N	N	—	0	1	2	2
Oregon	—	0	3	4	4	—	0	3	18	21	—	0	3	5	5
Washington	1	0	6	9	8	—	0	4	—	3	1	0	5	7	11
Territories															
American Samoa	N	0	0	N	N	N	0	0	N	N	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	1	N	0	0	N	N	—	0	1	—	4
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
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† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	Meningococcal disease, invasive† All serogroups					Mumps					Pertussis				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	10	15	53	380	428	—	11	217	140	2,084	67	547	2,925	5,676	6,691
New England	—	0	4	20	9	—	0	2	1	18	2	10	24	148	152
Connecticut	—	0	1	3	—	—	0	0	—	11	—	1	8	18	24
Maine§	—	0	1	3	3	—	0	1	—	1	2	1	8	52	14
Massachusetts	—	0	2	9	2	—	0	2	1	5	—	5	13	48	97
New Hampshire	—	0	1	1	—	—	0	2	—	1	—	1	4	25	5
Rhode Island§	—	0	1	—	—	—	0	0	—	—	—	0	7	3	9
Vermont§	—	0	3	4	4	—	0	0	—	—	—	0	4	2	3
Mid. Atlantic	—	1	5	38	42	—	3	209	18	1,837	26	39	125	569	367
New Jersey	—	0	1	—	13	—	1	8	8	297	—	2	10	42	63
New York (Upstate)	—	0	4	10	8	—	0	5	3	636	13	12	81	173	124
New York City	—	0	3	16	11	—	0	201	7	890	2	1	19	24	24
Pennsylvania	—	0	2	12	10	—	0	16	—	14	11	18	70	330	156
E.N. Central	—	2	7	48	75	—	1	7	37	35	—	112	198	1,288	1,603
Illinois	—	0	2	12	15	—	1	3	23	10	—	21	50	271	281
Indiana	—	0	2	6	16	—	0	1	—	3	—	11	26	87	253
Michigan	—	0	4	5	11	—	0	1	5	14	—	29	57	387	448
Ohio	—	1	2	17	18	—	0	5	9	7	—	32	80	401	522
Wisconsin	—	0	2	8	15	—	0	1	—	1	—	13	26	142	99
W.N. Central	1	1	4	26	31	—	0	4	18	71	2	38	501	452	515
Iowa	—	0	1	6	7	—	0	2	3	33	—	9	36	75	206
Kansas	—	0	1	2	4	—	0	1	3	3	—	2	9	33	77
Minnesota	—	0	2	—	2	—	0	4	1	3	—	0	469	157	5
Missouri	—	0	2	8	13	—	0	3	6	8	1	6	43	129	169
Nebraska§	1	0	2	7	4	—	0	1	1	23	1	4	13	36	39
North Dakota	—	0	1	1	1	—	0	3	4	—	—	0	30	20	—
South Dakota	—	0	1	2	—	—	0	1	—	1	—	0	2	2	19
S. Atlantic	5	2	8	71	80	—	0	4	10	34	11	36	106	581	621
Delaware	—	0	1	1	—	—	0	0	—	—	—	0	2	10	5
District of Columbia	—	0	1	—	—	—	0	1	—	2	—	0	2	2	3
Florida	3	1	5	30	39	—	0	2	2	6	6	5	15	126	128
Georgia	—	0	2	4	6	—	0	2	1	2	2	4	13	80	87
Maryland§	—	0	1	6	4	—	0	1	1	8	—	2	6	39	54
North Carolina	1	0	3	12	9	—	0	2	4	5	—	3	35	95	132
South Carolina§	1	0	1	7	7	—	0	1	—	3	1	6	25	66	132
Virginia§	—	0	2	9	13	—	0	2	2	6	2	7	41	118	72
West Virginia	—	0	1	2	2	—	0	0	—	2	—	1	41	45	8
E.S. Central	1	1	3	17	21	—	0	1	3	9	—	12	35	169	362
Alabama§	1	0	2	9	4	—	0	1	1	6	—	3	11	67	107
Kentucky	—	0	1	—	8	—	0	0	—	1	—	3	16	42	130
Mississippi	—	0	1	2	3	—	0	1	2	—	—	1	10	8	31
Tennessee§	—	0	2	6	6	—	0	1	—	2	—	3	11	52	94
W.S. Central	—	1	12	31	48	—	1	15	43	42	9	43	297	443	1,314
Arkansas§	—	0	1	7	5	—	0	1	1	3	—	3	18	28	67
Louisiana	—	0	2	5	11	—	0	2	—	4	—	1	3	10	20
Oklahoma	—	0	2	5	12	—	0	1	1	—	—	0	92	17	11
Texas§	—	1	10	14	20	—	1	14	41	35	9	35	187	388	1,216
Mountain	—	1	6	29	33	—	0	4	2	10	9	43	100	870	537
Arizona	—	0	2	8	7	—	0	1	—	4	5	14	29	342	195
Colorado	—	0	4	4	12	—	0	1	1	5	2	13	63	306	60
Idaho§	—	0	1	3	5	—	0	1	—	—	1	2	15	41	73
Montana§	—	0	2	3	1	—	0	0	—	—	1	2	16	58	24
Nevada§	—	0	1	3	5	—	0	1	—	—	—	0	7	15	7
New Mexico§	—	0	1	1	2	—	0	2	1	—	—	3	11	57	36
Utah	—	0	2	7	1	—	0	1	—	1	—	5	16	49	137
Wyoming§	—	0	1	—	—	—	0	1	—	—	—	0	2	2	5
Pacific	3	4	26	100	89	—	0	3	8	28	8	141	1,710	1,156	1,220
Alaska	—	0	1	1	1	—	0	1	1	1	—	0	6	16	12
California	3	2	17	69	56	—	0	3	2	18	1	122	1,569	887	981
Hawaii	—	0	1	3	1	—	0	1	2	2	—	1	6	17	26
Oregon	—	1	3	16	17	—	0	1	3	1	—	5	11	96	132
Washington	—	0	8	11	14	—	0	1	—	6	7	12	131	140	69
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	3	16	12	361	—	0	14	31	—
Puerto Rico	—	0	1	—	—	—	0	1	—	—	—	0	1	1	1
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
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† Data for meningococcal disease, invasive caused by serogroups A, C, Y, and W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	Rabies, animal					Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	14	64	172	1,064	1,924	590	876	1,812	13,305	16,094	58	95	264	1,497	1,541
New England	—	4	18	46	122	1	25	185	499	1,199	—	2	24	52	111
Connecticut	—	0	8	—	59	—	0	163	163	491	—	0	24	24	60
Maine§	—	1	3	23	27	—	2	8	47	44	—	0	3	11	3
Massachusetts	—	0	0	—	—	—	17	52	204	483	—	0	9	5	31
New Hampshire	—	0	6	6	4	1	3	12	56	70	—	0	3	9	11
Rhode Island§	—	0	3	2	10	—	1	9	10	90	—	0	1	—	1
Vermont§	—	1	3	15	22	—	1	5	19	21	—	0	2	3	5
Mid. Atlantic	4	16	33	295	509	57	87	217	1,484	1,984	6	9	30	162	156
New Jersey	—	0	0	—	—	—	14	57	129	386	—	2	9	31	39
New York (Upstate)	4	7	19	126	223	38	25	63	426	453	5	3	12	57	53
New York City	—	0	4	—	124	—	19	53	337	470	—	1	6	21	15
Pennsylvania	—	8	17	169	162	19	32	80	592	675	1	3	13	53	49
E.N. Central	2	2	27	46	64	6	82	265	1,411	2,219	2	11	48	170	261
Illinois	1	1	11	14	27	—	26	123	478	768	—	2	9	16	55
Indiana	—	0	3	4	—	—	10	61	143	234	—	2	10	36	38
Michigan	1	1	5	12	24	6	13	49	238	349	2	2	7	45	62
Ohio	—	0	12	16	13	—	21	46	377	559	—	2	11	50	46
Wisconsin	N	0	0	N	N	—	11	57	175	309	—	2	16	23	60
W.N. Central	—	2	40	34	106	20	48	121	760	983	15	13	49	178	270
Iowa	—	0	3	—	7	4	9	34	174	151	—	2	16	35	44
Kansas	—	1	4	15	30	—	7	18	108	150	—	1	5	24	24
Minnesota	—	0	34	—	14	—	5	30	—	278	—	2	20	—	73
Missouri	—	0	6	—	27	12	16	43	316	262	11	4	12	74	91
Nebraska§	—	0	3	12	24	4	4	13	79	73	4	1	6	32	26
North Dakota	—	0	6	7	4	—	0	15	15	13	—	0	10	4	3
South Dakota	—	0	0	—	—	—	3	17	68	56	—	0	4	9	9
S. Atlantic	5	20	52	516	552	236	276	624	3,912	3,763	7	18	31	369	220
Delaware	—	0	0	—	—	1	3	11	48	48	—	0	2	5	1
District of Columbia	—	0	0	—	—	—	1	7	13	42	—	0	1	1	6
Florida	—	0	29	49	121	100	109	226	1,605	1,691	5	6	15	176	70
Georgia	—	0	0	—	—	21	39	142	646	602	—	2	7	36	31
Maryland§	—	6	14	127	167	19	19	54	303	320	—	2	8	36	27
North Carolina	—	0	0	—	—	82	29	241	606	389	—	2	10	39	18
South Carolina§	N	0	0	N	N	4	28	99	317	293	—	0	4	11	10
Virginia§	5	12	27	289	227	9	21	68	341	301	2	3	9	63	52
West Virginia	—	0	30	51	37	—	0	14	33	77	—	0	4	2	5
E.S. Central	2	3	7	61	93	36	54	175	868	902	7	5	22	104	80
Alabama§	2	1	7	43	42	20	20	52	251	248	—	1	4	17	20
Kentucky	—	0	4	5	4	—	9	32	119	182	—	1	6	13	12
Mississippi	—	0	0	—	—	—	16	65	231	224	—	0	12	5	9
Tennessee§	—	1	4	13	47	16	17	53	267	248	7	3	12	69	39
W.S. Central	1	9	54	48	387	74	134	515	1,571	1,716	3	8	151	111	82
Arkansas§	1	0	10	36	11	4	14	43	195	146	3	0	4	12	19
Louisiana	—	0	0	—	—	—	17	52	141	410	—	0	2	3	8
Oklahoma	—	0	30	12	6	10	11	95	164	171	—	1	55	12	4
Texas§	—	7	30	—	370	60	93	381	1,071	989	—	6	95	84	51
Mountain	—	0	5	5	24	27	48	113	878	1,049	16	10	33	160	183
Arizona	N	0	0	N	N	2	15	43	278	325	—	1	14	36	27
Colorado	—	0	0	—	—	13	10	24	197	235	5	3	21	21	63
Idaho§	—	0	2	—	1	1	3	9	65	63	3	2	7	33	19
Montana§	N	0	0	N	N	7	2	6	44	44	4	1	3	14	20
Nevada§	—	0	2	—	2	2	4	21	71	96	1	0	6	15	10
New Mexico§	—	0	2	3	5	1	6	19	80	106	—	1	6	16	15
Utah	—	0	3	2	1	1	6	17	119	160	—	1	8	18	21
Wyoming§	—	0	4	—	15	—	1	8	24	20	3	0	3	7	8
Pacific	—	3	15	13	67	133	103	288	1,922	2,279	2	13	46	191	178
Alaska	—	0	2	9	11	—	1	4	28	38	—	0	1	—	1
California	—	2	10	—	48	96	75	232	1,452	1,566	1	8	36	133	79
Hawaii	—	0	0	—	—	7	6	13	129	133	—	0	3	4	15
Oregon	—	0	2	4	8	—	7	20	115	272	1	2	11	25	25
Washington	—	0	14	—	—	30	15	42	198	270	—	3	20	29	58
Territories															
American Samoa	N	0	0	N	N	—	0	1	—	1	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	3	6	2	—	0	0	—	—
Puerto Rico	—	0	6	18	23	—	7	25	31	244	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
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† Includes E. coli O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	Shigellosis					Spotted Fever Rickettsiosis (including RMSF)†									
						Confirmed					Probable				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	232	257	742	4,124	6,183	5	2	11	36	50	11	21	245	260	385
New England	3	3	19	76	171	—	0	0	—	—	—	0	1	1	1
Connecticut	—	0	17	17	69	—	0	0	—	—	—	0	0	—	—
Maine§	3	0	4	14	3	—	0	0	—	—	—	0	1	—	1
Massachusetts	—	2	16	42	86	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	2	1	4	—	0	0	—	—	—	0	1	—	—
Rhode Island§	—	0	4	—	8	—	0	0	—	—	—	0	1	1	—
Vermont§	—	0	1	2	1	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	2	15	74	231	819	—	0	1	3	2	1	1	6	8	36
New Jersey	—	3	16	40	186	—	0	0	—	1	—	0	4	—	25
New York (Upstate)	2	3	15	66	77	—	0	0	—	1	—	0	3	1	2
New York City	—	4	14	85	149	—	0	0	—	—	—	0	2	4	4
Pennsylvania	—	4	56	40	407	—	0	1	3	—	1	0	1	3	5
E.N. Central	2	18	37	251	908	—	0	1	—	—	—	1	7	16	29
Illinois	—	6	20	62	584	—	0	1	—	—	—	0	4	8	15
Indiana§	—	1	4	27	24	—	0	1	—	—	—	0	3	4	8
Michigan	2	4	9	63	110	—	0	0	—	—	—	0	1	—	1
Ohio	—	5	15	99	146	—	0	0	—	—	—	0	2	4	3
Wisconsin	—	0	4	—	44	—	0	0	—	—	—	0	1	—	2
W.N. Central	1	16	71	160	1,359	1	0	2	4	2	3	3	17	60	85
Iowa	—	1	4	8	28	—	0	0	—	—	—	0	1	1	2
Kansas§	—	3	12	27	136	—	0	0	—	—	—	0	0	—	—
Minnesota	—	0	4	—	20	—	0	0	—	—	—	0	2	—	—
Missouri	1	9	56	119	1,157	1	0	2	4	2	3	3	17	59	82
Nebraska§	—	0	10	3	14	—	0	2	—	—	—	0	1	—	1
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	2	3	4	—	0	0	—	—	—	0	0	—	—
S. Atlantic	122	63	122	1,586	892	1	1	7	20	32	2	6	59	74	101
Delaware§	—	0	2	1	31	—	0	1	1	1	—	0	2	6	9
District of Columbia	—	0	3	6	18	—	0	1	1	—	—	0	0	—	—
Florida§	101	32	83	1,153	330	—	0	1	2	2	—	0	2	1	5
Georgia	13	13	26	210	318	1	0	5	11	27	—	0	0	—	—
Maryland§	1	2	8	40	45	—	0	1	1	—	—	0	5	6	13
North Carolina	6	3	36	113	67	—	0	3	1	2	—	2	47	32	42
South Carolina§	—	1	5	21	32	—	0	1	3	—	1	0	2	8	3
Virginia§	1	2	8	38	50	—	0	2	—	—	—	2	12	20	29
West Virginia	—	0	66	4	1	—	0	0	—	—	1	0	0	1	—
E.S. Central	7	13	29	222	343	3	0	3	3	7	4	5	31	72	109
Alabama§	6	5	15	80	51	—	0	1	—	—	1	1	9	18	18
Kentucky	—	1	6	30	156	—	0	1	—	5	—	0	0	—	—
Mississippi	—	2	6	54	17	—	0	1	—	—	—	0	4	1	6
Tennessee§	1	4	14	58	119	3	0	2	3	2	3	4	20	53	85
W.S. Central	71	55	503	892	1,010	—	0	8	—	1	—	1	235	7	20
Arkansas§	—	2	7	24	20	—	0	2	—	—	—	0	28	1	6
Louisiana	—	5	13	49	116	—	0	0	—	—	—	0	1	—	1
Oklahoma	—	2	161	40	142	—	0	5	—	—	—	0	202	4	8
Texas§	71	46	338	779	732	—	0	1	—	1	—	0	5	2	5
Mountain	6	16	32	303	282	—	0	5	6	2	1	0	7	22	4
Arizona	2	7	19	84	152	—	0	4	6	—	—	0	7	19	—
Colorado§	1	2	8	37	37	—	0	1	—	—	—	0	1	1	—
Idaho§	—	0	3	8	8	—	0	0	—	—	—	0	1	—	1
Montana§	3	0	15	96	4	—	0	1	—	2	—	0	1	—	1
Nevada§	—	0	6	10	15	—	0	0	—	—	—	0	0	—	—
New Mexico§	—	3	10	50	50	—	0	0	—	—	—	0	0	—	1
Utah	—	1	4	17	16	—	0	0	—	—	—	0	1	—	1
Wyoming§	—	0	1	1	—	—	0	0	—	—	1	0	1	2	—
Pacific	18	23	63	403	399	—	0	2	—	4	—	0	1	—	—
Alaska	—	0	2	3	—	N	0	0	N	N	N	0	0	N	N
California	11	18	59	309	319	—	0	2	—	4	—	0	0	—	—
Hawaii	—	1	4	27	26	N	0	0	N	N	N	0	0	N	N
Oregon	—	1	4	26	28	—	0	0	—	—	—	0	1	—	—
Washington	7	1	22	38	26	—	0	1	—	—	—	0	0	—	—
Territories															
American Samoa	—	1	1	1	1	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	1	1	N	0	0	N	N	N	0	0	N	N
Puerto Rico	—	0	1	—	2	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Illnesses with similar clinical presentation that result from Spotted fever group rickettsia infections are reported as Spotted fever rickettsioses. Rocky Mountain spotted fever (RMSF) caused by Rickettsia rickettsii, is the most common and well-known spotted fever.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	*Streptococcus pneumoniae*,† invasive disease										Syphilis, primary and secondary				
	All ages					Age <5									
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	102	282	937	7,312	9,052	14	24	101	563	1,100	55	256	363	5,134	5,949
New England	—	11	79	209	480	—	1	5	23	66	1	8	19	168	207
Connecticut	—	0	49	7	216	—	0	3	6	20	—	1	8	24	40
Maine§	—	2	13	74	75	—	0	1	3	5	—	0	3	8	14
Massachusetts	—	0	3	14	50	—	0	3	6	35	—	5	14	100	128
New Hampshire	—	2	8	63	69	—	0	1	3	3	—	0	3	12	9
Rhode Island§	—	0	36	8	19	—	0	3	—	1	1	0	7	20	14
Vermont§	—	1	6	43	51	—	0	2	5	2	—	0	2	4	2
Mid. Atlantic	5	22	81	491	954	4	3	27	71	140	7	32	46	636	770
New Jersey	—	6	29	83	425	—	1	4	22	37	—	4	10	96	115
New York (Upstate)	3	2	10	50	99	2	1	9	28	75	5	2	20	81	43
New York City	2	14	42	358	430	2	0	14	21	28	—	16	31	303	431
Pennsylvania	N	0	0	N	N	N	0	0	N	N	2	7	13	156	181
E.N. Central	7	65	109	1,742	1,863	—	4	10	103	165	3	30	56	548	875
Illinois	N	0	0	N	N	N	0	0	N	N	—	14	23	212	431
Indiana	1	14	32	348	424	—	1	4	16	33	3	3	14	65	69
Michigan	2	14	29	391	425	—	1	4	24	52	—	4	10	84	127
Ohio	—	26	45	739	722	—	2	7	51	57	—	9	21	167	225
Wisconsin	4	9	24	264	292	—	0	3	12	23	—	1	4	20	23
W.N. Central	1	6	35	87	486	—	1	5	4	68	2	7	18	129	125
Iowa	N	0	0	N	N	N	0	0	N	N	—	0	3	9	7
Kansas	N	0	0	N	N	N	0	0	N	N	—	0	3	7	10
Minnesota	—	4	24	—	371	—	0	5	—	55	—	3	10	56	32
Missouri	N	0	0	N	N	N	0	0	N	N	2	2	9	55	71
Nebraska§	1	2	9	69	78	—	0	1	4	11	—	0	2	2	5
North Dakota	—	0	18	18	37	—	0	1	—	2	—	0	1	—	—
South Dakota	N	0	0	N	N	N	0	0	N	N	—	0	1	—	—
S. Atlantic	42	67	170	2,052	2,451	3	7	22	153	299	24	63	178	1,328	1,356
Delaware	2	1	6	33	21	—	0	1	—	—	2	0	4	8	3
District of Columbia	—	1	3	27	50	—	0	1	4	7	—	3	8	71	61
Florida	32	22	68	849	928	2	3	13	76	117	1	23	44	491	475
Georgia	5	18	54	431	801	—	2	7	35	94	—	10	130	211	297
Maryland§	2	9	32	299	287	1	0	4	15	34	—	7	17	168	116
North Carolina	N	0	0	N	N	N	0	0	N	N	12	7	19	178	223
South Carolina§	1	8	25	288	306	—	1	3	18	35	6	3	10	98	59
Virginia§	N	0	0	N	N	N	0	0	N	N	3	5	16	103	119
West Virginia	—	1	48	125	58	—	0	6	5	12	—	0	2	—	3
E.S. Central	10	19	36	553	625	2	1	4	32	61	2	15	34	290	407
Alabama§	N	0	0	N	N	N	0	0	N	N	—	3	11	67	120
Kentucky	N	0	0	N	N	N	0	0	N	N	—	2	16	48	61
Mississippi	N	0	0	N	N	N	0	0	N	N	1	3	16	63	94
Tennessee§	10	19	36	553	625	2	1	4	32	61	1	5	11	112	132
W.S. Central	17	34	368	1,087	1,055	1	4	30	97	136	8	37	71	746	909
Arkansas§	—	3	26	138	98	—	0	3	11	11	4	3	10	84	117
Louisiana	—	3	11	97	59	—	0	2	8	16	1	8	36	149	188
Oklahoma	N	0	0	N	N	N	0	0	N	N	3	1	6	25	47
Texas§	17	28	333	852	898	1	3	27	78	109	—	23	33	488	557
Mountain	20	31	72	1,004	1,078	4	3	8	74	152	3	12	24	228	244
Arizona	11	11	43	501	531	2	1	5	37	69	—	4	9	72	97
Colorado	9	9	23	276	313	2	1	3	18	44	—	2	8	49	56
Idaho§	N	0	0	N	N	N	0	0	N	N	—	0	2	4	2
Montana§	N	0	0	N	N	N	0	0	N	N	—	0	2	1	—
Nevada§	N	0	0	N	N	N	0	0	N	N	3	2	9	67	39
New Mexico§	—	3	13	147	98	—	0	2	9	13	—	1	4	29	15
Utah	—	3	8	63	126	—	0	3	10	24	—	0	5	6	35
Wyoming§	—	0	15	17	10	—	0	1	—	2	—	0	0	—	—
Pacific	—	2	11	87	60	—	0	2	6	13	5	51	66	1,061	1,056
Alaska	—	2	11	86	60	—	0	2	6	13	—	0	0	—	3
California	N	0	0	N	N	N	0	0	N	N	3	41	57	879	898
Hawaii	—	0	3	1	—	—	0	0	—	—	—	0	5	6	20
Oregon	N	0	0	N	N	N	0	0	N	N	—	1	7	38	27
Washington	N	0	0	N	N	N	0	0	N	N	2	6	13	138	108
Territories															
American Samoa	N	0	0	N	N	N	0	0	N	N	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	—	4	11	99	113
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Includes drug resistant and susceptible cases of invasive Streptococcus pneumoniae disease among children <5 years and among all ages. Case definition: Isolation of S. pneumoniae from a normally sterile body site (e.g., blood or cerebrospinal fluid).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2011, and June 19, 2010 (24th week)*

Reporting area	Varicella (chickenpox)					West Nile virus disease†									
						Neuroinvasive					Nonneuroinvasive§				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	93	247	358	5,689	8,735	—	0	71	—	6	—	0	53	1	15
New England	—	19	46	408	582	—	0	3	—	—	—	0	2	—	1
Connecticut	—	5	15	117	170	—	0	2	—	—	—	0	2	—	1
Maine¶	—	5	16	115	105	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	4	17	103	157	—	0	2	—	—	—	0	1	—	—
New Hampshire	—	1	9	9	70	—	0	1	—	—	—	0	0	—	—
Rhode Island¶	—	0	4	6	18	—	0	0	—	—	—	0	0	—	—
Vermont¶	—	2	10	58	62	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	28	29	50	728	949	—	0	19	—	—	—	0	13	—	—
New Jersey	13	8	26	234	353	—	0	3	—	—	—	0	6	—	—
New York (Upstate)	N	0	0	N	N	—	0	9	—	—	—	0	7	—	—
New York City	—	0	0	—	—	—	0	7	—	—	—	0	4	—	—
Pennsylvania	15	19	41	494	596	—	0	3	—	—	—	0	3	—	—
E.N. Central	10	68	118	1,606	2,985	—	0	15	—	—	—	0	7	—	—
Illinois	—	17	31	413	737	—	0	10	—	—	—	0	4	—	—
Indiana¶	3	5	18	123	211	—	0	2	—	—	—	0	2	—	—
Michigan	7	19	38	516	930	—	0	6	—	—	—	0	1	—	—
Ohio	—	20	58	553	801	—	0	1	—	—	—	0	1	—	—
Wisconsin	—	4	22	1	306	—	0	0	—	—	—	0	1	—	—
W.N. Central	—	9	35	176	454	—	0	7	—	—	—	0	11	—	7
Iowa	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
Kansas¶	—	2	8	53	196	—	0	1	—	—	—	0	3	—	2
Minnesota	—	0	0	—	—	—	0	1	—	—	—	0	3	—	—
Missouri	—	6	24	90	211	—	0	1	—	—	—	0	0	—	—
Nebraska¶	—	0	5	3	3	—	0	3	—	—	—	0	7	—	4
North Dakota	—	0	10	16	29	—	0	2	—	—	—	0	2	—	—
South Dakota	—	1	7	14	15	—	0	2	—	—	—	0	3	—	1
S. Atlantic	16	36	64	999	1,237	—	0	6	—	—	—	0	4	—	3
Delaware¶	—	0	3	5	19	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	1	8	13	—	0	1	—	—	—	0	1	—	—
Florida¶	11	15	38	504	626	—	0	3	—	—	—	0	1	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	3	—	3
Maryland¶	N	0	0	N	N	—	0	3	—	—	—	0	2	—	—
North Carolina	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
South Carolina¶	—	0	8	11	74	—	0	1	—	—	—	0	0	—	—
Virginia¶	5	9	29	230	261	—	0	1	—	—	—	0	1	—	—
West Virginia	—	7	32	241	244	—	0	0	—	—	—	0	0	—	—
E.S. Central	3	5	15	160	171	—	0	1	—	1	—	0	3	1	1
Alabama¶	3	5	14	152	165	—	0	1	—	—	—	0	1	—	1
Kentucky	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
Mississippi	—	0	3	8	6	—	0	1	—	1	—	0	2	1	—
Tennessee¶	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
W.S. Central	30	43	258	1,186	1,659	—	0	16	—	—	—	0	3	—	—
Arkansas¶	2	3	17	118	116	—	0	3	—	—	—	0	1	—	—
Louisiana	—	1	5	18	42	—	0	3	—	—	—	0	1	—	—
Oklahoma	N	0	0	N	N	—	0	1	—	—	—	0	0	—	—
Texas¶	28	38	247	1,050	1,501	—	0	15	—	—	—	0	2	—	—
Mountain	4	14	50	366	642	—	0	18	—	3	—	0	15	—	3
Arizona	—	0	0	—	—	—	0	13	—	3	—	0	9	—	2
Colorado¶	4	6	31	139	224	—	0	5	—	—	—	0	11	—	1
Idaho¶	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
Montana¶	—	2	28	92	129	—	0	0	—	—	—	0	0	—	—
Nevada¶	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
New Mexico¶	—	1	8	21	61	—	0	6	—	—	—	0	2	—	—
Utah	—	4	26	107	215	—	0	1	—	—	—	0	1	—	—
Wyoming¶	—	0	3	7	13	—	0	1	—	—	—	0	1	—	—
Pacific	2	3	6	60	56	—	0	8	—	2	—	0	6	—	—
Alaska	—	1	5	30	21	—	0	0	—	—	—	0	0	—	—
California	—	0	3	6	18	—	0	8	—	2	—	0	6	—	—
Hawaii	2	1	4	24	17	—	0	0	—	—	—	0	0	—	—
Oregon	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Washington	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	4	16	9	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	8	31	53	261	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
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† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table, except starting in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/osels/ph_surveillance/nndss/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending June 18, 2011 (24th week)

Reporting area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
New England	493	350	100	26	8	9	41
Boston, MA	114	77	24	9	3	1	5
Bridgeport, CT	33	27	4	1	1	—	5
Cambridge, MA	13	10	2	1	—	—	2
Fall River, MA	24	20	4	—	—	—	3
Hartford, CT	55	44	9	1	—	1	5
Lowell, MA	21	18	3	—	—	—	—
Lynn, MA	7	6	1	—	—	—	—
New Bedford, MA	14	11	2	1	—	—	3
New Haven, CT	45	20	22	2	—	1	2
Providence, RI	56	40	10	4	—	2	3
Somerville, MA	1	—	1	—	—	—	—
Springfield, MA	25	12	4	2	3	4	3
Waterbury, CT	30	21	8	—	1	—	1
Worcester, MA	55	44	6	5	—	—	9
Mid. Atlantic	2,205	1,480	547	98	46	33	120
Albany, NY	49	37	6	2	—	4	2
Allentown, PA	35	26	9	—	—	—	—
Buffalo, NY	63	41	16	1	2	3	6
Camden, NJ	28	17	7	2	1	1	3
Elizabeth, NJ	18	9	5	3	1	—	2
Erie, PA	48	29	14	3	1	1	1
Jersey City, NJ	19	14	4	1	—	—	1
New York City, NY	1,127	789	263	45	16	14	58
Newark, NJ	35	20	10	2	2	1	3
Paterson, NJ	15	9	5	—	—	1	1
Philadelphia, PA	457	262	137	33	17	7	22
Pittsburgh, PA§	33	25	7	1	—	—	1
Reading, PA	20	15	3	1	1	—	2
Rochester, NY	74	47	22	1	3	1	4
Schenectady, NY	20	13	5	1	1	—	3
Scranton, PA	17	12	4	1	—	—	—
Syracuse, NY	100	81	18	1	—	—	9
Trenton, NJ	23	16	6	—	1	—	—
Utica, NY	5	5	—	—	—	—	—
Yonkers, NY	19	13	6	—	—	—	2
E.N. Central	1,872	1,222	470	102	44	34	129
Akron, OH	52	30	15	3	1	3	5
Canton, OH	27	20	5	—	—	2	2
Chicago, IL	221	137	67	13	4	—	13
Cincinnati, OH	61	38	14	4	4	1	10
Cleveland, OH	225	154	53	15	3	—	13
Columbus, OH	209	134	53	8	9	5	9
Dayton, OH	125	94	25	5	—	1	13
Detroit, MI	172	88	54	15	9	6	8
Evansville, IN	41	28	12	1	—	—	1
Fort Wayne, IN	66	45	12	6	3	—	6
Gary, IN	14	7	7	—	—	—	1
Grand Rapids, MI	53	38	10	4	1	—	5
Indianapolis, IN	176	106	43	15	4	8	11
Lansing, MI	44	27	13	2	2	—	2
Milwaukee, WI	86	56	24	3	1	2	7
Peoria, IL	44	27	10	3	1	3	5
Rockford, IL	61	48	10	1	2	—	2
South Bend, IN	50	42	6	—	—	2	7
Toledo, OH	84	51	28	4	—	1	6
Youngstown, OH	61	52	9	—	—	—	3
W.N. Central	621	404	154	34	14	15	36
Des Moines, IA	85	58	23	2	—	2	6
Duluth, MN	35	23	11	1	—	—	3
Kansas City, KS	20	10	6	1	2	1	—
Kansas City, MO	79	51	20	4	3	1	3
Lincoln, NE	43	32	10	—	1	—	1
Minneapolis, MN	64	32	21	5	2	4	3
Omaha, NE	101	72	18	8	1	2	7
St. Louis, MO	22	10	8	1	2	1	1
St. Paul, MN	70	46	17	3	1	3	5
Wichita, KS	102	70	20	9	2	1	7
S. Atlantic	1,198	728	323	92	33	22	70
Atlanta, GA	165	90	55	12	6	2	6
Baltimore, MD	129	67	42	16	3	1	7
Charlotte, NC	135	85	27	14	4	5	9
Jacksonville, FL	105	72	28	2	2	1	4
Miami, FL	137	89	33	9	4	2	8
Norfolk, VA	55	36	11	4	1	3	1
Richmond, VA	66	31	22	8	5	—	5
Savannah, GA	69	46	19	4	—	—	8
St. Petersburg, FL	51	33	9	5	2	2	5
Tampa, FL	147	100	39	7	1	—	8
Washington, D.C.	123	68	34	10	5	6	8
Wilmington, DE	16	11	4	1	—	—	1
E.S. Central	891	551	239	57	24	20	62
Birmingham, AL	176	108	43	11	6	8	16
Chattanooga, TN	75	46	20	7	2	—	3
Knoxville, TN	98	73	18	5	1	1	14
Lexington, KY	83	49	29	3	1	1	2
Memphis, TN	176	115	39	15	3	4	10
Mobile, AL	88	53	24	5	3	3	6
Montgomery, AL	44	30	10	3	—	1	6
Nashville, TN	151	77	56	8	8	2	5
W.S. Central	1,023	631	269	73	28	22	64
Austin, TX	88	55	25	5	1	2	4
Baton Rouge, LA	U	U	U	U	U	U	U
Corpus Christi, TX	62	35	20	6	—	1	5
Dallas, TX	183	115	41	16	8	3	6
El Paso, TX	72	43	20	7	1	1	10
Fort Worth, TX	U	U	U	U	U	U	U
Houston, TX	155	69	53	13	8	12	14
Little Rock, AR	73	46	20	5	1	1	—
New Orleans, LA	U	U	U	U	U	U	U
San Antonio, TX	221	146	53	15	5	2	16
Shreveport, LA	42	29	11	2	—	—	3
Tulsa, OK	127	93	26	4	4	—	6
Mountain	1,106	698	276	91	25	15	60
Albuquerque, NM	106	68	26	8	2	2	7
Boise, ID	57	42	13	1	1	—	4
Colorado Springs, CO	50	26	9	13	2	—	1
Denver, CO	94	51	28	11	2	2	7
Las Vegas, NV	266	164	73	22	3	3	17
Ogden, UT	37	26	8	2	1	—	2
Phoenix, AZ	170	100	44	17	7	2	11
Pueblo, CO	31	19	9	3	—	—	1
Salt Lake City, UT	123	77	28	7	5	6	3
Tucson, AZ	172	125	38	7	2	—	7
Pacific	1,742	1,187	408	89	37	21	155
Berkeley, CA	20	13	7	—	—	—	1
Fresno, CA	130	89	27	9	3	2	12
Glendale, CA	36	28	4	3	—	1	7
Honolulu, HI	58	42	8	7	1	—	9
Long Beach, CA	58	38	15	3	1	1	7
Los Angeles, CA	243	153	66	11	7	6	22
Pasadena, CA	20	14	2	3	1	—	4
Portland, OR	118	72	38	5	1	2	12
Sacramento, CA	223	159	48	12	3	1	17
San Diego, CA	150	101	33	8	5	3	13
San Francisco, CA	119	69	42	6	2	—	12
San Jose, CA	197	154	32	5	4	2	16
Santa Cruz, CA	34	21	10	2	1	—	3
Seattle, WA	118	83	27	5	1	2	5
Spokane, WA	77	59	15	2	1	—	9
Tacoma, WA	141	92	34	8	6	1	6
Total¶	**11,151**	**7,251**	**2,786**	**662**	**259**	**191**	**737**

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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