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World AIDS Day, December 1, 2003

"Live and Let Live" is the theme for this year's World AIDS Day, December 1, 2003. This theme highlights the obstacles that stigma and discrimination pose to the success of prevention and care programs for persons living with human immunodeficiency virus (HIV). Discrimination against persons with infectious diseases is not new (*1*), and acquired immunodeficiency syndrome (AIDS) continues to be a stigmatizing health issue for those living with the disease (*2*).

Stigma and discrimination might pose barriers that keep persons at risk for HIV infection from getting tested (*3*). In the United States, approximately one fourth of the estimated 850,000–950,000 persons living with HIV are unaware of their infection (*4*) and thus are not receiving needed treatment and prevention services.

Worldwide, an estimated 42 million persons were living with HIV/AIDS at the end of 2002 (*5*). As in the United States, stigma and discrimination associated with HIV/AIDS remain key challenges to effective public health prevention programs. Information about HIV/AIDS is available from CDC at http://www.cdcnpin.org and http://www.cdc.gov/nchstp/od/nchstp.html, or by telephone, 800-342-2437.

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Increases in HIV Diagnoses — 29 States, 1999–2002

Since the advent of highly active antiretroviral therapy (HAART) in 1996, progression from receiving diagnosis of human immunodeficiency virus (HIV) infection to having acquired immunodeficiency syndrome (AIDS) has slowed substantially, making HIV-transmission patterns less predictable through AIDS surveillance alone. Consequently, CDC has recommended that states report diagnoses of HIV infections in addition to cases of AIDS (*1*). Recent estimates of HIV diagnoses suggested a leveling of the downward trend in HIV infections nationally and increases in HIV infections among certain populations (*2*). Reports of syphilis outbreaks and increased unprotected sex raised concerns regarding increases in HIV transmission among men who have sex with men (MSM) (*3–5*). In response to these developments, CDC analyzed trends in HIV diagnoses in 29 states* that conducted

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

INSIDE

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name-based HIV/AIDS surveillance during 1999–2002. This report summarizes the results of that study, which indicated that HIV diagnoses increased among men, particularly MSM, and also among non-Hispanic whites and Hispanics. The findings emphasize the need for new prevention strategies to reverse potential increases in HIV transmission among these populations.

In 1994, CDC began supporting a uniform system for national, integrated HIV and AIDS surveillance. At that time, 25 states required confidential reporting of persons with HIV infection whether or not their infection had progressed to AIDS. Four additional states included in this analysis have had confidential HIV reporting since at least 1999, the year the lowest number of HIV diagnoses was reported among the original 25 states. In this analysis, persons with HIV were defined as those who received a diagnosis of HIV with or without a diagnosis of AIDS. Annual numbers of HIV diagnoses during 1999–2002 were based on the earliest reported dates of diagnosis. All analyses were adjusted for delays in reporting. Reports with no identified mode of HIV exposure were later reclassified to an exposure category (e.g., MSM, injection-drug use, MSM who inject drugs, and heterosexual contact) (*6*). Variance estimates and standard deviations for the annual number of HIV diagnoses were calculated, taking into account adjustments for reporting delay and reclassification to exposure categories. Variance estimates were derived from variances based on monthly data submissions to CDC (*7*). Year-to-year differences in the numbers of new diagnoses were considered statistically significant when 95% confidence intervals (CIs) based on calculated standard deviations did not overlap for those years.

During 1999–2002, HIV infection was diagnosed in 102,590 persons in the 29 HIV-reporting states. Of these persons, 72,323 (70.5%) were male, and 30,264 (29.5%) were female (Table). Among racial/ethnic populations, the majority (56,872 [55.4%]) of HIV diagnoses were among non-Hispanic blacks, accounting for 71.8% of all diagnoses in female and 48.6% of all diagnoses in males. The remainder of the HIV diagnoses occurred primarily among non-Hispanic whites (32,077 [31.3%]), followed by Hispanics (11,829 [11.5%]). Among males, the most prevalent mode of exposure was MSM (59.7%), followed by heterosexual contact (17.8%), and injection-drug use (15.8%). Among females, the most prevalent exposure category was heterosexual contact (76.7%), followed by injection-drug use (20.3%).

During 1999–2002, the number of males with new HIV diagnoses increased 7.3%, from 17,556 (95% CI = 17,412–17,701) to 18,843 (95% CI = 18,360–19,326) (Table). Among MSM, the number with new HIV diagnoses increased 17.0%, from 9,988 (95% CI = 9,733–10,243) to 11,686 (95%

TABLE. Estimated number and percentage of persons with new diagnosis of HIV infection, by sex and selected characteristics — 29 states* with HIV reporting, 1999–2002

Characteristic	Male		Female		Total	
	No.	(%)	No.	(%)	No.	(%)
Age group (yrs)						
<13	315	(0.4)	398	(1.3)	**713**	**(0.7)**
13–24	6,337	(8.8)	5,074	(16.8)	**11,411**	**(11.1)**
25–34	20,378	(28.2)	9,330	(30.8)	**29,708**	**(29.0)**
35–44	27,518	(38.0)	9,383	(31.0)	**36,901**	**(36.0)**
45–54	12,776	(17.7)	4,365	(14.4)	**17,142**	**(16.7)**
55–64	3,811	(5.3)	1,278	(4.2)	**5,089**	**(5.0)**
≥65	1,189	(1.6)	436	(1.4)	**1,625**	**(1.6)**
Total†	**72,323**	**(100.0)**	**30,264**	**(100.0)**	**102,590**	**(100.0)**
Race/Ethnicity						
White, non-Hispanic	26,602	(36.8)	5,474	(18.1)	**32,077**	**(31.3)**
Black, non-Hispanic	35,127	(48.6)	21,744	(71.8)	**56,872**	**(55.4)**
Hispanic§	9,266	(12.8)	2,563	(8.5)	**11,829**	**(11.5)**
Asian/Pacific Islander	432	(0.6)	129	(0.4)	**562**	**(0.5)**
American Indian/Alaska Native	435	(0.6)	174	(0.6)	**609**	**(0.6)**
Unknown	461	(0.6)	179	(0.6)	**641**	**(0.6)**
Exposure category						
Men who have sex with men (MSM)	43,144	(59.7)	—	—	**43,144**	**(42.1)**
Injection-drug use	11,419	(15.8)	6,133	(20.3)	**17,553**	**(17.1)**
MSM who inject drugs	3,917	(5.4)	—	—	**3,917**	**(3.8)**
Heterosexual contact	12,879	(17.8)	23,205	(76.7)	**36,084**	**(35.2)**
Other	963	(1.3)	926	(3.1)	**1,891**	**(1.8)**
Year of diagnosis						
1999	17,556	(24.3)	7,575	(25.0)	**25,133**	**(24.5)**
2000	17,872	(24.7)	7,588	(25.1)	**25,461**	**(24.8)**
2001	18,050	(25.0)	7,542	(24.9)	**25,592**	**(24.9)**
2002	18,843	(26.1)	7,559	(25.0)	**26,403**	**(25.7)**

* Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.
† Includes persons for whom data on sex, age, or race/ethnicity are missing. Columns might not add to total because of rounding.
§ Hispanics might be of any race.

CI = 11,239–12,132) (Figure 1). The number of new HIV diagnoses did not change significantly during 1999–2002 among females (Table), persons exposed through heterosexual contact, injection-drug users, or MSM who inject drugs (Figure 1).

Trends varied among racial/ethnic populations. During 1999–2002, the number of HIV diagnoses increased 26.2% among Hispanics, from 2,622 (95% CI = 2,566–2,678) to 3,308 (95% CI = 3,106–3,510) and 8.1% among non-Hispanic whites, from 7,716 (95% CI = 7,618–7,814) to 8,341 (95% CI = 8,016–8,665). No significant changes were observed for non-Hispanic blacks or Asians/Pacific Islanders.

During 1999–2002, the number of persons in whom AIDS was diagnosed along with HIV did not change significantly (Figure 2); however, the number of persons with HIV diagnosis and no AIDS diagnosis during the same calendar month increased by 9.3%, from 18,712 (95% CI = 18,554–18,870) to 20,443 (95% CI = 19,925–20,961).

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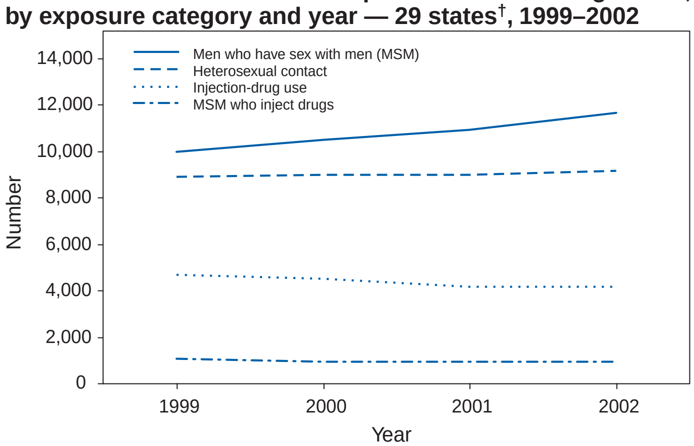
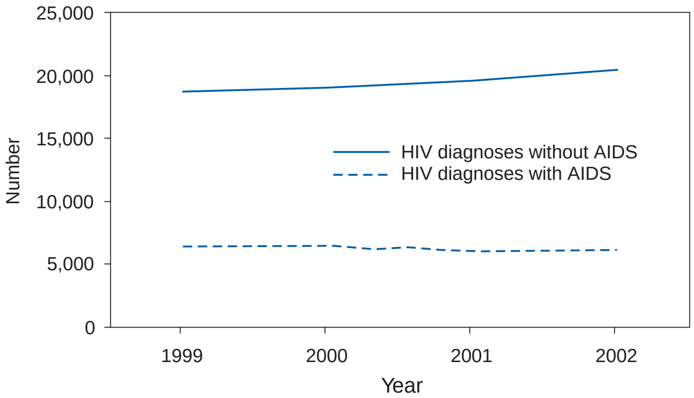
FIGURE 1. Estimated number of persons with HIV diagnoses*, by exposure category and year — 29 states†, 1999–2002



* Adjusted for reporting delays and redistribution of cases reported without exposure category.
† Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

Editorial Note: The increase in total HIV diagnoses during 1999–2002 reflects increases primarily among males, particularly MSM, and among non-Hispanic whites and Hispanics. The 29 states participating in these analyses did not include certain states (e.g., California, Illinois, New York, and Washington) that have reported increases among MSM in other sexually transmitted diseases (*3,4*). In addition, among states not participating, certain states (e.g., New York and Texas) have recently implemented confidential HIV reporting that will enable monitoring of HIV diagnoses; other states (e.g., California, Illinois, and Maryland) are implementing alternative forms of surveillance such as coded patient identifiers. Standard protocols are being developed to evaluate the performance of these alternative surveillance procedures. Nationwide reporting of HIV diagnoses would improve estimates of the size of the HIV-infected population.

FIGURE 2. Estimated number of persons with HIV diagnoses*, with and without AIDS, by year — 29 states†, 1999–2002



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

The findings in this report are subject to at least three limitations. First, delays in reporting were assumed to be ≤5 years, and reporting delays were assumed consistent within the preceding 5 years. When implemented fully, electronic laboratory reporting should decrease the time between HIV diagnosis and reporting to the surveillance system. Second, classification of cases with no identified mode of exposure into exposure categories was based on follow-up investigations. Cases with follow-up information were assumed to constitute a representative sample of all cases initially reported with no identified exposure, and the distribution among exposure categories was assumed consistent during the preceding 10 years. The validity of these estimates is being evaluated by sampling and intensive follow-up. Finally, completeness of reporting and potential duplicate reporting by different states is being evaluated in accordance with CDC's performance standards for HIV/AIDS surveillance (*1*).

Changes in the annual number of HIV diagnoses might be affected by changes in testing patterns for HIV infection. Additional data on testing patterns are needed; new testing technologies that distinguish between recent and long-term infections will allow for better characterization of recent HIV-transmission patterns and more rapid and targeted preventive measures (*8*). However, population surveys suggest stable trends in testing in recent years, with approximately 45% of U.S. adults reporting they ever had an HIV test (*9*). In addition, because the number of simultaneous diagnoses of HIV and AIDS did not increase, the increase in HIV diagnoses more likely reflects an increase in newly infected persons rather than more intensive testing efforts.

Hispanic and non-Hispanic black populations, with historically less access to treatment and prevention services, are affected disproportionately by HIV. New strategies are needed to remove access barriers to those populations and address the HIV epidemic among MSM. Advances in treatment for HIV infection can lower concern regarding AIDS and perhaps lead to an increase in high-risk sexual behaviors (*5*). To address these concerns, CDC's new initiative, Advancing HIV Prevention: New Strategies for a Changing Epidemic, promotes access to testing, medical care, and prevention services for all persons with HIV infection (*10*). CDC also is funding a series of projects regarding the prevention needs of MSM, both HIV positive and negative, and MSM who belong to racial/ethnic minority populations.

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Health Status of American Indians Compared with Other Racial/Ethnic Minority Populations — Selected States, 2001–2002

Despite overall declines in morbidity and mortality in the United States in recent years, a persistent gap in health status remains between American Indians (AIs) and non-Hispanic whites (*1,2*). This report compares the health status of AIs with that of other racial/ethnic minority populations by using data from a survey conducted during 2001–2002 in 21 communities through the Racial and Ethnic Approaches to

Community Health (REACH) 2010 project. The results indicate that although AIs had a higher prevalence of chronic disease risk factors than other racial/ethnic minority populations, they also were more likely to use preventive services. Culturally sensitive primary prevention strategies to reduce risk factors and disease burden in AI communities should be developed and implemented.

REACH 2010 is a community-based demonstration project designed to reduce racial/ethnic disparities in health. As a part of the project evaluation, CDC contracted with the National Opinion Research Center at University of Chicago to conduct the REACH 2010 Risk Factor Survey. The baseline survey was conducted during June 2001–August 2002 in 21 minority communities in the United States. Sample designs were customized for each of the 21 communities, taking into account geography, racial/ethnic density, expected telephone coverage, and other factors (e.g., suggestions received from the communities). In the 18 communities in which expected telephone coverage was >80%, interviews were conducted by telephone. Face-to-face interviews were conducted in three communities in which 1) the expected telephone coverage was low or inconclusive or 2) cooperation over the telephone was expected to be difficult. The survey sampled eligible households and interviewed an average of 1,000 minority residents aged ≥18 years in each community. Uniform screening and interview questionnaires were used for all households and were administered in English, Spanish, Vietnamese, Khmer, or Chinese. The median response rate was 74% (range: 60%–99%).

The 21 communities are located in 14 states (Alabama, California, Georgia, Illinois, Louisiana, Massachusetts, Michigan, North Carolina, New York, Oklahoma, South Carolina, Tennessee, Texas, and Washington). The survey included two AI groups, 14 black groups, seven Hispanic groups, and four Asian groups; five communities had multiple ethnic groups. For this report, data for persons of the same race/ethnicity from different communities were aggregated. The presence of a risk factor or chronic condition was based on self-reported data. Obesity was defined as body mass index of ≥30.0 kg/m2, calculated from self-reported height and weight. Cardiovascular disease was defined as having any of the following conditions: heart attack, coronary heart disease, or stroke. High blood cholesterol was defined as ever being told by a doctor or other health professional that blood cholesterol was high. Women who had diabetes diagnosed only during pregnancy were not considered to have diabetes. Data were weighted to represent the communities surveyed, and SUDAAN was used to account for the complex survey sampling designs.

The sample included 1,791 AIs, 10,953 blacks, 4,257 Hispanics, and 4,204 Asians (Table 1). Among both men and women in these four groups, AIs had the highest prevalences of obesity, current smoking, cardiovascular disease, and diabetes. Among men, AIs also had the highest prevalences of self-reported hypertension and high blood cholesterol levels. Among women, blacks had the highest prevalences of these two conditions, and AIs had the second highest prevalences. Approximately 80% of AIs had one or more adverse risk factor or chronic condition, and one third had three or more.

A substantial percentage of AIs received preventive services (Table 2). Compared with other minority populations, AIs with diabetes reported the highest percentages of receiving hemoglobin A1C (HbA1C) and foot examinations. AIs aged ≥65 years reported the highest prevalences of receiving pneumonia vaccination. Overall, AIs had the second highest rates for blood cholesterol screening, mammography, Papanicolaou (Pap) smear, and influenza vaccination. A total of 84% of AIs had received at least one preventive service.

TABLE 1. Prevalence of selected risk factors and chronic diseases among four minority populations, by race/ethnicity and sex — Racial and Ethnic Approaches to Community Health 2010 Risk Factor Survey, selected states, 2001–2002

	Men							
	American Indian (n = 751)		Black (n = 3,218)		Hispanic (n = 1,535)		Asian (n = 1,655)	
Risk factors/Chronic diseases	%	(95% CI*)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Obesity	40.1	(36.2–44.0)	26.5	(24.4–28.6)	26.6	(24.1–29.2)	2.7	(1.7–4.1)
Current smoking	42.6	(38.6–46.6)	29.3	(27.3–31.5)	26.8	(24.2–29.5)	34.4	(30.7–38.2)
Cardiovascular diseases	16.4	(13.6–19.7)	9.9	(8.7–11.3)	7.4	(6.0–9.1)	7.5	(5.6–10.1)
Hypertension	38.5	(34.6–42.5)	34.5	(32.3–36.7)	20.5	(18.2–23.0)	16.1	(13.7–18.9)
High cholesterol	37.1	(32.5–41.9)	31.4	(29.0–33.9)	35.7	(31.9–39.7)	31.4	(27.6–35.6)
Diabetes	16.8	(14.1–19.9)	11.6	(10.2–13.1)	7.1	(6.0–8.5)	4.8	(3.6–6.4)
No. risk factors/chronic diseases†								
0	11.7	(8.8–15.5)	24.8	(22.5–27.3)	25.4	(21.8–29.4)	36.3	(32.3–40.5)
1	26.1	(22.2–30.4)	30.5	(27.9–33.2)	34.6	(30.7–38.8)	37.1	(33.1–41.4)
2	26.4	(22.4–30.9)	22.9	(20.7–25.3)	20.0	(17.0–23.4)	19.3	(15.6–23.8)
≥3	35.7	(31.2–40.5)	21.7	(19.7–24.0)	19.9	(16.9–23.3)	7.2	(5.6–9.2)

* Confidence interval.
† Includes obesity, current smoking, cardiovascular diseases, hypertension, high cholesterol, and diabetes.

Reported by: *Y Liao, MD, P Tucker, DrPH, WH Giles, MD, Div of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings in this report indicate that AI communities bear a greater burden of health risk factors and chronic disease than other racial/ethnic minority populations. Although earlier investigations reported relatively low rates of hypertension in AIs who do not have diabetes (*3*), incidence is increasing (*4*). For the populations surveyed, self-reported hypertension was as common among AIs as it is among blacks. The Strong Heart Study conducted during 1989–1992 reported that fewer AIs had high blood cholesterol levels compared with national samples from the Third National Health and Nutrition Examination Survey (*5*). However, in the REACH 2010 survey, approximately one third of AIs had high blood cholesterol levels, and prevalence of cardiovascular disease was higher than in other minority populations. Diabetes was uncommon among AIs before World War II, but prevalence has increased sharply during the previous 20 years (*6*). Approximately half of the adult population in some tribes have diabetes (*6*). The epidemic of obesity also is a relatively recent phenomenon and is believed to contribute to the rising prevalence of diabetes, hypertension, and heart disease.

The age-adjusted death rates for heart diseases and cerebrovascular diseases are lower among AIs than the general U.S. population (*2*). However, the disproportionate burden of risk factors and disease in AIs likely will increase mortality rates in this population. The findings in this report underscore the importance of primary prevention in AI communities and the need for prevention strategies that emphasize lifestyle modification, including changes in diet, physical activity levels, weight control, and smoking cessation. Because habits often are formed early in life and carried into adulthood, culturally sensitive prevention strategies directed toward children and young adults are needed if increases in obesity, diabetes, and other risk factors among AIs are to be reversed.

Results of the REACH 2010 survey indicate that AIs had higher prevalence of self-reported use of certain preventive services than any other minority populations. In 2001, the prevalence of blood cholesterol screening among AIs was approaching national levels (74.9% for men and 79.5% for women in the U.S. general population) (*7*). Given the high burden of diabetes complications (e.g., eye and kidney disease, cardiovascular disease, and lower extremity amputation) among AIs (*6*), intensive measures are necessary to prevent these conditions. The REACH 2010 survey indicates that the proportions of AIs with diabetes who have had HbA1C measurements and foot examinations during the preceding year have surpassed national levels (*8*). For mammography and Pap smears, AIs have reached or are close to reaching the national health objectives for 2010 (i.e., 70% for mammogram during the preceding 2 years and 90% for Pap smear during the preceding 3 years [objectives 3-13 and 3-11b, respectively]) (*9*). This achievement demonstrates the commitment of AI communities, tribal corporations, public health authorities, and health-care providers.

The findings in this report are subject to at least two limitations. First, AIs from different tribal communities and locations exhibit ethnic, cultural, and social diversity. The REACH 2010 survey included only two AI communities and might not represent AIs from other communities. However, the data from this survey are consistent with the general pattern of health status in AIs reported in other studies (*4*). Second, because estimates are based on self-reported data, the prevalence of some chronic conditions and use of preventive services might be underestimated. However, the questions on the REACH 2010 survey have demonstrated good reliability and validity (*10*).

TABLE 1. (*Continued*) Prevalence of selected risk factors and chronic diseases among four minority populations, by race/ethnicity and sex — Racial and Ethnic Approaches to Community Health 2010 Risk Factor Survey, selected states, 2001–2002

	Women							
	American Indian (n = 1,040)		Black (n = 7,735)		Hispanic (n = 2,722)		Asian (n = 2,549)	
Risk factors/Chronic diseases	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Obesity	37.7	(34.4–41.1)	37.6	(36.1–39.2)	28.4	(26.4–30.6)	3.1	(2.3–4.1)
Current smoking	36.8	(33.6–40.1)	20.4	(19.2–21.7)	11.2	(9.9–12.7)	3.3	(2.3–4.7)
Cardiovascular diseases	13.0	(11.0–15.4)	9.4	(8.5–10.3)	5.6	(4.8–6.6)	5.5	(4.4–6.9)
Hypertension	36.8	(33.7–40.1)	40.9	(39.4–42.5)	22.4	(20.7–24.3)	17.6	(15.6–19.7)
High cholesterol	33.5	(30.0–37.2)	34.2	(32.5–35.8)	28.9	(26.5–31.5)	23.3	(20.5–26.3)
Diabetes	19.7	(17.2–22.4)	14.5	(13.4–15.7)	8.4	(7.4–9.5)	4.7	(3.8–5.8)
No. risk factors/chronic diseases[†]								
0	17.2	(14.3–20.4)	22.7	(21.1–24.4)	35.9	(32.9–38.9)	57.8	(54.5–60.9)
1	27.6	(24.3–31.2)	28.4	(26.7–30.1)	30.2	(27.6–33.1)	25.8	(22.7–29.2)
2	21.9	(18.9–25.2)	22.2	(20.8–23.7)	18.4	(16.2–20.7)	11.6	(9.6–14.0)
≥3	33.3	(29.8–37.1)	26.7	(25.1–28.3)	15.5	(13.7–17.5)	4.8	(3.6–6.3)

TABLE 2. Prevalence of use of preventive services among four minority populations, by race/ethnicity — Racial and Ethnic Approaches to Community Health 2010 Risk Factor Survey, selected states, 2001–2002

	American Indian		Black		Hispanic		Asian	
Preventive services	**%**	**(95% CI*)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**
Cholesterol checked ever								
Men	68.5	(64.7–72.1)	73.1	(70.8–75.2)	49.0	(46.0–52.0)	60.5	(56.6–64.3)
Women	76.0	(72.9–78.8)	79.2	(77.7–80.5)	57.0	(54.6–59.3)	63.4	(60.2–66.5)
Examinations during the preceding year†								
Hemoglobin A_1C	82.0	(77.0–86.0)	75.6	(72.3–78.7)	69.2	(64.1–73.9)	65.8	(55.6–74.7)
Eye	65.4	(59.5–70.8)	72.1	(68.6–75.3)	67.1	(61.9–72.0)	80.6	(72.9–86.5)
Foot	81.2	(76.2–85.4)	72.5	(69.2–75.6)	56.7	(51.2–61.9)	42.8	(33.7–52.5)
Mammogram during the preceding 2 years§	75.3	(70.3–79.6)	84.1	(82.4–85.6)	74.2	(70.3–77.8)	73.6	(69.2–77.6)
Pap smear during the preceding 3 years¶	85.5	(82.6–87.9)	89.6	(88.3–90.7)	79.3	(76.9–81.5)	67.3	(64.2–70.2)
Influenza shot during the preceding year**	70.0	(63.4–75.8)	54.2	(50.9–57.5)	52.6	(45.6–59.6)	81.5	(76.5–85.6)
Pneumonia vaccination ever**	67.1	(60.2–73.3)	50.2	(46.9–53.5)	38.8	(32.2–45.8)	37.3	(31.5–43.4)

* Confidence interval.
† Limited to diabetes patients.
§ Limited to women aged ≥50 years.
¶ Limited to women.
** Limited to persons aged ≥65 years.

The REACH 2010 demonstration project is under way in eight AI and Alaska Native communities. Community coalitions have been established, priority target areas have been identified, and several public health education and prevention programs to reduce health risk factors and chronic diseases are being implemented. The findings of the REACH 2010 survey underscore the need for additional, nationwide efforts to eliminate health disparities between AIs and other populations.

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Diabetes Among Hispanics — Los Angeles County, California, 2002–2003

Diabetes is associated with severe morbidity and premature death and affects U.S. Hispanics disproportionately (*1*). Although regional variation in diabetes prevalence has been observed among Hispanics (*2*), limited information is available on how sociodemographic factors affect the risk for diabetes among Hispanics in urban settings. Los Angeles County (LAC), California, has the largest urban Hispanic population in the United States (*3*). To assess the prevalence of diabetes among Hispanic adults in LAC and to examine variations in diabetes prevalence across sociodemographic groups in this population, the LAC Department of Health Services analyzed data from the 2002–2003 LAC Health Survey (LACHS). This report summarizes the results of that analysis, which indicate that the prevalence of diabetes is approximately two times higher among Hispanics than among non-Hispanic whites and is strongly associated with living below poverty level*. These findings underscore the need to provide additional diabetes prevention and treatment interventions for Hispanics in LAC, particularly those living in poverty.

LACHS is a periodic, random-digit–dialed telephone survey of the noninstitutionalized population in LAC (*4*). Adults aged ≥18 years were surveyed during October 2002–February 2003. Interviews were conducted in English, Spanish, and four Asian languages. Of 15,262 households contacted, 8,167 interviews were completed (response rate: 53.5%).

* Based on the 2002 federal poverty level (FPL), which takes into account both income and household size. For example, in 2002, FPL was an annual household income of $18,244 for a family of two adults and two dependents.

Respondents were considered to have diabetes if they answered "yes" to the question, "Have you ever been told by a doctor or other health professional that you had diabetes?" Women who reported having had diabetes only during pregnancy were classified as not having diabetes. Data were weighted to reflect the age, sex, and racial/ethnic distribution of the county population on the basis of 2002 projections from U.S. Census Bureau data. The prevalence of diabetes among Hispanics and non-Hispanic whites was assessed by sex, race/ethnicity, age group, annual household income level, education level, country of birth, health insurance coverage, and body mass index (BMI) from respondents' self-reported weight and height (BMI = kg/m^2). Persons were classified as overweight if their BMI was 25.0–29.9 and obese if their BMI was ≥30.0. Black, Asian, and other populations were not included in the analysis because of insufficient sample size. Among non-U.S.–born Hispanics, diabetes prevalence also was assessed by the number of years lived in the United States and preferred language (i.e., English versus Spanish, with preference determined by the language used for the interview). Results were age-adjusted to the 2000 U.S. standard population; the Mantel-Haenszel chi square test was used to assess whether differences in diabetes prevalence among population groups were statistically significant. Logistic regression analysis was conducted to assess the independent association between income and diabetes prevalence among Hispanics after controlling for age, health insurance status, and BMI.

During 2002–2003, the age-adjusted prevalence of diabetes among Hispanics was approximately two times higher than among non-Hispanic whites (11.9% versus 5.6%; $p<0.01$) (Table). Among members of both populations, the prevalence of diabetes increased with age. Diabetes prevalence was highest among Hispanics with annual household incomes below federal poverty level (FPL) (17.2%) and those who were obese (15.5%). Lower income levels were significantly associated with a higher prevalence of diabetes among Hispanics ($p<0.01$, chi square test for trend) but not among non-Hispanic whites, whereas lower levels of education were associated with higher prevalence of diabetes among both Hispanics and non-Hispanic

TABLE. Age-adjusted prevalence* of self-reported diabetes among Hispanics and non-Hispanic whites aged ≥18 years, by sociodemographic characteristics — Los Angeles County Health Survey, Los Angeles County, California, 2002–2003

	Hispanic			White, non-Hispanic		
Characteristic	**No.†**	**(%)**	**(95% CI§)**	**No.**	**(%)**	**(95% CI)**
Sex						
Men	1,227	(11.4)	(9.8–13.1)	1,447	(6.1)	(4.6–7.5)
Women	1,852	(11.8)	(10.3–13.4)	1,812	(5.2)	(3.9–6.5)
Age group (yrs)¶						
18–44	2,238	(3.1)	(2.3–3.9)	1,353	(1.3)	(0.6–1.9)
45–64	690	(18.5)	(15.3–21.8)	1,245	(7.8)	(6.0–9.5)
≥65	151	(25.7)	(18.2–33.3)	661	(15.4)	(12.3–18.5)
Annual household income**						
<100% FPL	1,039	(17.2)	(15.1–19.3)	185	(5.6)	(1.6–9.7)
100%–199% FPL	1,008	(11.4)	(9.4–13.3)	375	(8.8)	(5.2–12.4)
≥200% FPL	1,032	(8.0)	(6.3–9.6)	2,699	(5.1)	(4.1–6.1)
Education						
<High school	1,227	(12.7)	(10.8–14.6)	123	(8.4)	(2.3–14.6)
High school	809	(9.3)	(7.6–11.0)	579	(5.6)	(3.2–8.0)
Some college or trade school	667	(13.5)	(11.2–15.8)	971	(6.6)	(4.8–8.5)
College or post graduate	365	(6.1)	(3.7–8.6)	1,575	(4.2)	(3.1–5.3)
Body mass index (BMI)††						
<25.0	935	(6.1)	(4.6–7.6)	1,577	(2.8)	(1.8–3.7)
25.0–29.9	1,051	(11.2)	(9.3–13.2)	1,026	(5.7)	(3.8–7.6)
≥30.0	622	(15.5)	(12.5–18.5)	501	(11.8)	(8.1–15.6)
Health insurance						
No	1,030	(5.9)	(4.5–7.3)	282	(2.4)	(0.0–4.9)
Yes	1,916	(12.5)	(10.9–14.1)	2,881	(5.5)	(4.4–6.6)
Preferred language§§						
English	1,490	(11.1)	(9.5–12.7)	NA¶¶	—	—
Spanish	1,589	(12.3)	(10.7–13.9)	NA	—	—
Birthplace						
United States	1,124	(11.8)	(10.0–13.6)	2,890	(5.6)	(4.5–6.6)
Outside United States	1,951	(11.9)	(10.5–13.3)	369	(5.0)	(1.9–8.1)
Country/region of birth						
Mexico	1,384	(13.3)	(10.8–15.7)	NA	—	—
Central America	409	(8.3)	(5.6–11.0)	NA	—	—
Years in United States						
<10	441	(9.6)	(7.5–11.8)	NA	—	—
10–19	766	(8.3)	(6.8–9.8)	NA	—	—
≥20	727	(13.4)	(10.2–16.5)	NA	—	—
Total	**3,079**	**(11.9)**	**(10.7–13.0)**	**3,259**	**(5.6)**	**(4.6–6.6)**

* Number of respondents; persons with missing information were excluded.
† Age-adjusted percentage according to the 2000 U.S. standard population aged ≥18 years.
§ Confidence interval.
¶ Data not age-adjusted.
** Based on the 2002 federal poverty level (FPL). For example, in 2002, FPL was an annual household income of $18,244 for a family of two adults and two dependents.
†† Based on self-reported weight and height (BMI = kg/m^2).
§§ Based on language of interview.
¶¶ No data available.

whites (p = 0.02, chi square test for trend). The prevalence of diabetes was similar among both Spanish- and English-speaking Hispanics (12.3% versus 11.1%) and among both U.S.- and non-U.S.–born Hispanics (11.8% versus 11.9%). Among non-U.S.–born Hispanics, the age-adjusted prevalence of diabetes was significantly higher among those born in Mexico than among those born in Central America (13.3% versus 8.3%; p<0.01) and among those who had lived in the United States for ≥20 years than among those who did so for <20 years (13.4% versus 9.4%; p<0.01). Hispanics living in poverty were approximately three times more likely (adjusted odds ratio [AOR] = 2.9; 95% confidence interval [CI] = 2.0–4.3) to have diabetes than were Hispanics with incomes of ≥200% FPL (e.g., incomes of ≥$36,488 for a family of two adults and two dependents) after controlling for age and health insurance coverage. This difference remained significant even after controlling for BMI (AOR = 2.7; 95% CI = 1.8–4.0).

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Editorial Note: Consistent with national studies (*2*), the findings in this report indicate that the prevalence of diabetes among Hispanics is approximately two times higher than among non-Hispanic whites. Among Hispanics in LAC, the age-adjusted prevalence of diabetes varied substantially across population subgroups. Poverty was one factor associated with the prevalence of diabetes. The factors contributing to this association remain unclear but could reflect an increased risk for diabetes among those living in poverty or a decline in income after a diabetes diagnosis. Although overweight and obesity are important contributors to racial/ethnic disparities in the prevalence of diabetes (*5*), the association between poverty and diabetes in this survey was largely independent of BMI. Physical inactivity and dietary factors independent of overweight and obesity also could explain the association but were not assessed in the study.

The prevalence of diabetes among U.S.-born Hispanics in LAC was similar to that among non-U.S.–born Hispanics, and the prevalence among English-speaking Hispanics was similar to that among Spanish-speaking Hispanics. However, among non-U.S.–born Hispanics, diabetes prevalence was highest among those who had lived in the United States for ≥20 years, suggesting a potential acculturation effect unrelated to language. In addition, the higher prevalence of diabetes among Hispanics born in Mexico than among those born in Central American countries highlights the heterogeneity of the Hispanic population and might indicate different risk profiles for developing diabetes.

The findings in this report are subject to at least four limitations. First, because households without telephones were excluded from the sampling frame, the results do not include a segment of the population that might be at increased risk for diabetes (*6*). Second, prevalence estimates based on self-reports do not account for adults with undiagnosed diabetes, a group estimated to constitute approximately one third of the total U.S. adult population with diabetes (*7*). Third, the lower prevalence of diagnosed diabetes among those without health insurance coverage suggests that barriers to health care might have influenced the results. Although health insurance status was controlled for in the multivariate analysis, other barriers to health are might have introduced bias. Finally, the response rate was 53.5%; however, the sociodemographic distribution of respondents was similar to that of the adult population in LAC.

Increases in the national prevalence of both diabetes and obesity (*8*) underscore the need for additional national and state programs and community-level interventions to address these public health threats. In April 2003, the U.S. Department of Health and Human Services announced the Steps to a HealthierUS initiative to support evidence-based and community-focused prevention programs for diabetes, obesity, and asthma. In LAC, efforts are under way to expand diabetes prevention and control efforts within low-income Hispanic and black communities, including campaigns to promote physical activity (e.g., Fuel Up/Lift Off! LA and Adopt-A-Park campaigns), interventions to improve nutrition (e.g., Project LEAN and the 5-a-Day campaigns), and community outreach to increase access to health-care services among persons with or at risk for diabetes. Ongoing population-based tracking of diabetes prevalence and diabetes-related morbidity in LAC will be essential for assessing the effectiveness of these efforts and for guiding future program planning.

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Hepatitis A Outbreak Associated with Green Onions at a Restaurant — Monaca, Pennsylvania, 2003

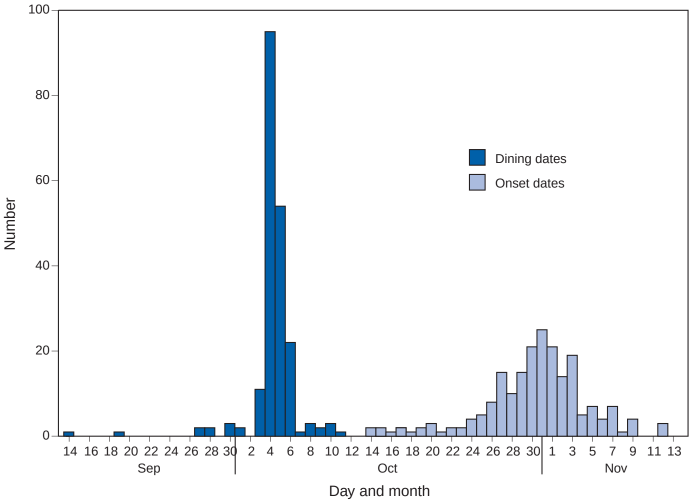
On November 21, 2003, this report was posted on the MMWR *website* (*http://www.cdc.gov/mmwr*). *However, two errors* were found. The text of the report printed here has been corrected.*

The Pennsylvania Department of Health and CDC are investigating an outbreak of hepatitis A outbreak among patrons of a restaurant (Restaurant A) in Monaca, Pennsylvania. As of November 20, approximately 555 persons with hepatitis A have been identified, including at least 13 Restaurant A food service workers and 75 residents of six other states who dined at Restaurant A. Three persons have died. Preliminary sequence analysis of a 340 nucleotide region of viral RNA obtained from three patrons who had hepatitis A indicated that all three virus sequences were identical. Preliminary analysis of a case-control study implicated green onions as the source of the outbreak.

Among 207 persons with hepatitis A who were interviewed and who ate at Restaurant A only once during the 2–6 weeks (i.e., the typical incubation period for hepatitis A) before illness, dates of illness onset were between October 14 and November 12. These 207 patrons reported eating food prepared in Restaurant A during September 14–October 17; a total of 181 (87%) persons reported eating at Restaurant A during October 3–6 (Figure). All infected Restaurant A food service workers became ill after October 26, suggesting that a food service worker could not have been the source of the outbreak. However, during late October–early November, these ill food service workers were working in Restaurant A when they could have been infectious. For this reason, immune globulin has been provided to approximately 9,000 persons who ate food from Restaurant A during this time or had exposures to ill persons involved in the outbreak. The restaurant has been closed.

* In the fourth sentence of the fifth paragraph, green onions were stated to have been stored for ≥5 days before processing rather than ≤5 days. In the third sentence of the fifth paragraph of the Editorial Note, the word "of" appeared before "plant surfaces are particularly complex or adherent to viral or fecal particles."

FIGURE. Number of hepatitis A cases*, by date of eating at Restaurant A and illness onset — Monaca, Pennsylvania, 2003



* N = 206. Excludes one case-patient whose illness onset date was not available. Dining dates for three persons who ate at Restaurant A on October 15 (n = one) and October 17 (n = two) are not shown.

A case-control study was conducted to identify menu item(s) or ingredient(s) associated with illness. A case-patient was defined as a person who had illness onset during October 14–November 12, had laboratory confirmation of acute hepatitis A virus (HAV) infection (i.e., positive IgM anti-HAV), reported eating food prepared at Restaurant A during October 3–6, and had eaten only once at Restaurant A during the 2–6 weeks before illness onset. Controls included persons without hepatitis A who either had dined with case-patients at Restaurant A or were identified through credit card receipts as having dined at Restaurant A during October 3–6. Controls with a previous history of hepatitis A, hepatitis A vaccination, or receipt of immune globulin within 2 weeks after eating Restaurant A food were excluded. Enrolled case-patients and controls were asked about Restaurant A food that they had eaten.

The median age of the 181 case-patients in the study was 34 years (range: 4–73 years), and that of the 83 controls was 28 years (range: 2–81, p>0.05). Of 133 menu items, only chili con queso and mild salsa were associated significantly with illness. Mild salsa was eaten by 94% of case-patients, compared with 39% of controls (odds ratio [OR] = 24.2; 95% confidence interval [CI] = 11.4–51.4). Chili con queso was eaten by 15% of case-patients, compared with 3% of controls (OR = 5.2, 95% CI = 1.5–17.8). Both menu items associated with illness contained uncooked or minimally heated fresh green onions. Among 11 case-patients who reported not eating mild salsa, seven ate at least one of the other 52 menu items that contained green onions. Of 103 ingredients used at the restaurant, 12 were associated with illness in a univariate analysis. Of these, 10 had been consumed by <50% of case-patients. Eating a menu item containing green onions was reported by 98% of case-patients, compared with 69% of controls (OR = 20.2, 95%CI = 6.8–59.9). Eating a menu item containing white onions also was associated with illness. However, among the 176 case-patients who reported eating white onions, 174 (99%) also ate green onions. Among the four case-patients and 28 controls who reported not eating green onions, white onions were not associated with illness (OR = 2.5, 95% 0.3–20.9).

During interviews conducted at Restaurant A, food service workers described green onion storage, washing, and preparation practices. Green onions were shipped in 8.5-lb. boxes containing multiple small bundles (6–8 green onions per bundle). Each box was unpacked, and bundles were stored upright (root side down) and refrigerated in a bucket with ice included in the shipment. Green onions were stored ≤5 days before processing, which consisted of rinsing intact onion bundles, cutting the roots off, and removing the rubber bands. Green onions from each box were chopped by machine to yield approximately 8 qts. Chopped green onions were refrigerated for approximately 2 days.

Periodically (i.e., every 1–3 days), salsas were prepared in batches of 40–80 qts. Mild salsa included chopped fresh green onions; hot salsa did not. Salsas were refrigerated in 8-quart containers with a shelf life of 3 days. Mild and hot salsa were ladled into bowls and provided free with tortilla chips upon seating at Restaurant A.

The Food and Drug Administration (FDA), CDC, and the state health departments are investigating the source of the green onions associated with this outbreak and how they became contaminated with HAV. Preliminary traceback information indicates that green onions supplied to Restaurant A were grown in Mexico.

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Editorial Note: This report describes a large hepatitis A outbreak associated with eating a food item containing green onions at a single restaurant. The majority of ill patrons interviewed as of November 21 were exposed during a 3-day period in early October. No ill food service worker identified could have been the source of the outbreak. The green onions likely were contaminated with HAV in the distribution system or during growing, harvest, packing, or cooling. Traceback investigations completed to date have determined that the green onion source is one or more farms in Mexico.

Both green onions and white onions were associated with illness in the univariate analysis. However, white onions were not associated with illness among those who did not eat green onions. This association with white onions observed in the univariate analysis might not remain when multivariate modeling is completed. Restaurant A purchases previously chopped white onions and adds them to several menu items, including hot and mild salsa. Mild salsa, which contains both green onions and white onions, was associated with illness; however, hot salsa, which contains only white onions, was not associated with illness.

The genetic sequence of the outbreak strain is very similar to viral sequences obtained from persons involved in hepatitis A outbreaks in Tennessee, Georgia, and North Carolina during September 2003 that were linked epidemiologically to green onions. These sequences also were identical or very similar to sequences observed among persons with hepatitis A living along the United States-Mexico border and travelers returning from Mexico, consistent with a source in Mexico (CDC, unpublished data, 2003). Raw green onions from three firms in Mexico have been implicated in the Tennessee and Georgia outbreaks. FDA is still reviewing records to determine if additional firms are involved. The Mexican government is assisting with the traceback investigation in Mexico and the investigation to determine the source of the contamination.

Previous hepatitis A outbreaks linked to green onions have been reported and have involved patrons of a single restaurant (*1*). However, the outbreak at Restaurant A was unusually large. Several characteristics of the way food was prepared and served in Restaurant A could have contributed to the outbreak's size, including 1) multiple opportunities for intermingling of uncontaminated and contaminated green onions in a common bucket for 5 days with the ice in which they were shipped and 2) serving contaminated items with a relatively long shelf life (e.g., mild salsa) to a large proportion of patrons over several days.

HAV is transmitted by the fecal-oral route. Green onions require extensive handling during harvesting and preparation for packing. Contamination of green onions could occur 1) by contact with HAV-infected workers, especially children, working in the field during harvesting and preparation and 2) by contact with HAV-contaminated water during irrigation, rinsing, processing, cooling, and icing of the product. Green onions and other selected produce items (e.g., strawberries [*2*]) might be more vulnerable to contamination because plant surfaces are particularly complex or adherent to viral or fecal particles. Outbreaks of other enteric pathogens linked to green onions have been reported (*3*).

On November 15, FDA issued an alert to consumers about the recent hepatitis A outbreaks associated with green onions (available at http://www.fda.gov/bbs/topics/ANSWERS/2003/ANS01262.html). FDA advised consumers concerned about the possibility of getting hepatitis A from green onions to cook green onions thoroughly before eating and to ask about use of green onions in prepared foods. Unless directed otherwise by public health officials, persons who have recently eaten green onions do not need postexposure prophylaxis (i.e., immune globulin).

CDC is working with state health departments to identify other hepatitis A outbreaks associated with green onions. As of November 21, no other hepatitis A outbreaks have been identified. To identify other cases related to these outbreaks, state and local health officials should interview persons with hepatitis A with onset after October 1. Persons without typical risk factors for hepatitis A (*4*) should be asked about food and restaurant exposures during their incubation period. Because molecular epidemiologic techniques have been useful for identifying related cases of foodborne hepatitis A in previous outbreaks (*2*), health departments might consider obtaining serum specimens for cases of interest.

An increasing proportion of reported foodborne outbreaks have been linked to fresh produce (*3*). This increase might be attributed to increased consumption of fresh produce or better surveillance techniques. HAV contamination of fresh produce can be reduced by using approaches such as the application of Good Agricultural Practices/Good Manufacturing Practices recommended by FDA (*5*) Recommended control measures include providing sanitary facilities for field workers, ensuring appropriate water quality, use of properly treated manure or biosolids, and ensuring worker health. Reducing HAV transmission in areas where produce is grown and discouraging the presence of children in areas where food is harvested also will reduce opportunities for HAV contamination. Further investigation of this and other hepatitis A outbreaks linked to green onions, including observation of cultivation and harvesting practices, can guide additional specific critical control measures.

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Global Progress Toward Certifying Polio Eradication and Laboratory Containment of Wild Polioviruses — August 2002–August 2003

Since the 1988 World Health Assembly resolution to eradicate poliomyelitis, the number of countries in which polio is endemic has declined from 125 to seven. These countries are in three of the six World Health Organization (WHO) regions (i.e., African, Eastern Mediterranean, and South East Asian) (*1*). The other three regions (i.e., Americas, European, and Western Pacific) were certified previously as polio-free (*2–4*). This report summarizes the progress made toward global certification of poliomyelitis eradication and implementation of measures to ensure laboratory containment of wild polioviruses (WPVs). The findings indicate that, although much progress has been made, wide disparities in certification and laboratory-containment capabilities underscore the need for continued efforts to verify the eradication of polio worldwide.

Certification Definitions and Operating Procedures

The Global Certification Commission (GCC) will declare the world free of WPV transmission when no WPVs have been found by certification-standard surveillance for 3 consecutive years and all laboratories with WPV-containing materials have adopted appropriate containment measures (*5*). GCC was appointed by WHO in 1995 and oversees certification of global polio eradication through Regional Certification Commissions (RCCs) and National Certification Commissions (NCCs). RCCs are now functioning in all WHO regions. As of August 2003, NCCs had been established in all WHO member states except Somalia (Eastern Mediterranean Region), Monaco and San Marino (European Region), and East Timor (South East Asian Region).

To meet certification standards, an acute flaccid paralysis (AFP) surveillance system must each year detect at least one nonpolio AFP case per 100,000 persons aged <15 years, collect two adequate stool specimens* from $\geq$80% of persons with AFP, and test all stool specimens for poliovirus at a WHO-accredited laboratory.

The laboratory-containment requirements for global certification of polio eradication are outlined in the WHO global action plan for laboratory containment of WPVs (*5*). In phase I, each country conducts a national survey to create an inventory of biomedical laboratories holding WPV-infectious or potentially infectious materials. Phase II will begin after 1 year with no WPV found anywhere in the world. This phase requires destruction of all unneeded stocks of WPV and containment of retained WPV stocks under appropriate biosafety conditions. Documentation of these efforts from all countries is required for global certification.

* Stool specimens are considered adequate if two specimens are collected at least 24 hours apart, within 14 days of onset of paralysis, and arrive in the laboratory in good condition.

Surveillance and Containment in Polio-Free Regions

On August 20, 1994, the Americas Region was certified as polio-free. At that time, both the RCC and country-level NCCs were dissolved, leaving no independent groups monitoring activities to maintain the region's polio-free status. However, through the efforts of individual countries and WHO, certification-standard AFP surveillance has been maintained in most countries of the region. At the time of the Americas Region certification, laboratory containment was not required. To meet the new requirements, all countries in the region have appointed national containment task forces. Laboratory surveys are under way in 47 of 48 countries, with surveys completed in 99,630 (90%) of 110,254 laboratories and institutions registered for survey (Table). All countries are expected to submit a report to a new RCC, to be established in early 2004.

On October 29, 2000, the Western Pacific Region was certified as polio-free. As of August 2003, the RCC, NCCs and a subregional committee for Pacific Island countries maintain active efforts to sustain polio-free status and to monitor the progress of laboratory containment. By August 2003, laboratory surveys had been completed in all Western Pacific Region countries except China and Japan, with 12,691 (72%) of 14,977 laboratories and institutions surveyed. China and Japan are expected to complete their activities in 2004.

On June 21, 2002, the European Region was certified as polio-free. At the time of certification, laboratory surveys had been completed in 41 of 51 countries, with 39,130 (91%) of 43,018 laboratories and institutions surveyed. Completion of phase I activities in all countries of the region is expected in 2004. The European Region RCC meets annually to monitor the polio-free status of the region and to ensure completion of the containment activities.

Certification and Containment in Regions with Endemic Polio

In countries where polio is endemic, interrupting the spread of virus is a higher priority than certification and containment activities. However, certain countries that have not reported a case of polio in years have made considerable progress toward certification and containment.

TABLE. Number of countries* with national task forces, plans, and inventories and number of laboratories reporting wild poliovirus (WPV)-containing materials, by World Health Organization (WHO) region, August 2003

WHO region	No. countries in region	No. with task force	No. countries surveying laboratories	No. laboratories and institutions registered to be surveyed†	No. laboratories and institutions surveyed	No. laboratories or institutions reporting WPV-containing materials§	No. countries with national inventory reviewed by commission¶
Certified polio-free regions							
Americas	48	48	47	110,254	99,630	206	0
European	51	51	50	43,018	39,130	122	41
Western Pacific	36	36	36	14,976	12,691	129	34
Polio-endemic regions							
Africa	46	31	1	47	47	0	0
Eastern Mediterranean	23	19	16	17,534	9,724	30	5
South East Asia	10	9	7	6650	3427	20	0
Total	**214**	**194**	**157**	**192,479**	**164,649**	**507**	**80**

* Number of countries and territories.
† Certain countries report number of laboratories; others report institutions (e.g., universities) with jurisdiction over several laboratories.
§ Includes materials potentially containing WPV; however, data have not been confirmed officially.
¶ Confirmed as holding WPV-containing materials.

NCCs have been established in all Eastern Mediterranean Region countries except Somalia, for which WHO and the United Nations Children's Fund (UNICEF) will facilitate certification activities; 16 of the 22 NCCs have begun reporting to the RCC. Documentation claiming polio-free status has been provisionally accepted from nine countries. Laboratory surveys have been started in 16 of 23 countries in the region and completed in five. The most critical obstacle to containment is obtaining information from the numerous unregistered biomedical laboratories that operate in the region.

In the South East Asian Region, East Timor is the only country without an NCC. Full national documentation has been reviewed from Sri Lanka and Thailand, both with no WPV for >3 years. Bangladesh and Nepal will be the next countries to present full national documentation. Laboratory-containment activities have begun in all countries in the region, and two countries have completed the process; 3,427 (52%) of 6,650 laboratories and institutions have been surveyed.

Certification activities in the African Region began in 1998. The RCC continues to train and orient NCCs in the region's 46 countries, several of which were established recently. RCC members also are beginning to conduct country visits to advocate improvements in surveillance and supplementary immunization activities. Containment activities have begun in Cameroon, Guinea-Bissau, Senegal, Tanzania, Togo, and Uganda. Information gained from the experiences of these countries will be used to introduce phase I containment activities in the remaining countries in 2004.

Reported by: *Vaccines and Biologicals Dept, World Health Organization, Geneva, Switzerland. Global Immunization Div, National Immunization Program, CDC.*

Editorial Note: Activities to certify eradication of WPV are an essential component of the global polio eradication initiative. Success of the certification process depends on 1) application of lessons learned from global smallpox eradication efforts and polio eradication in the Americas and 2) integration of key new program elements such as laboratory containment of WPVs. The soundness of the certification process is supported by the inability of certification-standard AFP surveillance to detect indigenous WPV in any of the three regions certified as polio-free.

However, several challenges remain. Not all NCCs in regions in which polio is endemic have attained the level of expertise needed to assess and verify data critically. Also, RCCs must work together more closely to scrutinize data from areas that share common chains of virus transmission but belong to more than one WHO region (e.g., the Horn of Africa). Efficiently coordinating certification activities across regions will require regular joint meetings of RCCs.

Ensuring effective laboratory containment at the time of global certification is critical to maintaining the achievements of polio eradication. Toward this end, GCC has identified the need for appropriate expertise in biosafety and polio eradication to advise on the status of containment, including means of verifying the absence of circulating vaccine-derived polioviruses.

Regions already certified as polio-free have faced decreases in interest and support from national governments. Sustaining certification-level surveillance and containment are possible only through continued commitments from national governments and ministries of health and through the support of scientists and public health experts who donate their time to certification committees. These continued efforts will be necessary to document and certify the global interruption of WPV transmission and guard against any reemergence of poliovirus.

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3. CDC. Certification of poliomyelitis eradication—European Region, June 2002. MMWR 2002;51:572–4.
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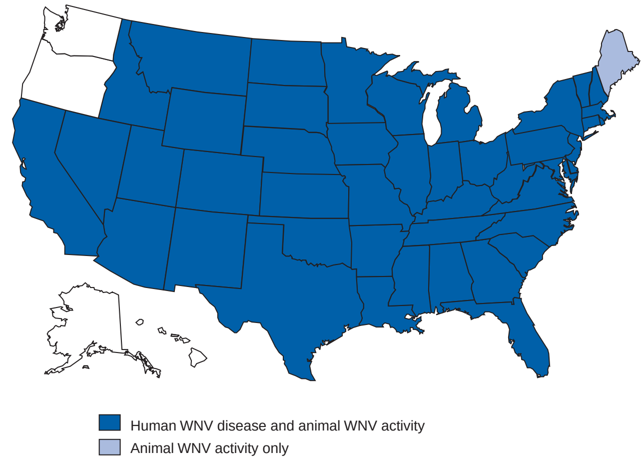
West Nile Virus Activity — United States, November 20–25, 2003

This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m., Mountain Standard Time, November 25, 2003.

During the reporting week of November 20–25, a total of 98 human cases of WNV infection were reported from 10 states (Florida, Illinois, Indiana, Michigan, Minnesota, Missouri, Pennsylvania, South Dakota, Tennessee, and Texas), including 10 fatal cases from four states (Florida, Indiana, Missouri, and Texas). During the same period, WNV infections were reported in 137 dead birds, 23 mosquito pools, 41 horses and three dogs.

During 2003, a total of 8,567 human cases of WNV infection have been reported from Colorado (n = 2,477), Nebraska (n = 1,727), South Dakota (n = 1,001), Texas (n = 558), North Dakota (n = 422), Wyoming (n = 339), Pennsylvania (n = 232), Montana (n = 222), New Mexico (n = 202), Minnesota (n = 145), Iowa (n = 142), Ohio (n = 107), Louisiana (n = 105), Kansas (n = 88), Oklahoma (n = 75), New York (n = 67), Florida (n = 65), Mississippi (n = 62), Missouri (n = 61), Maryland (n = 56), Illinois (n = 52), Georgia (n = 42), Indiana (n = 41), Alabama (n = 33), New Jersey (n = 31), Arkansas (n = 25), Tennessee (n = 25), North Carolina (n = 24), Virginia (n = 23), Delaware (n = 16), Massachusetts (n = 16), Michigan (n = 15), Kentucky (n = 14),Wisconsin (n = 13), Connecticut (n = 12), Arizona (n = eight), Rhode Island (n = seven), the District of Columbia (n = three), New Hampshire (n = three), Vermont (n = three), California (n = two), Nevada (n = two), Idaho (n = one), South Carolina (n = one), Utah (n = one), and West Virginia (n = one) (Figure). Of 8,430 (98%) cases for which demographic data were available, 4,462 (53%) occurred among males; the median age was 47 years (range: 1 month–99 years), and the dates of illness onset ranged from March 28 to November 3. Of the 8,430 cases, 199 fatal cases were reported from Colorado (n = 45), Texas (n = 28), Nebraska (n = 21), South Dakota (n = 13), New York (n = eight), Wyoming (n = eight), Pennsylvania (n = seven), Florida (n = six), Missouri (n = six), Maryland (n = five), Georgia (n = four), Indiana (n = four), Iowa (n = four), Kansas (n = four), Louisiana (n = four), Minnesota (n = four), New Mexico (n = four), North Dakota (n = four), Ohio (n = four), Alabama (n = three), Delaware (n = two), Montana (n = two), New Jersey (n = two), Arizona (n = one), Illinois (n = one), Kentucky (n = one), Michigan (n = one), Mississippi (n = one), Tennessee (n = one), and Virginia (n = one). A total of 737 presumptive West Nile viremic blood donors have been reported to ArboNET, including 627 (85%) from the following nine western and midwestern states: Colorado, Kansas, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, and Wyoming. Of the 605 donors for whom data were reported completely, six (1%) subsequently had neuroinvasive disease (median age: 45 years; range: 28–76 years), and 98 (16%) had West Nile fever.

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2003*



* As of 3 a.m., Mountain Standard Time, November 25, 2003.

In addition, 11,350 dead birds with WNV infection have been reported from 43 states, the District of Columbia, and New York City. WNV infections also have been reported from 41 states in horses (n = 4,146), dogs (n = 30), squirrels (n = 17), cats (n = one), and unidentified animal species (n = 32). During 2003, WNV seroconversions have been reported in 1,377 sentinel chicken flocks from 15 states. Of the 61 seropositive sentinel horses reported, Illinois reported 43, West Virginia reported eight; Minnesota reported seven; and South Dakota reported three. In addition, seropositivity was reported from one other unidentified animal species. A total of 7,725 WNV-positive mosquito pools have been reported from 38 states, the District of Columbia, and New York City.

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

Notice to Readers

Call for Abstracts: International Conference on Emerging Infectious Diseases 2000

The International Conference on Emerging Infectious Diseases 2000 (ICEID 2000) is calling for late-breaker abstracts. Abstracts should address new, reemerging, or drug-resistant infectious diseases that affect human health. The late-breaker abstract submission website will open on December 10, 2003, and close promptly on January 16, 2004, at 5 p.m., Eastern Standard Time. Information about submitting a late-breaker abstract is available at http://www.iceid.org/abssub.asp.

ICEID 2000 will be held February 29–March 3, 2004, at the Marriott Marquis Hotel in Atlanta, Georgia. Cosponsors include CDC, Council of State and Territorial Epidemiologists, American Society for Microbiology, Association of Public Health Laboratories, CDC Foundation, and World Health Organization. Registration information is available at http://www.iceid.org and at http://www.cdc.gov/ncidod and by e-mail at meetinginfo@asmusa.org or at dsy1@cdc.gov.

Errata: Vol. 52, No. 44

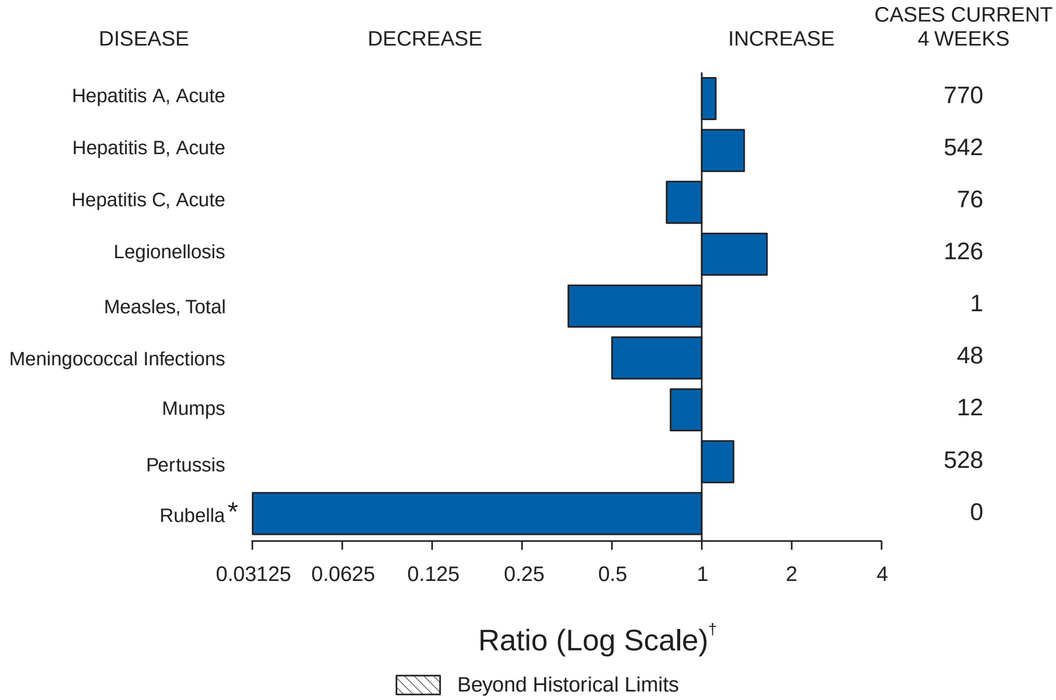
In the report, "Probable Transfusion-Transmitted Malaria—Houston, Texas, 2003," an error occurred in the second sentence on page 1075. The sentence should read, "The last reported case of transfusion-transmitted malaria occurred in April 2002 (*1*); before that, a total of 12 cases were identified during 1990–1998 (*2*)."

On page 1076, the first reference should read, "Purdy E, Perry E, Gorlin J, Jensen K. Transfusion-transmitted malaria: unpreventable by current donor guidelines? Abstract. Transfusion 2003;43:79A."

Erratum: Vol. 52, No. 46

In the report, "Primary and Secondary Syphilis — United States, 2002," an error occurred in the second sentence of the first paragraph on page 1118. The sentence should read, "Rates increased 71.4% among non-Hispanic whites (83.3% among men) and 28.6% among Hispanics (36.4% among men); rates were unchanged among women of both populations."

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 22, 2003, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 47 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending November 22, 2003 (47th Week)*

	Cum. 2003	Cum. 2002		Cum. 2003	Cum. 2002
Anthrax	-	2	Hansen disease (leprosy)†	49	78
Botulism:	-	-	Hantavirus pulmonary syndrome†	16	17
foodborne	11	26	Hemolytic uremic syndrome, postdiarrheal†	140	193
infant	58	60	HIV infection, pediatric†§	187	146
other (wound & unspecified)	24	18	Measles, total	42¶	39**
Brucellosis†	75	109	Mumps	174	242
Chancroid	42	61	Plague	1	1
Cholera	1	2	Poliomyelitis, paralytic	-	-
Cyclosporiasis†	61	155	Psittacosis†	14	16
Diphtheria	1	1	Q fever†	66	52
Ehrlichiosis:	-	-	Rabies, human	3	3
human granulocytic (HGE)†	315	291	Rubella	7	16
human monocytic (HME)†	177	185	Rubella, congenital	-	1
other and unspecified	40	22	Streptococcal toxic-shock syndrome†	131	102
Encephalitis/Meningitis:	-	-	Tetanus	13	21
California serogroup viral†	81	141	Toxic-shock syndrome	115	97
eastern equine†	9	7	Trichinosis	4	13
Powassan†	-	1	Tularemia†	72	72
St. Louis†	31	20	Yellow fever	-	-
western equine†	2	-			

-: No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 26, 2003.
¶ Of 42 cases reported, 31 were indigenous, and 11 were imported from another country.
** Of 39 cases reported, 24 were indigenous, and 15 were imported from another country.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 22, 2003, and November 23, 2002 (47th Week)*

Reporting area	AIDS		Chlamydia[†]		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2003[§]	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	38,482	36,572	733,825	752,802	3,631	3,815	2,963	2,750	1,626	2,543
NEW ENGLAND	1,277	1,435	24,447	25,046	-	-	158	183	-	27
Maine	49	28	1,600	1,560	N	N	19	11	-	-
N.H.	34	35	1,037	1,413	-	-	11	29	-	-
Vt.	15	12	969	845	-	-	30	33	-	-
Mass.	518	752	10,397	9,894	-	-	65	73	-	18
R.I.	90	86	2,669	2,501	-	-	16	21	-	-
Conn.	571	522	7,775	8,833	N	N	17	16	-	9
MID. ATLANTIC	9,040	8,429	98,448	84,701	-	-	365	379	166	126
Upstate N.Y.	853	665	18,184	15,224	N	N	126	129	5	40
N.Y. City	4,989	5,063	29,638	27,635	-	-	87	133	-	28
N.J.	1,356	1,250	11,103	12,894	-	-	7	15	16	23
Pa.	1,842	1,451	39,523	28,948	N	N	145	102	145	35
E.N. CENTRAL	3,556	3,871	125,371	138,710	7	22	874	916	116	1,444
Ohio	718	726	28,938	34,603	-	-	156	118	105	278
Ind.	482	463	14,618	15,785	N	N	80	54	1	18
Ill.	1,609	1,866	38,867	43,941	-	2	77	116	1	554
Mich.	581	647	28,553	28,926	7	20	130	125	9	544
Wis.	166	169	14,395	15,455	-	-	431	503	-	50
W.N. CENTRAL	685	676	42,086	42,779	1	1	534	384	338	183
Minn.	144	131	8,808	9,339	N	N	142	186	49	17
Iowa	72	71	3,344	5,270	N	N	118	42	78	-
Mo.	319	335	16,224	14,580	-	-	40	38	32	107
N. Dak.	2	3	1,027	1,089	N	N	13	24	5	-
S. Dak.	10	10	2,342	1,994	-	-	38	29	40	14
Nebr.[¶]	52	58	4,234	4,356	1	1	18	49	47	35
Kans.	86	68	6,107	6,151	N	N	165	16	87	10
S. ATLANTIC	10,692	10,764	140,302	142,635	5	4	360	300	169	68
Del.	195	165	2,720	2,426	N	N	4	3	12	-
Md.	1,285	1,664	15,123	15,044	5	4	23	19	44	21
D.C.	859	622	2,893	3,042	-	-	17	5	-	-
Va.	819	713	15,282	16,506	-	-	42	23	17	-
W. Va.	79	79	2,369	2,268	N	N	4	2	1	2
N.C.	1,006	837	23,668	22,601	N	N	45	32	-	-
S.C.[¶]	719	747	13,885	13,108	-	-	8	6	1	1
Ga.	1,667	1,431	27,888	29,630	-	-	119	114	46	21
Fla.	4,063	4,506	36,474	38,010	N	N	98	96	48	23
E.S. CENTRAL	1,704	1,797	47,035	47,539	N	N	112	114	45	274
Ky.	175	277	7,164	7,991	N	N	23	8	11	42
Tenn.	738	725	18,333	14,580	N	N	37	53	18	8
Ala.	390	387	11,046	14,460	-	-	42	45	16	34
Miss.	401	408	10,492	10,508	N	N	10	8	-	190
W.S. CENTRAL	4,110	3,814	90,148	98,429	4	11	92	60	476	418
Ark.	165	223	7,009	6,724	-	-	17	8	22	11
La.	522	898	15,840	17,299	N	N	2	9	43	204
Okla.	176	166	10,147	9,929	N	N	18	16	25	-
Tex.	3,247	2,527	57,152	64,477	4	11	55	27	386	203
MOUNTAIN	1,342	1,236	40,203	46,778	2,310	2,375	123	149	312	3
Mont.	13	10	1,727	2,004	N	N	18	5	216	1
Idaho	21	28	2,220	2,260	N	N	26	28	-	1
Wyo.	7	8	860	841	1	-	5	9	89	-
Colo.	328	283	9,800	12,961	N	N	33	55	-	-
N. Mex.	103	80	6,284	6,774	7	7	9	18	3	-
Ariz.	584	487	11,452	13,453	2,251	2,314	6	16	1	1
Utah	60	57	3,034	3,072	17	11	19	14	1	-
Nev.	226	283	4,826	5,413	34	43	7	4	2	-
PACIFIC	6,076	4,550	125,785	126,185	1,303	1,401	345	265	4	-
Wash.	422	412	14,848	13,500	N	N	59	36	-	-
Oreg.	229	288	6,585	6,134	-	-	36	37	4	-
Calif.	5,321	3,714	97,940	99,137	1,303	1,401	249	189	-	-
Alaska	15	28	3,276	3,322	-	-	1	1	-	-
Hawaii	89	108	3,136	4,092	-	-	-	2	-	-
Guam	6	2	-	595	-	-	-	-	-	-
P.R.	944	1,042	1,755	2,287	N	N	N	N	-	-
V.I.	31	63	208	125	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 26, 2003.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 22, 2003, and November 23, 2002 (47th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC): O157:H7 Cum. 2003	O157:H7 Cum. 2002	Shiga toxin positive, serogroup non-O157 Cum. 2003	Shiga toxin positive, serogroup non-O157 Cum. 2002	Shiga toxin positive, not serogrouped Cum. 2003	Shiga toxin positive, not serogrouped Cum. 2002	Giardiasis Cum. 2003	Giardiasis Cum. 2002	Gonorrhea Cum. 2003	Gonorrhea Cum. 2002
UNITED STATES	2,368	3,454	247	176	123	47	16,310	18,831	280,335	319,288
NEW ENGLAND	149	253	53	46	16	6	1,247	1,635	6,467	7,037
Maine	10	37	3	8	1	-	169	192	162	123
N.H.	12	33	2	-	-	-	22	41	76	113
Vt.	16	12	-	1	-	1	113	132	77	86
Mass.	63	115	8	19	15	5	617	882	2,775	2,975
R.I.	1	12	-	1	-	-	106	145	858	834
Conn.	47	44	40	17	-	-	220	243	2,519	2,906
MID. ATLANTIC	223	386	18	1	35	7	3,196	3,857	37,537	38,664
Upstate N.Y.	90	157	11	-	17	-	948	1,133	7,136	7,863
N.Y. City	5	18	-	-	-	-	1,032	1,334	11,709	11,563
N.J.	20	59	1	-	-	1	314	446	6,292	7,099
Pa.	108	152	6	1	18	6	902	944	12,400	12,139
E.N. CENTRAL	530	805	23	31	22	4	2,695	3,303	56,360	67,675
Ohio	127	148	17	11	21	3	837	860	16,006	19,850
Ind.	83	75	-	1	-	-	-	-	5,851	6,822
Ill.	108	174	-	6	-	-	685	937	17,524	22,097
Mich.	85	132	-	3	-	1	675	863	12,267	13,186
Wis.	127	276	6	10	1	-	498	643	4,712	5,720
W.N. CENTRAL	418	491	53	30	20	6	1,847	1,906	14,927	16,468
Minn.	130	155	23	25	1	-	732	708	2,507	2,816
Iowa	102	117	-	-	-	-	253	293	775	1,245
Mo.	84	68	17	-	1	-	449	464	7,723	8,108
N. Dak.	13	18	4	-	8	2	35	30	56	69
S. Dak.	28	40	4	2	-	-	74	74	204	250
Nebr.	33	62	4	3	-	-	108	162	1,414	1,451
Kans.	28	31	1	-	10	4	196	175	2,248	2,529
S. ATLANTIC	144	345	65	32	9	1	2,554	2,695	69,871	80,831
Del.	11	9	N	N	N	N	44	52	1,032	1,446
Md.	11	27	-	-	-	-	110	107	7,174	8,267
D.C.	1	-	-	-	-	-	47	43	2,293	2,422
Va.	38	63	10	9	-	-	321	282	7,025	9,303
W. Va.	5	9	-	-	-	1	40	54	779	889
N.C.	4	130	28	-	-	-	N	N	13,764	14,441
S.C.	2	5	-	-	-	-	128	132	7,551	8,364
Ga.	30	43	4	7	-	-	859	852	14,037	16,285
Fla.	42	59	23	16	9	-	1,005	1,173	16,216	19,414
E.S. CENTRAL	77	103	2	-	7	10	326	356	23,288	27,481
Ky.	25	30	2	-	7	10	N	N	3,198	3,402
Tenn.	33	44	-	-	-	-	167	173	7,651	8,605
Ala.	13	18	-	-	-	-	159	183	7,037	9,296
Miss.	6	11	-	-	-	-	-	-	5,402	6,178
W.S. CENTRAL	85	106	5	2	9	8	270	235	37,311	44,037
Ark.	12	11	-	-	-	-	135	159	3,589	4,261
La.	3	4	-	-	-	-	9	6	9,574	10,664
Okla.	28	22	-	-	-	-	125	67	4,168	4,256
Tex.	42	69	5	2	9	8	1	3	19,980	24,856
MOUNTAIN	313	328	24	27	5	5	1,466	1,528	8,780	10,282
Mont.	16	30	-	-	-	-	98	78	93	102
Idaho	79	42	15	16	-	-	181	121	66	83
Wyo.	4	14	1	2	-	-	21	29	39	55
Colo.	70	97	3	6	5	5	410	521	2,365	3,199
N. Mex.	10	12	4	3	-	-	44	137	1,007	1,358
Ariz.	37	33	N	N	N	N	238	188	3,132	3,362
Utah	74	72	-	-	-	-	344	303	323	324
Nev.	23	28	1	-	-	-	130	151	1,755	1,799
PACIFIC	429	637	4	7	-	-	2,709	3,316	25,794	26,813
Wash.	108	139	1	-	-	-	312	414	2,455	2,641
Oreg.	96	203	3	7	-	-	368	407	878	788
Calif.	213	252	-	-	-	-	1,876	2,307	21,233	22,158
Alaska	4	7	-	-	-	-	81	108	483	553
Hawaii	8	36	-	-	-	-	72	80	745	673
Guam	N	N	-	-	-	-	-	7	-	44
P.R.	-	1	-	-	36	-	129	80	184	320
V.I.	-	-	-	-	-	-	-	-	55	31
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 22, 2003, and November 23, 2002 (47th Week)*

	Haemophilus influenzae, invasive[†]								Hepatitis (viral, acute), by type	
	All ages		Age <5 years						A	
	All serotypes		Serotype b		Non-serotype b		Unknown serotype			
Reporting area	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	1,480	1,497	19	28	80	124	166	138	6,504	8,095
NEW ENGLAND	108	112	1	-	5	10	5	2	297	279
Maine	4	1	-	-	-	-	1	-	17	8
N.H.	11	9	1	-	-	-	-	-	11	11
Vt.	8	7	-	-	-	-	-	-	6	1
Mass.	46	43	-	-	5	4	3	2	179	137
R.I.	9	10	-	-	-	-	1	-	15	30
Conn.	30	42	-	-	-	6	-	-	69	92
MID. ATLANTIC	327	276	-	2	1	14	46	22	1,544	1,042
Upstate N.Y.	121	107	-	2	1	4	14	8	131	168
N.Y. City	54	64	-	-	-	-	10	9	400	418
N.J.	55	52	-	-	-	-	7	5	137	175
Pa.	97	53	-	-	-	10	15	-	876	281
E.N. CENTRAL	213	290	4	3	8	12	31	42	641	988
Ohio	64	73	-	-	-	1	11	9	157	287
Ind.	42	38	1	1	4	7	-	-	67	46
Ill.	69	115	-	-	-	-	15	20	180	253
Mich.	21	15	3	2	4	4	1	-	195	212
Wis.	17	49	-	-	-	-	4	13	42	190
W.N. CENTRAL	111	66	2	1	7	2	15	6	176	272
Minn.	45	43	2	1	7	2	2	4	45	39
Iowa	-	1	-	-	-	-	-	-	28	61
Mo.	40	12	-	-	-	-	12	2	61	80
N. Dak.	3	4	-	-	-	-	-	-	1	3
S. Dak.	1	1	-	-	-	-	-	-	-	3
Nebr.	3	-	-	-	-	-	-	-	12	17
Kans.	19	5	-	-	-	-	1	-	29	69
S. ATLANTIC	354	328	3	5	15	16	21	26	1,667	2,223
Del.	-	-	-	-	-	-	-	-	7	15
Md.	84	81	1	2	7	4	1	1	165	286
D.C.	-	-	-	-	-	-	-	-	43	74
Va.	51	31	-	-	-	-	6	5	94	137
W. Va.	15	17	-	-	-	1	-	1	15	19
N.C.	36	30	-	-	3	3	2	-	98	198
S.C.	4	12	-	-	-	-	1	2	35	56
Ga.	59	74	-	-	-	-	5	11	817	458
Fla.	105	83	2	3	5	8	6	6	393	980
E.S. CENTRAL	73	63	1	1	2	5	10	11	240	254
Ky.	6	6	-	-	2	1	-	1	29	41
Tenn.	45	32	-	-	-	1	6	7	181	113
Ala.	20	16	1	1	-	3	3	1	15	38
Miss.	2	9	-	-	-	-	1	2	15	62
W.S. CENTRAL	64	56	1	2	8	10	5	3	356	970
Ark.	7	1	-	-	1	-	-	-	19	68
La.	12	8	-	-	-	-	5	3	51	81
Okla.	43	45	-	-	7	10	-	-	21	48
Tex.	2	2	1	2	-	-	-	-	265	773
MOUNTAIN	143	171	4	6	19	37	21	15	448	500
Mont.	-	-	-	-	-	-	-	-	8	13
Idaho	4	2	-	-	-	-	1	1	16	29
Wyo.	2	2	-	-	-	-	-	-	1	3
Colo.	36	31	-	-	-	-	7	3	67	71
N. Mex.	14	25	-	-	4	6	1	1	19	28
Ariz.	64	82	4	4	6	25	8	6	247	256
Utah	13	17	-	1	5	4	4	1	42	52
Nev.	10	12	-	1	4	2	-	3	48	48
PACIFIC	87	135	3	8	15	18	12	11	1,135	1,567
Wash.	11	3	-	2	7	1	3	-	62	145
Oreg.	40	52	-	-	-	-	4	3	56	59
Calif.	20	43	3	6	8	17	4	4	997	1,328
Alaska	-	1	-	-	-	-	-	1	9	10
Hawaii	16	36	-	-	-	-	1	3	11	25
Guam	-	-	-	-	-	-	-	-	-	1
P.R.	-	1	-	-	-	-	-	-	50	220
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

[†] Non-serotype b: nontypeable and type other than b; Unknown serotype: type unknown or not reported. Previously, cases reported without type information were counted as non-serotype b.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 22, 2003, and November 23, 2002 (47th Week)*

	Hepatitis (viral, acute), by type									
	B		C		Legionellosis		Listeriosis		Lyme disease	
Reporting area	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	6,252	6,724	1,697	1,649	1,816	1,159	558	591	16,129	20,518
NEW ENGLAND	232	273	6	20	93	106	43	59	3,125	6,743
Maine	1	12	-	-	2	3	7	5	205	102
N.H.	11	20	-	-	6	6	3	4	95	240
Vt.	3	6	6	13	6	35	1	3	43	33
Mass.	177	143	-	6	38	43	14	33	982	1,785
R.I.	18	28	-	1	15	5	-	1	564	335
Conn.	22	64	U	U	26	14	18	13	1,236	4,248
MID. ATLANTIC	809	1,412	149	101	517	327	111	175	10,512	10,537
Upstate N.Y.	120	109	39	44	143	93	33	54	4,214	4,600
N.Y. City	270	694	-	-	46	61	19	38	5	58
N.J.	165	302	-	5	62	32	15	34	1,786	2,269
Pa.	254	307	110	52	266	141	44	49	4,507	3,610
E.N. CENTRAL	373	642	147	111	363	273	64	80	777	1,236
Ohio	128	97	10	2	213	115	23	22	76	72
Ind.	34	51	8	-	24	20	7	11	20	20
Ill.	1	141	16	22	3	25	7	20	33	47
Mich.	179	308	113	83	107	78	19	19	10	26
Wis.	31	45	-	4	16	35	8	8	638	1,071
W.N. CENTRAL	291	206	230	625	59	62	20	16	395	368
Minn.	32	28	8	2	3	14	10	1	279	271
Iowa	11	19	1	1	9	12	-	2	47	42
Mo.	203	107	220	607	30	18	5	9	55	39
N. Dak.	2	5	-	-	1	1	-	1	-	1
S. Dak.	2	2	-	1	2	4	-	1	1	2
Nebr.	24	24	1	14	4	13	4	1	2	6
Kans.	17	21	-	-	10	-	1	1	11	7
S. ATLANTIC	1,959	1,571	148	193	486	203	119	79	1,055	1,296
Del.	7	13	-	-	26	9	N	N	173	181
Md.	121	120	17	11	125	47	24	18	590	708
D.C.	12	21	-	-	19	6	-	-	15	22
Va.	163	184	7	15	88	29	8	7	83	146
W. Va.	37	18	4	3	17	-	6	-	22	17
N.C.	148	207	11	25	36	11	16	6	95	124
S.C.	146	111	24	5	7	9	4	8	8	24
Ga.	741	416	5	63	29	19	31	14	16	2
Fla.	584	481	80	71	139	73	30	26	53	72
E.S. CENTRAL	387	353	76	128	88	45	29	21	59	68
Ky.	63	51	15	4	40	21	7	4	15	22
Tenn.	180	121	18	26	32	16	8	12	16	24
Ala.	57	96	7	10	13	8	12	4	5	11
Miss.	87	85	36	88	3	-	2	1	23	11
W.S. CENTRAL	885	964	782	315	59	32	41	34	77	137
Ark.	59	106	3	10	2	-	1	-	-	3
La.	100	123	97	93	1	4	2	4	6	5
Okla.	41	66	2	5	7	3	3	9	-	-
Tex.	685	669	680	207	49	25	35	21	71	129
MOUNTAIN	553	553	50	49	68	48	30	28	19	17
Mont.	16	9	2	1	4	3	2	-	-	-
Idaho	8	7	1	1	3	1	2	2	3	4
Wyo.	29	17	-	5	2	2	-	-	2	2
Colo.	78	73	16	6	15	8	10	6	4	1
N. Mex.	31	144	-	2	2	2	2	3	1	1
Ariz.	257	197	7	4	11	12	10	13	3	3
Utah	58	48	-	4	22	14	-	3	3	5
Nev.	76	58	24	26	9	6	4	1	3	1
PACIFIC	763	750	109	107	83	63	101	99	110	116
Wash.	63	67	15	24	10	5	5	8	3	10
Oreg.	100	119	14	11	N	N	4	9	16	12
Calif.	571	546	77	71	73	55	87	74	88	91
Alaska	10	8	1	-	-	2	-	-	3	3
Hawaii	19	10	2	1	-	1	5	8	N	N
Guam	-	1	-	-	-	-	-	-	-	-
P.R.	80	170	-	-	-	-	-	2	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 22, 2003, and November 23, 2002 (47th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	1,034	1,288	1,401	1,624	6,726	7,494	5,123	7,086	828	977
NEW ENGLAND	40	73	65	87	853	748	524	859	-	7
Maine	3	5	6	5	12	17	62	57	-	-
N.H.	4	7	3	12	60	18	13	45	-	-
Vt.	2	4	3	4	61	141	30	88	-	-
Mass.	11	32	41	47	679	531	198	284	-	3
R.I.	2	7	2	5	20	13	57	71	-	4
Conn.	18	18	10	14	21	28	164	314	-	-
MID. ATLANTIC	262	349	166	191	860	473	862	1,202	35	55
Upstate N.Y.	57	43	45	46	534	317	393	654	2	-
N.Y. City	128	220	31	34	-	21	6	19	12	10
N.J.	37	40	22	27	65	2	62	171	10	16
Pa.	40	46	68	84	261	133	401	358	11	29
E.N. CENTRAL	82	155	195	249	573	894	153	161	16	32
Ohio	21	22	52	72	253	401	52	39	10	13
Ind.	2	14	41	32	61	126	27	31	1	4
Ill.	26	61	43	55	-	160	23	31	-	12
Mich.	23	45	41	42	106	54	44	46	5	3
Wis.	10	13	18	48	153	153	7	14	-	-
W.N. CENTRAL	45	57	133	141	403	675	520	451	69	104
Minn.	21	17	26	34	141	341	38	37	1	-
Iowa	6	4	25	24	124	118	100	74	2	3
Mo.	5	15	61	47	78	136	51	49	53	96
N. Dak.	1	1	1	3	6	7	52	52	-	-
S. Dak.	3	2	1	2	5	6	67	88	5	1
Nebr.	-	5	8	23	9	8	58	-	3	4
Kans.	9	13	11	8	40	59	154	151	5	-
S. ATLANTIC	286	303	242	263	631	388	2,321	2,443	506	462
Del.	3	5	8	7	8	3	58	24	1	1
Md.	68	103	26	8	79	61	256	372	104	40
D.C.	14	20	-	-	3	2	-	-	1	2
Va.	36	31	24	41	90	133	469	540	29	40
W. Va.	4	3	6	4	19	31	81	164	5	2
N.C.	21	21	32	30	118	40	726	655	252	274
S.C.	3	8	21	29	178	43	211	138	33	71
Ga.	55	49	30	30	32	26	346	384	68	19
Fla.	82	63	95	114	104	49	174	166	13	13
E.S. CENTRAL	19	19	76	89	133	243	170	211	105	128
Ky.	8	7	17	15	43	92	37	26	2	5
Tenn.	5	3	25	36	68	110	99	108	63	81
Ala.	3	4	15	21	16	32	33	73	12	15
Miss.	3	5	19	17	6	9	1	4	28	27
W.S. CENTRAL	75	75	165	198	569	1,505	210	1,169	86	171
Ark.	4	3	13	23	37	488	25	94	33	97
La.	4	4	32	42	6	7	-	-	-	-
Okla.	4	10	17	21	27	35	185	113	42	61
Tex.	63	58	103	112	499	975	-	962	11	13
MOUNTAIN	45	46	69	87	877	997	165	303	10	14
Mont.	-	2	5	2	5	5	20	19	1	1
Idaho	1	-	7	4	71	66	15	38	2	-
Wyo.	1	-	2	-	123	11	6	18	3	5
Colo.	21	23	22	23	330	399	38	59	2	2
N. Mex.	3	3	8	4	63	182	5	10	-	1
Ariz.	13	10	15	29	126	190	63	135	-	-
Utah	5	5	2	5	125	97	14	13	2	-
Nev.	1	3	8	20	34	47	4	11	-	5
PACIFIC	180	211	290	319	1,827	1,571	198	287	1	4
Wash.	25	24	29	61	654	418	-	-	-	-
Oreg.	10	9	54	46	421	170	6	14	-	3
Calif.	137	169	194	200	735	951	184	247	1	1
Alaska	1	2	3	4	7	4	8	26	-	-
Hawaii	7	7	10	8	10	28	-	-	-	-
Guam	-	-	-	1	-	2	-	-	-	-
P.R.	1	1	5	7	1	3	67	85	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 22, 2003, and November 23, 2002 (47th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive: Drug resistant, all ages		*Streptococcus pneumoniae*, invasive: Age <5 years	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	36,896	39,762	19,662	19,358	4,769	4,152	1,856	2,192	394	329
NEW ENGLAND	1,891	2,066	295	318	349	298	40	105	8	3
Maine	125	136	6	8	26	20	-	-	-	-
N.H.	100	128	5	11	21	35	-	-	N	N
Vt.	66	72	7	1	19	10	6	5	4	2
Mass.	1,107	1,152	193	194	166	100	N	N	N	N
R.I.	126	163	20	17	15	15	10	13	4	1
Conn.	367	415	64	87	102	118	24	87	U	U
MID. ATLANTIC	4,152	5,343	2,065	1,655	837	658	116	105	87	77
Upstate N.Y.	1,059	1,415	509	289	336	257	65	82	69	63
N.Y. City	1,186	1,288	354	456	119	147	U	U	U	U
N.J.	483	987	240	585	134	141	N	N	N	N
Pa.	1,424	1,653	962	325	248	113	51	23	18	14
E.N. CENTRAL	4,834	5,148	1,545	2,009	962	886	393	214	160	135
Ohio	1,260	1,280	277	586	277	190	254	68	91	22
Ind.	531	517	152	104	98	48	139	144	45	56
Ill.	1,525	1,688	780	966	182	254	-	2	-	-
Mich.	716	818	225	176	336	279	N	N	N	N
Wis.	802	845	111	177	69	115	N	N	24	57
W.N. CENTRAL	2,327	2,399	756	990	303	231	147	419	54	53
Minn.	514	511	98	204	147	113	-	292	45	49
Iowa	364	467	83	118	N	N	N	N	N	N
Mo.	903	775	352	175	68	42	11	5	2	1
N. Dak.	37	40	4	18	14	3	3	1	7	3
S. Dak.	111	109	16	156	21	13	1	1	-	-
Nebr.	131	167	101	230	25	23	-	25	N	N
Kans.	267	330	102	89	28	37	132	95	N	N
S. ATLANTIC	10,020	10,422	6,634	6,462	830	675	952	1,007	18	33
Del.	89	92	154	316	6	2	1	3	N	N
Md.	794	870	547	1,093	246	110	-	-	-	23
D.C.	46	75	70	60	14	8	2	-	7	3
Va.	978	1,119	400	900	93	71	N	N	N	N
W. Va.	118	140	-	12	33	19	67	42	11	7
N.C.	1,228	1,440	923	405	100	112	N	N	U	U
S.C.	664	773	465	116	36	37	126	176	N	N
Ga.	2,051	1,818	1,542	1,572	110	123	225	250	N	N
Fla.	4,052	4,095	2,533	1,988	192	193	531	536	N	N
E.S. CENTRAL	2,479	3,040	864	1,366	192	107	129	122	-	-
Ky.	355	358	120	177	43	19	16	17	N	N
Tenn.	700	764	339	117	149	88	113	105	N	N
Ala.	498	802	242	744	-	-	-	-	N	N
Miss.	926	1,116	163	328	-	-	-	-	-	-
W.S. CENTRAL	4,452	4,402	4,086	2,978	323	269	53	173	62	24
Ark.	748	1,011	95	188	5	7	8	8	-	-
La.	420	762	226	454	1	1	45	165	8	9
Okla.	440	471	776	538	81	41	N	N	33	3
Tex.	2,844	2,158	2,989	1,798	236	220	N	N	21	12
MOUNTAIN	2,071	2,055	1,128	845	417	514	23	47	5	4
Mont.	103	82	2	4	2	-	-	-	-	-
Idaho	162	136	29	13	18	9	N	N	N	N
Wyo.	73	104	8	8	2	7	6	13	-	-
Colo.	440	564	273	191	124	112	-	-	-	-
N. Mex.	231	291	217	209	96	100	17	33	-	-
Ariz.	688	506	490	342	163	256	-	-	N	N
Utah	209	170	47	30	10	30	-	-	5	4
Nev.	165	202	62	48	2	-	-	1	-	-
PACIFIC	4,670	4,887	2,289	2,735	556	514	3	-	-	-
Wash.	495	481	139	165	70	60	-	-	N	N
Oreg.	382	318	207	100	N	N	N	N	N	N
Calif.	3,507	3,765	1,893	2,399	380	369	N	N	N	N
Alaska	92	78	10	5	-	-	-	-	N	N
Hawaii	194	245	40	66	106	85	3	-	-	-
Guam	-	39	-	32	-	-	-	4	-	-
P.R.	323	513	8	30	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 22, 2003, and November 23, 2002 (47th Week)*

	Syphilis				Tuberculosis		Typhoid fever		Varicella (Chickenpox)
	Primary & secondary		Congenital						
Reporting area	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003
UNITED STATES	6,017	6,118	315	392	9,947	11,569	281	301	11,487
NEW ENGLAND	180	131	1	1	287	386	23	13	1,650
Maine	7	2	1	-	5	20	-	-	773
N.H.	14	6	-	-	7	15	2	-	-
Vt.	1	1	-	-	7	6	-	-	721
Mass.	121	88	-	1	190	205	12	7	151
R.I.	16	7	-	-	28	48	2	-	5
Conn.	21	27	-	-	50	92	7	6	-
MID. ATLANTIC	758	671	55	63	1,906	1,991	48	75	36
Upstate N.Y.	43	30	9	4	262	284	10	9	N
N.Y. City	426	394	31	24	1,002	961	18	40	-
N.J.	142	152	15	34	359	449	14	18	-
Pa.	147	95	-	1	283	297	6	8	36
E.N. CENTRAL	777	1,111	65	61	1,006	1,171	23	32	5,115
Ohio	190	149	3	3	181	210	2	6	1,053
Ind.	45	55	10	3	116	112	4	2	-
Ill.	301	437	19	35	468	549	7	16	-
Mich.	229	446	33	20	189	239	10	4	3,348
Wis.	12	24	-	-	52	61	-	4	714
W.N. CENTRAL	131	116	4	2	427	472	4	9	71
Minn.	40	56	-	1	173	204	-	3	N
Iowa	7	3	-	-	25	30	2	-	N
Mo.	49	32	4	1	99	119	1	2	-
N. Dak.	2	-	-	-	4	6	-	-	71
S. Dak.	2	-	-	-	16	11	-	-	-
Nebr.	8	6	-	-	18	25	1	4	-
Kans.	23	19	-	-	92	77	-	-	-
S. ATLANTIC	1,628	1,571	55	84	2,036	2,390	49	41	1,936
Del.	6	11	-	-	23	19	-	-	28
Md.	265	192	10	15	214	263	8	8	-
D.C.	51	52	-	1	-	-	-	-	27
Va.	71	63	1	1	223	242	12	7	478
W. Va.	2	2	-	-	20	28	-	-	1,169
N.C.	140	264	16	18	281	310	9	2	N
S.C.	87	124	4	12	147	146	-	-	234
Ga.	421	344	6	13	337	475	7	5	-
Fla.	585	519	18	24	791	907	13	19	N
E.S. CENTRAL	290	429	11	29	597	676	5	4	2
Ky.	31	85	1	3	113	117	1	4	N
Tenn.	122	156	3	10	191	261	2	-	N
Ala.	106	144	5	10	205	185	2	-	-
Miss.	31	44	2	6	88	113	-	-	2
W.S. CENTRAL	844	769	57	82	1,387	1,681	33	30	2,096
Ark.	49	31	-	11	86	115	-	-	-
La.	155	138	-	-	-	-	-	-	11
Okla.	59	60	1	2	133	151	1	2	N
Tex.	581	540	56	69	1,168	1,415	32	28	2,085
MOUNTAIN	267	293	22	16	335	381	5	9	581
Mont.	-	-	-	-	5	6	-	-	N
Idaho	11	7	-	-	8	13	-	-	N
Wyo.	-	-	-	-	4	3	-	-	45
Colo.	24	61	3	2	62	85	3	4	-
N. Mex.	57	32	1	-	6	34	-	1	3
Ariz.	160	172	18	14	193	200	2	-	4
Utah	5	6	-	-	35	26	-	2	529
Nev.	10	15	-	-	22	14	-	2	-
PACIFIC	1,142	1,027	45	54	1,966	2,421	91	88	-
Wash.	74	57	-	1	218	221	3	6	-
Oreg.	40	21	-	-	95	102	5	2	-
Calif.	1,026	941	45	52	1,544	1,923	82	75	-
Alaska	-	-	-	-	50	45	-	-	-
Hawaii	2	8	-	1	59	130	1	5	-
Guam	-	6	-	-	-	64	-	-	-
P.R.	177	266	1	21	86	90	-	-	402
V.I.	1	1	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending November 22, 2003 (47th Week)

Reporting Area	All causes, by age (years)						P&I[†]
	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	578	418	118	29	7	6	66
Boston, Mass.	149	97	36	12	2	2	19
Bridgeport, Conn.	31	26	5	-	-	-	3
Cambridge, Mass.	23	19	4	-	-	-	2
Fall River, Mass.	26	21	5	-	-	-	6
Hartford, Conn.	51	36	12	3	-	-	4
Lowell, Mass.	31	26	4	-	1	-	1
Lynn, Mass.	15	11	3	1	-	-	1
New Bedford, Mass.	31	21	2	6	2	-	-
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	63	45	14	2	-	2	10
Somerville, Mass.	4	2	2	-	-	-	1
Springfield, Mass.	48	34	10	3	-	1	5
Waterbury, Conn.	29	25	2	1	1	-	4
Worcester, Mass.	77	55	19	1	1	1	10
MID. ATLANTIC	2,682	1,870	564	159	49	37	137
Albany, N.Y.	58	42	10	1	2	3	6
Allentown, Pa.	13	10	3	-	-	-	1
Buffalo, N.Y.	91	64	15	5	5	2	11
Camden, N.J.	26	13	7	3	-	3	1
Elizabeth, N.J.	24	17	6	1	-	-	-
Erie, Pa.	37	28	7	1	-	1	-
Jersey City, N.J.	51	33	14	2	-	2	-
New York City, N.Y.	1,710	1,187	382	97	23	18	65
Newark, N.J.	38	14	14	8	2	-	3
Paterson, N.J.	21	9	7	3	2	-	2
Philadelphia, Pa.	252	167	51	20	9	5	15
Pittsburgh, Pa.[§]	30	20	6	2	1	1	1
Reading, Pa.	16	13	2	1	-	-	1
Rochester, N.Y.	124	107	12	4	1	-	14
Schenectady, N.Y.	35	28	5	2	-	-	-
Scranton, Pa.	U	U	U	U	U	U	U
Syracuse, N.Y.	74	57	11	3	1	2	12
Trenton, N.J.	33	24	4	3	2	-	2
Utica, N.Y.	21	14	3	3	1	-	-
Yonkers, N.Y.	28	23	5	-	-	-	3
E.N. CENTRAL	2,141	1,448	478	120	47	47	148
Akron, Ohio	45	31	10	3	-	1	3
Canton, Ohio	34	26	5	2	-	1	5
Chicago, Ill.	399	244	106	25	14	9	16
Cincinnati, Ohio	69	42	15	2	6	4	6
Cleveland, Ohio	207	149	45	6	1	6	14
Columbus, Ohio	222	143	57	14	5	3	21
Dayton, Ohio	136	109	18	6	1	2	7
Detroit, Mich.	170	85	54	23	6	2	16
Evansville, Ind.	48	39	5	3	-	1	6
Fort Wayne, Ind.	77	52	16	4	1	4	6
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	52	43	5	1	1	2	6
Indianapolis, Ind.	195	132	37	16	6	4	14
Lansing, Mich.	51	37	11	2	1	-	1
Milwaukee, Wis.	120	85	26	6	-	3	5
Peoria, Ill.	45	34	9	2	-	-	4
Rockford, Ill.	42	32	6	1	-	3	6
South Bend, Ind.	65	46	15	1	3	-	-
Toledo, Ohio	101	71	24	3	1	2	9
Youngstown, Ohio	63	48	14	-	1	-	3
W.N. CENTRAL	529	371	95	33	19	11	47
Des Moines, Iowa	86	66	9	7	1	3	6
Duluth, Minn.	30	22	4	4	-	-	1
Kansas City, Kans.	19	9	5	2	1	2	-
Kansas City, Mo.	76	48	15	5	6	2	5
Lincoln, Nebr.	45	32	7	3	3	-	6
Minneapolis, Minn.	69	49	15	2	2	1	7
Omaha, Nebr.	79	56	17	4	1	1	9
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	47	34	8	2	1	2	6
Wichita, Kans.	78	55	15	4	4	-	7
S. ATLANTIC	1,460	886	345	151	36	42	77
Atlanta, Ga.	171	91	44	20	3	13	3
Baltimore, Md.	220	135	51	26	5	3	22
Charlotte, N.C.	111	77	22	9	2	1	9
Jacksonville, Fla.	182	118	40	17	4	3	14
Miami, Fla.	41	24	12	3	-	2	2
Norfolk, Va.	42	27	8	5	1	1	1
Richmond, Va.	51	25	18	6	1	1	4
Savannah, Ga.	58	36	14	4	2	2	5
St. Petersburg, Fla.	67	46	12	6	1	2	3
Tampa, Fla.	202	125	47	19	6	5	7
Washington, D.C.	296	166	74	36	11	9	6
Wilmington, Del.	19	16	3	-	-	-	1
E.S. CENTRAL	834	586	169	50	15	13	55
Birmingham, Ala.	147	102	30	10	3	1	18
Chattanooga, Tenn.	85	63	15	3	3	1	7
Knoxville, Tenn.	130	86	33	8	2	1	1
Lexington, Ky.	70	54	12	1	1	2	7
Memphis, Tenn.	115	82	20	11	2	-	3
Mobile, Ala.	84	60	17	5	1	1	3
Montgomery, Ala.	46	37	6	1	-	2	7
Nashville, Tenn.	157	102	36	11	3	5	9
W.S. CENTRAL	1,096	735	228	80	30	23	51
Austin, Tex.	94	65	18	8	2	1	5
Baton Rouge, La.	U	U	U	U	U	U	U
Corpus Christi, Tex.	52	34	13	5	-	-	5
Dallas, Tex.	183	102	51	18	5	7	7
El Paso, Tex.	110	77	23	6	3	1	4
Ft. Worth, Tex.	120	85	17	8	3	7	6
Houston, Tex.	U	U	U	U	U	U	U
Little Rock, Ark.	81	50	21	7	1	2	3
New Orleans, La.	27	17	7	3	-	-	-
San Antonio, Tex.	231	164	41	15	8	3	13
Shreveport, La.	70	54	15	-	-	1	1
Tulsa, Okla.	128	87	22	10	8	1	7
MOUNTAIN	1,048	653	176	70	31	18	72
Albuquerque, N.M.	118	80	25	8	2	3	5
Boise, Idaho	58	47	9	2	-	-	10
Colo. Springs, Colo.	48	32	12	3	1	-	1
Denver, Colo.	106	71	16	11	3	5	9
Las Vegas, Nev.	266	169	65	16	15	1	15
Ogden, Utah	40	33	3	2	2	-	1
Phoenix, Ariz.	102	1	-	1	-	-	7
Pueblo, Colo.	27	19	7	1	-	-	1
Salt Lake City, Utah	118	80	22	8	3	5	6
Tucson, Ariz.	165	121	17	18	5	4	17
PACIFIC	1,663	1,157	345	96	31	34	120
Berkeley, Calif.	13	9	3	1	-	-	2
Fresno, Calif.	144	103	27	10	1	3	8
Glendale, Calif.	26	20	2	2	2	-	-
Honolulu, Hawaii	77	56	12	6	1	2	4
Long Beach, Calif.	68	47	16	1	2	2	10
Los Angeles, Calif.	452	305	98	31	8	10	21
Pasadena, Calif.	22	16	5	-	-	1	7
Portland, Oreg.	122	82	29	9	1	1	3
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	170	122	34	8	5	1	9
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	218	150	47	6	7	8	28
Santa Cruz, Calif.	30	21	5	3	1	-	3
Seattle, Wash.	153	106	31	10	1	5	9
Spokane, Wash.	55	39	13	2	1	-	7
Tacoma, Wash.	113	81	23	7	1	1	9
TOTAL	12,031[¶]	8,124	2,518	788	265	231	773

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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