HIV/AIDS Mortality — Continued

In 1989, HIV infection/AIDS was the second leading cause of death for men and the sixth leading cause of death for women aged 25–44 years in the United States (*2*). In comparison, in 1989 in Baltimore, HIV-infection/AIDS-related mortality among persons aged 25–44 years was more than twice the national average for white men and three times the national average for black men. The increase of HIV-infection/AIDS-related mortality among blacks reflects the disproportionate representation of minorities in urban communities with a high incidence of HIV infection. The findings in this report also are consistent with national trends that indicate HIV infection/AIDS is becoming a leading cause of death among young women. For example, in New York City, HIV infection/AIDS is now the leading cause of death among women aged 25–44 years (*3*).

In Baltimore and other metropolitan areas, the reduction of new HIV infections will require the cooperative efforts of public and private organizations in providing 1) public information about HIV infection/AIDS; 2) HIV health education and risk-reduction initiatives; 3) HIV counseling, testing, referral, and partner-notification services; and 4) HIV early intervention services. For example, the Baltimore community used the HIV-infection/AIDS-related mortality data at city health conferences and seminars to train health professionals to work with subpopulations within the metropolitan area through the development of 1) a "grass roots" HIV-infection prevention campaign for persons with high-risk behaviors and 2) a needle clean-up program within neighborhoods with high levels of HIV infection.

References

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2. NCHS. Advance report of final mortality statistics, 1989. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1992. (Monthly vital statistics report; vol 40, no. 8, suppl 2).
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Elevated Blood Lead Levels in Adults — United States, Second Quarter, 1992

In the United States, more than 95% of elevated blood lead levels (BLLs) in adults result from workplace exposure (*1*). Beginning with this issue of *MMWR*, CDC's National Institute for Occupational Safety and Health (NIOSH) will report on a quarterly basis summary results of state-based surveillance programs for elevated BLLs (≥25 µg/dL) among adults (Table 1). In addition to the 18 states with blood lead surveillance programs previously reported (*2*), three other states maintain such activities, including Arizona (physician reporting of BLLs ≥25 µg/dL, all ages), Florida (laboratory reporting of BLLs ≥10 µg/dL, all ages), and Nebraska (laboratory reporting of BLLs ≥10 µg/dL, all ages).

Of the 21 states, 12 currently maintain the data-entry and analytic capability necessary to provide quarterly reports. In 1992, NIOSH will assist the other states in standardizing reporting fields and in providing for timely analysis of their data.

Reported by: B Harrell, MPA, Div of Epidemiology; CH Woernle, MD, State Epidemiologist, Alabama Dept of Public Health. A Osorio, MD, Occupational Health Surveillance and Evaluation

Blood Lead Levels — Continued

Program, California Dept of Health Svcs. N Tolentino, MPH, Connecticut State Dept of Health Svcs. M Lehnherr, Occupational Disease Registry; H Howe, PhD, Div of Epidemiologic Studies, Illinois Dept of Public Health. K Choquette, MS, R Currier, DVM, State Epidemiologist, Iowa Dept of Public Health. E Coe, MPH, Health Registries Div, Maryland Dept of the Environment. R Rabin, MSPH, Div of Occupational Hygiene, Massachusetts Dept of Labor and Industries. B Gerwel, MD, Occupational Disease Prevention Program, New Jersey State Dept of Health. R Stone, PhD, New York State Dept of Health. M Barnett, MS, JE Gordon, PhD, Environmental Epidemiologist, State Health Div, Oregon Dept of Human Resources. T Willis, DM Perrotta, PhD, Environmental Epidemiologist, Texas Dept of Health. L Hanrahan, MS, Wisconsin Dept of Health and Social Svcs. Div of Surveillance, Hazard Evaluations, and Field Studies, National Institute for Occupational Safety and Health, CDC.

TABLE 1. Reports of elevated blood lead levels (BLLs) in adults — 12 states,* second quarter, 1992

Reported BLL (μg/dL)	Second quarter, 1992	Cumulative, 1992	Cumulative, 1991†
25–39	2861	6336	—
40–49	632	1536	—
50–59	159	380	—
≥60	105	191	—
Total	**3757**	**8443**	**9994**

*Alabama, California, Connecticut, Illinois, Iowa, Maryland, Massachusetts, New Jersey, New York, Oregon, Texas, and Wisconsin.
†Data stratified by BLL not available for 1991. Cumulative through second quarter 1991.

References

1. Rabin R, Davis L, Brooks D. Lead at work: elevated blood lead levels in Massachusetts, April–October 1991. Boston: Occupational Lead Registry, Division of Occupational Hygiene, Massachusetts Department of Labor and Industries, and Occupational Health Surveillance Program, Bureau of Statistics, Research and Evaluation, Massachusetts Department of Public Health, 1992.
2. CDC. Surveillance of elevated blood lead levels among adults—United States, 1992. MMWR 1992;41:285–8.

Notices to Readers

Announcement of Meeting on Tuberculosis Prevention in Health-Care Facilities

CDC will sponsor a meeting, "Issues in Preventing Tuberculosis Transmission in Health-Care Facilities," October 22–23, 1992, in Atlanta. The goal of the meeting is to review and assess the need to revise CDC guidelines for reducing the risk for tuberculosis (TB) transmission in health-care settings (*1*).

The meeting will bring together experts in TB prevention and control, nosocomial infection prevention, biosafety, and occupational safety and health, as well as representatives of labor, medical, hospital, and administration organizations. Topics will include patient management; TB isolation precautions; engineering controls, such as ventilation and ultraviolet irradiation; health-care worker TB screening; and personal respiratory protection, including discussion of recent recommendations by CDC's National Institute for Occupational Safety and Health (*2*).

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Topics in Minority Health

Safety-Belt Use and Motor-Vehicle–Related Injuries — Navajo Nation, 1988–1991

Injuries are the second leading cause of death among American Indians and Alaskan Natives; during 1986–1988, injuries accounted for 22% of all deaths (*1*). The risk for motor-vehicle–related injury deaths is nearly threefold higher among American Indians and Alaskan Natives than among the total U.S. population (age-adjusted death rates: 57.5 per 100,000 versus 19.5 per 100,000) (*1–3*). For residents of many rural, western, Indian reservations, age-adjusted motor-vehicle–related death rates are substantially higher; in particular, the rates for Navajos* are fivefold greater than for the total U.S. population (97.9 per 100,000 versus 19.5 per 100,000) (*1*) and almost three times the rate for all New Mexico residents (35.2 per 100,000) (*4*). To increase safety-belt use by front-seat occupants and thereby reduce motor-vehicle–related injuries, the Navajo Area Indian Health Service (IHS) Office of Environmental Health and Engineering, the Navajo Department of Highway Safety, and the Navajo Nation implemented a primary enforcement† safety-belt use law and educational campaign. This report summarizes results of their effort.

The initial focus of the Navajo safety-belt campaign was to build support among tribal leaders for passage of a safety-belt use law§ for the Navajo Nation. In July 1988, the Navajo Nation enacted a primary enforcement safety-belt use law. The campaign then initiated an intensive public information program about the new law and the benefits of safety-belt use. Enforcement (i.e., issuing citations for nonuse of safety belts), the last major component of the campaign, was initiated by the Navajo Nation

*The Navajo Nation is one of the largest American Indian tribes in the United States (estimated 1990 population: 191,000) and territorially includes parts of Arizona, New Mexico, and Utah, with a land size comparable to the state of West Virginia.
†Primary enforcement of safety-belt use laws permit law enforcement officers to stop drivers for a safety-belt use violation alone, whereas secondary enforcement laws require that a vehicle must first be stopped for some other traffic violation.
§Federally recognized Indian tribes and their reservations are considered sovereign nations, where some state motor-vehicle codes such as mandatory occupant-restraint laws often do not apply.