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Health Disparities Experienced by Black or African Americans — United States

In the 2000 census, 36.4 million persons, approximately 12.9% of the U.S. population, identified themselves as Black or African American; 35.4 million of these persons identified themselves as non-Hispanic (*1*). For many health conditions, non-Hispanic blacks bear a disproportionate burden of disease, injury, death, and disability. Although the top three causes and seven of the 10 leading causes of death are the same for non-Hispanic blacks and non-Hispanic whites (the largest racial/ethnic population in the United States), the risk factors and incidence, morbidity, and mortality rates for these diseases and injuries often are greater among blacks than whites. In addition, three of the 10 leading causes of death for non-Hispanic blacks are not among the leading causes of death for non-Hispanic whites: homicide (sixth), human immunodeficiency virus (HIV) disease (seventh), and septicemia (ninth) (Table). This week's *MMWR* is the third in a series* focusing on racial/ethnic health disparities. Eliminating these disparities will require culturally appropriate public health initiatives, community support, and equitable access to quality health care.

In 2002, non-Hispanic blacks who died from HIV disease had approximately 11 times† as many age-adjusted years of potential life lost before age 75 years per 100,000 population as non-Hispanic whites. Non-Hispanic blacks also had substantially more years of potential life lost than non-Hispanic whites for homicide (nine times as many), stroke (three times as many), perinatal diseases (three times as many), and diabetes (three times as many) (*2*).

Cancer is the second leading cause of death for both non-Hispanic blacks and non-Hispanic whites (Table). However, in 2001, the age-adjusted incidence per 100,000 population was substantially higher for black females than for white females for certain cancers, including colon/rectal (54.0 versus 43.3), pancreatic (13.0 versus 8.9), and stomach (9.0 versus 4.5) cancers. Among males, the age-adjusted incidence was higher for black males than for white males for certain cancers, including prostate (251.3 versus 167.8), lung/bronchus (108.2 versus 72.8), colon/rectal (68.3 versus 58.9), and stomach (16.3 versus 10.0) cancers (*3*).

Stroke is the third leading cause of death for both non-Hispanic blacks and non-Hispanic whites (Table). However, during 1999–2002, non-Hispanic black males and females aged 20–74 years had higher† age-adjusted rates per 100,000 population of hypertension than their white counterparts (36.8 versus 23.9 for males; 39.4 versus 23.3 for females) (*4*).

Racial/ethnic health disparities are reflected in leading indicators of progress toward achievement of the national health objectives for 2010 (*5*). In 2002, non-Hispanic blacks trailed non-Hispanic whites in at least four positive health indicators†, including percentages of 1) persons aged <65 years with health insurance (81% of non-Hispanic blacks versus 87% of non-Hispanic whites), 2) adults aged ≥65 years vaccinated against influenza (50% versus 69%) and pneumococcal dis-

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*See also: CDC. Health disparities experienced by racial/ethnic minority populations. MMWR 2004;53:755. CDC. Health disparities experienced by Hispanics—United States. MMWR 2004;53:935–7.

† Differences not tested for statistical significance.

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* Proposed.

ease (37% versus 60%), 3) women receiving prenatal care in the first trimester (75% versus 89%), and 4) persons aged ≥18 years who participated in regular moderate physical activity (25% versus 35%). In addition, non-Hispanic blacks had substantially higher proportions of certain negative health indicators than non-Hispanic whites, including 1) new cases of gonorrhea (742 versus 31 per 100,000 population; 2002 data), 2) deaths from homicide (21.6 versus 2.8; 2002 data), 3) persons aged 6–19 years who were overweight or obese (22% versus 12%; 2000 data), and 4) adults who were obese (40% versus 29%; 2000 data).

Since the 1970s, racial/ethnic disparities in measles cases and measles-vaccine coverage have been all but eliminated (*6*). However, during 1996–2001, the vaccination-coverage gap between non-Hispanic white and non-Hispanic black children widened by an average of 1.1% each year for children aged 19–35 months who were up to date for the 4:3:1:3:3 series of vaccines (recommended to prevent diphtheria, tetanus, and pertussis; polio; measles; *Haemophilus influenzae* type b disease; and hepatitis B) (*7*). In 2002, among children aged 19–35 months, 68% of non-Hispanic black children were fully vaccinated, compared with 78% of non-Hispanic white children.

Reported by: *Office of Minority Health, Office of the Director, CDC.*

Editorial Note: Multiple factors contribute to racial/ethnic health disparities, including socioeconomic factors (e.g., education, employment, and income), lifestyle behaviors (e.g., physical activity and alcohol intake), social environment (e.g., educational and economic opportunities, racial/ethnic discrimination, and neighborhood and work conditions), and access to preventive health-care services (e.g., cancer screening and vaccination) (*8*). Recent immigrants also can be at increased risk for chronic disease and injury, particularly those who lack fluency in English and familiarity with the U.S. health-care system or who have different cultural attitudes about the use of traditional versus conventional medicine. Approximately 6% of persons who identified themselves as Black or African American in the 2000 census were foreign-born.

For blacks in the United States, health disparities can mean earlier deaths, decreased quality of life, loss of economic opportunities, and perceptions of injustice. For society, these disparities translate into less than optimal productivity, higher health-care costs, and social inequity. By 2050, an estimated 61 million black persons will reside in the United States, amounting to approximately 15% of the total U.S. population (*9*).

To promote consistency in measuring progress toward achieving the national health objectives, a workgroup appointed by the U.S. Department of Health and Human Services (DHHS) has recommended that 1) progress toward eliminating disparities for individual subpopulations be mea-

TABLE. Ten leading causes of death among non-Hispanic blacks and non-Hispanic whites — National Vital Statistics System, United States, 2002

	Black, non-Hispanic			White, non-Hispanic		
Rank	Cause of death	No.	(%)	Cause of death	No.	(%)
1.	Heart disease	76,694	(26.8)	Heart disease	577,761	(29.2)
2.	Cancer	61,996	(21.6)	Cancer	458,754	(23.1)
3.	Stroke	18,691	(6.5)	Stroke	133,118	(6.7)
4.	Diabetes	12,583	(4.4)	Chronic lower respiratory disease	112,128	(5.7)
5.	Unintentional injury	12,285	(4.3)	Unintentional injury	80,605	(4.1)
6.	Homicide	8,147	(2.8)	Influenza and pneumonia	55,419	(2.8)
7.	Chronic lower respiratory disease	7,730	(2.7)	Alzheimer's disease	53,486	(2.7)
8.	Human immunodeficiency virus	7,714	(2.7)	Diabetes	52,463	(2.6)
9.	Nephritis	7,410	(2.6)	Nephritis	30,669	(1.5)
10.	Septicemia	6,074	(2.1)	Suicide	26,691	(1.3)
	All others	67,249	(23.5)	All others	400,879	(20.2)
Total		**286,573**	**(100.0)**	**Total**	**1,981,973**	**(100.0)**

sured by the percentage difference between each subpopulation rate and the most favorable or best subpopulation rate in each domain and 2) all measures be expressed in terms of adverse events (*10*). DHHS conducts periodic reviews to monitor progress toward achieving the national health objectives, and progress toward elimination of health disparities is part of those reviews.

The reports in this week's *MMWR* describe health disparities experienced by blacks in stroke, hypertension, nationally notifiable diseases, and childhood asthma. Information about ongoing public awareness initiatives to eliminate racial/ethnic health disparities (e.g., Closing the Health Gap and Take a Loved One to the Doctor Day) is available at http://www.cdc.gov/omh/aboutus/disparities.htm.

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Differences in Disability Among Black and White Stroke Survivors — United States, 2000–2001

Stroke is a leading cause of serious, long-term disability in the United States (*1*) and was responsible for an estimated $53.6 billion in direct and indirect costs during 2004 (*2*). Stroke survivors can experience residual physical, psychological, and social impairment (*3*); nearly 45% of all stroke survivors aged ≥65 years have moderate or severe disability (*4*). Furthermore, persons in certain racial/ethnic populations experience disparities in stroke-related disability (*5*). To assess the prevalence of functional limitations among U.S. adult stroke survivors and to examine potential racial/ethnic disparities in stroke-related disability, CDC analyzed National Health Interview Survey (NHIS) data from 2000–2001. The results of this analysis indicated that black stroke survivors had greater activity limitations than white stroke survivors. To increase the quality and length of life among stroke survivors and to eliminate disparities in stroke incidence, greater

efforts are needed to implement stroke prevention and intervention activities among black populations, particularly young to middle-aged adults. Increasing public awareness of stroke-related warning signs and encouraging patients to seek immediate treatment might reduce stroke-related disabilities and costs.

NHIS is a household survey designed and conducted annually by CDC to collect self-reported information from a representative sample of the U.S. civilian, noninstitutionalized population. Data collected in 2000 and 2001 were combined. Respondents who reported having ever been told by a doctor or other health professional that they had had a stroke were identified as stroke survivors. Stroke survivors were asked about their ability to perform the following 12 activities: 1) walk a quarter mile (i.e., approximately three city blocks); 2) walk up 10 steps without resting; 3) stand or be on feet for approximately 2 hours; 4) sit for approximately 2 hours; 5) stoop, bend, or kneel; 6) reach up over head; 7) use fingers to grasp or handle small objects; 8) lift or carry something as heavy as 10 pounds (e.g., a full bag of groceries); 9) push or pull large objects (e.g., living room chair); 10) go out (e.g., shopping, movies, or sporting events); 11) participate in social activities (e.g., visit friends, attend clubs or meetings, or go to parties; and 12) do things to relax at home or for leisure (e.g., read, watch TV, sew, or listen to music). Limitation of activity was defined as a reported response of either "very difficult" or "can't do at all" (compared with "not at all difficult," "only a little difficult," "somewhat difficult," or "do not do this activity"). The need for special equipment (e.g., cane, wheelchair, special bed, or special telephone) was also assessed.

A total of 65,700 persons aged ≥18 years participated in the 2000 and 2001 NHIS surveys; 1,613 (2.2%) respondents reported ever having a stroke. Differences in sociodemographic characteristics and limitation of activities between non-Hispanic blacks and non-Hispanic whites with stroke were compared. The prevalence of stroke was 2.3% among whites and 2.7% among blacks; approximately 3.4 million non-Hispanic whites and 600,000 non-Hispanic blacks survived a stroke and lived at home during 2000–2001. Hispanics and persons of other races/ethnicities were excluded because of small sample size; the sample consisted of 1,391 noninstitutionalized stroke survivors, including 297 blacks and 1,094 whites. Statistical software was used for all analyses to account for complex multistage sampling design and to obtain estimates representative of the U.S. population.

Compared with whites, blacks with stroke were significantly ($p<0.05$) more likely to be aged <65 years (blacks: 52.7%; whites: 34.8%), have less than a high school education (blacks: 47.5%; whites: 29.2%), live below the poverty level (blacks: 22.6%; whites: 8.9%), and report an annual income of less than $20,000 (blacks: 53.4%; whites: 33.3%); however, no statistically significant racial differences by sex or employment status were observed among stroke survivors (Table 1). Among stroke survivors, the most common limitations of activity were in standing or being on one's feet for approximately 2 hours (blacks: 50.2%; whites: 41.1%); pushing or pulling large objects (blacks: 45.2%; whites: 32.5%); walking a quarter mile (blacks: 45.1%; whites: 36.5); stooping, bending, or kneeling (blacks: 44.8%; whites: 37.7%); and walking up 10 steps without resting (blacks: 42.4%; whites: 28.6%)(Table 2). Blacks (49.6%) were significantly more likely ($p<0.05$) than whites (33.8%) to mention stroke as one of the health conditions causing limitations in activities. After adjustment for age and sex, blacks were significantly more likely ($p<0.05$) than white stroke survivors to report limitations in all of the 12 activities (Table 2). For example, blacks were 80% more likely to report walking up 10 steps without resting as "very difficult" or "can't do at all" compared with whites (adjusted odds ratio [AOR] = 1.79; 95% confidence interval [CI] = 1.59–2.01). In addition, after adjustment for education, blacks were significantly more likely ($p<0.05$) than whites to have limitations in seven of the 12 activities. In addition, 50.1% of blacks

TABLE 1. Selected demographic characteristics of noninstitutionalized stroke survivors aged ≥18 years, by race/ethnicity* and characteristic — National Health Interview Survey, United States, 2000–2001

	Race/Ethnicity			
	Black, non-Hispanic†		White, non-Hispanic§	
Characteristic	%	(SE¶)	%	(SE)
Selected demographics				
Aged <65 yrs	52.7	(±3.3)	34.8	(±1.8)
Male	43.5	(±3.7)	47.4	(±1.7)
Female	56.5	(±3.7)	52.6	(±1.7)
Education**				
Less high school	47.5	(±3.7)	29.2	(±1.6)
High school	24.9	(±3.4)	30.0	(±1.5)
More high school	25.1	(±2.8)	39.1	(±1.6)
Poverty level				
Below poverty	22.6	(±3.0)	8.9	(±1.0)
Above or equal to poverty	50.5	(±3.4)	61.9	(±1.7)
Don't know/Refused	26.9	(±3.2)	29.2	(±1.5)
Family income				
<$20,000	53.4	(±3.9)	33.3	(±1.6)
≥$20,000	37.6	(±3.3)	58.4	(±1.7)
Don't know/Refused	9.1	(±2.0)	8.3	(±1.0)
Employment during previous 12 mos				
Employed	18.9	(±2.5)	22.7	(±1.6)
Not employed	81.0	(±2.5)	77.2	(±1.6)
Don't know/Refused	0.2	(±0.2)	0.1	(±0.1)

* $p<0.05$ in unadjusted analyses comparing non-Hispanic blacks with non-Hispanic whites.
† Weighted N = 611,240.
§ Weighted N = 3,383,886.
¶ Standard error.
** Percentages do not total to 100% because of missing values for education.

TABLE 2. Percentage of noninstitutionalized stroke survivors aged ≥18 years reporting limitation of activity*, by race/ethnicity and type of activity — National Health Interview Survey, United States, 2000–2001

Limitation of activity	Race/Ethnicity: Black, non-Hispanic %	(SE†)	White, non-Hispanic %	(SE)	OR§ adjusted for age and sex	(95% CI¶)	OR adjusted for age, sex, and education	(95% CI)
Walk a quarter of a mile — about three city blocks	45.1	(±3.7)	36.5	(±1.5)	1.59	(1.44–1.77)	1.30	(1.17–1.45)
Walk up 10 steps without resting	42.4	(±3.4)	28.6	(±1.5)	1.79	(1.59–2.01)	1.46	(1.29–1.64)
Stand or be on your feet for about 2 hours	50.2	(±3.5)	41.1	(±1.5)	1.41	(1.29–1.54)	1.19	(1.08–1.30)
Sit for about 2 hours	16.4	(±2.6)	10.7	(±0.9)	1.39	(1.17–1.65)	1.15	(0.97–1.38)
Stoop, bend, or kneel	44.8	(±3.8)	37.7	(±1.5)	1.19	(1.07–1.32)	1.01	(0.91–1.12)
Reach up over your head	21.6	(±3.5)	14.7	(±1.2)	1.28	(1.09–1.51)	1.03	(0.88–1.21)
Use your fingers to grasp or handle small objects	18.2	(±3.3)	11.1	(±1.0)	1.36	(1.10–1.67)	1.10	(0.89–1.36)
Lift or carry something as heavy as 10 pounds such as a full bag of groceries	40.6	(±3.2)	24.6	(±1.5)	1.74	(1.53–1.97)	1.39	(1.22–1.58)
Push or pull large objects like a living room chair	45.2	(±3.4)	32.5	(±1.7)	1.45	(1.29–1.62)	1.18	(1.05–1.32)
Go out to things like shopping, movies, or sporting events	30.1	(±3.4)	20.0	(±1.5)	1.61	(1.39–1.86)	1.29	(1.11–1.49)
Participate in social activities such as visiting friends, attending clubs and meetings, or going to parties	23.8	(±3.5)	16.2	(±1.2)	1.80	(1.52–2.12)	1.42	(1.20–1.68)
Do things to relax at home or for leisure (reading, watching TV, sewing, listening to music)	9.6	(±2.8)	5.4	(±0.8)	1.70	(1.31–2.19)	1.31	(1.00–1.71)

* Limitation of activity was determined by self-report of "very difficult" or "can't do at all" (compared with responses of "not at all difficult," "only a little difficult," "somewhat difficult," or "do not do this activity").
† Standard error.
§ Odds ratio.
¶ Confidence interval.

reported using special equipment (e.g., canes, wheelchairs, special beds, or special telephones), compared with 35.6% of whites (AOR = 1.55; 95% CI = 1.37–1.75).

Reported by: *HF McGruder, PhD, KJ Greenlund, PhD, JB Croft, PhD, ZJ Zheng, PhD, Div of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: This study observed that more than half of non-Hispanic black stroke survivors living at home were aged <65 years compared with one third of non-Hispanic white stroke survivors. In addition, blacks were more likely than whites to report limitations in performing all of the activities considered in this study. Researchers have suggested that racial differences in disability status might be attributed to socioeconomic status and morbidity (*5*). Black adults aged ≥65 years had significantly higher levels of disability when compared with older whites, and stroke and other health conditions (e.g., heart trouble, diabetes, hip fracture, broken bones, and cancer) were associated with disability (*5*). In a British study, blacks characterized their health status and health transition (i.e., change from much better to much worse health) 3 months after stroke substantially lower than white stroke survivors (*6*). According to the study, blacks might have experienced more disability and a lower quality of life compared with whites after stroke because they were younger and had more severe and disabling strokes than whites (*6*). To meet national health objectives of increasing quality and years of healthy life and eliminating health disparities (*7*), greater efforts are needed to implement prevention and intervention activities for stroke among black populations, particularly among young to middle-aged adults.

The findings in this report are subject to at least five limitations. First, reports of stroke and limitation of activity were obtained from self-reports and were not confirmed by medical records or neurologic examination. Second, NHIS does not collect information regarding the severity of the stroke or whether it was a first or recurrent stroke. Third, NHIS does not include institutionalized persons, including those living in nursing homes or other institutions. Fourth, the survey does not assess activity levels before the adverse health event. Although this report indicates stroke as the common health condition causing self-reported limitations in activities, the extent to which stroke limited participation in these activities is unclear. Finally, this report only examines functional disabilities and not disabilities associated with personal activities of daily living (e.g., bathing, dressing, using the toilet, and eating) and independent living activities (e.g., preparing meals, managing money, performing light housework, or using the telephone) that can provide a broader perspective concerning disabilities among stroke survivors. Future analyses should examine stroke-related limitations associated with a broader range of activities.

National public health efforts to reduce stroke disability address both stroke prevention and treatment interventions (*8*). For example, the CDC Paul Coverdell National Acute Stroke Registry operates in Georgia, Illinois, Massachusetts, and North Carolina to track and improve delivery of care to hospital patients with acute stroke. Data from this registry will help state health departments and hospitals develop plans to reduce delay times in emergency transport, promote health-system adherence to clinical practice guidelines for stroke evaluation and treatment, improve the quality of life of stroke survivors, and reduce disability from stroke. In addition, CDC funds health departments in 32 states and the District of Columbia to develop, implement, and evaluate programs that promote cardiovascular health, increase public awareness, prevent disease, and eliminate health disparities. An example of eliminating health disparities is to collaborate on developing systems and intervention programs to detect and control high blood pressure among high-risk groups. CDC and its partners are implementing a plan (*9*) to address specific steps toward preventing heart disease and stroke through 2020 and beyond.

Improvements in stroke survival and reduction of disability might be influenced by implementing culturally appropriate public education messages. These messages should increase awareness of stroke signs and symptoms and the need to promptly call 911 to reduce treatment delay (*10*).

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Chinese Proverb

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Racial/Ethnic Disparities in Prevalence, Treatment, and Control of Hypertension — United States, 1999–2002

High blood pressure (HBP) is a major risk factor for heart disease and stroke, end-stage renal disease, and peripheral vascular disease and is a chief contributor to adult disability (*1*). Approximately one in four adults in the United States has hypertension (*2*). Although effective therapy has been available for more than 50 years (*3*), most persons with hypertension do not have their blood pressure (BP) under control (*4*). National health objectives for 2010 include reducing the proportion of adults with HBP to 16% (baseline: 28%), increasing the proportion of adults with hypertension who are taking action to control it to 95% (baseline: 82%), and increasing the proportion of adults with controlled BP to 50% (baseline: 18%) (*5*). During 1990–2000, the prevalence of hypertension, the percentage of those with hypertension who were aware of their condition, and treatment and control of hypertension increased among non-Hispanic whites, non-Hispanic blacks, and Hispanics (*6,7*). CDC analyzed data from the National Health and Nutrition Examination Surveys (NHANES) for 1999–2002. This report summarizes the results of that analysis, which determined that racial/ethnic disparities in awareness of, treatment for, and control of hypertension persist. If national health objectives are to be met, public health efforts must continue to focus on the prevention of HBP and must improve awareness, treatment, and control of hypertension among minority populations.

NHANES is a stratified, multistage probability sample of the civilian, noninstitutionalized U.S. population. Both the survey interview population of 7,000 U.S. adults aged ≥20 years and the 5,000 respondents who completed the health examination each year included oversamples of low-income persons, persons aged ≥60 years, blacks, and Mexican Americans. The analysis described in this report is based on data from those persons who were non-Hispanic white, non-Hispanic black, or Mexican American with BP measurements. Pregnant women were excluded from the analysis. Hypertension was defined as having an average systolic BP ≥140 mm Hg or diastolic BP ≥90 mm Hg or taking BP medication. BP measures were based on the average of three BP readings. Persons with hypertension were considered 1) to be aware of their condition if they reported in the interview that a health-care professional had told them their BP was high, 2) to have been treated if they reported using antihypertensive medication, and 3) to have controlled BP if they were hypertensive but their BP measurements were <140/90 mm Hg. Statistical software was used to obtain weighted population estimates, age-specific and age-standardized prevalences and proportions, and 95% confidence intervals (CIs).

During 1999–2002, the age-adjusted prevalence of hypertension in the study population was 28.6% (CI = 26.8%–30.4%). The prevalence of hypertension increased with age and was higher among women than men (Table). The age-

TABLE. Percentage of noninstitutionalized U.S. adults with hypertension* and, among those with hypertension, estimated percentage of persons who are aware of†, treated for§, and in control of¶ their condition, by sex, race/ethnicity, and age group — United States, 1999–2002

	Hypertension prevalence		Awareness of condition		Under current treatment		Condition controlled	
Characteristic**	**%**	**(95% CI††)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**
Sex								
Men	27.8	(24.9–29.7)	59.4	(55.8–63.1)	45.2	(40.9–49.6)	27.5	(23.7–31.3)
Women	29.0	(27.3–30.8)	69.3	(61.7–77.0)	56.1	(29.2–63.1)	35.5	(28.4–42.7)
Race/Ethnicity								
White, non-Hispanic	27.4	(25.3–29.5)	62.9	(57.3–68.5)	48.6	(44.1–53.1)	29.8	(25.7–34.0)
Black, non-Hispanic	40.5	(38.2–42.8)	70.3	(64.9–75.8)	55.4	(51.2–59.6)	29.8	(25.2–34.5)
Mexican American	25.1	(23.1–27.1)	49.8	(40.4–59.2)	34.9	(27.5–42.3)	17.3	(10.7–23.8)§§
Age group (yrs)								
20–39	6.7	(5.3–8.2)	48.7	(38.8–58.7)	28.1	(20.1–36.1)	17.6	(11.6–23.7)
40–59	29.1	(25.9–32.4)	73.5	(69.1–77.9)	61.2	(57.1–65.2)	40.5	(36.4–44.5)
≥60	65.2	(62.4–68.0)	72.4	(70.0–74.7)	65.6	(61.9–69.3)	31.4	(28.7–34.2)
Total¶¶	**28.6**	**(26.8–30.4)**	**63.4**	**(59.4–67.4)**	**45.3**	**(45.3–52.8)**	**29.3**	**(26.0–32.7)**

* Had a blood pressure measurement ≥140 mm Hg systolic or ≥90 mm Hg diastolic or took antihypertensive medication.
† Told by a health-care professional that blood pressure was high.
§ Took antihypertensive medication.
¶ Hypertension levels <140 mm Hg systolic and <90 mm Hg diastolic.
** All characteristic estimates (excluding age group) are age adjusted.
†† Confidence interval.
§§ Estimate should be used with caution; relative standard error is 20%–29%.
¶¶ Total population estimates (including sex and age group) include only non-Hispanic whites, non-Hispanic blacks, and Mexican Americans.

adjusted prevalence of hypertension was 40.5% among non-Hispanic blacks, 27.4% among non-Hispanic whites, and 25.1% among Mexican Americans. Of those with HBP, 63.4% (CI = 59.4%–67.4%) had been told that their BP was high. The proportion who were aware of having a high BP was greater among those aged ≥40 years (73.5% versus 48.7%), and the proportion was higher among women than men (69.3% versus 59.4%). Among adults with hypertension, the proportion who were aware of having HBP was 70.3% among non-Hispanic blacks, 62.9% among non-Hispanic whites, and 49.8% among Mexican Americans. Among those with hypertension, 45.3% (CI = 45.3%–52.8%) had been treated with antihypertensive medication. Percentages of those treated for HBP were higher among women than men (56.1% versus 45.2%) and increased with age. The age-adjusted proportion who reported treatment was 55.4% among non-Hispanic blacks, 48.6% among non-Hispanic whites, and 34.9% among Mexican Americans. Only 29% of U.S. adults with hypertension had controlled BP levels (<140/90 mm Hg), and the proportion of hypertensive adults who had controlled their BP varied substantially by age group: 17.6% of those aged 20–39 years, 40.5% of those aged 40–59 years, and 31.4% of those aged ≥60 years. The proportion with controlled BP was similar among non-Hispanic blacks (29.8%) and non-Hispanic whites (29.8%) but substantially lower among Mexican Americans (17.3%).

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Editorial Note: The findings of this report demonstrate continuing racial/ethnic disparities in the prevalence of hypertension and in the percentages of those with HBP who are aware of, are being treated for, and are in control of their condition. Because of the serious health consequences associated with HBP, greater efforts are needed to prevent HBP and/or improve BP control and HBP diagnosis rates among all populations. Greater efforts are needed specifically to prevent HBP among non-Hispanic blacks, who have a higher prevalence, and to increase BP treatment and control among Mexican Americans, who appear to have lower rates of treatment and control, compared with other racial/ethnic populations. For this report, CDC analyzed a 4-year period instead of the 2-year period represented in data published recently from 1999–2000 NHANES (*7,8*); therefore, this report also represents an update of those findings.

During 1991–1999, nearly 95% of U.S. adults had had a BP screening within the previous 2 years; however, levels of BP screening were lower among Hispanics than among non-Hispanic whites or non-Hispanic blacks (*6*). Lack of access to health-care services, insufficient attention by health-care providers, lack of necessary resources to engage in appropriate lifestyle modifications, cultural norms, and compliance in medication use might be barriers to prevention and control of HBP.

The findings in this report are subject to at least four limitations. First, NHANES only surveyed the noninstitutionalized population; persons in nursing homes and other institutions were not included. Second, Mexican Americans were the only Hispanic subpopulation sampled, even though the Hispanic population consists of only 66.1% Mexican Americans (*9*); information for the other Hispanic subpopulations was not of sufficient size for reliable analysis. Third, although a strength of NHANES is the collection of actual BP measurements, these measurements are taken during the same visit and therefore do not reflect the actual care guidelines, which state that the determination of HBP should be based on measurements from two separate visits. Finally, analyses were restricted to NHANES participants who had BP measurements and do not include those who might have hypertension but did not have BP measurements.

The prevention and management of HBP is a major public health challenge. HBP usually has no signs or symptoms and is called "the silent killer." Untreated or uncontrolled HBP increases risk for heart disease, renal disease, and stroke. Recommendations by the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure advise health-care providers regarding screening, detecting, treating, and monitoring cases of HBP and hypertension (*3*). In addition, BP surveillance data should be used to monitor and evaluate the effectiveness of interventions designed to prevent and control HBP. To reduce disparities and improve HBP prevention and control among U.S. adults, public health officials and clinicians need to increase their efforts to treat and control BP levels among persons with hypertension, and promote physical activity, nutrition changes (e.g., reducing high salt/sodium), weight reduction or management, stress reduction, and routine BP screening.

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Racial Disparities in Nationally Notifiable Diseases — United States, 2002

Infectious diseases are a major cause of morbidity, mortality, and disability in the United States and often affect racial/ethnic populations disproportionately (*1,2*). Eliminating racial disparities is a goal of many of the national health objectives for 2010 (*3*). To estimate racial disparities in the incidence of nationally notifiable infectious diseases by race/ethnicity, CDC reviewed 2002 data from the Nationally Notifiable Diseases Surveillance System (NNDSS), collected through the National Electronic Telecommunications System for Surveillance (NETSS). This report summarizes the results of that analysis, which indicated that incidence rates were at least two times greater for blacks than whites for eight of 42 nationally notifiable diseases; however, substantial gaps exist in the reporting of racial/ethnic data for the 42 diseases, which accounted for approximately 1.3 million of the cases reported by NNDSS. Public health practitioners and policy makers might use these results to address disparities in disease rates among blacks and other racial/ethnic populations, but they also should work to close gaps in data reporting to accurately measure progress toward achieving the national health objectives.

NNDSS is a public health surveillance system that collects data on cases of notifiable diseases. The system is maintained by CDC, in collaboration with the Council of State and Territorial Epidemiologists (CSTE), which determines nationally notifiable conditions and standard case definitions. The decision to make a disease nationally notifiable is based on its public health importance (e.g., number of cases or severity of the disease) and its preventability. Since 1990, case data have been reported to NNDSS by the 50 states, District of Columbia, New York City, and U.S. territories. For this analysis, notifiable diseases were reviewed for completeness of racial data where 25 or more cases were reported; incidence rates were reported by race where five or more cases were reported. For this report, racial classifications might include both persons who are Hispanic and non-Hispanic. Hispanic ethnicity was only considered in determining the percentage of cases for which ethnicity data were not provided; no incidence rates were calculated for Hispanics. The number of cases, rate per 100,000 population by racial population, and black/white rate ratio were determined for 42 nationally notifiable diseases. Data for primary and secondary syphilis were combined. Data were analyzed for cases reported directly through NETSS; data from U.S. territories were excluded. Population data from states in which diseases were not notifiable or disease data were not available were excluded from rate calculations.

For 42 nationally notifiable infectious diseases in 2002, a total of 1,362,628 cases were reported (Table). Racial data were provided for 70% of cases; Hispanic ethnicity data were provided for 65% of cases. Missing data on race ranged from six (5%) cases of streptococcal toxic shock syndrome to 3,527 (71%) cases of coccidioidomycosis; missing data on Hispanic ethnicity ranged from zero for syphilis to 66% for coccidiodomycosis. By state, missing data on race ranged from 1% to 63% of cases, with an interquartile range of 13%–35%; missing data on Hispanic ethnicity ranged from zero to 98% of cases, with an interquartile range of 16%–45%. Nineteen diseases had ≥30% cases with missing race information.

At least 20,000 cases were reported by each of six infectious diseases: chlamydia (834,555 cases), gonorrhea (351,852), salmonellosis (44,264), Lyme disease (23,763), shigellosis (23,541), and giardiasis (21,206). For three of those six diseases, and eight of the 42 nationally notifiable diseases, the incidence rate for blacks was at least twice as high as the rate for whites in 1992. For gonorrhea, the incidence rate for blacks was 24 times greater, at 570.4 per 100,000 population, compared with 23.6 for whites. For malaria, the rates were 1.8 for blacks and 0.2 for whites; for chlamydia, 805.9 for blacks and 90.2 for whites; for syphilis, 9.4 for blacks and 1.1 for whites; for shigellosis, 16.8 for blacks and 4.0 for whites; for typhoid fever, 0.1 for blacks and 0.02 for whites; for hepatitis B, 3.9 for blacks and 1.5 for whites; and for S*treptococcus pneumoniae* (i.e., invasive, drug resistant), 1.5 for blacks and 0.7 for whites.

In other findings, the incidence rate for Lyme disease among whites (7.8 per 100,000 population) was approximately 11 times greater than that for blacks (0.7), and the incidence rate for giardiasis was approximately two times greater for whites (5.4) than for blacks (2.5). Among racial populations, the highest incidence rates of salmonellosis (17.4 per 100,000 population) and shigellosis (19.7) were among American Indians/Alaska Natives (AI/AN).

TABLE. Number of cases* and rate†, by racial classification§, and percentage of cases with missing racial and ethnic data for 42 selected nationally notifiable diseases — United States, 2002

	Racial classification											
	Black		White			American Indian/ Alaska Native		Asian/ Pacific Islander			Race not stated	Ethnicity not stated
Disease	No.	Rate	No.	Rate	Black/white rate ratio	No.	Rate	No.	Rate	Total	%	%
Botulism, foodborne	0	—¶	7	—	—	15	0.7	0	—	**28**	21	25
Botulism, infant	1	—	42	1.4	—	0	—	5	3.0	**69**	30	29
Brucellosis	1	—	51	—	—	0	—	2	—	**125**	56	16
Chlamydia**	280,075	805.9	178,802	90.2	**8.9**	10,924	512.1	11,871	108.0	**834,555**	42	28
Coccidioidomycosis	148	0.8	1,154	1.1	**0.7**	42	3.2	87	1.1	**4,968**	71	66
Cryptosporidiosis	267	0.8	1,842	0.9	**0.9**	11	0.5	26	0.2	**3,016**	28	40
Cyclosporiasis	5	—	105	0.1	—	0	—	2	—	**156**	28	37
Ehrlichiosis, human granulocytic	2	—	267	0.1	—	2	—	2	—	**511**	46	65
Ehrlichiosis, human monocytic	6	—	146	0.1	—	1	—	0	—	**216**	29	32
Encephalitis, California serogroup viral	5	—	122	0.1	—	1	—	0	—	**164**	21	59
Encephalitis, St. Louis	1	—	14	—	—	0	—	0	—	**28**	46	14
Encephalitis, West Nile	366	1.1	1,669	0.8	**1.4**	5	0.2	8	0.1	**2,840**	28	65
E. coli, 0157:H7	101	0.3	2,412	1.2	**0.3**	153	7.2	63	0.6	**3,840**	28	37
E. coli, non-0157	5	—	113	0.1	—	1	—	1	—	**194**	39	46
Escherichia coli, not serogrouped	2	—	32	—	—	0	—	0	—	**60**	42	57
Giardiasis	808	2.5	9,853	5.4	**0.5**	76	3.8	498	4.6	**21,206**	47	54
Gonorrhea	198,221	570.4	46,781	23.6	**24.2**	2,049	96.1	2,013	18.3	**351,852**	29	23
Haemophilus influenzae, invasive	209	0.6	1,020	0.5	**1.2**	39	1.8	25	0.2	**1,743**	25	42
Hansen disease	3	—	24	—	—	0	—	23	0.2	**96**	47	28
Hemolytic uremic syndrome post diarrheal	6	—	153	0.1	—	0	—	6	0.1	**216**	21	30
Hepatitis A, acute	705	2.0	4,544	2.3	**0.9**	90	4.2	252	2.3	**8,795**	36	34
Hepatitis B, acute	1,343	3.9	2,932	1.5	**2.6**	118	5.6	237	2.2	**7,996**	42	47
Hepatitis C; non-A, non-B	141	0.4	913	0.5	**0.8**	16	0.8	9	0.1	**1,835**	41	46
Legionellosis	160	0.5	860	0.4	**1.3**	5	0.2	10	0.1	**1,321**	21	41
Listeriosis	60	0.2	351	0.2	**1.0**	2	—	35	0.3	**665**	32	38
Lyme disease	229	0.7	15,408	7.8	**0.1**	45	2.1	134	1.2	**23,763**	33	52
Malaria	634	1.8	321	0.2	**9.0**	3	—	66	0.6	**1,430**	26	38
Measles	2	—	28	—	—	0	—	9	0.1	**44**	9	50
Meningococcal disease	230	0.7	1,107	0.6	**1.2**	16	0.8	28	0.3	**1,814**	24	28
Mumps	16	0.1	139	0.1	—	3	—	38	0.4	**270**	27	7
Pertussis	538	1.6	7,355	3.7	**0.4**	89	4.2	110	1.0	**9,771**	17	16
Q fever	3	—	40	—	—	0	—	1	—	**61**	28	28
Rocky Mountain spotted fever	73	0.2	816	0.4	**0.5**	21	1.0	6	0.1	**1,104**	17	25
Salmonellosis	3,863	11.1	21,557	10.9	**1.0**	371	17.4	607	5.5	**44,264**	40	50
Shigellosis	5,838	16.8	7,884	4.0	**4.2**	421	19.7	159	1.5	**23,541**	39	47
Syphilis, primary and secondary	3,268	9.4	2,190	1.1	**8.5**	49	2.3	89	0.8	**6,862**	18	0
Tetanus	1	—	15	—	—	0	—	1	—	**25**	32	24
Tularemia	5	—	60	—	**0.3**	6	0.3	0	—	**90**	21	9
Streptococcal toxic-shock syndrome	18	0.1	94	0.1	**1.0**	0	—	0	—	**118**	5	36
Streptococcus pneumoniae, invasive††	428	1.5	1,431	0.7	**2.1**	10	0.8	11	0.1	**2,546**	26	51
Toxic-shock syndrome	4	—	84	0.1	—	0	—	1	—	**109**	18	38
Typhoid fever	29	0.1	44	—	**4.0**	2	—	80	0.7	**321**	48	38
Total	**497,820**		**312,782**			**14,586**		**16,515**		**1,362,628**		

* Cases missing data on race were excluded from racial classification counts but included in totals for each disease.
† Per 100,000 population, calculated by using U.S. Census Bureau population estimates. Rates were not calculated where fewer than five cases were reported for a racial classification.
§ Racial classifications might include persons who are Hispanic or non-Hispanic.
¶ Rate not calculated or <0.1.
** *Chlamydia trachomatis* infection.
†† Drug resistant.

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Editorial Note: The findings in this report indicate substantial disparities between racial populations in notifiable infectious diseases, including three of the six diseases with more than 20,000 cases per year. Public health efforts should attempt to reduce these disparities in diseases, including gonorrhea, chlamydia, and shigellosis among blacks, salmonellosis and shigellosis among AI/AN, and giardiasis and Lyme disease among whites. However, efforts to reduce these disparities require more accurate and complete racial/ethnic data for nationally notifiable diseases. The amounts of missing racial/ethnic data from NETSS described in this report are similar to those reported previously (*4*).

The findings in this report are subject to at least four limitations. First, surveillance practices vary among states/areas, and definitions can be misapplied. Second, availability of resources can influence the detail of reporting (e.g., racial/

ethnic data) by states/areas. Third, underreporting of certain diseases might reflect lack of awareness of a disease or its low priority with state and local officials; conversely, concerted efforts to reduce syphilis might explain the high percentage of syphilis cases reported with racial/ethnic data. Finally, the substantial gaps in collection of racial/ethnic data might be attributable to various factors and could result in underreporting of certain racial populations.

Although NETSS data have been useful at national and state levels (*3*), implementing the National Electronic Disease Surveillance System (NEDSS)*, including the NEDSS Base System, might lead to improvement in the reporting of racial/ethnic data, especially if the data are contained in electronic clinical records that are moved directly into NEDSS components. Implementing NEDSS might also improve the compatibility of racial/ethnic data reporting across states and across programs; data are collected in the same format and coding system as those used for the decennial census.

Infectious diseases continue to place a considerable burden on the nation, and better prevention and more effective control measures are needed (*5–7*). To plan programs and evaluate the success of efforts to control infectious diseases of public health importance, improvements are necessary in the data-collection methods of surveillance systems to enable targeting of populations at greatest risk and to reduce health disparities among racial/ethnic populations.

* NEDSS is designed as a major component of the Public Health Information Network to promote the use of data and information system standards to advance the development of efficient, integrated, and interoperable surveillance systems at federal, state, and local levels. The NEDSS Base System can be used by health departments for the surveillance and analysis of notifiable diseases. With NEDSS, providers can transfer clinical and laboratory-based data electronically to health departments, thereby lessening the burden of reporting, reducing missing data, and improving timeliness. Additional information is available at http://www.cdc.gov/nedss.

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Reducing Childhood Asthma Through Community-Based Service Delivery — New York City, 2001–2004

Since 1980, asthma prevalence, hospitalization, and mortality have been increasing in the United States (*1*). Because of concern about asthma-related morbidity among children in Central Harlem, New York City (NYC), the Harlem Children's Zone Asthma Initiative (HCZAI) was established in 2001 to reduce asthma-related morbidity through improved surveillance, health-care use, and health-care service delivery for children aged ≤12 years living in a 60-block radius of Central Harlem known as the Harlem Children's Zone Project*. Families of children with asthma or asthma-like signs† or physical findings consistent with asthma are invited to participate in the program. This report summarizes preliminary data collected during 2001–2004 on the effectiveness of the program in reducing asthma-related morbidity; data indicate decreased parental/guardian reports of school absences among children enrolled in the program, both for any reason and because of asthma. In addition, emergency department and unscheduled physician office visits for treatment of asthma decreased from 35% to 8% after 18 months of the program, indicating improved asthma management and appropriate use of health-care services by program enrollees. The effectiveness of HCZAI underscores the utility of community-based public health programs in reducing asthma morbidity.

Potential participants in HCZAI are identified through screening of all children aged ≤12 years who live or attend school in the Harlem Children's Zone Project or participate in any Harlem Children's Zone, Inc., program (*2*). Screening consists of a written survey completed by a parent/guardian and a physical examination of the child conducted by a physician or nurse (*6*). Participation rates for the various sites ranged from 66% to 100%, with 88% of parents/guardians consenting to physical examination of their children.

Because of the large number of children identified with asthma or asthma-like signs, participation is prioritized for children with recent symptoms. Over time, all eligible chil-

* Partners of this ongoing health intervention are Harlem Children's Zone, Inc. (*2*) and the Department of Pediatrics at Harlem Hospital Center (*3,4*). The Harlem Health Promotion Center, one of 33 Prevention Research Centers funded by CDC (*5*), provides translational research support to better document, monitor, and inform HCZAI during its efforts to address the asthma epidemic in Central Harlem.

† For children with asthma, a parent/guardian indicated that the child had ever been told by a doctor or nurse that the child had asthma. For children with asthma-like signs, a health-care provider indicated that the child's chest radiograph was not clear, or peak expiratory flow rate for children aged ≥6 years was correctly performed and abnormal.

dren may enroll and participate in the program. As part of HCZAI, a pediatric asthma team (including four community workers, a social worker, a nurse, and three physicians) offers medical, educational, environmental, social, and legal services to families of enrolled children. Among participants, monitoring of 13 selected indicators (Table 1) of asthma symptoms and management strategies is conducted via home visits by community workers who interview the parents/guardians of enrolled children at 3-month follow-up intervals (*7,8*). Prevalence estimates for item responses were calculated by using statistical software. To assess changes in the prevalence of asthma symptoms and management strategies over time, chi-squared tests on five degrees of freedom were calculated; significance levels were replicated by using repeated measures models in statistical software.

As of September 2004, a total of 3,132 children had been screened; of these, 982 (31.4%) had asthma or asthma-like signs, and 314 (10.0%) were enrolled in HCZAI (Table 2). Program enrollees were more likely than nonenrollees to have health insurance (87.0% versus 67.8%). Approximately 32.3% of children enrolled in the program had a household member who smoked at the time of screening, compared with 20.8% of children not enrolled and 16.4% of children without asthma or asthma-like signs.

Preliminary data are available on the effectiveness of HCZAI in reducing asthma morbidity, as measured for all 13 selected asthma symptoms and management strategies at six 3-month follow-up time points (18 months) (Table 1). Because children were enrolled sequentially, data are not yet available for 18 months of follow-up for all 314 enrolled children.

School absences reported by the parents/guardians of enrollees declined during the preceding 14 days, both for any reason (from 34.4% to 16.0% in 18 months) and because of asthma (from 23.3% to 8.0% in 18 months). In addition, emergency department and unscheduled physician office visits for treatment of asthma decreased from 35.0% to 8.0% in 18 months, indicating improved asthma management and appropriate use of health-care services by program enrollees. Reported use of asthma management strategies (e.g., using a spacer device[§] and having an asthma action plan) by parents/guardians of enrolled children increased substantially over time (Table 1).

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[§] A spacer device (e.g., AeroChamber®, Optichamber®, or InspirEase®) helps deliver inhaled medications deep into the lungs for effective relief of asthma symptoms.

TABLE 1. Percentage of parents/guardians of enrolled children who reported selected asthma symptoms and management strategies at 3-month follow-up time points — Harlem Children's Zone Asthma Initiative, New York City, 2001–2004

Symptoms and strategies	Time 1* (n = 314)	Time 2 (n = 186)	Time 3 (n = 145)	Time 4 (n = 111)	Time 5 (n = 70)	Time 6 (n = 50)	p value†
Asthma symptoms reported during preceding 14 days							
Child experienced wheezing or tightness in chest	61.5%	43.0%	40.7%	42.3%	42.8%	48.0%	<0.001
Child had to slow down or stop play or activities because of asthma	48.7%	40.3%	36.5%	39.6%	42.8%	48.0%	0.14
Child woke up because of asthma, wheezing, cough, or tightness in chest	49.0%	36.6%	32.4%	36.9%	40.0%	42.0%	<0.01
Child missed school for any reason	34.4%	22.6%	9.7%	13.5%	8.6%	16.0%	<0.001
Child missed school because of asthma	23.3%	15.0%	9.7%	7.2%	7.1%	8.0%	<0.001
Asthma symptoms reported during preceding 3 months							
Child visited the emergency department or made an unscheduled visit to a physician's office for treatment of asthma	35.0%	20.9%	15.8%	11.7%	14.3%	8.0%	<0.001
Child was admitted to a hospital and stayed overnight for asthma	8.6%	4.8%	2.7%	2.7%	2.8%	0.0%	<0.01
Child took any medications for asthma	81.2%	88.2%	84.8%	83.8%	84.3%	90.0%	0.34
Reported use of asthma management strategies							
Child took any medications prescribed for asthma every day, even when well, to prevent asthma symptoms	32.2%	37.1%	42.8%	43.2%	47.1%	52.0%	<0.05
Child has a spacer device such as AeroChamber®, Optichamber®, or InspirEase®	48.1%	87.6%	95.2%	97.3%	98.6%	98.0%	<0.001
Child uses a spacer device with any inhaled medications	41.4%	74.7%	87.6%	91.9%	95.7%	96.0%	<0.001
Child has a peak flow meter	21.9%	72.6%	82.1%	85.6%	91.4%	92.0%	<0.001
Child has an asthma plan	19.7%	32.8%	35.2%	44.1%	41.4%	60.0%	<0.001

* Time 1 = baseline; each subsequent time point represents a 3-month follow-up. (Exact follow-up lengths might differ because of variations in family schedules.) Decreasing number of participants does not necessarily reflect permanent loss to follow up. Families are invited back when their resources allow them to continue or if they return to New York City to live.

† P-values are from chi-squared tests on five degrees of freedom. Significance levels were replicated by using repeated measures models in statistical software.

TABLE 2. Percentage of children screened for asthma or asthma-like signs*, by program enrollment status and selected demographic and health characteristics — Harlem Children's Zone Asthma Initiative, New York City, 2001–2004

Characteristic	Children with asthma or asthma-like signs, enrolled (n = 314)†	Children with asthma or asthma-like signs, not enrolled (n = 668)	Children without asthma or asthma-like signs (n = 2,150)	Total children screened (N = 3,132)
Age group (yrs)				
0–5	39.2%	29.1%	34.5%	**33.8%**
6–10	41.9%	54.1%	53.9%	**52.7%**
11–15	18.9%	16.8%	11.6%	**13.5%**
Sex				
Female	45.2%	44.2%	51.8%	**49.4%**
Male	54.8%	55.8%	48.2%	**50.6%**
Race/Ethnicity				
Black, non-Hispanic	75.8%	83.2%	85.6%	**84.2%**
Black/Hispanic	9.7%	7.3%	6.2%	**6.8%**
White/Hispanic	3.8%	3.0%	1.8%	**2.3%**
Other	10.6%	6.5%	6.4%	**6.7%**
Child has a regular source of health care				
Yes	85.4%	86.7%	83.1%	**84.0%**
No	14.6%	13.3%	16.9%	**16.0%**
Child has health insurance				
Yes	87.0%	67.8%	68.0%	**69.9%**
No	13.0%	32.2%	32.0%	**30.1%**
Household member smokes cigarettes				
Yes	32.3%	20.8%	16.4%	**18.9%**
No	67.7%	79.2%	83.6%	**81.1%**

* For children with asthma, a parent/guardian indicated that the child had ever been told by a doctor or nurse that the child had asthma. For children with asthma-like signs, a health-care provider indicated that the child's chest radiograph was not clear, or peak expiratory flow rate for children aged ≥6 years was correctly performed and abnormal. Thus, 314 + 668 = 982 and 982/3132 = 31.4% of children surveyed have asthma or asthma-like signs.
† Percentages might not total 100% because of missing values.

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Editorial Note: Since 2001, HCZAI has documented both a high prevalence (>30%) of childhood asthma or asthma-like signs among children in the Harlem Children's Zone Project and has substantially decreased asthma symptoms and increased asthma management strategies for enrolled children during the first 18 months of follow-up. Nonetheless, 668 children with asthma or asthma-like signs identified through screening have yet to be enrolled in HCZAI, and children aged ≤12 years in other Harlem Children's Zone Project schools remain to be screened for asthma and potentially enrolled. An expanded program model is planned for ensuing years.

Based on findings from a qualitative evaluation involving parents/guardians of children enrolled in HCZAI and the pediatric asthma team, at least three limitations were documented. First, some families did not believe their child's diagnosis of asthma was correct, or they believed that it was outdated. Thus, they were unwilling to enroll their children in HCZAI. Second, other nonparticipants cited problems with scheduling of home visits or reported that socioeconomic needs and lack of housing precluded enrollment in HCZAI. Third, monitoring effectiveness proved burdensome for some staff and clients and failed to capture the full extent of client needs and service provision.

To be more effective in reducing asthma morbidity among children in Central Harlem, additional activities will be implemented in HCZAI. These include 1) building closer working alliances with other community organizations and agencies, particularly the NYC Department of Education and the NYC Department of Health and Mental Hygiene; 2) developing protocols for situations in which family and mental health problems preclude participation in HCZAI; and 3) expanding community education regarding asthma to enhance health literacy through existing Harlem Children's Zone, Inc., programs (*2*).

Previous research has indicated that an individualized, home-based, comprehensive environmental intervention decreased exposure to indoor allergens, resulting in reduced asthma-related morbidity (*9*). By incorporating HCZAI into an ongoing, community-building initiative and linking it to programs targeted to meet children's medical, educational, environmental, social, and legal needs, positive outcomes will be sustained throughout their lifetimes. Additional information about HCZAI is available at http://www.hcz.org.

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Update: Influenza Activity — United States, 2004–05 Season

Influenza activity was low in the United States during October through early December but has increased steadily since mid-December. Current surveillance indicators suggest that influenza activity for the season has not yet peaked. Laboratory-confirmed influenza infections have been reported from 45 states, and this season's influenza vaccine strains have been well matched antigenically to the influenza viruses isolated so far this season. In response to this season's influenza vaccine supply shortage, the Department of Health and Human Services (DHHS) has purchased 1.2 million doses of 2004–05 inactivated influenza vaccine from GlaxoSmithKline (GSK). The GSK vaccine is produced, licensed, and distributed globally but is not licensed for use in the United States; therefore, it will be administered in the United States under an Investigational New Drug (IND) protocol. This report summarizes influenza activity during October 3, 2004–January 1, 2005* and provides information on the availability of additional influenza vaccine from GSK.

* As of January 13, 2005, reporting is incomplete.

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Influenza Surveillance Reports

During October 3–January 1, World Health Organization (WHO) collaborating laboratories and National Respiratory and Enteric Virus Surveillance System laboratories in the United States tested 34,497 respiratory specimens for influenza viruses; 1,369 (4.0%) were positive. The percentages of specimens testing positive for influenza ranged each week from 0.7% to 12.1% and first exceeded 10% during the week ending December 25. During the 2001–02, 2002–03, and 2003–04 influenza seasons, peak percentages of specimens testing positive for influenza ranged from 24.7% to 35.2% (CDC, unpublished data, 2004). During October 3–January 1, influenza viruses were reported from 45 states. As of January 1, approximately one half of the viruses have been reported from the Mid-Atlantic[†] (26.4%) and New England[§] (23.1%) regions. Of the 1,369 influenza viruses identified since October 3, a total 1,128 (82.4%) were influenza A viruses, and 241 (17.6%) were influenza B viruses. Of the 1,128 influenza A viruses, 406 (36.0%) have been subtyped; 404 (99.5%) were influenza A (H3N2) viruses, and two (0.5%) were influenza A (H1)[¶] viruses.

CDC has characterized antigenically 107 influenza viruses collected by U.S. laboratories since October 3. All 85 of the influenza A (H3N2) isolates were A/Fujian/411/2002-like (H3N2), the influenza A (H3N2) strain recommended for the 2004–05 influenza vaccine[**]. Nineteen influenza B isolates were from the B/Yamagata lineage and were characterized as B/Shanghai/361/2002-like, the influenza B strain in the 2004–05 influenza vaccine. Three B isolates belonged to the B/Victoria lineage and were characterized as B/Hong Kong/330/2001-like. Influenza B viruses fall into one of two antigenically and genetically distinct lineages represented by B/Yamagata/16/88 and B/Victoria/2/87 viruses. During 1990–2001, B/Yamagata lineage viruses circulated worldwide, whereas B/Victoria-like viruses were identified only in Asia. However, during March 2001–October 2003, B/Victoria-like viruses were the predominant B viruses in several countries, including the United States. Victoria-lineage and Yamagata-lineage viruses continue to be reported worldwide. However, Yamagata-lineage viruses have been reported more frequently and are represented in the current vaccine.

During October 3–January 1, weekly percentages of patient visits for influenza-like illness (ILI)[††] reported by approximately 1,500 U.S. sentinel providers in 50 states, New York City (NYC), Chicago, and the District of Columbia have ranged from 1.0% to 3.0%. During the week ending January 1, the percentage of patient visits for ILI was 3.0%, exceeding the national baseline of 2.5% for the first time this season[§§]. During the 2001–02, 2002–03, and 2003–04 influenza seasons, national weekly peak percentages of patient visits for ILI ranged from 3.2% to 7.6% (CDC, unpublished data, 2004).

Since the week ending October 9, a total of 16 states and NYC have reported widespread or regional influenza activity. During the week ending January 1, two states and NYC reported widespread activity, 12 states reported regional activity, and 13 states and the District of Columbia reported local activity. During the same week, 6.7% of recorded deaths in the 122 Cities Mortality Reporting System were attributed to pneumonia and influenza (P&I), which is below the epidemic threshold of 7.9%[¶¶] for that week. The percentage of P&I deaths exceeded the epidemic threshold for 1 week during October 3–January 1 but otherwise has remained below.

The New Vaccine Surveillance Network (NVSN) consists of three sites (Cincinnati, Ohio; Nashville, Tennessee; and Rochester, New York) that conduct population-based surveillance for laboratory-confirmed influenza among children aged ≤4 years who are admitted to the hospital with fever or acute respiratory illnesses. During October 3–December 25, 2004, two such hospitalizations occurred (preliminary rate: 0.42 per 10,000 children). During 2000–2003, the end-of-season hospitalization rates in the NVSN sites ranged from 3.7 to 12.0 per 10,000 children.

In June 2004, the Council of State and Territorial Epidemiologists changed nationally notifiable conditions to include deaths in children aged <18 years associated with laboratory test-confirmed influenza a nationally notifiable condition. Data collection began in October 2004, and as of January 8, 2005, one pediatric death has been reported to CDC by the Bureau of Health in Maine.

Purchase of Additional Inactivated Influenza Vaccine

DHHS has purchased 1.2 million doses of the GSK influenza vaccine, Fluarix®, for use in areas with continued vaccine shortages. The Fluarix vaccine obtained by DHHS is

[†] New Jersey, New York, and Pennsylvania.

[§] Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

[¶] Includes both the A (H1N1) and A (H1N2) influenza virus subtypes.

[**] The A/Fujian/411/2002-like virus used by U.S. vaccine manufacturers was A/Wyoming/03/2003, an antigenically equivalent virus appropriate for vaccine production.

[††] Temperature of ≥100.0°F (≥37.8°C) and either cough or sore throat in the absence of a known cause.

[§§] The national baseline was calculated as the mean weighted percentage of visits for ILI during noninfluenza weeks, plus two standard deviations. Wide variability in regional data precludes calculating region-specific baselines; applying the national baseline to regional data is inappropriate.

[¶¶] The expected seasonal baseline proportion of P&I deaths reported by 122 Cities Mortality Reporting System is projected by using a robust regression procedure in which a periodic regression model is applied to the observed percentage of deaths from P&I during the previous 5 years. The epidemic threshold is 1.645 standard deviations above the seasonal baseline.

Please note: An erratum has been published for this issue. To view the erratum, please click here.

similar to other injectable U.S.-licensed influenza vaccines and is licensed and used in more than 78 countries, including the 25 countries of the European Union, Australia, and New Zealand. Because both Fluarix and U.S.-licensed influenza vaccines adhere to the WHO vaccine strain recommendations, components of the two vaccines are similar. However, Fluarix must be used under an IND protocol in the United States because it is not currently licensed by the Food and Drug Administration (FDA) and the time available is not sufficient to obtain FDA licensure for this vaccine to be administered as a licensed product for this season. This vaccine will be available for:

- Adults aged ≥50 years,
- Persons aged ≥3 years with underlying chronic medical conditions***,
- Pregnant women in the 2nd or 3rd trimester or women in the 1st trimester with other high-risk conditions for influenza complications***,
- Residents of nursing homes and long-term–care facilities,
- Children aged 3–18 years on chronic aspirin therapy***,
- Health-care workers involved in direct patient care,
- Out-of-home caregivers and household contacts of persons with high-risk conditions†††.

During the next several weeks, the IND vaccine will be available in identified clinics in selected areas of the United States where need for more influenza vaccine persists. CDC is working with state and local public health officials to finalize the clinic locations. When decisions have been finalized, information on the clinic locations will be available through local and state public health authorities, at telephone 800-232-4636, and on the CDC website. Persons who wish to receive this vaccine must call the clinic for appointments during regular clinic hours, sign a consent form, and provide limited additional information for monitoring the IND vaccine program. The cost of vaccination will be paid by Medicare for persons with Medicare part B coverage. These persons should be prepared to provide their Medicare number and other billing information at the time of vaccination. Persons without Medicare will be responsible for the cost of the vaccine and its administration at the time of their appointment.

Reported by: *L Brammer, MPH, E Murray, MSPH, K Teates, MPH, S Harper, MD, K Fukuda, MD, A Klimov, PhD, N Cox, PhD, WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza, Div of Viral and Rickettsial Diseases; L Rotz, MD, National Center for Infectious Diseases; R Seither, MPH, M Iwane, PhD; Epidemiology and Surveillance Div; J Copeland, MS, National Immunization Program, CDC.*

Editorial Note: Influenza activity has been low but is increasing in the United States and does not appear to have reached a peak. Influenza viruses might continue to circulate for several more months, and persons for whom influenza vaccine is recommended are strongly encouraged to seek vaccination. Influenza vaccine coverage estimates from December suggest that many persons in vaccine priority groups had not yet been vaccinated and that vaccination rates lagged substantially behind vaccination coverage estimates for the previous year (*1*).

The influenza vaccine strains are well-matched antigenically to the circulating influenza virus strains. The match between vaccine demand and vaccine availability varies depending on the area. Overall, supplies of both inactivated vaccine and live, attenuated influenza vaccine licensed for use in the United States are available. Beginning January 3, 2005, the priority groups for influenza vaccine have been expanded to include persons aged 50–64 years and household contacts of any person at increased risk for influenza-related complications. Efforts should continue to utilize existing licensed influenza vaccine to vaccinate persons in priority groups. Additional information is available at http://www.cdc.gov/flu/protect/whoshouldget.htm.

In addition, IND inactivated influenza vaccine will become available this month to further increase supply. Thus, persons who were not successful in obtaining vaccination earlier in the season are encouraged to contact their personal physicians or their local health departments to determine where vaccine is available in their areas. Influenza surveillance reports for the United States are published weekly during October–May and are available at http://www.cdc.gov/flu/weekly or through CDC's voice (888-232-3228) and fax (888-232-3299, document number 361100) information systems.

Acknowledgments

This report is based on data contributed by participating state and territorial epidemiologists and state public health laboratory directors, WHO collaborating laboratories, National Respiratory and Enteric Virus Surveillance System collaborating laboratories, U.S. Influenza Sentinel Provider Surveillance System, New Vaccine Surveillance Network.

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*** Groups differ from the Advisory Committee on Immunization Practices recommendations to accommodate for differences in Fluarix licensed indications or lack of pediatric doses of the IND vaccine

††† Persons at high risk include adults aged ≥65 years, children aged 6–23 months, persons aged 2–64 years with underlying chronic medical conditions, women who will be pregnant during the influenza season, residents of nursing homes and long-term–care facilities, and children aged 2–18 years on chronic aspirin therapy.

Notice to Readers

Changes to Data Presented in Tables I and II

This issue of *MMWR* incorporates modifications to Tables I and II, Provisional Cases of Selected Notifiable Diseases, United States. This year, the modifications add serogroup data to the meningococcal disease category reported in Table II and broaden domestic arboviral disease data presented in Tables I and II to include both neuroinvasive and non-neuroinvasive illness.

Meningococcal Disease Data

Meningococcal disease is nationally reportable and the cumulative (year-to-date) incidence data for the current and preceding year are reported by state in Table II. Confirmed cases are those in which *Neisseria meningitidis* is isolated from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF] or less commonly, joint, pleural, or pericardial fluid) (*1*). Probable cases of meningococcal disease include those with a positive antigen test in CSF or clinical purpura fulminans in the absence of a positive blood culture.

Most meningococcal disease in the United States is caused by *N. meningitidis* belonging to one of three serogroups, B, C, and Y, which caused 23%, 31%, and 39% of reported cases, respectively, during 1996–2001 (*2*). Two additional serogroups, A and W-135, are important causes of disease in other parts of the world. Disease caused by four of these serogroups, A, C, Y, and W-135 can be prevented by vaccination with a quadrivalent meningococcal polysaccharide vaccine marketed in the United States as Menomune®. However, this vaccine is not routinely used in the general U.S. population because of its poor immunogenicity in children, short duration of protection, and inability to induce herd immunity (*2*). A new, quadrivalent A/C/Y/W-135 protein-conjugate vaccine might become available in the United States in 2005 for persons aged 11–55 years. The vaccine is expected to have improved immunogenicity in young children, provide longer-lasting immunity, and might provide herd immunity if used in certain strategies. The Advisory Committee on Immunization Practices is considering recommendations for its use. Other meningococcal conjugate vaccines, with different formulations, combinations, and target age groups are expected to be available within the next 5 years.

To monitor changes in the incidence of vaccine-preventable meningococcal disease, meningococcal disease reports should include serogroup information. However, in 2003, only 459 (26.0%) of 1,768 cases of meningococcal disease reported to CDC included this information. To encourage serogroup reporting, the Council of State and Territorial Epidemiologists (CSTE) recommends that state, territorial, and local health departments encourage bacterial culture for all suspected cases of meningococcal invasive disease and that every isolate of *N. meningitidis* from normally sterile sites be serogrouped. CSTE further recommends that state, territorial, and local health departments collect serogroup information for all reported cases and report this information to CDC (*3*).

Beginning with this issue, meningococcal disease data reported in Table II will be presented in five columns under the headings "All Serogroups," "Serogroup A, C, Y, W-135," "Serogroup B," "Other serogroup," and "Serogroup unknown." These changes are intended to stimulate more complete serogroup reporting and will make Table II more informative by permiting the data to be used for monitoring the impact of vaccine interventions on the incidence of meningococcal disease.

Domestic Arboviral Disease Data

At its 2004 meeting, CSTE broadened the surveillance case definition for domestic arboviral diseases to include both neuroinvasive and non-neuroinvasive illness (*4*). For each low-incidence domestic arbovirus (California serogroup, eastern and western equine, Powassan, and St. Louis encephalitis viruses), neuroinvasive and non-neuroinvasive disease reports meeting the revised case definition will be combined and continue to appear in Table I. Case reports of West Nile virus disease will continue to appear in Table II, with separate columns for neuroinvasive and non-neuroinvasive disease, consistent with the revised case definition.

References

1. CDC. Case definitions for infectious conditions under public health surveillance. MMWR 1997;46(No. RR-10):24.
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4. Council of State and Territorial Epidemiologists. Position statement 04-ID-01: revision of national surveillance case definition of disease caused by neurotropic domestic aboviruses, including the addition to the NNDSS of non-neuroinvasive illnesses caused by these viruses. Available at http://www.cste.org/ps/2004pdf/04-ID-01-final.pdf.

Notice to Readers

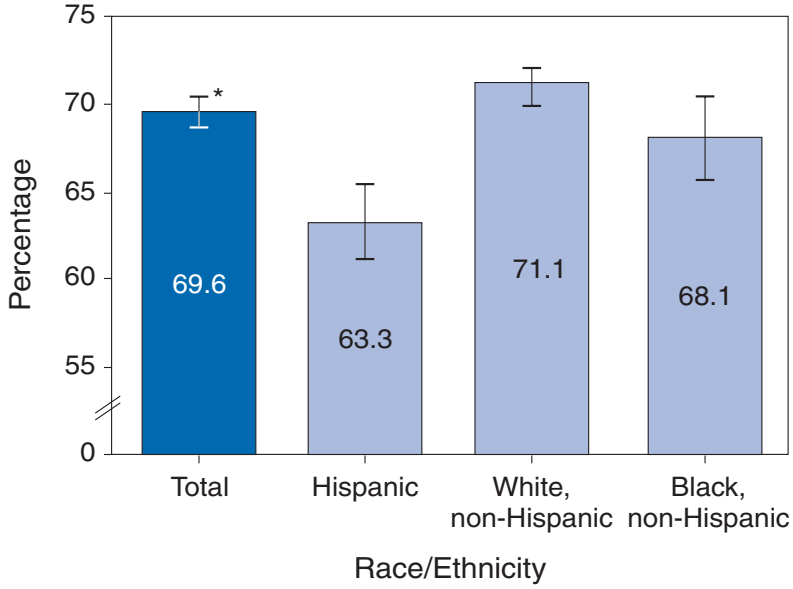
QuickStats from the National Center for Health Statistics

A new feature will appear in *MMWR*, beginning with this issue. QuickStats will provide updates on key indicators, important trends, and critical relations in public health, based on data from CDC's National Center for Health Statistics (NCHS). NCHS monitors the nation's health through its many data systems, collecting and analyzing information regarding a range of health topics. Each QuickStats will feature the latest available data and provide an Internet link to additional information.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Women Who Reported Ever Having a Mammogram



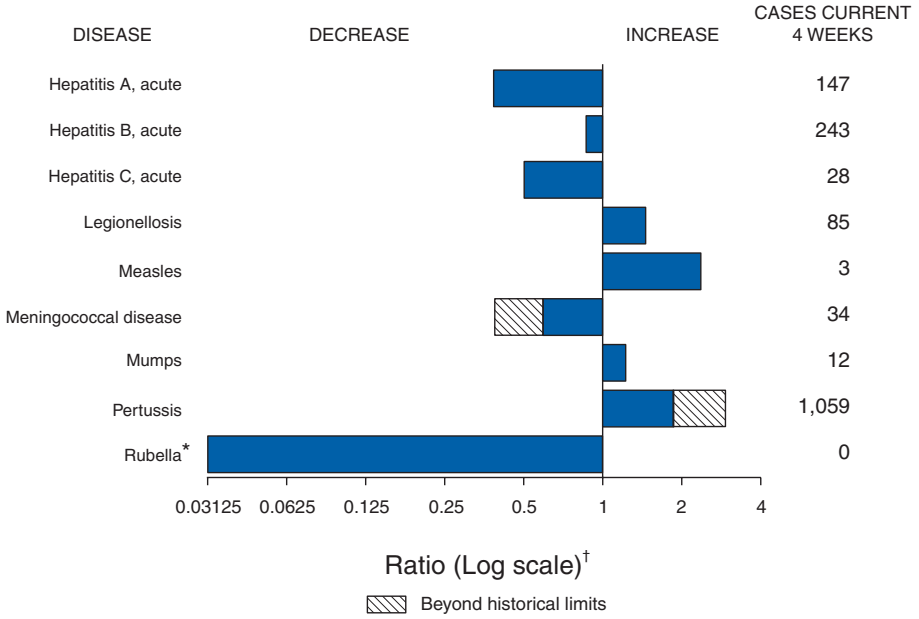
* Confidence interval.

Approximately 70% of U. S. women have ever had a mammogram. The likelihood that a woman has had a mammogram at some time in her life varies by race/ethnicity. Hispanic women were the least likely to have ever had a mammogram, whereas non-Hispanic white women were the most likely.

DATA SOURCE: 2003 National Health Interview Survey. Available at http://www.cdc.gov/nchs/nhis.htm.

Estimates are age-adjusted to the projected 2000 U.S. population by using age groups 18–29 years, 30–39 years, 40–49 years, 50–59 years, 60–69 years, 70–79 years, and ≥80 years.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals January 8, 2005, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 1 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 January 8, 2005 (1st Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	1	—
Botulism:			HIV infection, pediatric†¶	—	—
foodborne	—	—	Influenza-associated pediatric mortality†**	1	—
infant	—	1	Measles	1††	1§§
other (wound & unspecified))	—	—	Mumps	2	4
Brucellosis	1	1	Plague	—	—
Chancroid	2	1	Poliomyelitis, paralytic	—	—
Cholera	—	1	Psittacosis†	—	—
Cyclosporiasis†	—	—	Q fever†	1	1
Diphtheria	—	—	Rabies, human	—	—
Domestic arboviral diseases			Rubella	—	—
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	—	—
California serogroup†§	—	—	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	*Staphylococcus aureus*:		
St. Louis†§	—	—	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	1	9
human granulocytic (HGE)†	—	3	Tetanus	—	—
human monocytic (HME)†	—	—	Toxic-shock syndrome	—	2
human, other and unspecified †	—	—	Trichinellosis¶¶	—	—
Hansen disease†	—	1	Tularemia†	—	—
Hantavirus pulmonary syndrome†	—	—	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update November 28, 2004.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† The one case reported was indigenous.
§§ The one case reported was imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2005, and January 10, 2004 (1st Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	—	17	7,551	14,267	47	22	18	50
NEW ENGLAND	—	—	616	492	—	—	—	5
Maine	—	—	53	27	N	N	—	2
N.H.	—	—	32	35	—	—	—	—
Vt.¶	—	—	6	24	—	—	—	1
Mass.	—	—	244	218	—	—	—	2
R.I.	—	—	82	123	—	—	—	—
Conn.	—	—	199	65	N	N	—	—
MID. ATLANTIC	—	14	1,015	1,597	—	—	3	5
Upstate N.Y.	—	—	55	130	N	N	1	2
N.Y. City	—	14	282	617	—	—	—	2
N.J.	—	—	225	379	—	—	—	—
Pa.	—	—	453	471	N	N	2	1
E.N. CENTRAL	—	—	622	2,372	—	—	4	8
Ohio	—	—	—	488	N	N	4	2
Ind.	—	—	361	323	N	N	—	—
Ill.	—	—	155	769	—	—	—	3
Mich.	—	—	—	515	—	—	—	1
Wis.	—	—	106	277	—	—	—	2
W.N. CENTRAL	—	—	84	910	—	—	1	3
Minn.	—	—	—	240	N	N	—	—
Iowa	—	—	—	125	N	N	—	—
Mo.	—	—	—	350	—	—	—	1
N. Dak.	—	—	12	21	N	N	—	—
S. Dak.	—	—	61	23	—	—	1	—
Nebr.¶	—	—	—	87	—	—	—	—
Kans.	—	—	11	64	N	N	—	2
S. ATLANTIC	—	—	2,509	2,746	—	—	9	14
Del.	—	—	63	47	N	N	—	—
Md.	—	—	275	319	—	—	3	1
D.C.	—	—	44	63	—	—	—	—
Va.	—	—	571	535	—	—	—	—
W. Va.	—	—	39	45	N	N	—	—
N.C.	—	—	590	529	N	N	2	7
S.C.¶	—	—	247	—	—	—	—	1
Ga.	—	—	174	800	—	—	2	3
Fla.	—	—	506	408	N	N	2	2
E.S. CENTRAL	—	—	339	999	—	—	1	3
Ky.	—	—	188	130	N	N	—	—
Tenn.¶	—	—	—	416	N	N	—	1
Ala.¶	—	—	2	217	—	—	1	1
Miss.	—	—	149	236	—	—	—	1
W.S. CENTRAL	—	—	1,026	2,296	—	—	—	1
Ark.	—	—	118	93	—	—	—	—
La.	—	—	—	931	—	—	—	—
Okla.	—	—	—	230	N	N	—	—
Tex.¶	—	—	908	1,042	N	N	—	1
MOUNTAIN	—	—	609	690	45	—	—	2
Mont.	—	—	6	—	N	N	—	—
Idaho	—	—	—	26	N	N	—	—
Wyo.	—	—	13	17	—	—	—	—
Colo.	—	—	67	198	N	N	—	2
N. Mex.	—	—	21	128	—	—	—	—
Ariz.	—	—	484	188	45	—	—	—
Utah	—	—	18	25	—	—	—	—
Nev.¶	—	—	—	108	—	—	—	—
PACIFIC	—	3	731	2,165	2	22	—	9
Wash.	—	—	286	157	N	N	—	—
Oreg.¶	—	—	100	67	—	—	—	—
Calif.	—	3	337	1,798	2	22	—	9
Alaska	—	—	8	18	—	—	—	—
Hawaii	—	—	—	125	—	—	—	—
Guam	—	—	—	22	—	—	—	—
P.R.	—	—	20	26	N	N	N	N
V.I.	—	—	—	6	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	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 2004 and 2005 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, National Center for HIV, STD, and TB Prevention. Last update November 28, 2004.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2005, and January 10, 2004 (1st Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	6	22	1	—	4	1	64	239	2,739	5,793
NEW ENGLAND	—	—	—	—	—	—	3	25	140	121
Maine	—	—	—	—	—	—	1	4	1	5
N.H.	—	—	—	—	—	—	—	1	2	1
Vt.	—	—	—	—	—	—	—	1	1	—
Mass.	—	—	—	—	—	—	2	19	50	64
R.I.	—	—	—	—	—	—	—	—	10	19
Conn.	—	—	—	—	—	—	—	—	76	32
MID. ATLANTIC	—	3	—	—	—	—	11	56	291	560
Upstate N.Y.	—	—	—	—	—	—	3	6	48	43
N.Y. City	—	1	—	—	—	—	—	19	58	228
N.J.	—	—	—	—	—	—	6	11	62	132
Pa.	—	2	—	—	—	—	2	20	123	157
E.N. CENTRAL	3	6	—	—	1	1	11	44	268	1,056
Ohio	3	2	—	—	1	1	11	21	—	394
Ind.	—	—	—	—	—	—	—	—	168	109
Ill.	—	2	—	—	—	—	—	10	55	337
Mich.	—	2	—	—	—	—	—	11	—	138
Wis.	—	—	—	—	—	—	—	2	45	78
W.N. CENTRAL	—	3	—	—	—	—	2	20	16	388
Minn.	—	—	—	—	—	—	—	3	—	118
Iowa	—	—	—	—	—	—	—	4	—	36
Mo.	—	2	—	—	—	—	—	9	—	170
N. Dak.	—	—	—	—	—	—	—	—	1	2
S. Dak.	—	—	—	—	—	—	—	—	4	5
Nebr.	—	—	—	—	—	—	2	—	—	36
Kans.	—	1	—	—	—	—	—	4	11	21
S. ATLANTIC	2	2	—	—	3	—	14	42	1,071	1,343
Del.	—	—	N	N	N	N	—	—	11	19
Md.	2	—	—	—	—	—	4	1	139	145
D.C.	—	—	—	—	—	—	—	—	29	60
Va.	—	—	—	—	—	—	—	—	152	217
W. Va.	—	—	—	—	—	—	—	—	12	16
N.C.	—	—	—	—	3	—	N	N	264	284
S.C.	—	—	—	—	—	—	—	—	138	—
Ga.	—	1	—	—	—	—	1	24	85	374
Fla.	—	1	—	—	—	—	9	17	241	228
E.S. CENTRAL	—	—	—	—	—	—	4	2	153	562
Ky.	—	—	—	—	—	—	N	N	86	72
Tenn.	—	—	—	—	—	—	1	2	—	208
Ala.	—	—	—	—	—	—	3	—	3	172
Miss.	—	—	—	—	—	—	—	—	64	110
W.S. CENTRAL	—	1	—	—	—	—	—	1	457	1,015
Ark.	—	—	—	—	—	—	—	—	78	46
La.	—	—	—	—	—	—	—	1	—	475
Okla.	—	—	—	—	—	—	—	—	—	104
Tex.	—	1	—	—	—	—	N	N	379	390
MOUNTAIN	—	—	1	—	—	—	10	17	160	195
Mont.	—	—	—	—	—	—	—	—	1	—
Idaho	—	—	—	—	—	—	—	1	—	1
Wyo.	—	—	—	—	—	—	—	—	1	—
Colo.	—	—	1	—	—	—	9	12	44	67
N. Mex.	—	—	—	—	—	—	—	1	2	11
Ariz.	—	—	N	N	N	N	1	—	111	58
Utah	—	—	—	—	—	—	—	1	1	6
Nev.	—	—	—	—	—	—	—	2	—	52
PACIFIC	1	7	—	—	—	—	9	32	183	553
Wash.	—	—	—	—	—	—	—	—	35	38
Oreg.	—	1	—	—	—	—	3	7	19	6
Calif.	—	4	—	—	—	—	3	25	128	474
Alaska	—	—	—	—	—	—	2	—	1	3
Hawaii	1	2	—	—	—	—	1	—	—	32
Guam	N	N	—	—	—	—	—	—	—	6
P.R.	—	—	—	—	—	—	—	—	8	—
V.I.	—	—	—	—	—	—	—	—	—	2
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. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2005, and January 10, 2004 (1st Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	20	55	—	—	1	—	1	9
NEW ENGLAND	—	3	—	—	—	—	—	—
Maine	—	—	—	—	—	—	—	—
N.H.	—	—	—	—	—	—	—	—
Vt.	—	1	—	—	—	—	—	—
Mass.	—	2	—	—	—	—	—	—
R.I.	—	—	—	—	—	—	—	—
Conn.	—	—	—	—	—	—	—	—
MID. ATLANTIC	7	19	—	—	—	—	—	2
Upstate N.Y.	1	3	—	—	—	—	—	—
N.Y. City	1	2	—	—	—	—	—	1
N.J.	1	6	—	—	—	—	—	1
Pa.	4	8	—	—	—	—	—	—
E.N. CENTRAL	2	8	—	—	—	—	—	4
Ohio	1	3	—	—	—	—	—	1
Ind.	1	—	—	—	—	—	—	—
Ill.	—	2	—	—	—	—	—	1
Mich.	—	2	—	—	—	—	—	1
Wis.	—	1	—	—	—	—	—	1
W.N. CENTRAL	—	3	—	—	—	—	—	—
Minn.	—	—	—	—	—	—	—	—
Iowa	—	—	—	—	—	—	—	—
Mo.	—	—	—	—	—	—	—	—
N. Dak.	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	—	3	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	—	—
S. ATLANTIC	10	11	—	—	1	—	1	2
Del.	—	—	—	—	—	—	—	—
Md.	3	5	—	—	1	—	1	—
D.C.	—	—	—	—	—	—	—	—
Va.	—	—	—	—	—	—	—	—
W. Va.	—	—	—	—	—	—	—	—
N.C.	2	—	—	—	—	—	—	—
S.C.	—	—	—	—	—	—	—	—
Ga.	—	4	—	—	—	—	—	2
Fla.	5	2	—	—	—	—	—	—
E.S. CENTRAL	—	1	—	—	—	—	—	—
Ky.	—	—	—	—	—	—	—	—
Tenn.	—	1	—	—	—	—	—	—
Ala.	—	—	—	—	—	—	—	—
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	—	1	—	—	—	—	—	—
Ark.	—	—	—	—	—	—	—	—
La.	—	1	—	—	—	—	—	—
Okla.	—	—	—	—	—	—	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	—	8	—	—	—	—	—	1
Mont.	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	—	—	—	—
Colo.	—	4	—	—	—	—	—	—
N. Mex.	—	3	—	—	—	—	—	1
Ariz.	—	—	—	—	—	—	—	—
Utah	—	—	—	—	—	—	—	—
Nev.	—	1	—	—	—	—	—	—
PACIFIC	1	1	—	—	—	—	—	—
Wash.	—	—	—	—	—	—	—	—
Oreg.	—	1	—	—	—	—	—	—
Calif.	—	—	—	—	—	—	—	—
Alaska	1	—	—	—	—	—	—	—
Hawaii	—	—	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	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 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2005, and January 10, 2004 (1st Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	25	100	43	72	4	19
NEW ENGLAND	10	13	2	4	—	—
Maine	—	—	—	—	—	—
N.H.	—	—	—	—	—	—
Vt.	—	—	—	—	—	—
Mass.	8	12	2	2	—	—
R.I.	—	—	—	—	—	—
Conn.	2	1	—	2	—	—
MID. ATLANTIC	—	22	14	10	1	3
Upstate N.Y.	—	—	—	—	—	—
N.Y. City	—	5	—	1	—	—
N.J.	—	7	13	5	—	—
Pa.	—	10	1	4	1	3
E.N. CENTRAL	1	8	1	3	—	1
Ohio	1	1	1	1	—	—
Ind.	—	—	—	—	—	—
Ill.	—	6	—	—	—	—
Mich.	—	1	—	2	—	1
Wis.	—	—	—	—	—	—
W.N. CENTRAL	—	2	1	7	—	4
Minn.	—	—	—	—	—	—
Iowa	—	—	—	—	—	—
Mo.	—	—	—	6	—	4
N. Dak.	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—
Nebr.	—	2	1	1	—	—
Kans.	—	—	—	—	—	—
S. ATLANTIC	6	27	24	26	2	2
Del.	—	—	—	—	—	—
Md.	—	2	1	1	2	1
D.C.	—	—	—	—	—	—
Va.	—	—	—	—	—	—
W. Va.	—	—	—	—	—	—
N.C.	—	—	10	—	—	—
S.C.	—	—	—	—	—	—
Ga.	—	17	3	17	—	1
Fla.	6	8	10	8	—	—
E.S. CENTRAL	—	2	—	5	1	1
Ky.	—	—	—	—	—	—
Tenn.	—	—	—	—	—	—
Ala.	—	2	—	—	1	—
Miss.	—	—	—	5	—	1
W.S. CENTRAL	—	18	—	5	—	6
Ark.	—	—	—	—	—	—
La.	—	1	—	5	—	4
Okla.	—	—	—	—	—	—
Tex.	—	17	—	—	—	2
MOUNTAIN	7	1	—	4	—	—
Mont.	1	—	—	—	—	—
Idaho	—	—	—	—	—	—
Wyo.	—	—	—	1	—	—
Colo.	—	1	—	—	—	—
N. Mex.	—	—	—	—	—	—
Ariz.	6	—	—	—	—	—
Utah	—	—	—	—	—	—
Nev.	—	—	—	3	—	—
PACIFIC	1	7	1	8	—	2
Wash.	—	—	—	—	—	—
Oreg.	1	—	—	3	—	1
Calif.	—	7	1	5	—	—
Alaska	—	—	—	—	—	—
Hawaii	—	—	—	—	—	1
Guam	—	—	—	—	—	—
P.R.	—	—	—	—	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	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 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2005, and January 10, 2004 (1st Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	4	30	4	6	53	156	7	24
NEW ENGLAND	—	—	—	—	—	15	—	2
Maine	—	—	—	—	—	—	—	—
N.H.	—	—	—	—	—	—	—	—
Vt.	—	—	—	—	—	—	—	—
Mass.	—	—	—	—	—	15	—	2
R.I.	—	—	—	—	—	—	—	—
Conn.	—	—	—	—	—	—	—	—
MID. ATLANTIC	2	9	1	2	31	128	1	5
Upstate N.Y.	—	—	—	—	—	28	—	—
N.Y. City	—	—	—	—	—	—	—	2
N.J.	1	6	—	2	21	44	1	1
Pa.	1	3	1	—	10	56	—	2
E.N. CENTRAL	—	10	1	1	5	1	—	1
Ohio	—	5	1	1	5	—	—	—
Ind.	—	—	—	—	—	—	—	—
Ill.	—	3	—	—	—	—	—	1
Mich.	—	2	—	—	—	—	—	—
Wis.	—	—	—	—	U	1	—	—
W.N. CENTRAL	—	—	—	—	—	2	—	1
Minn.	—	—	—	—	—	—	—	—
Iowa	—	—	—	—	—	1	—	—
Mo.	—	—	—	—	—	1	—	1
N. Dak.	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	—	—	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	—	—
S. ATLANTIC	2	6	2	1	6	6	1	10
Del.	—	—	N	N	—	—	—	—
Md.	—	2	—	—	3	6	1	2
D.C.	—	—	—	—	—	—	—	—
Va.	—	—	—	—	—	—	—	—
W. Va.	—	—	—	—	—	—	—	—
N.C.	1	3	1	1	—	—	—	—
S.C.	—	1	—	—	—	—	—	1
Ga.	1	—	—	—	—	—	—	4
Fla.	—	—	1	—	3	—	—	3
E.S. CENTRAL	—	2	—	—	1	—	2	—
Ky.	—	—	—	—	—	—	—	—
Tenn.	—	—	—	—	1	—	2	—
Ala.	—	2	—	—	—	—	—	—
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	—	2	—	—	—	1	—	2
Ark.	—	—	—	—	—	—	—	—
La.	—	—	—	—	—	—	—	1
Okla.	—	—	—	—	—	—	—	—
Tex.	—	2	—	—	—	1	—	1
MOUNTAIN	—	1	—	1	10	—	2	1
Mont.	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	—	—	—	—
Colo.	—	1	—	1	—	—	—	—
N. Mex.	—	—	—	—	—	—	—	—
Ariz.	—	—	—	—	10	—	1	—
Utah	—	—	—	—	—	—	1	—
Nev.	—	—	—	—	—	—	—	1
PACIFIC	—	—	—	1	—	3	1	2
Wash.	—	—	—	—	—	—	—	—
Oreg.	N	N	—	1	—	—	1	—
Calif.	—	—	—	—	—	3	—	2
Alaska	—	—	—	—	—	—	—	—
Hawaii	—	—	—	—	N	N	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	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 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2005, and January 10, 2004 (1st Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	7	59	—	1	—	—	—	—	—	—
NEW ENGLAND	1	3	—	—	—	—	—	—	—	—
Maine	—	—	—	—	—	—	—	—	—	—
N.H.	—	—	—	—	—	—	—	—	—	—
Vt.	1	—	—	—	—	—	—	—	—	—
Mass.	—	3	—	—	—	—	—	—	—	—
R.I.	—	—	—	—	—	—	—	—	—	—
Conn.	—	—	—	—	—	—	—	—	—	—
MID. ATLANTIC	—	5	—	—	—	—	—	—	—	—
Upstate N.Y.	—	2	—	—	—	—	—	—	—	—
N.Y. City	—	1	—	—	—	—	—	—	—	—
N.J.	—	2	—	—	—	—	—	—	—	—
Pa.	—	—	—	—	—	—	—	—	—	—
E.N. CENTRAL	1	11	—	1	—	—	—	—	—	—
Ohio	1	6	—	—	—	—	—	—	—	—
Ind.	—	—	—	—	—	—	—	—	—	—
Ill.	—	—	—	—	—	—	—	—	—	—
Mich.	—	5	—	1	—	—	—	—	—	—
Wis.	—	—	—	—	—	—	—	—	—	—
W.N. CENTRAL	—	2	—	—	—	—	—	—	—	—
Minn.	—	—	—	—	—	—	—	—	—	—
Iowa	—	—	—	—	—	—	—	—	—	—
Mo.	—	1	—	—	—	—	—	—	—	—
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—	—	—	—	—
Nebr.	—	—	—	—	—	—	—	—	—	—
Kans.	—	1	—	—	—	—	—	—	—	—
S. ATLANTIC	3	10	—	—	—	—	—	—	—	—
Del.	—	—	—	—	—	—	—	—	—	—
Md.	—	2	—	—	—	—	—	—	—	—
D.C.	—	—	—	—	—	—	—	—	—	—
Va.	—	—	—	—	—	—	—	—	—	—
W. Va.	—	—	—	—	—	—	—	—	—	—
N.C.	1	—	—	—	—	—	—	—	—	—
S.C.	—	—	—	—	—	—	—	—	—	—
Ga.	—	2	—	—	—	—	—	—	—	—
Fla.	2	6	—	—	—	—	—	—	—	—
E.S. CENTRAL	—	3	—	—	—	—	—	—	—	—
Ky.	—	—	—	—	—	—	—	—	—	—
Tenn.	—	2	—	—	—	—	—	—	—	—
Ala.	—	1	—	—	—	—	—	—	—	—
Miss.	—	—	—	—	—	—	—	—	—	—
W.S. CENTRAL	—	9	—	—	—	—	—	—	—	—
Ark.	—	—	—	—	—	—	—	—	—	—
La.	—	5	—	—	—	—	—	—	—	—
Okla.	—	—	—	—	—	—	—	—	—	—
Tex.	—	4	—	—	—	—	—	—	—	—
MOUNTAIN	1	1	—	—	—	—	—	—	—	—
Mont.	—	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	—	—	—	—	—	—
Colo.	1	1	—	—	—	—	—	—	—	—
N. Mex.	—	—	—	—	—	—	—	—	—	—
Ariz.	—	—	—	—	—	—	—	—	—	—
Utah	—	—	—	—	—	—	—	—	—	—
Nev.	—	—	—	—	—	—	—	—	—	—
PACIFIC	1	15	—	—	—	—	—	—	—	—
Wash.	—	—	—	—	—	—	—	—	—	—
Oreg.	1	5	—	—	—	—	—	—	—	—
Calif.	—	10	—	—	—	—	—	—	—	—
Alaska	—	—	—	—	—	—	—	—	—	—
Hawaii	—	—	—	—	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	—	—	—	—	—	—	—	—
C.N.M.I.	—	U	—	—	—	—	—	—	—	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2005, and January 10, 2004 (1st Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	148	123	41	312	3	6	192	474	36	194
NEW ENGLAND	4	49	11	3	—	—	5	33	—	4
Maine	—	—	1	—	—	—	—	2	—	—
N.H.	—	—	—	—	—	—	—	1	—	—
Vt.	3	—	—	—	—	—	4	1	—	—
Mass.	1	49	8	3	—	—	1	29	—	4
R.I.	—	—	—	—	—	—	—	—	—	—
Conn.	—	—	2	—	—	—	—	—	—	—
MID. ATLANTIC	21	27	1	11	—	2	12	62	—	18
Upstate N.Y.	3	3	—	—	—	—	1	3	—	2
N.Y. City	—	2	1	—	—	1	—	24	—	4
N.J.	—	8	—	—	—	—	1	18	—	9
Pa.	18	14	—	11	—	1	10	17	—	3
E.N. CENTRAL	62	10	—	—	1	—	17	80	2	28
Ohio	62	5	—	—	1	—	17	15	2	3
Ind.	—	—	—	—	—	—	—	—	—	—
Ill.	—	—	—	—	—	—	—	41	—	19
Mich.	—	3	—	—	—	—	—	14	—	2
Wis.	—	2	—	—	—	—	—	10	—	4
W.N. CENTRAL	2	15	—	5	—	—	2	15	—	4
Minn.	—	—	—	—	—	—	—	—	—	—
Iowa	—	4	—	1	—	—	—	1	—	—
Mo.	—	9	—	—	—	—	—	7	—	3
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—	1	—	—	—
Nebr.	2	—	—	—	—	—	1	2	—	—
Kans.	—	2	—	4	—	—	—	5	—	1
S. ATLANTIC	6	2	21	240	2	2	112	125	24	65
Del.	—	—	—	—	—	—	—	—	—	—
Md.	3	2	—	7	—	—	10	12	3	3
D.C.	—	—	—	—	—	—	—	—	—	—
Va.	—	—	6	4	—	—	—	—	—	—
W. Va.	—	—	—	1	—	—	—	—	—	—
N.C.	—	—	11	14	—	—	33	18	—	10
S.C.	—	—	—	—	—	2	—	—	—	1
Ga.	—	—	—	7	2	—	26	36	15	20
Fla.	3	—	4	207	—	—	43	59	6	31
E.S. CENTRAL	3	2	1	38	—	2	6	23	1	3
Ky.	—	—	—	1	—	—	—	—	—	—
Tenn.	—	2	—	36	—	1	1	10	—	—
Ala.	3	—	1	1	—	—	5	2	1	2
Miss.	—	—	—	—	—	1	—	11	—	1
W.S. CENTRAL	1	—	3	13	—	—	2	50	—	50
Ark.	1	—	3	—	—	—	—	1	—	—
La.	—	—	—	—	—	—	—	8	—	5
Okla.	—	—	—	1	—	—	—	1	—	3
Tex.	—	—	—	12	—	—	2	40	—	42
MOUNTAIN	49	4	3	2	—	—	24	24	9	9
Mont.	1	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	—	—	1	—	—	—
Colo.	47	3	—	—	—	—	7	14	1	4
N. Mex.	—	1	—	—	—	—	—	3	—	5
Ariz.	1	—	3	2	—	—	16	—	8	—
Utah	—	—	—	—	—	—	—	1	—	—
Nev.	—	—	—	—	—	—	—	6	—	—
PACIFIC	—	14	1	—	—	—	12	62	—	13
Wash.	—	—	—	—	—	—	—	—	—	—
Oreg.	—	14	—	—	—	—	1	13	—	2
Calif.	—	—	1	—	—	—	7	44	—	9
Alaska	—	—	—	—	—	—	1	1	—	—
Hawaii	—	—	—	—	—	—	3	4	—	2
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	—	2	—	—
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. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2005, and January 10, 2004 (1st Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	47	140	31	73	11	12	49	122	—	10
NEW ENGLAND	2	6	—	—	—	1	3	2	—	—
Maine	—	—	—	—	—	—	—	—	—	—
N.H.	—	—	—	—	—	—	—	—	—	—
Vt.	—	—	—	—	—	—	—	—	—	—
Mass.	2	6	N	N	—	1	3	—	—	—
R.I.	—	—	—	—	—	—	—	—	—	—
Conn.	—	—	—	—	U	U	—	2	—	—
MID. ATLANTIC	8	18	1	5	1	2	5	10	—	1
Upstate N.Y.	4	4	—	—	—	1	—	—	—	—
N.Y. City	—	5	U	U	U	U	—	5	—	—
N.J.	1	2	—	—	1	—	4	4	—	—
Pa.	3	7	1	5	—	1	1	1	—	1
E.N. CENTRAL	1	35	6	10	6	1	—	12	—	1
Ohio	1	12	6	10	6	—	—	2	—	—
Ind.	—	—	—	—	—	—	—	1	—	—
Ill.	—	12	—	—	—	—	—	5	—	—
Mich.	—	8	N	N	—	—	—	3	—	1
Wis.	—	3	N	N	—	1	—	1	—	—
W.N. CENTRAL	3	5	—	1	1	—	—	1	—	—
Minn.	—	—	—	—	—	—	—	—	—	—
Iowa	N	N	N	N	—	—	—	—	—	—
Mo.	—	2	—	1	—	—	—	1	—	—
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	2	—	—	—	—	—	—	—	—	—
Nebr.	1	1	—	—	1	—	—	—	—	—
Kans.	—	2	N	N	—	—	—	—	—	—
S. ATLANTIC	21	23	20	47	2	1	24	31	—	4
Del.	—	—	—	—	—	—	—	1	—	—
Md.	11	3	—	—	2	1	4	6	—	1
D.C.	—	—	—	—	—	—	3	—	—	—
Va.	—	—	N	N	—	—	—	1	—	1
W. Va.	—	—	—	—	—	—	—	—	—	—
N.C.	4	—	N	N	U	U	8	1	—	—
S.C.	—	1	—	—	—	—	—	3	—	—
Ga.	2	11	5	27	—	—	—	2	—	—
Fla.	4	8	15	20	—	—	9	17	—	2
E.S. CENTRAL	1	10	2	2	—	—	—	7	—	—
Ky.	—	—	—	—	—	—	—	3	—	—
Tenn.	1	10	2	2	—	—	—	3	—	—
Ala.	—	—	—	—	—	—	—	1	—	—
Miss.	—	—	—	—	—	—	—	—	—	—
W.S. CENTRAL	—	16	1	3	—	2	11	20	—	3
Ark.	—	—	—	—	—	—	—	1	—	—
La.	—	—	1	3	—	1	—	3	—	—
Okla.	—	—	N	N	—	—	—	—	—	—
Tex.	—	16	N	N	—	1	11	16	—	3
MOUNTAIN	5	10	—	1	1	5	2	4	—	—
Mont.	—	—	—	—	—	—	—	—	—	—
Idaho	—	—	N	N	—	—	—	—	—	—
Wyo.	—	1	—	—	—	—	—	—	—	—
Colo.	5	4	—	—	1	5	—	2	—	—
N. Mex.	—	5	—	1	—	—	—	1	—	—
Ariz.	—	—	N	N	—	—	2	1	—	—
Utah	—	—	—	—	—	—	—	—	—	—
Nev.	—	—	—	—	—	—	—	—	—	—
PACIFIC	6	17	1	4	—	—	4	35	—	1
Wash.	—	—	—	—	—	—	—	—	—	—
Oreg.	N	N	N	N	—	—	—	—	—	—
Calif.	2	16	N	N	—	—	4	35	—	1
Alaska	—	—	—	—	—	—	—	—	—	—
Hawaii	4	1	1	4	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	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. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2005, and January 10, 2004 (1st Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	13	122	—	2	145	257	—	—	—
NEW ENGLAND	—	3	—	—	2	17	—	—	—
Maine	—	—	—	—	2	—	—	—	—
N.H.	—	—	—	—	—	—	—	—	—
Vt.	—	—	—	—	—	17	—	—	—
Mass.	—	—	—	—	—	—	—	—	—
R.I.	—	1	—	—	—	—	—	—	—
Conn.	—	2	—	—	—	—	—	—	—
MID. ATLANTIC	—	30	—	—	1	1	—	—	—
Upstate N.Y.	—	—	—	—	—	—	—	—	—
N.Y. City	—	30	—	—	—	—	—	—	—
N.J.	—	—	—	—	—	—	—	—	—
Pa.	—	—	—	—	1	1	—	—	—
E.N. CENTRAL	3	3	—	1	31	116	—	—	—
Ohio	1	—	—	1	31	43	—	—	—
Ind.	2	1	—	—	—	—	—	—	—
Ill.	—	—	—	—	—	—	—	—	—
Mich.	—	—	—	—	—	66	—	—	—
Wis.	—	2	—	—	—	7	—	—	—
W.N. CENTRAL	—	—	—	—	2	—	—	—	—
Minn.	—	—	—	—	—	—	—	—	—
Iowa	—	—	—	—	N	N	—	—	—
Mo.	—	—	—	—	—	—	—	—	—
N. Dak.	—	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	2	—	—	—	—
Nebr.	—	—	—	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	—	—	—
S. ATLANTIC	—	25	—	—	51	45	—	—	—
Del.	—	—	—	—	—	—	—	—	—
Md.	—	—	—	—	—	—	—	—	—
D.C.	—	—	—	—	—	—	—	—	—
Va.	—	—	—	—	—	—	—	—	—
W. Va.	—	—	—	—	51	44	—	—	—
N.C.	—	—	—	—	—	—	—	—	—
S.C.	—	1	—	—	—	1	—	—	—
Ga.	—	24	—	—	—	—	—	—	—
Fla.	—	—	—	—	—	—	—	—	—
E.S. CENTRAL	—	1	—	—	—	—	—	—	—
Ky.	—	—	—	—	—	—	—	—	—
Tenn.	—	—	—	—	—	—	—	—	—
Ala.	—	1	—	—	—	—	—	—	—
Miss.	—	—	—	—	—	—	—	—	—
W.S. CENTRAL	—	57	—	—	3	72	—	—	—
Ark.	—	—	—	—	—	—	—	—	—
La.	—	—	—	—	—	—	—	—	—
Okla.	—	1	—	—	—	—	—	—	—
Tex.	—	56	—	—	3	72	—	—	—
MOUNTAIN	—	1	—	—	55	6	—	—	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	1	3	—	—	—
Colo.	—	—	—	—	54	—	—	—	—
N. Mex.	—	—	—	—	—	1	—	—	—
Ariz.	—	—	—	—	—	—	—	—	—
Utah	—	1	—	—	—	2	—	—	—
Nev.	—	—	—	—	—	—	—	—	—
PACIFIC	10	2	—	1	—	—	—	—	—
Wash.	5	—	—	—	—	—	—	—	—
Oreg.	1	—	—	—	—	—	—	—	—
Calif.	—	—	—	1	—	—	—	—	—
Alaska	—	—	—	—	—	—	—	—	—
Hawaii	4	2	—	—	—	—	—	—	—
Guam	—	1	—	—	—	4	—	—	—
P.R.	—	—	—	—	—	9	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	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 2004 and 2005 are provisional and cumulative (year-to-date).

† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending January 8, 2005 (1st Week)

Reporting Area	All causes, by age (years)						P&I†
	All Ages	≥65	45–64	25–44	1–24	<1	Total
NEW ENGLAND	672	490	132	34	9	7	95
Boston, Mass.	174	124	38	7	1	4	27
Bridgeport, Conn.	44	35	8	1	—	—	6
Cambridge, Mass.	22	19	3	—	—	—	7
Fall River, Mass.	28	20	5	2	1	—	6
Hartford, Conn.	72	46	16	7	1	2	10
Lowell, Mass.	20	14	4	—	2	—	4
Lynn, Mass.	20	13	4	3	—	—	—
New Bedford, Mass.	30	25	5	—	—	—	6
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	89	62	20	5	2	—	11
Somerville, Mass.	5	2	2	1	—	—	—
Springfield, Mass.	45	29	10	4	1	1	7
Waterbury, Conn.	41	35	5	1	—	—	4
Worcester, Mass.	82	66	12	3	1	—	7
MID. ATLANTIC	2,677	1,926	523	167	36	23	169
Albany, N.Y.	57	45	9	3	—	—	7
Allentown, Pa.	26	24	1	1	—	—	3
Buffalo, N.Y.	92	62	22	6	2	—	7
Camden, N.J.	36	21	7	3	4	1	4
Elizabeth, N.J.	24	20	1	2	1	—	3
Erie, Pa.	56	52	3	1	—	—	6
Jersey City, N.J.	59	41	9	7	—	2	—
New York City, N.Y.	1,453	1,021	309	87	19	15	77
Newark, N.J.	62	32	13	15	—	2	3
Paterson, N.J.	11	4	4	3	—	—	—
Philadelphia, Pa.	303	221	56	21	4	1	19
Pittsburgh, Pa.§	48	36	9	2	—	1	4
Reading, Pa.	29	28	—	—	1	—	2
Rochester, N.Y.	175	125	39	8	3	—	17
Schenectady, N.Y.	32	26	3	2	1	—	2
Scranton, Pa.	27	21	6	—	—	—	—
Syracuse, N.Y.	102	81	15	5	1	—	9
Trenton, N.J.	26	18	6	1	—	1	1
Utica, N.Y.	30	25	5	—	—	—	2
Yonkers, N.Y.	29	23	6	—	—	—	3
E.N. CENTRAL	2,441	1,658	550	142	45	46	196
Akron, Ohio	83	56	21	2	2	2	7
Canton, Ohio	57	43	11	1	1	1	8
Chicago, Ill.	349	225	97	20	4	3	18
Cincinnati, Ohio	66	46	15	3	—	2	12
Cleveland, Ohio	306	224	57	16	4	5	13
Columbus, Ohio	308	205	71	17	10	5	33
Dayton, Ohio	168	112	39	13	2	2	11
Detroit, Mich.	237	132	69	19	9	8	17
Evansville, Ind.	59	45	14	—	—	—	6
Fort Wayne, Ind.	62	39	9	6	1	7	5
Gary, Ind.	12	2	7	3	—	—	—
Grand Rapids, Mich.	71	49	17	4	—	1	19
Indianapolis, Ind.	188	124	43	12	1	8	12
Lansing, Mich.	16	13	1	1	1	—	1
Milwaukee, Wis.	126	91	25	6	4	—	13
Peoria, Ill.	71	50	14	4	3	—	2
Rockford, Ill.	74	60	11	2	—	1	6
South Bend, Ind.	46	35	5	4	2	—	3
Toledo, Ohio	94	67	16	9	1	1	6
Youngstown, Ohio	48	40	8	—	—	—	4
W.N. CENTRAL	691	471	146	40	9	25	48
Des Moines, Iowa	118	90	23	2	1	2	9
Duluth, Minn.	24	17	4	2	1	—	2
Kansas City, Kans.	28	21	5	—	2	—	3
Kansas City, Mo.	74	50	14	6	2	2	8
Lincoln, Nebr.	57	42	10	4	—	1	5
Minneapolis, Minn.	67	43	13	6	1	4	5
Omaha, Nebr.	73	53	13	5	—	2	4
St. Louis, Mo.	129	67	40	11	1	10	9
St. Paul, Minn.	55	42	13	—	—	—	1
Wichita, Kans.	66	46	11	4	1	4	2
S. ATLANTIC	1,449	912	348	120	30	39	76
Atlanta, Ga.	159	101	37	17	3	1	5
Baltimore, Md.	180	100	57	19	1	3	22
Charlotte, N.C.	126	85	21	10	4	6	12
Jacksonville, Fla.	197	124	52	14	2	5	5
Miami, Fla.	60	45	6	3	5	1	4
Norfolk, Va.	47	31	11	2	1	2	2
Richmond, Va.	87	47	30	8	—	2	6
Savannah, Ga.	70	49	14	3	—	4	6
St. Petersburg, Fla.	98	68	14	12	3	1	5
Tampa, Fla.	206	139	46	10	6	5	6
Washington, D.C.	199	109	55	22	5	8	3
Wilmington, Del.	20	14	5	—	—	1	—
E.S. CENTRAL	870	549	210	57	34	20	54
Birmingham, Ala.	176	119	39	12	4	2	12
Chattanooga, Tenn.	80	49	25	2	1	3	4
Knoxville, Tenn.	112	73	26	9	2	2	3
Lexington, Ky.	50	28	12	7	2	1	2
Memphis, Tenn.	156	97	33	9	10	7	9
Mobile, Ala.	63	34	18	7	3	1	1
Montgomery, Ala.	46	31	8	1	4	2	8
Nashville, Tenn.	187	118	49	10	8	2	15
W.S. CENTRAL	1,840	1,144	441	160	49	46	113
Austin, Tex.	110	81	22	5	1	1	5
Baton Rouge, La.	46	34	6	4	—	2	—
Corpus Christi, Tex.	48	36	12	—	—	—	5
Dallas, Tex.	212	113	56	23	9	11	17
El Paso, Tex.	115	69	29	10	5	2	7
Ft. Worth, Tex.	163	94	49	12	4	4	10
Houston, Tex.	420	240	120	32	14	14	31
Little Rock, Ark.	95	70	17	3	2	3	5
New Orleans, La.	52	31	14	7	—	—	—
San Antonio, Tex.	386	279	63	25	11	8	18
Shreveport, La.	56	33	19	3	1	—	1
Tulsa, Okla.	137	64	34	36	2	1	14
MOUNTAIN	833	568	184	37	21	23	61
Albuquerque, N.M.	142	107	28	2	4	1	11
Boise, Idaho	64	44	15	2	2	1	4
Colo. Springs, Colo.	55	39	12	3	1	—	1
Denver, Colo.	102	57	25	7	2	11	6
Las Vegas, Nev.	235	150	57	13	10	5	17
Ogden, Utah	25	20	3	2	—	—	2
Phoenix, Ariz.	61	40	14	4	2	1	3
Pueblo, Colo.	20	15	4	1	—	—	3
Salt Lake City, Utah	129	96	26	3	—	4	14
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	1,805	1,294	351	96	45	18	192
Berkeley, Calif.	20	14	4	2	—	—	3
Fresno, Calif.	125	90	24	7	3	1	15
Glendale, Calif.	23	20	2	1	—	—	6
Honolulu, Hawaii	96	78	14	1	2	—	15
Long Beach, Calif.	93	65	19	5	4	—	15
Los Angeles, Calif.	298	216	62	13	5	2	37
Pasadena, Calif.	21	18	3	—	—	—	4
Portland, Oreg.	127	90	28	6	1	2	9
Sacramento, Calif.	200	134	39	15	12	—	17
San Diego, Calif.	182	123	40	8	4	7	22
San Francisco, Calif.	102	73	22	5	1	1	12
San Jose, Calif.	151	114	28	5	2	2	15
Santa Cruz, Calif.	39	25	10	2	2	—	2
Seattle, Wash.	137	97	22	12	4	2	4
Spokane, Wash.	72	52	16	2	1	1	9
Tacoma, Wash.	119	85	18	12	4	—	7
TOTAL	13,278¶	9,012	2,885	853	278	247	1,004

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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