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MORBIDITY AND MORTALITY WEEKLY REPORT

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Health Objectives for the Nation

Consensus Set of Health Status Indicators for the General Assessment of Community Health Status – United States

Healthy People 2000 establishes a framework for the development of an explicit prevention program for the nation (1); the Year 2000 Health Objectives Planning Act* provides legislative support for such a program. To address both the requirements of that act and Objective 22.1 of *Healthy People 2000*, a consensus set of 18 health status indicators has been developed to assist communities in assessing their general health status and in focusing local, state, and national efforts in tracking the year 2000 objectives (Table 1). Priority in selecting the indicators was given to measures for which data are readily available and that are commonly used in public health.

The set of health status indicators was developed by a committee[†] established to implement Objective 22.1 through a consensus process involving local, state, and federal health officials and representatives from academic institutions and professional associations. The health status indicators are intended to ensure data comparability and facilitate use by public health agencies at all levels of government. These indicators are *not* intended to supersede specific measures suggested in *Healthy People 2000*; however, they will provide a broad indication of the general health status of a community.

In addition to this consensus set of health status indicators, modifications to existing data collection systems have been recommended to emphasize additional measures of outcomes, risk factors, and processes that will be helpful for planning prevention programs devoted to achieving the year 2000 objectives (Table 2). This

*Public Law no. 101-582 (42 USC § 246 [1990]).

[†]Committee members and representations: *American Public Health Association*—T. Colton, Ph.D., Boston University School of Public Health; D. Rice, Sc.D., University of California, San Francisco. *Association of State and Territorial Health Officials*—L. Novick, M.D., New York State Department of Health; R. Eckoff, M.D., Iowa Department of Public Health. *National Association of County Health Officials*—M. Luth, M.P.H., Washington County Health Department; F. Guerra, M.D., San Antonio Health Department. *Public Health Foundation*—L. Olsen, M.D., Delaware Division of Public Health; O. Shisana, Sc.D., District of Columbia Commission of Public Health. *United States Conference of Local Health Officers*—R. Biery, M.D., Kansas City Health Department. The committee was convened by CDC.

Health Status Indicators – Continued

additional list includes data needs for indicators of selected chronic diseases, access to medical care, and environmental exposures or behavioral risks.

Reported by: National Center for Health Statistics; Epidemiology Program Office; National Center for Chronic Disease Prevention and Health Promotion; Public Health Practice Program Office; Office of the Director, CDC.

Editorial Note: The need and rationale for a consensus set of health status indicators has been described previously (1,2). Development of this initial set of indicators involved broad input by policy and technical experts representing all levels of public health practice in the United States.

As public health priorities change and other data sets become available, the list of indicators will be modified through similar public consensus processes. CDC encourages both the immediate adoption of this list of health status indicators in public health practice and the development of the new and/or modified data systems recommended by the committee.

References

1. Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1990; DHHS publication no. (PHS)91-50212.
2. Institute of Medicine. The future of public health. Washington, DC: National Academy Press, 1988.

TABLE 1. Consensus set of indicators* for assessing community health status and monitoring progress toward the year 2000 objectives – United States, July 1991

Indicators of health status outcome

1. Race/ethnicity-specific infant mortality, as measured by the rate (per 1000 live births) of deaths among infants <1 year of age

Death rates (per 100,000 population)[†] for:

2. Motor vehicle crashes
3. Work-related injury
4. Suicide
5. Lung cancer
6. Breast cancer
7. Cardiovascular disease
8. Homicide
9. All causes

Reported incidence (per 100,000 population) of:

10. Acquired immunodeficiency syndrome
11. Measles
12. Tuberculosis
13. Primary and secondary syphilis

Indicators of risk factors

14. Incidence of low birth weight, as measured by percentage of total number of live-born infants weighing <2500 g at birth
15. Births to adolescents (females aged 10–17 years) as a percentage of total live births
16. Prenatal care, as measured by percentage of mothers delivering live infants who did not receive prenatal care during first trimester
17. Childhood poverty, as measured by the proportion of children <15 years of age living in families at or below the poverty level
18. Proportion of persons living in counties exceeding U.S. Environmental Protection Agency standards for air quality during previous year

*Position or number of the indicator does not imply priority.

[†]Age-adjusted to the 1940 standard population.

*Health Status Indicators – Continued***TABLE 2. Priority data needs* to augment the consensus set of health status indicators**

The measures in the following areas either do not exist or are incomplete. The committee[†] identified them as measures that could be obtained with minor modifications to existing data-collection systems.

Indicators of processes

- Proportion of children 2 years of age who have been immunized with the basic series (as defined by the Immunization Practices Advisory Committee)
- Proportion of adults aged ≥ 65 years who have been immunized for pneumococcal pneumonia and influenza
- Proportion of assessed rivers, lakes, and estuaries that support beneficial uses (fishing and swimming approved)
- Proportion of women receiving a Papanicolaou smear at an interval appropriate for their age
- Proportion of women receiving a mammogram at an interval appropriate for their age
- Proportion of the population uninsured for medical care
- Proportion of the population without a regular source of primary care (including dental services)

Indicators of risk factors (age-specific prevalence rates)

- Cigarette smoking
- Alcohol misuse
- Obesity
- Hypertension
- Hypercholesterolemia
- Confirmed abuse and neglect of children

Indicators of health status outcomes

- Percentage of children < 5 years of age who are tested and have blood lead levels exceeding 15 $\mu\text{g/dL}$
- Incidence of hepatitis B, per 100,000 population
- Proportion of children aged 6–8 and 15 years with one or more decayed primary or permanent teeth

*Position of the indicator does not imply priority.

[†]Convened by CDC to interpret Objective 22.1 of the year 2000 health objectives (1).

*Current Trends***Rocky Mountain Spotted Fever – United States, 1990**

In 1990, state health departments reported 649 cases of Rocky Mountain spotted fever (RMSF) to CDC, a 7.6% increase from the 603 cases reported in 1989. The incidence rate was 0.26 per 100,000 persons. Of the 649 cases, 292 (45.0%) and 101 (15.6%) were reported from the South Atlantic and the West South Central regions, respectively. Rates were highest in North Carolina (178 cases, 2.7 per 100,000 population), Oklahoma (70 cases, 2.2 per 100,000), Tennessee (58 cases, 1.2 per 100,000), and South Carolina (43 cases, 1.2 per 100,000) (Figure 1).

Detailed case reports were submitted on 531 (81.8%) cases. Of these, 286 (53.9%) were laboratory-confirmed*, 12 (2.3%) were classified as probable[†], and 233 (43.9%) were not confirmed. Of patients with confirmed cases, 59.6% were male; 78.2% reported that onset of symptoms occurred during May 1–August 31 (44.1% of cases

*A case is considered serologically confirmed if testing reveals an indirect fluorescent antibody (IFA) titer of $\geq 1:64$, a complement-fixation (CF) titer of $\geq 1:16$, or a fourfold rise in titer by the CF, IFA, microagglutination (MA), latex agglutination (LA), or indirect hemagglutination (IHA) tests.

[†]A case is considered probable if testing reveals a fourfold rise in titer or a single titer $\geq 1:320$ in the Weil-Felix test (OX-19 or OX-2) or an IHA, LA, or MA single titer of $\geq 1:128$.

Rocky Mountain Spotted Fever – Continued

occurred in May or June); and 54.2% reported a tick bite within 14 days of symptom onset. Clinical manifestations included fever (88.2% of cases), headache (85.0%), myalgia (85.0%), rash (73.9%), and rash on palms (49.0%). The triad of fever, headache, and rash was present in 44.6% of the cases.

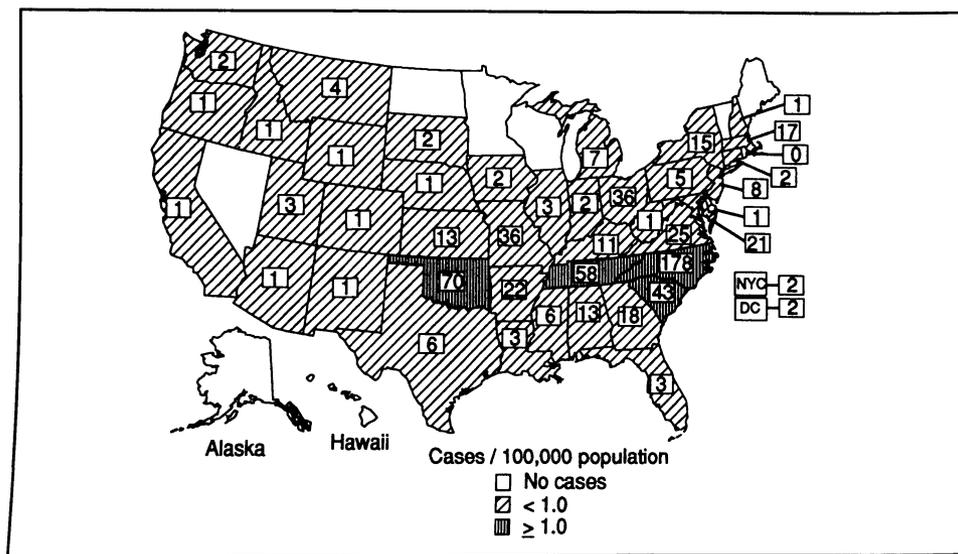
In 1990, age-specific incidence rates for laboratory-confirmed cases were highest for persons aged 5–9 years (0.21 per 100,000) and lowest for persons aged 20–29 years (0.07 per 100,000). The overall case-fatality rate for persons with laboratory-confirmed cases was 5.2%. For persons aged ≥ 20 years, the case-fatality rate was 6.8%, and for persons aged < 20 years, 2.4%.

Surveillance data from 1981 through 1990 also indicate that RMSF was most common among children 5–9 years of age and least common among persons aged 20–29 years (Figure 2). During this 10-year period, the case-fatality rate was highest for persons aged ≥ 40 years (Figure 3); for this age group, the average case-fatality rate was 8.2%, compared with 2.3% for persons aged < 40 years. The case-fatality rate was also higher (6.2%) for persons whose treatment began more than 3 days after onset of symptoms than for those treated within the first 3 days of illness (1.3%).

Reported by: Viral and Rickettsial Zoonoses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: Following a sharp increase in the number of reported cases of RMSF in the early 1980s, the number and rate of cases has remained stable since 1985, with the annual incidence varying from 0.24 to 0.32 per 100,000 population. However, cases in the South Atlantic region appear to have increased after declining to a low of 200 reported cases in 1988 (224 cases reported in 1989, and 292 in 1990). For the first time since 1982, North Carolina had both the highest number of cases and the highest incidence rate. Two of the three other states with high incidence rates—Tennessee and South Carolina—border on North Carolina, suggesting a possible resurgence of cases in this area.

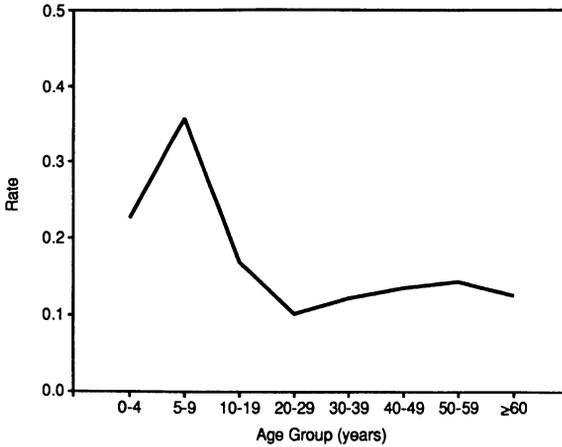
FIGURE 1. Reported cases and incidence rates of Rocky Mountain spotted fever, by state – United States, 1990



Rocky Mountain Spotted Fever – Continued

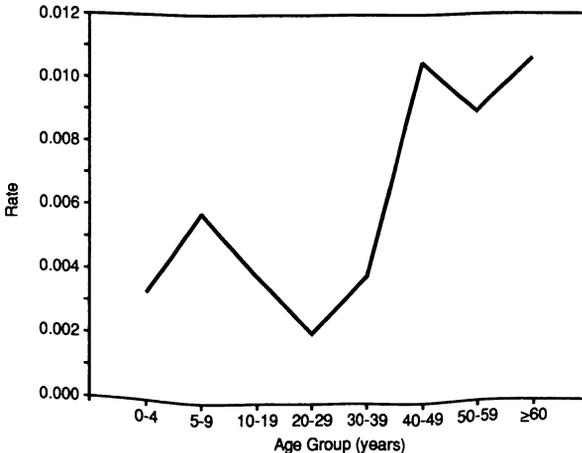
Persons who reside and/or work in tick-infested areas should be informed about tickborne diseases and their prevention. The optimal method for preventing RMSF is avoidance of tick-infested areas. Persons who must enter these areas should wear protective clothing and use tick repellent. In addition, exposed areas of the body should be examined every few hours for tick attachment. Ticks should be removed by grasping them with fine tweezers at the point of attachment and pulling slowly and steadily. The bite should be cleansed as any skin wound, especially if tick mouth parts

FIGURE 2. Age-specific incidence rates* of laboratory-confirmed Rocky Mountain spotted fever – United States, 1981–1990



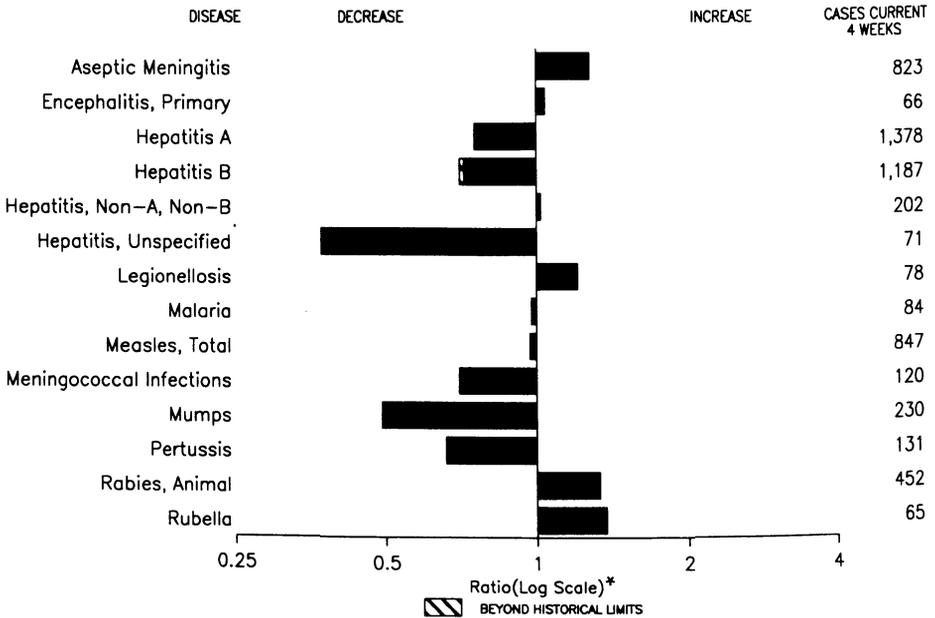
*Per 100,000 population.

FIGURE 3. Age-specific fatality rates* of laboratory-confirmed Rocky Mountain spotted fever – United States, 1981–1990



*Per 100,000 population.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending July 6, 1991, with historical data — United States



*Ratio of current 4-week total to the 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 — cases of specified notifiable diseases, United States, cumulative, week ending July 6, 1991 (27th Week)

	Cum. 1991		Cum. 1991
AIDS	21,993	Measles: imported	111
Anthrax	-	indigenous	7,254
Botulism: Foodborne	11	Plague	-
Infant	28	Poliomyelitis, Paralytic*	-
Other	4	Psittacosis	54
Brucellosis	33	Rabies, human	-
Cholera	14	Syphilis, primary & secondary	21,843
Congenital rubella syndrome	11	Syphilis, congenital, age < 1 year	12
Diphtheria	1	Tetanus	14
Encephalitis, post-infectious	44	Toxic shock syndrome	169
Gonorrhea	296,064	Trichinosis	11
<i>Haemophilus influenzae</i> (invasive disease)	1,793	Tuberculosis	11,107
Hansen Disease	71	Tularemia	58
Leptospirosis	34	Typhoid fever	167
Lyme Disease	2,653	Typhus fever, tickborne (RMSF)	199

*No cases of suspected poliomyelitis have been reported in 1991; none of the 6 suspected cases in 1990 have been confirmed to date. Five of the 13 suspected cases in 1989 were confirmed and all were vaccine associated.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending July 6, 1991, and July 7, 1990 (27th Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
			Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1990	Cum. 1991	Cum. 1991		
UNITED STATES	21,993	3,291	336	44	296,064	349,127	12,624	8,470	1,529	707	575	2,653
NEW ENGLAND	931	190	16	1	7,306	9,311	303	436	50	25	41	118
Maine	32	9	3	-	81	119	13	15	2	-	-	-
N.H.	20	13	2	-	154	108	22	16	4	-	2	13
Vt.	10	73	1	-	26	32	14	4	5	-	2	2
Mass.	539	53	8	1	3,002	3,749	151	329	27	23	34	49
R.I.	36	35	-	-	605	543	56	16	10	2	3	42
Conn.	294	7	2	-	3,438	4,760	47	56	2	-	-	12
MID. ATLANTIC	5,910	365	26	10	35,552	48,892	1,083	746	150	13	168	1,867
Upstate N.Y.	751	188	12	6	6,414	7,383	512	305	95	7	57	1,220
N.Y. City	3,310	64	-	-	13,010	21,042	258	78	5	-	18	-
N.J.	1,296	-	-	-	6,058	8,021	148	184	27	-	20	333
Pa.	553	113	14	4	10,070	12,446	165	179	23	6	73	314
E.N. CENTRAL	1,488	551	96	6	54,402	65,457	1,526	1,001	256	31	106	104
Ohio	244	160	37	2	16,550	19,889	219	240	116	13	54	60
Ind.	152	68	11	1	5,783	5,696	231	131	1	1	10	6
Ill.	715	93	20	3	16,404	20,406	622	133	28	1	5	1
Mich.	262	215	25	-	12,701	15,071	188	318	71	16	27	37
Wis.	115	15	3	-	2,964	4,395	266	179	40	-	10	-
W.N. CENTRAL	548	208	13	6	14,488	17,968	1,309	382	164	12	29	117
Minn.	108	33	8	-	1,417	2,206	199	36	12	2	4	9
Iowa	60	50	-	4	986	1,341	33	24	6	3	8	7
Mo.	291	83	3	2	9,084	10,672	340	261	142	4	10	97
N. Dak.	4	1	-	-	22	67	28	3	2	1	1	-
S. Dak.	1	4	-	-	172	114	497	2	-	-	3	-
Nebr.	32	12	-	-	906	867	162	22	1	-	3	-
Kans.	52	25	-	-	1,901	2,701	50	34	1	2	-	4
S. ATLANTIC	5,500	756	67	15	89,665	99,042	915	1,765	215	154	96	176
Del.	45	11	1	-	1,297	1,624	6	28	4	2	2	19
Md.	510	65	12	-	9,381	10,472	162	235	37	13	19	69
D.C.	351	24	1	-	5,135	6,712	49	81	1	1	-	-
Va.	360	121	19	3	8,887	9,193	105	109	20	110	7	43
W. Va.	24	3	1	-	595	653	13	33	1	6	-	7
N.C.	260	73	21	-	17,238	16,365	99	250	83	-	12	22
S.C.	187	26	-	-	6,601	7,991	27	404	16	3	19	3
Ga.	805	86	6	2	22,248	22,039	105	244	20	-	9	6
Fla.	2,958	347	6	10	18,283	23,993	349	381	33	19	28	7
E.S. CENTRAL	548	282	17	-	26,889	27,634	125	712	195	3	32	63
Ky.	91	48	3	-	2,984	3,381	17	88	5	2	13	23
Tenn.	172	93	9	-	10,041	8,561	75	534	176	-	10	30
Ala.	176	113	5	-	6,770	8,839	27	82	10	1	8	10
Miss.	109	28	-	-	7,094	6,853	6	8	4	-	1	-
W.S. CENTRAL	1,952	410	34	1	35,421	38,164	1,813	1,092	51	124	22	39
Ark.	94	40	3	-	3,765	4,659	178	59	1	4	5	12
La.	344	51	9	-	8,180	7,207	80	152	4	4	5	-
Okla.	91	1	3	-	3,396	3,259	161	120	20	8	5	22
Tex.	1,423	318	19	1	20,080	23,039	1,394	761	26	108	7	5
MOUNTAIN	621	85	11	1	6,249	7,183	2,068	531	81	94	40	7
Mont.	19	2	1	-	58	97	57	41	3	5	1	-
Idaho	12	-	-	-	76	63	51	43	-	-	3	-
Wyo.	8	-	-	-	54	101	75	5	-	-	-	5
Colo.	239	32	2	1	1,753	1,790	303	79	31	16	7	-
N. Mex.	54	10	-	-	591	652	564	122	7	27	1	-
Ariz.	111	21	8	-	2,360	2,865	670	103	12	37	15	-
Utah	59	8	-	-	167	225	150	28	11	9	4	-
Nev.	119	12	-	-	1,190	1,390	198	110	17	-	9	2
PACIFIC	4,495	444	56	4	26,092	35,476	3,482	1,805	367	251	41	162
Wash.	297	-	6	-	2,217	3,208	340	256	89	14	1	-
Oreg.	135	-	-	-	1,065	1,316	209	166	68	6	1	-
Calif.	3,950	402	48	4	22,037	29,946	2,834	1,338	196	230	37	162
Alaska	12	15	2	-	418	619	80	19	12	1	-	-
Hawaii	101	27	-	-	355	387	19	26	2	-	2	-
Guam	1	-	-	-	-	142	-	-	-	-	-	-
P.R.	859	150	-	1	338	455	59	252	100	32	-	-
V.I.	4	-	-	-	249	233	-	4	-	-	-	-
Amer. Samoa	-	-	-	-	-	51	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	122	-	-	-	-	-	-

N: Not notifiable

U: Unavailable

C.N.M.I.: Commonwealth of the Northern Mariana Islands

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending July 6, 1991, and July 7, 1990 (27th Week)

Reporting Area	Measles (Rubeola)					Men- gococcal Infections	Mumps		Pertussis			Rubella			
	Malaria		Indigenous		Imported*		Total	1991	Cum. 1991	1991	Cum. 1991	Cum. 1990	1991	Cum. 1991	Cum. 1990
	Cum. 1991	1991	1991	Cum. 1991	Cum. 1990										
UNITED STATES	520	185	7,254	2	111	15,079	1,242	80	2,583	36	1,057	1,665	8	1,010	629
NEW ENGLAND	35	10	44	-	10	254	83	-	20	-	170	193	-	2	7
Maine	1	U	-	U	-	29	6	U	-	U	44	6	U	-	-
N.H.	2	-	-	-	-	8	7	-	3	-	12	12	-	1	1
Vt.	1	-	5	-	-	1	10	-	2	-	3	6	-	-	-
Mass.	17	10	19	-	8	19	46	-	-	-	98	157	-	1	2
R.I.	7	-	2	-	-	30	-	-	3	-	-	2	-	-	1
Conn.	7	-	18	-	2	167	14	-	12	-	13	10	-	-	3
MID. ATLANTIC	72	37	3,745	-	6	1,030	131	2	188	1	91	312	1	556	2
Upstate N.Y.	17	1	302	-	4	303	74	2	73	-	62	244	1	535	1
N.Y. City	25	25	1,500	-	-	174	7	-	-	-	-	-	-	-	-
N.J.	23	-	430	-	1	206	24	-	53	-	1	19	-	-	-
Pa.	7	11	1,513	-	1	347	26	-	62	1	28	49	-	21	1
E.N. CENTRAL	46	-	65	-	8	3,313	187	3	245	4	181	424	-	162	30
Ohio	10	-	-	-	1	439	64	2	56	3	71	80	-	147	1
Ind.	2	-	-	-	1	405	10	-	6	-	44	63	-	1	-
Ill.	17	-	24	-	-	1,268	52	-	93	-	30	153	-	3	18
Mich.	15	-	39	-	-	453	42	1	75	1	23	38	-	11	9
Wis.	2	-	2	-	6	748	19	-	15	-	13	90	-	-	2
W.N. CENTRAL	18	2	32	-	2	711	76	5	74	5	68	56	-	15	6
Minn.	6	2	8	-	2	268	15	3	9	3	22	7	-	6	1
Iowa	3	-	15	-	-	24	7	-	14	-	7	6	-	5	4
Mo.	4	-	-	-	-	84	29	2	22	2	25	36	-	4	-
N. Dak.	1	-	-	-	-	-	1	-	1	-	1	1	-	-	1
S. Dak.	-	-	-	-	-	23	2	-	-	-	2	1	-	-	-
Nebr.	-	-	-	-	-	106	6	-	4	-	5	2	-	-	-
Kans.	4	-	9	-	-	206	16	-	24	-	6	3	-	-	-
S. ATLANTIC	102	3	402	1	16	921	230	46	956	6	99	143	1	11	14
Del.	1	-	21	-	-	11	1	-	6	-	-	4	-	-	-
Md.	30	1	167	-	-	199	24	-	181	1	16	37	-	6	1
D.C.	6	-	-	-	-	17	7	-	21	-	-	14	-	1	1
Va.	18	-	21	1†	4	68	25	-	38	1	11	14	-	-	1
W. Va.	1	-	-	-	-	6	11	-	16	-	6	10	-	-	-
N.C.	3	1	30	-	2	29	45	24	195	3	18	32	1	1	-
S.C.	7	-	12	-	-	4	24	16	319	-	9	5	-	-	-
Ga.	12	-	10	-	4	78	47	5	31	1	22	13	-	-	-
Fla.	24	1	141	-	6	509	46	1	149	-	17	14	-	3	11
E.S. CENTRAL	10	1	6	1	1	108	90	2	139	1	35	77	-	100	1
Ky.	2	1	1	1‡	1	25	32	-	-	-	-	-	-	-	-
Tenn.	5	-	5	-	-	40	26	1	113	1	15	29	-	100	1
Ala.	3	-	-	-	-	17	31	1	8	-	20	43	-	-	-
Miss.	-	-	-	-	-	26	1	-	18	-	5	5	-	-	-
W.S. CENTRAL	30	72	115	-	12	3,723	90	4	276	6	29	34	1	5	2
Ark.	3	-	-	-	5	40	15	-	38	-	3	2	-	1	1
La.	8	-	-	-	-	10	21	1	19	-	9	11	-	-	-
Okla.	2	-	-	-	-	151	12	1	7	-	11	21	-	-	1
Tex.	17	72	115	-	7	3,522	42	2	212	6	6	6	-	1	4
MOUNTAIN	20	43	811	-	15	720	51	12	249	6	129	162	-	4	97
Mont.	1	-	-	-	-	1	7	-	-	-	-	23	-	-	13
Idaho	1	14	296	-	2	21	7	-	7	-	20	32	-	2	47
Wyo.	-	-	-	-	-	15	1	-	3	-	3	-	-	-	-
Colo.	6	-	1	-	4	114	10	10	100	5	66	57	-	-	3
N. Mex.	4	-	113	-	5	90	7	N	N	1	16	9	-	-	-
Ariz.	6	-	274	-	-	247	14	2	116	-	8	27	-	-	29
Utah	1	29	111	-	4	56	-	-	13	-	14	10	-	-	1
Nev.	1	-	16	-	-	176	5	-	10	-	2	4	-	2	4
PACIFIC	187	17	2,034	-	41	4,299	304	6	436	7	255	264	5	155	470
Wash.	16	-	1	-	3	248	37	-	88	2	67	63	-	-	-
Oreg.	4	-	34	-	26	194	39	N	N	-	37	23	-	2	8
Calif.	163	17	1,995	-	9	3,770	220	5	323	5	115	156	5	151	453
Alaska	-	-	-	-	1	80	7	-	9	-	6	3	-	-	-
Hawaii	4	-	4	-	2	7	1	1	16	-	30	19	-	2	9
Guam	-	U	-	U	-	1	-	U	-	U	-	-	U	-	-
P.R.	1	-	80	-	1	914	15	-	8	3	25	5	-	1	-
V.I.	-	U	-	U	-	21	-	U	5	U	-	-	U	-	-
Amer. Samoa	-	U	-	U	-	249	-	U	-	U	-	-	U	-	-

*For measles only, imported cases includes both out-of-state and international importations.

N: Not notifiable U: Unavailable †International ‡Out-of-state

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending July 6, 1991, and July 7, 1990 (27th Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic- shock Syndrome	Tuberculosis		Tula- remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1991	Cum. 1990	Cum. 1991	Cum. 1991	Cum. 1990	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991
UNITED STATES	21,843	25,392	169	11,107	11,558	58	167	199	3,062
NEW ENGLAND	588	937	8	287	248	-	13	4	18
Maine	-	5	3	11	-	-	1	-	-
N.H.	12	39	1	-	3	-	-	-	1
Vt.	1	1	-	3	7	-	-	-	-
Mass.	278	364	4	152	130	-	11	3	-
R.I.	33	7	-	27	35	-	-	-	-
Conn.	264	521	-	94	73	-	1	1	17
MID. ATLANTIC	3,722	5,465	28	2,548	2,750	-	33	3	971
Upstate N.Y.	103	447	13	183	235	-	6	3	332
N.Y. City	1,851	2,407	1	1,577	1,673	-	16	-	-
N.J.	759	880	-	455	462	-	9	-	446
Pa.	1,009	1,731	14	333	380	-	2	-	193
E.N. CENTRAL	2,486	1,724	32	1,096	1,112	2	13	13	53
Ohio	338	273	20	160	172	-	2	8	7
Ind.	68	33	-	82	100	-	-	4	2
Ill.	1,188	648	6	575	563	-	3	1	10
Mich.	650	569	6	225	232	2	7	-	9
Wis.	242	201	-	54	45	-	1	-	25
W.N. CENTRAL	370	242	30	280	287	17	2	12	479
Minn.	42	49	7	56	53	-	2	-	167
Iowa	33	30	6	37	33	-	-	1	90
Mo.	250	120	8	120	133	15	-	5	7
N. Dak.	-	1	-	3	13	-	-	-	58
S. Dak.	1	1	1	23	9	1	-	1	123
Nebr.	9	8	1	11	14	-	-	2	9
Kans.	35	33	7	30	32	1	-	3	25
S. ATLANTIC	6,497	8,071	15	2,058	2,112	4	32	86	752
Del.	84	99	1	16	24	-	-	-	87
Md.	536	591	-	201	176	-	6	10	274
D.C.	405	506	1	109	80	-	2	-	5
Va.	515	435	3	173	159	-	7	5	149
W. Va.	17	7	-	40	38	-	1	1	31
N.C.	996	925	7	256	261	1	-	44	-
S.C.	810	483	-	218	262	1	-	17	59
Ga.	1,587	2,057	-	402	310	1	4	8	127
Fla.	1,547	2,968	3	643	802	1	12	1	20
E.S. CENTRAL	2,343	2,145	8	803	867	6	2	34	84
Ky.	41	42	4	164	206	2	2	10	25
Tenn.	831	847	4	266	234	4	-	17	18
Ala.	823	664	-	202	270	-	-	7	41
Miss.	648	592	-	171	157	-	-	-	-
W.S. CENTRAL	4,104	4,053	6	1,298	1,412	21	6	43	393
Ark.	339	290	3	97	157	14	-	8	22
La.	1,288	1,253	-	109	191	-	1	-	4
Okla.	99	121	3	85	106	7	-	35	116
Tex.	2,378	2,389	-	1,007	958	-	5	-	251
MOUNTAIN	304	470	20	312	241	6	5	2	92
Mont.	2	-	-	3	10	5	-	2	16
Idaho	3	6	-	4	6	-	-	-	1
Wyo.	3	1	-	3	3	1	-	-	49
Colo.	50	28	4	33	13	-	1	-	3
N. Mex.	19	24	5	38	48	-	-	-	1
Ariz.	196	334	4	166	120	-	3	-	17
Utah	4	4	7	25	12	-	-	-	2
Nev.	27	73	-	40	29	-	1	-	3
PACIFIC	1,429	2,285	22	2,425	2,529	2	61	2	220
Wash.	76	239	3	154	134	1	2	1	1
Oreg.	42	76	-	52	63	-	2	1	1
Calif.	1,304	1,944	19	2,083	2,214	1	56	-	214
Alaska	3	11	-	31	28	-	-	-	3
Hawaii	4	15	-	105	90	-	1	-	1
Guam	-	1	-	-	22	-	-	-	-
P.R.	252	197	-	99	66	-	7	-	-
V.I.	61	1	-	1	4	-	-	-	25
Amer. Samoa	-	-	-	-	11	-	-	-	-
C.N.M.I.	-	1	-	-	30	-	-	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending
July 6, 1991 (27th Week)

Reporting Area	All Causes, By Age (Years)						P&I**	Reporting Area	All Causes, By Age (Years)						P&I**
	All Ages	≥65	45-64	25-44	1-24	<1			Total	All Ages	≥65	45-64	25-44	1-24	
NEW ENGLAND	531	376	86	37	17	15	35	S. ATLANTIC	1,093	674	207	141	30	41	45
Boston, Mass.	128	85	20	13	3	7	14	Atlanta, Ga.	134	76	33	22	3	-	7
Bridgeport, Conn.	41	29	6	3	2	1	1	Baltimore, Md.	183	103	44	26	6	4	15
Cambridge, Mass.	23	19	3	1	-	-	-	Charlotte, N.C.‡	U	U	U	U	U	U	U
Fall River, Mass.	27	21	4	2	-	-	3	Jacksonville, Fla.	91	62	14	8	3	4	9
Hartford, Conn.	41	21	13	4	1	2	1	Miami, Fla.	110	67	26	13	1	3	-
Lowell, Mass.	21	14	4	2	1	-	-	Norfolk, Va.	36	25	3	6	1	1	-
Lynn, Mass.	13	8	5	-	-	-	-	Richmond, Va.	55	32	13	7	-	3	-
New Bedford, Mass.	25	22	2	-	1	-	2	Savannah, Ga.	67	39	13	10	4	1	2
New Haven, Conn.	35	21	7	2	4	1	1	St. Petersburg, Fla.	79	56	12	5	4	2	1
Providence, R.I.	39	32	4	2	-	1	2	Tampa, Fla.	117	83	15	12	3	4	8
Somerville, Mass.	6	5	1	-	-	-	-	Washington, D.C.	202	114	34	31	5	18	3
Springfield, Mass.	37	27	5	2	1	2	3	Wilmington, Del.	19	17	-	1	-	1	-
Waterbury, Conn.	36	28	5	3	-	-	3	E.S. CENTRAL	662	463	118	49	18	14	54
Worcester, Mass.	59	44	7	3	4	1	3	Birmingham, Ala.‡	U	U	U	U	U	U	U
MID. ATLANTIC	2,336	1,474	451	295	69	47	120	Chattanooga, Tenn.	70	53	9	3	4	1	6
Albany, N.Y.	61	32	12	9	2	6	4	Knoxville, Tenn.	102	73	19	6	1	3	12
Allentown, Pa.	19	17	2	-	-	-	-	Louisville, Ky.	54	38	7	5	1	3	4
Buffalo, N.Y.	102	72	20	6	2	2	5	Memphis, Tenn.	172	113	34	17	6	2	20
Camden, N.J.	28	14	8	3	1	2	2	Mobile, Ala.	102	78	17	6	-	1	4
Elizabeth, N.J.	17	10	4	2	-	1	1	Montgomery, Ala.	31	21	7	1	-	2	-
Erie, Pa.†	37	26	8	-	3	-	1	Nashville, Tenn.	131	87	25	11	6	2	8
Jersey City, N.J.	54	40	10	4	-	-	-	W.S. CENTRAL	761	466	160	82	31	22	26
New York City, N.Y.	1,183	706	235	178	40	24	47	Austin, Tex.	58	39	11	6	1	1	1
Newark, N.J.	81	36	22	16	6	1	12	Baton Rouge, La.	50	30	6	7	5	2	2
Paterson, N.J.	15	8	3	3	-	1	1	Corpus Christi, Tex.	40	27	10	2	-	1	1
Philadelphia, Pa.	393	256	73	46	11	7	28	Dallas, Tex.	149	79	34	22	11	3	4
Pittsburgh, Pa.†	48	34	8	5	-	1	-	El Paso, Tex.	38	28	5	3	1	1	2
Reading, Pa.	35	30	3	2	-	-	5	Ft. Worth, Tex.	74	45	12	7	4	6	2
Rochester, N.Y.	102	76	15	8	1	2	5	Houston, Tex.‡	U	U	U	U	U	U	U
Schenectady, N.Y.‡	U	U	U	U	U	U	U	Little Rock, Ark.‡	U	U	U	U	U	U	U
Scranton, Pa.†	23	19	3	1	-	-	-	New Orleans, La.	65	38	14	9	1	3	-
Syracuse, N.Y.	78	54	15	7	2	-	3	San Antonio, Tex.	155	92	39	18	3	3	3
Trenton, N.J.	10	8	1	1	-	-	2	Shreveport, La.	77	47	19	6	3	2	8
Utica, N.Y.	27	18	6	2	1	-	1	Tulsa, Okla.	55	41	10	2	2	-	3
Yonkers, N.Y.	23	18	3	2	-	-	3	MOUNTAIN	605	389	119	55	28	14	27
E.N. CENTRAL	1,753	1,067	320	190	103	73	80	Albuquerque, N.M.	77	46	11	11	8	1	2
Akron, Ohio	36	28	6	1	1	-	-	Colo. Springs, Colo.	37	23	8	3	2	1	2
Canton, Ohio	30	22	6	1	-	-	-	Denver, Colo.	106	70	17	9	6	4	6
Chicago, Ill.	311	120	66	65	51	9	9	Las Vegas, Nev.	92	61	18	11	2	-	2
Cincinnati, Ohio	124	81	26	10	2	5	14	Ogden, Utah	21	17	2	2	-	-	2
Cleveland, Ohio	121	68	25	14	6	8	2	Phoenix, Ariz.	121	74	28	12	2	5	3
Columbus, Ohio	120	75	23	11	5	6	3	Pueblo, Colo.	24	14	8	1	-	1	-
Dayton, Ohio	90	58	19	7	5	1	4	Salt Lake City, Utah	28	12	10	3	1	2	2
Detroit, Mich.	194	114	38	23	8	11	5	Tucson, Ariz.	99	72	17	3	7	-	8
Evansville, Ind.	30	23	4	1	2	-	1	PACIFIC	1,502	986	265	156	54	38	87
Fort Wayne, Ind.	41	29	5	2	1	4	2	Berkeley, Calif.	9	4	2	3	-	-	1
Gary, Ind.	12	7	2	2	1	-	-	Fresno, Calif.	49	33	7	4	3	2	-
Grand Rapids, Mich.	52	39	5	3	3	2	10	Glendale, Calif.	16	14	-	1	-	1	-
Indianapolis, Ind.	167	99	36	16	7	9	15	Honolulu, Hawaii	83	58	16	7	-	2	6
Madison, Wis.	40	26	6	4	1	3	2	Long Beach, Calif.	68	45	16	1	3	3	9
Milwaukee, Wis.	99	76	13	6	-	4	4	Los Angeles, Calif.	378	238	68	49	15	5	21
Peoria, Ill.	41	32	3	5	-	1	1	Oakland, Calif.‡	U	U	U	U	U	U	U
Rockford, Ill.	45	25	12	5	2	1	1	Pasadena, Calif.	30	23	4	1	2	-	2
South Bend, Ind.	38	24	5	5	2	2	3	Portland, Ore.	140	103	20	12	3	2	3
Toledo, Ohio	107	81	11	9	4	2	3	Sacramento, Calif.	135	86	25	14	7	3	10
Youngstown, Ohio	55	40	9	-	2	4	1	San Diego, Calif.	116	72	25	9	4	6	10
W.N. CENTRAL	569	415	85	45	12	12	29	San Francisco, Calif.	113	61	27	24	-	1	1
Des Moines, Iowa	53	37	11	4	1	-	2	San Jose, Calif.	133	84	28	10	7	4	10
Duluth, Minn.	35	28	2	2	1	2	1	Seattle, Wash.	122	90	10	10	6	6	2
Kansas City, Kans.	22	16	3	2	1	-	-	Spokane, Wash.	38	22	10	5	1	-	3
Kansas City, Mo.	111	80	17	7	5	2	6	Tacoma, Wash.	72	53	7	6	3	3	9
Lincoln, Nebr.	13	12	-	-	-	1	1	TOTAL	9,812 ^{††}	6,310	1,811	1,050	362	276	503
Minneapolis, Minn.	104	74	17	9	2	2	7								
Omaha, Nebr.	51	37	9	3	-	2	2								
St. Louis, Mo.	92	63	15	9	2	3	4								
St. Paul, Minn.	53	41	7	5	-	-	6								

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. 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 these 3 Pennsylvania cities, these numbers are partial counts for the current week.

Complete counts will be available in 4 to 6 weeks.

††Total includes unknown ages.

‡Report for this week is unavailable (U).

Rocky Mountain Spotted Fever – Continued

remain. Ticks can be removed by hand, but care should be taken to avoid direct contact with the tick; fingers should be protected with tissue paper and washed afterwards.

The incubation period for RMSF is 3–12 days following tick bite. Although only a small proportion of persons bitten by ticks will develop RMSF or other tickborne diseases, RMSF should be considered and medical treatment sought by any potentially exposed person who develops fever, myalgia, or headache, even in the absence of a rash. Prompt treatment is particularly important for older persons, for whom the case-fatality rate is higher (1). If RMSF is suspected, treatment with tetracycline or chloramphenicol should be promptly instituted.

Reference

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*Health Objectives for the Nation***Progress Toward Achieving the 1990 National Health Objectives for Improved Nutrition**

Seventeen of the 1990 health objectives for the nation (1) addressed improved nutrition for persons in the United States; the Public Health Service gave special priority to 15 of these objectives (2). Progress was made toward achieving six of the objectives; the others either were not achieved or data were insufficient to assess progress. This report summarizes the status of efforts to achieve the 15 priority objectives through June 1990.

OBJECTIVES PARTIALLY MET

By 1990, growth retardation of infants and children caused by inadequate diets should have been eliminated in the United States as a public health problem.

Data from CDC's Pediatric Nutrition Surveillance System (3) provided information on the nutritional status of infants and children in families with low income served by the Supplemental Food Program for Women, Infants, and Children (WIC Program) and other public-health services. In 1988, the prevalence of low height-for-age ranged from 6% to 16% for different age and ethnic groups (representing an excess over the 5% of otherwise healthy children who are statistically likely to be in this population). From 1980 through 1988, substantial changes in height-for-age occurred only among Asian children, reflecting the beneficial impact of nutrition and health services provided to Southeast Asian immigrants.

By 1990, 50 percent of the overweight population should have adopted weight loss regimens, combining an appropriate balance of diet and physical activity.

In 1985, among persons aged ≥ 18 years who were classified as overweight (i.e., $\geq 120\%$ of desirable weight, based on self-reported weight and height), approximately 64% of women and 48% of men reported they were trying to lose weight. Approximately 30% of overweight men and 25% of overweight women reported they had adopted weight-loss regimens that combined exercise and diet restriction (4).

Nutrition Objectives – Continued

By 1990, the mean serum cholesterol level in the adult population aged 18 to 74 should be at or below 200 mg/dl.

Mean serum cholesterol levels in men and women aged 20–74 years decreased from 217 and 223 mg/dL, respectively, in 1960–1962 to 211 and 215 mg/dL, respectively, in 1976–1980 (5). Preliminary data from Minnesota (6) and other areas suggest this declining trend was sustained during the 1980s. In addition, data collected in various diet and health knowledge surveys during the 1980s indicated that increasing proportions of the population recognized that high blood cholesterol was a risk factor for heart disease, knew that dietary factors were related to heart disease, reported using label information to avoid or limit fat and cholesterol, and reported being on a blood cholesterol-lowering diet.

By 1990, the proportion of the population which is able to identify the principal dietary factors known or strongly suspected to be related to disease, should exceed 75 percent for each of the following diseases: heart disease, high blood pressure, dental caries, and cancer.

The Food and Drug Administration's (FDA) Health and Diet Survey in 1988 indicated that more than 75% of U.S. residents were aware of a relation between diet and hypertension and between diet and heart disease (7). The survey also demonstrated increasing public awareness of the relation between specific dietary components and other diseases.

By 1990, the labels of all packaged foods should contain useful calorie and nutrient information to enable consumers to select diets that promote and protect good health. Similar information should be displayed where nonpackaged foods are obtained or purchased.

In 1988, approximately 60% of packaged, processed foods regulated by the FDA had nutrition labeling, an increase from 42% in 1978 (8). The Nutrition Labeling and Education Act of 1990 required nutrition labeling on most products regulated by the FDA, including fresh fruits, vegetables, and fish. In addition, the U.S. Department of Agriculture (USDA) has proposed nutrition labeling for the products it regulates. Accordingly, this objective should be achieved by the mid-1990s.

Before 1990, a comprehensive National nutrition status monitoring system should have the capability for detecting nutritional problems in special population groups, as well as for obtaining baseline data for decisions on National nutrition policies.

By the early 1980s, a National Nutrition Monitoring System had been implemented that sampled population groups at presumed increased risk for malnutrition, including persons with low incomes, pregnant women, older adults, and ethnic minorities. However, data had not been collected on the nutritional status of persons in hospitals, nursing homes, and institutions for the developmentally disabled; physically, mentally, and developmentally disabled persons in community settings; children in day care facilities; Native Americans on reservations; persons in correctional institutions; and homeless persons.

OBJECTIVES NOT MET OR DATA INSUFFICIENT TO ASSESS PROGRESS

By 1990, the proportion of pregnant women with iron deficiency anemia (as estimated by hemoglobin concentrations early in pregnancy) should be reduced to 3.5 percent.

The most consistent available data were based on CDC's Pregnancy Nutrition Surveillance System (PNSS) and reflected the status of low-income women enrolled

Nutrition Objectives – Continued

in the WIC Program in approximately 15 states. Using CDC's most recent criteria for anemia in pregnancy (9), there was no overall reduction in this problem from 1980 through 1988.

By 1990, the prevalence of significant overweight (120 percent of "desired" weight) among the U.S. adult population should be decreased to 10 percent of men and 17 percent of women, without nutritional impairment.

Using a definition of obesity based on body mass index, two surveys (the Second National Health and Nutrition Examination Survey [NHANES II] in 1976–1980 and Hispanic HANES in 1982–1984) indicated the prevalence of obesity among persons aged 20–74 years to be approximately 24% among men and 27% among women. These prevalence estimates were virtually unchanged from the early 1960s. Based on the most recent data available, the prevalence of overweight was lowest among non-Hispanic white women (25%) and highest among non-Hispanic black women (44%). In general, the prevalence of overweight among women was inversely related to socioeconomic status. Among men, the prevalence of overweight was lowest among non-Hispanic whites (24%) and highest among Mexican Americans (30%).

By 1990, the average daily salt* ingestion (as measured by excretion) by adults should be reduced at least to the 3 to 6 gram range.

Data were not available from large-scale surveys to estimate sodium ingestion as measured by excretion. However, data from the USDA's Continuing Survey of Food Intakes by Individuals indicated that in 1985 mean (1-day) dietary intakes of sodium from food (excluding salt added at the table) were approximately 2.5 g for women aged 19–50 years and 3.6 g for men aged 19–50 years (10,11).

By 1990, the proportion of women who breastfed their babies at hospital discharge should be increased to 75 percent and 35 percent at six months of age.

Although the prevalence of breastfeeding increased in the early to mid-1980s, it has remained level or declined in more recent years. Among low-income women included in the PNSS, the percentage of children in different ethnic groups who were ever breastfed increased from approximately 15%–34% in 1980 to approximately 30%–50% in 1984–1985. The proportion of breastfed children has been greatest among white, Hispanic, and American Indian women, and lower among Asian and black women.

By 1990, 70 percent of adults should be able to identify the major foods which are: low in fat content, low in sodium content, high in calories, good sources of fiber.

Although reading of nutrient content on food labels was reported as substantial by consumers, progress toward this objective could not be assessed definitively. A population-based survey in 1990 indicated that 79% of consumers read labels before purchasing a food product for the first time; 83% reported that labels influenced their purchasing and that they closely examined sodium, fat, caloric, cholesterol, and sugar content.

By 1990, 90 percent of adults should understand that to lose weight people must either consume foods that contain fewer calories or increase physical activity—or both.

Although awareness of these relations was high, data were inadequate to determine whether this objective had been achieved. In 1985, 74% of the population

*When originally written, this objective incorrectly referred to "daily sodium ingestion." Three to 6 g of salt is equivalent to 1.2–2.4 g of sodium.

Nutrition Objectives – Continued

>18 years of age believed that eating fewer calories was one of the two best ways to lose weight; 73% believed that increasing physical activity was one of the two best ways.

By 1985, the proportion of employee and school cafeteria managers who are aware of, and actively promoting, USDA/DHHS dietary guidelines should be greater than 50 percent.

Progress on this objective could not be assessed definitively. In 1988, the USDA revised recipe files for school lunch programs for consistency with the Dietary Guidelines for Americans and distributed these files to every school that participated in the school lunch program. In addition, the American School Food Service Association and its members actively supported and promoted the guidelines.

By 1990, all States should include nutrition education as part of required comprehensive school health education at elementary and secondary levels.

In 1985, 12 states mandated nutrition as a core content area in school health education, compared with 10 states in 1978.

By 1990, virtually all routine health contacts with health professionals should include some element of nutrition education and nutrition counseling.

Data are inadequate to assess progress toward this broad objective. A similar, but more specific, objective is included in the nutrition objectives for the year 2000.

Reported by: Office of Disease Prevention and Health Promotion, Food and Drug Administration, Div of Nutrition, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: Although the nutrition objectives were only partially achieved by 1990, many of the problems are of continuing public health concern and have been targeted in the nutrition objectives for the year 2000. These objectives address iron deficiency anemia, growth retardation, overweight, sodium, breastfeeding, nutrition labeling, use of dietary guidelines in school lunch programs, and nutrition education and counseling.

In the decade since formulation of the 1990 national health objectives, there have been substantial increases in public and professional awareness regarding the effect of nutrition on health. In particular, attention has focused on nutritional inadequacies among poor and homeless persons and nutritional excesses reflected by obesity and elevated cholesterol. Efforts such as the National Cholesterol Education Program have further heightened awareness of nutritional issues.

The nutrition objectives for the year 2000 reflect this heightened awareness, especially regarding nutrition-related factors that affect risks for chronic disease. The reduction of obesity and dietary fat intake are special priorities. The National Academy of Sciences recently emphasized three strategies to further implement dietary recommendations (12): 1) increasing the role of government and health-care professionals in developing nutrition policy and agendas; 2) improving nutrition knowledge and practice among the public; and 3) increasing availability of foods that conform to dietary recommendations.

Implementation of these strategies will require coordinated efforts directed toward particular populations at increased nutritional risk and include effective communication of nutrition messages. In addition, consumers will require improved access to affordable and convenient food choices that are both healthy and appetizing. These changes will entail cooperative efforts between the public and private sectors toward the common goals of improved nutrition and health.

*Nutrition Objectives – Continued**References*

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*Notice to Readers***Title Change of Four Centers Within CDC**

The Secretary of Health and Human Services has authorized CDC to include “National” in retitling four centers, as follows: the National Center for Chronic Disease Prevention and Health Promotion, the National Center for Environmental Health and Injury Control, the National Center for Infectious Diseases, and the National Center for Prevention Services. The National Institute for Occupational Safety and Health and the National Center for Health Statistics were brought into CDC under previous organizational changes; these two organizations were named previously by legislation. With these current changes, CDC programs are now uniformly titled to reinforce the similarity in scope among major organizational components.

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The data in this report are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday. Accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials, as well as matters pertaining to editorial or other textual considerations should be addressed to: Editor, *Morbidity and Mortality Weekly Report*, Mailstop C-08, Centers for Disease Control, Atlanta, Georgia 30333; telephone (404) 332-4555.

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