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Epidemiologic Notes and Reports

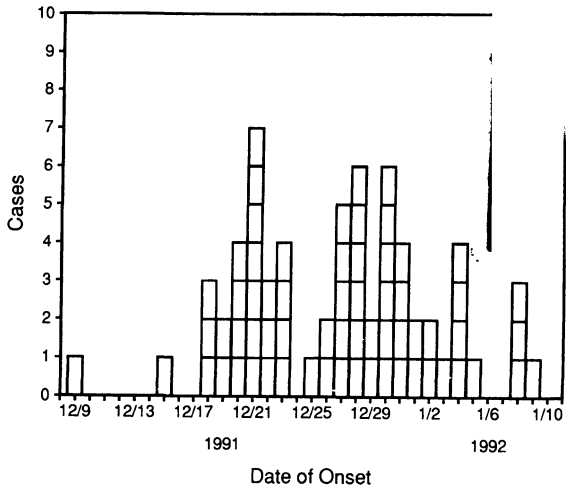
Outbreak of Influenza A in a Nursing Home – New York, December 1991–January 1992

During December 1991 and January 1992, an outbreak of influenza A occurred among residents of a nursing home in New York. From mid-October through mid-November 1991, influenza vaccine was administered to 295 (88%) of the 337 residents of the nursing home. The residents shared common dining and recreational areas; the mean age of residents was 83 years (range: 51–103 years); 256 (76%) were female. The prevalence of underlying illness in vaccinated and unvaccinated patients was not determined.

From December 9 through January 10, 65 (19%) of the residents had onset of influenza-like illness (ILI)* (Figure 1). Among those with ILI, 34 (52%) developed

*Illness characterized by fever ≥100 F (≥38 C) with cough or sore throat.

FIGURE 1. Influenza-like illness* among nursing home residents, by date of onset – New York, December 9, 1991–January 10, 1992



*Illness characterized by fever ≥100 F (≥38 C) with cough or sore throat.

Influenza A in a Nursing Home — Continued

pneumonia, 19 (29%) required hospitalization, and two died. In addition to fever, symptoms included cough (72%), congestion (57%), pharyngitis (38%), and rhinitis (8%). Isolates from throat-swab specimens obtained from two patients were identified as influenza A(H3N2) by the New York State Wadsworth Center for Laboratories and Research.

ILI occurred among 52 (18%) vaccinated residents and 13 (31%) unvaccinated residents (relative risk = 1.8; 95% confidence interval [CI] = 1.1–2.9). Pneumonia following ILI occurred among 27 (9%) vaccinated residents and seven (17%) unvaccinated residents. The calculated vaccine efficacy for preventing ILI and pneumonia was 43% (95% CI = 5%–66%) and 45% (95% CI = −18%–74%), respectively.

On January 6, the New York State Department of Health was notified of the outbreak and recommended amantadine therapy for patients with ILI. However, medical staff administered amantadine only to a limited number of residents.

Questionnaires were distributed to nursing home employees with patient contact to determine the vaccination coverage and incidence of ILI among these staff. Of 449 employees, 339 (76%) completed questionnaires. Thirty-three (10%) employees had been vaccinated in the fall before or during the outbreak. From November 1 through January 9, 65 (19%) had ILI; the calculated vaccine efficacy for preventing ILI in nursing home employees was 86% (95% CI = 34%–99%).

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Editorial Note: The 1991–92 influenza season has been characterized by widespread activity and associated with substantial mortality in the United States (*1*). Influenza A(H3N2) has been the predominant cause of illness during the 1991–92 influenza season, and outbreaks associated with this virus have been reported in a variety of settings (*1*). The outbreak described in this report underscores the potentially severe impact of influenza A among residents of nursing homes and other high-risk groups in institutional settings.

Estimates of influenza vaccine effectiveness may vary from year to year and among different groups during a given year. Influenza vaccine efficacy is influenced by various factors, including host immune response to the vaccine and the degree of antigenic similarity between the circulating influenza virus strain(s) and those included in the vaccine. The calculated vaccine effectiveness is also influenced by various factors. These include 1) the extent to which persons are exposed to the circulating virus, 2) the presence of immunity to the virus that is independent of vaccination (e.g., through immunity induced by a previous influenza infection), and 3) the reduced susceptibility to infection among persons receiving amantadine prophylaxis during the time of exposure to the virus. In this outbreak, the calculated vaccine effectiveness against ILI and pneumonia is within the range of vaccine effectiveness estimates found during other nursing home outbreaks caused by influenza A(H3N2) viruses that are similar to the vaccine strain (*2*).

Because the effectiveness of influenza vaccine may vary, and because many persons at increased risk for serious complications of influenza may not be vaccinated before exposure during an outbreak, amantadine chemoprophylaxis has been recommended as an additional preventive measure during influenza A outbreaks (*3,4*). Amantadine prophylaxis may be a particularly helpful adjunct for controlling influenza in groups of persons in nursing homes and other institutional settings (*3,4*).

Influenza A in a Nursing Home — Continued

Other influenza outbreaks in health-care settings have also documented a low level of vaccination among employees that may have contributed to the outbreaks (*5,6*). Influenza vaccine is recommended for all health-care workers and others in close contact with high-risk persons to reduce their exposure to influenza from care providers (*4*).

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Viscerotropic Leishmaniasis in Persons Returning from Operation Desert Storm — 1990–1991

From November 1990 through December 1991, seven men among the approximately 500,000 military personnel from the United States who participated in Operation Desert Storm had leishmaniasis involving internal organs diagnosed at Walter Reed Army Medical Center. In at least five of the cases, the species of the infecting parasite was *Leishmania tropica* (previously known as *L. tropica minor*), a parasite more commonly associated with cutaneous than with visceral leishmaniasis.

The seven men, whose illnesses were termed viscerotropic leishmaniasis, were a median of 30 years of age (range: 21–40 years). They had served in five different military units throughout the eastern province of Saudi Arabia; some were in urban and others in desert settings. Six of the seven men were symptomatic; the asymptomatic man was identified during an epidemiologic investigation of a unit with a symptomatic person. Symptoms developed a median of 7 months (range: 8 weeks–1 year) after the men arrived in the Persian Gulf and within 5 months after they left the area.

Five of the six symptomatic men were febrile. Four had an acute syndrome with high fever (maximum of 103.0–105.6 F [39.4–40.9 C]), chills, and malaise. Of these four men, one had mild hepatosplenomegaly; one had generalized lymphadenopathy; and one, who was found to be coinfected with human immunodeficiency virus (HIV), developed generalized lymphadenopathy after antileishmanial therapy was begun (he was seronegative for HIV infection when tested in February 1990). The other two symptomatic men had predominantly gastrointestinal symptoms, including nausea, low-volume watery diarrhea, and abdominal pain; the abdominal pain initially was nonfocal but later localized to the left upper quadrant and was associated

Leishmaniasis – Continued

with mild splenomegaly. One of these two men also had a newly diagnosed renal-cell carcinoma. None of the seven men had skin lesions.

At the time leishmaniasis was diagnosed, six of the men (including the asymptomatic one) had modest elevations in their liver enzymes (median for alanine aminotransferase: 131 international units [IU]/L; normal: 5–42 IU/L). Three were mildly anemic (lowest hemoglobin level for these three: 12 g/dL). One had transient hypoalbuminemia. None had leukopenia, thrombocytopenia, or hypergammaglobulinemia.

Leishmania parasites were cultured from bone-marrow aspirates from all seven men. *L. tropica* was identified by isoenzyme analysis as the infecting species in five men; insufficient numbers of parasites for this analysis were obtained in cultures from the other two men. In addition, parasites were visualized in smears of the bone-marrow aspirates of all seven men using a *Leishmania*-specific monoclonal antibody (indirect immunofluorescent monoclonal antibody test) (*1*). Giemsa-stained smears were not routinely prepared; however, in at least one case, no parasites were found when a Giemsa-stained smear was examined.

The five men who were still symptomatic when leishmaniasis was diagnosed were treated with the pentavalent antimonial compound sodium stibogluconate. Although the 30-day course of parenteral therapy was discontinued after 8 and 18 days for two patients (including the HIV-positive patient) who developed reversible thrombocytopenia, all treated patients were clinically well 3 months to 1 year after therapy was stopped. The man who was apparently asymptomatic has remained clinically well during 7 months of follow-up.

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Editorial Note: An estimated 12 million persons in the tropics and subtropics have leishmaniasis, a protozoan parasitic disease transmitted by the bite of infected sandflies (*2*). The major clinical syndromes are visceral, cutaneous, and mucosal leishmaniasis that result from infection of macrophages in the reticuloendothelial system, skin, and nasal and oral mucosae, respectively.

Although the various species and subspecies of the genus *Leishmania* traditionally have been considered either viscerotropic or dermotropic, exceptions have been reported. Species in the *L. donovani* complex have been considered primarily viscerotropic but also have been causative agents of cutaneous leishmaniasis without dissemination to the viscera (*3–5*). *L. tropica*, an important agent of cutaneous leishmaniasis in the Old World, has reportedly been isolated occasionally from persons with visceral leishmaniasis (*6–9*). Whether visceral involvement with *L. tropica* is exceptional or relatively common but only rarely recognized is unknown. Also unknown is whether strains that disseminate to the viscera differ subtly from strains that do not. Host factors, such as lack of previous exposure to the parasite and type of immune response to the parasite, may also play a role in whether strains disseminate to the viscera.

Leishmaniasis was diagnosed for the cases described in this report because of aggressive medical evaluations and the use of specialized laboratory techniques. The soldiers' symptoms and signs, which may have been attributable in part to other medical conditions, were nonspecific. Although five of the men were febrile and

Leishmaniasis — Continued

several had mild splenomegaly, none had the marked hepatosplenomegaly, pancytopenia, hypergammaglobulinemia, and cachexia classically associated with visceral leishmaniasis (i.e., kala-azar) caused by *L. donovani*. Because of these differences, the syndrome described in this report has been referred to as viscerotropic rather than visceral leishmaniasis. Whether infection with *L. tropica* generally results in milder disease than does infection with *L. donovani* is unknown. However, *L. donovani* may result in life-threatening disease in only a small proportion of those infected (*10,11*).

The diagnosis of viscerotropic leishmaniasis should be considered for persons who have been in the Middle East and have an unexplained illness of at least several weeks' duration, especially if the illness is associated with fever or signs of involvement of the reticuloendothelial system. The incubation period for viscerotropic leishmaniasis caused by *L. tropica* is unknown; if the incubation period is similar to that of visceral leishmaniasis caused by *L. donovani*, most persons would be expected to become ill within 6 months after exposure. However, the diagnosis of leishmaniasis should not be excluded for persons who become ill later. CDC and the U.S. Department of Defense do not recommend evaluating asymptomatic persons for evidence of infection: effective screening tests are not available, and whether treating asymptomatic persons is beneficial is unknown. Household contacts of persons who were in the Middle East are not at risk for acquiring leishmaniasis.

The diagnosis of cutaneous leishmaniasis should be considered for persons with skin lesions of at least several weeks' duration. Through December 1991, cutaneous leishmaniasis had been diagnosed in 16 military personnel from Operation Desert Storm.

Military and civilian physicians with questions about the diagnostic evaluation of military personnel, including reservists, who were associated with Operation Desert Storm and have persistent signs or symptoms suggestive of leishmaniasis should contact the following: U.S. Army—Walter Reed Army Medical Center, Washington, D.C. (telephone: [800] 423-0231); U.S. Navy/Marines—Naval Hospital, San Diego (telephone: [619] 532-7475 [Duty Station Number (DSN): 522-7475]); U.S. Air Force—USAF Medical Center, Lackland Air Force Base, San Antonio, Texas (telephone: [512] 670-7444 [DSN: 554-7444]). Physicians caring for civilian employees of the U.S. government stationed in the Middle East and associated with Operation Desert Storm should contact Walter Reed Army Medical Center. Physicians caring for civilians not included in the categories listed above should contact CDC's Parasitic Diseases Branch, Division of Parasitic Diseases, National Center for Infectious Diseases (telephone [404] 488-4050).

Sodium stibogluconate for treating persons confirmed to have leishmaniasis is available to military physicians through Walter Reed Army Medical Center and to civilian physicians through the CDC Drug Service ([404] 639-3670) under an investigational new drug protocol.

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Leishmaniasis — Continued

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Cholera Associated with an International Airline Flight, 1992

On February 19, 1992, the Los Angeles County Health Department and the California Department of Health Services received reports that *Vibrio cholerae* O1 had been isolated from stool cultures of five persons with diarrhea who became ill after traveling on the same international airline flight. The flight, Aerolineas Argentinas flight 386, departed from Buenos Aires, Argentina, on the afternoon of February 14; stopped in Lima, Peru, for passengers to disembark and board; and landed in Los Angeles later that evening. On arrival in Los Angeles, the flight had 336 passengers and 20 crew members.

As of February 26, 31 persons on the flight had culture-confirmed *V. cholerae* infection: 10 in Los Angeles County, eight in other parts of California, nine in Nevada, three in Japan, and one in Argentina; one person died. Fifty-four other passengers have reported diarrheal illness.

Studies to determine the mode of transmission and to characterize the strains are in progress.

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Editorial Note: Until this outbreak, only 20 cases of cholera in the United States had been related to the Latin American epidemic that began in January 1991. This outbreak demonstrates that clinicians should suspect cholera in persons with severe watery diarrhea and that this suspicion should be increased in persons returning from areas with cholera (*1*). An outbreak of cholera in Australia in 1972 was also associated with an international airline flight (*2*).

Cholera — Continued

Culture of rectal swabs on thiosulfate-citrate-bile salts-sucrose (TCBS) medium should be requested for any patient suspected to have cholera. Patients with cholera have substantial ongoing fluid losses that need to be replaced; frequent monitoring is necessary to ensure that hydration is adequate. All but severely dehydrated persons can be managed with oral rehydration solution (ORS) (*1*). If a patient is severely dehydrated or if ORS is not available, intravenous therapy with Ringer's lactate solution should be administered. Antibiotics with demonstrated effectiveness in reducing the duration of illness include doxycycline, tetracycline, trimethoprim-sulfamethoxazole, and furazolidone. Because secondary transmission in the United States is rare, prophylactic antibiotic treatment of contacts is not advised. Household contacts of persons with cholera should receive instructions about proper handwashing and should seek medical care if they develop diarrhea in the week following illness onset in the index patient. Public health authorities should ensure that patients' feces are disposed of through proper sewage treatment or a functioning septic tank.

Persons who were on this flight should contact their health departments if they have not yet been contacted. In the United States, all suspected and confirmed cases of cholera should be reported immediately to the local or state health department. Health departments and ministries of health with information on passengers should contact CDC's Enteric Diseases Branch, Division of Bacterial and Mycotic Diseases, National Center for Infectious Diseases (telephone [404] 639-2206), or the Los Angeles County Health Department (telephone [213] 725-5411 or [213] 725-5413).

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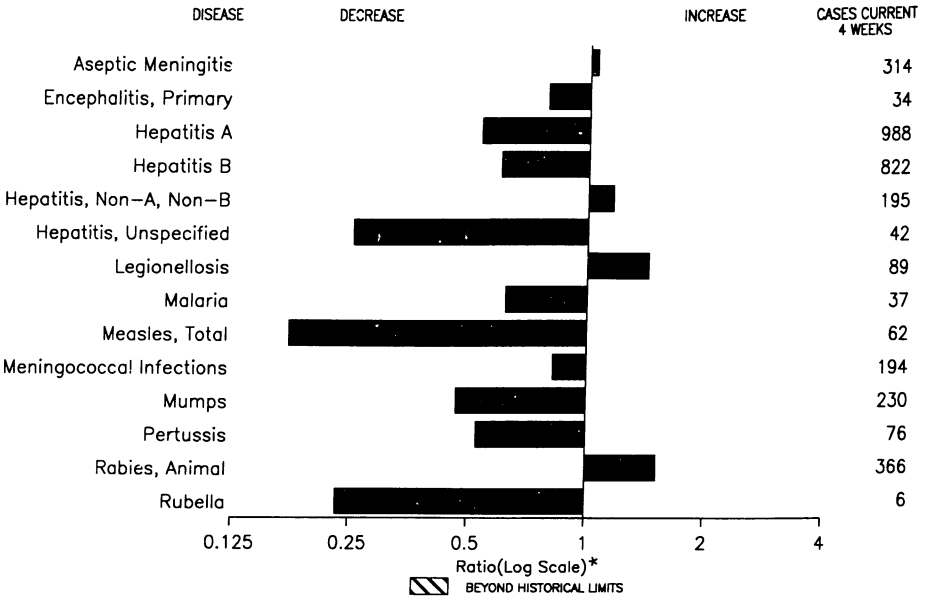
Current Trends

Childbearing and Contraceptive-Use Plans Among Women at High Risk for HIV Infection — Selected U.S. Sites, 1989–1991

From September 1990 through August 1991, 2655 (49%) of the 5457 women reported with acquired immunodeficiency syndrome (AIDS) in the United States had been injecting-drug users (IDUs), and 1136 (21%) had had sexual intercourse with men who were IDUs (*1*). During the same period, 413 (56%) of the 735 children (aged <13 years) reported with AIDS were born to mothers who were either IDUs (38%) or sex partners of IDUs (18%) (*1*). Even though messages and services regarding prevention of human immunodeficiency virus (HIV) infection and pregnancy planning for women at high risk for HIV infection should be tailored to their specific needs, information regarding pregnancy history, plans for childbearing, and contraceptive use among such women is limited. This report characterizes the childbearing

(Continued on page 141)

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending February 22, 1992, 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 February 22, 1992 (8th Week)

	Cum. 1992		Cum. 1992
AIDS	7,211	Measles: imported	15
Anthrax	-	indigenous	102
Botulism: Foodborne	3	Plague	-
Infant	5	Poliomyelitis, Paralytic*	-
Other	-	Psittacosis	12
Brucellosis	2	Rabies, human	-
Cholera	2	Syphilis, primary & secondary	4,830
Congenital rubella syndrome	-	Syphilis, congenital, age < 1 year	-
Diphtheria	1	Tetanus	3
Encephalitis, post-infectious	10	Toxic shock syndrome	37
Gonorrhea	71,493	Trichinosis	2
Haemophilus influenzae (invasive disease)	255	Tuberculosis	2,161
Hansen Disease	12	Tularemia	12
Leptospirosis	3	Typhoid fever	31
Lyme Disease	398	Typhus fever, tickborne (RMSF)	14

*Nine suspected cases of poliomyelitis have been reported in 1991; 4 of the 8 suspected cases in 1990 were confirmed, and all were vaccine associated.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending February 22, 1992, and February 23, 1991 (8th Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	7,211	686	68	10	71,493	85,658	2,116	1,663	430	65	162	398
NEW ENGLAND	247	72	3	-	1,662	2,957	91	121	11	10	11	30
Maine	7	6	-	-	12	15	11	8	-	-	2	-
N.H.	6	3	-	-	-	41	8	8	2	-	1	4
Vt.	-	2	1	-	1	12	-	1	1	-	1	1
Mass.	173	20	2	-	627	999	49	81	5	10	5	2
R.I.	10	41	-	-	138	153	13	10	3	-	2	18
Conn.	51	-	-	-	884	1,737	10	13	-	-	-	5
MID. ATLANTIC	1,795	81	6	1	4,002	10,673	209	223	78	2	49	287
Upstate N.Y.	292	24	-	-	16	1,609	56	45	48	1	23	170
N.Y. City	898	13	-	-	1,379	3,646	50	17	1	-	4	-
N.J.	388	4	-	-	572	1,795	33	76	23	-	7	21
Pa.	217	40	6	1	2,035	3,623	70	85	6	1	15	96
E.N. CENTRAL	644	117	17	2	12,597	14,549	295	289	30	2	39	26
Ohio	162	45	9	-	4,642	3,515	82	49	23	-	23	16
Ind.	63	16	-	-	1,417	1,872	107	98	-	1	5	5
Ill.	257	4	1	-	4,883	4,435	21	3	-	-	-	-
Mich.	137	52	7	2	1,328	3,622	21	99	2	1	11	5
Wis.	25	-	-	-	327	1,105	64	40	5	-	-	-
W.N. CENTRAL	211	41	3	2	3,820	4,406	204	74	17	1	8	5
Minn.	34	1	-	-	502	462	29	3	-	-	-	-
Iowa	13	13	-	1	299	315	4	6	-	-	2	5
Mo.	82	9	-	-	2,235	2,637	38	57	17	1	-	-
N. Dak.	-	1	-	-	-	13	8	-	-	-	-	-
S. Dak.	2	2	-	1	35	64	92	-	-	-	-	-
Nebr.	10	4	-	-	33	330	16	3	-	-	6	-
Kans.	70	11	3	-	716	585	17	5	-	-	-	-
S. ATLANTIC	1,515	133	20	3	27,392	26,556	141	297	36	4	24	20
Del.	12	6	2	-	267	338	1	6	-	-	-	5
Md.	192	26	5	-	2,612	2,845	32	68	5	3	4	1
D.C.	106	2	-	-	1,271	1,779	3	16	-	-	5	-
Va.	43	33	3	1	3,311	2,262	16	32	4	1	1	10
W. Va.	14	-	1	-	150	186	2	10	-	-	-	1
N.C.	70	21	8	-	3,379	5,301	16	61	16	-	5	1
S.C.	77	2	-	-	1,675	2,104	8	7	-	-	8	-
Ga.	175	10	-	-	10,581	6,676	19	35	5	-	-	-
Fla.	826	33	1	2	4,146	5,065	44	62	6	-	1	2
E.S. CENTRAL	275	57	-	-	7,088	7,653	47	147	165	-	11	7
Ky.	24	32	-	-	759	828	18	17	-	-	6	6
Tenn.	75	10	-	-	1,673	2,878	16	103	161	-	4	1
Ala.	124	11	-	-	2,863	2,035	5	27	4	-	1	-
Miss.	52	4	-	-	1,793	1,912	8	-	-	-	-	-
W.S. CENTRAL	632	7	-	1	6,757	8,531	69	54	7	2	-	4
Ark.	30	6	-	-	1,058	1,013	17	14	-	-	-	1
La.	103	1	-	-	1,145	1,849	14	8	-	1	-	-
Okla.	43	-	-	1	725	985	38	32	7	1	-	3
Tex.	456	-	-	-	3,829	4,684	-	-	-	-	-	-
MOUNTAIN	179	16	3	-	1,213	1,768	283	76	14	12	9	-
Mont.	1	-	1	-	14	9	21	8	-	-	1	-
Idaho	2	-	-	-	20	22	10	12	-	-	-	-
Wyo.	1	-	-	-	6	18	-	1	3	-	-	-
Colo.	96	4	1	-	373	513	80	17	9	9	-	-
N. Mex.	17	4	1	-	125	168	10	6	-	-	1	-
Ariz.	21	7	-	-	498	679	129	10	2	-	3	-
Utah	12	-	-	-	25	55	17	1	-	3	-	-
Nev.	29	1	-	-	152	304	16	21	-	-	4	-
PACIFIC	1,713	162	16	1	6,962	8,565	777	382	72	32	11	19
Wash.	32	-	-	-	650	753	40	35	9	-	3	-
Oreg.	67	-	-	-	196	296	44	37	10	1	-	-
Calif.	1,582	135	14	1	5,944	7,248	675	307	53	30	8	19
Alaska	4	1	2	-	123	121	1	2	-	1	-	-
Hawaii	28	26	-	-	49	147	17	1	-	-	-	-
Guam	-	-	-	-	12	-	1	-	-	2	-	-
P.R.	107	21	-	-	1	65	2	21	-	1	-	-
V.I.	1	-	-	-	15	77	5	1	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	13	2	-	-	-	-	-	-

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 February 22, 1992, and February 23, 1991 (8th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	1992	Cum. 1992	Cum. 1991
UNITED STATES	86	18	102	7	15	761	420	53	352	19	136	339	-	25	70
NEW ENGLAND	1	-	1	-	1	3	26	-	-	1	7	20	-	4	-
Maine	-	-	-	-	-	-	3	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	-	-	-	-	-	1	4	8	-	-	-
Vt.	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
Mass.	1	-	1	-	1	-	12	-	-	-	3	11	-	-	-
R.I.	-	-	-	-	-	-	-	-	-	-	-	-	-	4	-
Conn.	-	-	-	-	-	3	11	-	-	-	-	-	-	-	-
MID. ATLANTIC	22	4	22	-	3	416	35	-	24	1	24	43	-	2	25
Upstate N.Y.	2	-	-	-	1	8	15	-	10	1	10	23	-	1	23
N.Y. City	11	4	6	-	1	36	4	-	4	-	-	-	-	-	-
N.J.	7	-	15	-	1	160	8	-	1	-	6	3	-	1	-
Pa.	2	-	1	-	-	212	8	-	9	-	8	17	-	-	2
E.N. CENTRAL	3	-	2	-	1	15	79	4	42	2	14	76	-	4	2
Ohio	-	-	2	-	1	1	13	2	14	2	2	21	-	-	-
Ind.	1	-	-	-	-	-	16	1	5	-	9	15	-	-	1
Ill.	-	-	-	-	-	10	29	-	8	-	-	19	-	4	-
Mich.	1	-	-	-	-	3	18	1	14	-	2	13	-	-	1
Wis.	1	-	-	-	-	1	3	-	1	-	1	8	-	-	-
W.N. CENTRAL	6	-	-	-	-	-	24	6	8	-	5	33	-	1	2
Minn.	2	-	-	-	-	-	3	-	-	-	2	11	-	-	1
Iowa	2	-	-	-	-	-	3	1	3	-	1	4	-	-	-
Mo.	1	-	-	-	-	-	5	5	5	-	-	14	-	-	1
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-
Nebr.	-	-	-	-	-	-	3	-	-	-	1	2	-	-	-
Kans.	1	-	-	-	-	-	10	-	-	-	-	-	-	1	-
S. ATLANTIC	15	8	24	-	1	22	75	32	183	2	16	17	-	2	-
Del.	1	-	-	-	-	1	2	-	-	-	-	-	-	-	-
Md.	6	-	1	-	-	-	6	5	20	1	8	-	-	-	-
D.C.	2	-	-	-	-	-	-	-	2	-	-	-	-	1	-
Va.	2	-	3	-	1	-	12	-	10	-	2	2	-	-	-
W. Va.	-	-	-	-	-	-	4	3	9	-	-	5	-	-	-
N.C.	1	-	-	-	-	-	16	-	26	-	4	6	-	-	-
S.C.	-	-	-	-	-	12	9	-	36	-	-	-	-	-	-
Ga.	-	-	-	-	-	-	10	-	-	-	-	3	-	-	-
Fla.	3	8	20	-	-	9	16	24	80	1	2	1	-	1	-
E.S. CENTRAL	3	4	36	-	-	-	40	4	12	-	5	8	-	-	-
Ky.	-	4	36	-	-	-	19	-	-	-	-	-	-	-	-
Tenn.	1	-	-	-	-	-	11	3	6	-	-	5	-	-	-
Ala.	2	-	-	-	-	-	10	1	4	-	5	3	-	-	-
Miss.	-	-	-	-	-	-	-	-	2	-	-	-	-	-	-
W.S. CENTRAL	2	-	-	-	-	5	12	-	9	2	8	9	-	-	-
Ark.	-	-	-	-	-	5	5	-	4	-	3	-	-	-	-
La.	-	-	-	-	-	-	1	-	4	-	-	6	-	-	-
Okla.	2	-	-	-	-	-	6	-	1	2	5	3	-	-	-
Tex.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MOUNTAIN	7	-	-	-	-	74	16	1	16	1	11	52	-	-	1
Mont.	-	-	-	-	-	-	3	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	1	2	-	1	-	4	9	-	-	-
Wyo.	-	-	-	-	-	-	1	-	-	-	-	3	-	-	-
Colo.	4	-	-	-	-	1	3	1	3	1	3	13	-	-	-
N. Mex.	2	-	-	-	-	62	-	N	N	-	4	10	-	-	-
Ariz.	1	-	-	-	-	3	3	-	9	-	-	7	-	-	-
Utah	-	-	-	-	-	-	-	-	1	-	-	10	-	-	-
Nev.	-	-	-	-	-	7	4	-	2	-	-	-	-	-	1
PACIFIC	27	2	17	7	9	226	113	6	58	10	46	81	-	12	40
Wash.	2	-	-	7†§	7	-	19	1	3	4	5	9	-	-	-
Oreg.	1	-	1	-	-	-	18	N	N	1	5	6	-	1	-
Calif.	22	2	11	-	1	226	70	5	53	5	33	47	-	9	39
Alaska	-	-	5	-	1	-	3	-	-	-	-	5	-	-	-
Hawaii	2	-	-	-	-	-	3	-	2	-	3	14	-	2	1
Guam	-	U	-	U	-	-	-	U	1	U	-	-	U	-	-
P.R.	-	-	-	-	-	1	2	-	-	1	2	5	-	-	-
V.I.	-	-	-	-	-	1	-	1	6	-	-	-	-	-	-
Amer. Samoa	-	U	-	U	-	-	-	U	-	U	-	-	U	-	-
C.N.M.I.	-	U	-	U	-	-	-	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 February 22, 1992, and February 23, 1991 (8th Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	4,830	6,336	37	2,161	2,580	12	31	14	847
NEW ENGLAND	99	168	3	30	77	-	7	1	85
Maine	-	-	-	16	16	-	-	-	-
N.H.	-	1	2	-	-	-	-	-	-
Vt.	-	1	-	-	-	-	-	-	-
Mass.	39	86	1	14	23	-	5	1	-
R.I.	7	7	-	-	16	-	-	-	-
Conn.	53	73	-	-	22	-	2	-	85
MID. ATLANTIC	603	1,186	4	382	622	-	3	2	289
Upstate N.Y.	-	87	1	-	47	-	1	-	196
N.Y. City	336	531	-	284	445	-	-	2	-
N.J.	36	183	-	29	106	-	1	-	55
Pa.	231	385	3	69	24	-	1	-	38
E.N. CENTRAL	691	585	11	234	330	-	2	4	16
Ohio	95	73	3	41	64	-	1	3	1
Ind.	38	13	3	22	10	-	-	1	-
Ill.	357	298	-	131	195	-	-	-	2
Mich.	128	122	5	29	42	-	1	-	1
Wis.	73	79	-	11	19	-	-	-	12
W.N. CENTRAL	185	101	5	43	69	2	-	-	139
Minn.	14	11	2	8	6	-	-	-	43
Iowa	3	13	2	4	14	-	-	-	23
Mo.	137	68	-	22	26	2	-	-	2
N. Dak.	-	-	1	-	3	-	-	-	11
S. Dak.	-	1	-	4	3	-	-	-	11
Nebr.	1	-	-	-	3	-	-	-	1
Kans.	30	8	-	5	14	-	-	-	48
S. ATLANTIC	1,520	1,963	3	379	329	2	4	3	196
Del.	35	18	-	5	6	-	-	-	41
Md.	110	197	-	47	29	2	1	-	78
D.C.	85	108	-	21	27	-	1	-	4
Va.	96	149	-	20	24	-	1	-	24
W. Va.	3	4	-	11	14	-	1	-	4
N.C.	362	281	1	56	55	-	-	3	1
S.C.	208	255	1	44	49	-	-	-	18
Ga.	327	457	-	68	57	-	-	-	26
Fla.	294	494	1	107	68	-	-	-	-
E.S. CENTRAL	688	689	-	116	184	3	-	-	17
Ky.	19	9	-	43	47	2	-	-	9
Tenn.	151	325	-	-	37	1	-	-	-
Ala.	299	183	-	58	58	-	-	-	8
Miss.	219	172	-	15	42	-	-	-	-
W.S. CENTRAL	814	996	-	121	203	5	-	3	34
Ark.	142	53	-	13	27	2	-	2	5
La.	295	359	-	-	-	-	-	-	-
Okla.	36	27	-	10	11	3	-	1	29
Tex.	341	557	-	98	165	-	-	-	-
MOUNTAIN	79	97	3	56	66	-	-	1	14
Mont.	2	1	-	-	-	-	-	-	1
Idaho	1	3	-	4	-	-	-	-	-
Wyo.	-	1	-	-	-	-	-	-	8
Colo.	11	15	1	-	6	-	-	-	-
N. Mex.	7	6	-	13	-	-	-	-	-
Ariz.	36	70	1	29	42	-	-	-	5
Utah	1	1	1	-	13	-	-	1	-
Nev.	21	-	-	10	5	-	-	-	-
PACIFIC	151	551	8	800	700	-	15	-	57
Wash.	9	31	-	32	31	-	-	-	-
Oreg.	7	19	-	10	12	-	-	-	-
Calif.	124	500	8	732	620	-	14	-	54
Alaska	-	1	-	8	9	-	-	-	3
Hawaii	11	-	-	18	28	-	1	-	-
Guam	1	-	-	-	-	-	-	-	-
P.R.	19	47	-	12	15	-	-	-	7
V.I.	9	14	-	1	1	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	3	4	-	-	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending February 22, 1992 (8th Week)

Reporting Area	All Causes, By Age (Years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	643	477	98	43	12	13	48
Boston, Mass.	149	101	23	15	3	7	14
Bridgeport, Conn.	58	45	7	2	2	2	4
Cambridge, Mass.	28	26	1	1	-	-	2
Fall River, Mass.	36	28	7	1	-	-	1
Hartford, Conn.	74	53	13	5	1	2	5
Lowell, Mass.	18	12	2	3	1	-	1
Lynn, Mass.	18	15	2	1	-	-	1
New Bedford, Mass.	33	22	9	2	-	-	2
New Haven, Conn.	40	30	5	3	2	-	3
Providence, R.I.	24	18	4	1	1	-	1
Somerville, Mass.	9	8	1	-	-	-	1
Springfield, Mass.	46	37	6	3	-	-	5
Waterbury, Conn.	39	26	10	2	1	-	7
Worcester, Mass.	71	56	8	4	1	2	1
MID. ATLANTIC	2,675	1,748	521	270	71	65	164
Albany, N.Y.	49	32	9	3	4	1	5
Allentown, Pa.	20	14	5	1	-	-	1
Buffalo, N.Y.	105	63	27	10	2	3	5
Camden, N.J.	38	18	7	4	5	4	-
Elizabeth, N.J.	36	26	8	1	-	1	1
Erie, Pa.§	35	23	10	1	-	1	1
Jersey City, N.J.	48	26	13	5	2	2	1
New York City, N.Y.	1,254	790	245	164	35	20	64
Newark, N.J.	79	35	19	15	3	7	4
Paterson, N.J.	26	12	6	5	-	3	-
Philadelphia, Pa.	488	336	90	40	8	14	39
Pittsburgh, Pa.§	91	72	12	3	2	2	7
Reading, Pa.	46	38	5	2	1	-	11
Rochester, N.Y.	136	99	24	6	3	4	10
Schenectady, N.Y.	32	25	7	-	-	-	2
Scranton, Pa.§	27	17	8	2	-	-	2
Syracuse, N.Y.	80	63	12	3	-	2	3
Trenton, N.J.	31	21	5	2	3	-	6
Utica, N.Y.	19	14	2	1	1	1	1
Yonkers, N.Y.	35	24	7	2	2	-	1
E.N. CENTRAL	2,080	1,310	389	199	109	73	136
Akron, Ohio	73	46	17	4	1	5	5
Canton, Ohio	40	28	8	4	-	-	5
Chicago, Ill.	441	179	91	82	65	24	18
Cincinnati, Ohio	137	91	24	14	3	5	12
Cleveland, Ohio	U	U	U	U	U	U	U
Columbus, Ohio	154	101	29	14	5	5	5
Dayton, Ohio	102	71	24	2	2	3	7
Detroit, Mich.	238	139	48	26	12	13	9
Evansville, Ind.	66	49	7	9	1	-	3
Fort Wayne, Ind.	62	42	12	3	3	2	3
Gary, Ind.	16	7	6	2	1	-	2
Grand Rapids, Mich.	83	60	18	2	-	3	12
Indianapolis, Ind.	196	137	38	8	6	7	15
Madison, Wis.	34	25	3	3	2	1	5
Milwaukee, Wis.	117	95	14	5	1	2	16
Peoria, Ill.	52	42	5	5	-	-	5
Rockford, Ill.	53	40	8	4	-	1	1
South Bend, Ind.	46	33	6	6	1	-	6
Toledo, Ohio	95	70	15	3	5	2	6
Youngstown, Ohio	75	55	16	3	1	-	1
W.N. CENTRAL	826	600	128	55	17	26	40
Des Moines, Iowa	106	78	16	9	-	3	7
Duluth, Minn.	28	19	6	3	-	-	1
Kansas City, Kans.	31	19	6	2	1	3	2
Kansas City, Mo.	116	83	16	9	3	5	3
Lincoln, Nebr.	29	19	6	3	-	1	2
Minneapolis, Minn.	164	136	11	10	5	2	15
Omaha, Nebr.	80	57	18	1	1	3	3
St. Louis, Mo.	158	112	25	12	4	5	-
St. Paul, Minn.	61	42	12	3	1	3	5
Wichita, Kans.	53	35	12	3	2	1	2
S. ATLANTIC	1,272	755	273	143	28	68	64
Atlanta, Ga.	159	102	27	20	1	9	4
Baltimore, Md.	220	136	50	23	2	9	19
Charlotte, N.C.	103	74	18	9	1	1	4
Jacksonville, Fla.	127	89	22	13	1	2	9
Miami, Fla.	117	55	35	15	7	5	-
Norfolk, Va.	49	28	13	3	4	1	3
Richmond, Va.	U	U	U	U	U	U	U
Savannah, Ga.	58	39	11	4	2	2	4
St. Petersburg, Fla.	56	37	10	2	1	6	-
Tampa, Fla.	190	118	48	15	2	4	16
Washington, D.C.	163	59	31	36	7	28	5
Wilmington, Del.	30	18	8	3	-	1	-
E.S. CENTRAL	810	530	184	60	19	16	58
Birmingham, Ala.	116	82	20	9	2	3	3
Chattanooga, Tenn.	59	37	15	4	2	1	4
Knoxville, Tenn.	125	87	27	9	2	-	11
Louisville, Ky.	64	38	17	5	1	3	3
Memphis, Tenn.	201	127	51	13	6	3	19
Mobile, Ala.	84	54	15	7	4	4	7
Montgomery, Ala.	48	34	11	2	1	-	1
Nashville, Tenn.	113	71	28	11	1	2	10
W.S. CENTRAL	1,343	869	251	123	50	50	108
Austin, Tex.	74	52	5	9	1	7	6
Baton Rouge, La.	14	11	2	1	-	-	-
Corpus Christi, Tex.	51	32	13	2	3	1	3
Dallas, Tex.	195	125	32	26	8	4	5
El Paso, Tex.	73	58	6	5	1	3	3
Ft. Worth, Tex.	99	65	19	7	6	2	10
Houston, Tex.	347	194	81	40	14	18	47
Little Rock, Ark.	91	55	22	4	6	4	7
New Orleans, La.	111	74	18	13	4	2	-
San Antonio, Tex.	163	106	31	13	5	8	14
Shreveport, La.	44	33	9	1	1	-	11
Tulsa, Okla.	81	64	13	2	1	1	2
MOUNTAIN	817	505	153	101	39	19	62
Albuquerque, N.M.	79	54	16	8	1	-	3
Colo. Springs, Colo.	34	23	8	-	2	1	3
Denver, Colo.	116	73	12	19	4	8	13
Las Vegas, Nev.	119	70	37	9	2	1	4
Ogden, Utah	22	16	3	2	-	1	2
Phoenix, Ariz.	190	78	38	48	21	5	17
Pueblo, Colo.	37	29	6	2	-	-	4
Salt Lake City, Utah	87	61	12	9	3	2	7
Tucson, Ariz.	133	101	21	4	6	1	9
PACIFIC	1,244	848	193	133	39	29	96
Berkeley, Calif.	20	13	4	1	-	2	-
Fresno, Calif.	39	27	3	5	1	3	1
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	82	57	14	4	1	6	13
Long Beach, Calif.	80	46	18	8	5	3	16
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	32	28	3	1	-	-	5
Portland, Oreg.	108	75	15	10	6	2	4
Sacramento, Calif.	146	105	21	14	5	1	15
San Diego, Calif.	139	84	28	20	5	2	12
San Francisco, Calif.	135	80	21	29	3	-	3
San Jose, Calif.	165	109	33	14	6	3	14
Santa Cruz, Calif.	25	19	3	3	-	-	2
Seattle, Wash.	147	111	13	14	6	3	3
Spokane, Wash.	48	38	6	3	-	1	5
Tacoma, Wash.	78	56	11	7	1	3	3
TOTAL	11,710¶	7,642	2,190	1,127	384	359	776

*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.

U: Unavailable

Contraceptive-Use Plans — Continued

and contraceptive-use plans of women at high risk* for HIV infection interviewed during 1989–1991 in three settings—methadone-maintenance programs, drug-free outpatient programs, and detention facilities—in Florida, New Jersey, New York, and Pennsylvania.

Since 1988, CDC has collaborated with seven state and local health departments, hospitals, and family-planning organizations, including those described in this report, to implement and evaluate perinatal HIV-prevention programs for women in a variety of settings (*2*). These women, who are at high risk for HIV infection, are provided HIV-prevention, reproductive-health, family-planning, and/or educational services. Upon participants' enrollment in the perinatal HIV-prevention program, investigators use a standardized questionnaire to obtain information including demographic attributes, pregnancy history, childbearing plans, contraceptive use, sexual behavior, and drug use. The findings in this report are based on interviews with women in four states (Florida: detention and drug-treatment programs in Broward and Dade counties; New Jersey: drug-treatment programs in Newark, Paterson, and Jersey City; Pennsylvania: drug-treatment programs in Philadelphia; and New York: drug-treatment programs in New York City, including Harlem and Brooklyn).

A total of 736 women aged 18–44 years who were not pregnant were interviewed. These women were from methadone-maintenance clinics (103 [30%] from New York City, 103 [30%] from New Jersey, and 137 [40%] from Philadelphia); drug-free outpatient clinics (36 [21%] from Florida, 11 [6%] from New Jersey, and 126 [73%] from Philadelphia), and detention facilities (220 from Florida). Women who reported no sexual intercourse during the 8 weeks before the enrollment interview, who were surgically sterilized, or who reported being HIV seropositive were excluded from this analysis.

Most respondents (412 [56%]) were aged 25–34 years, and 507 (69%) were members of racial/ethnic minorities (Table 1). Women in methadone-maintenance clinics were more likely to have histories of injecting-drug use and to have a primary sex partner† who was at risk for HIV infection, while women in drug-free outpatient clinics were more likely to have histories of exchanging sex for drugs or money and less likely to have a primary sex partner. Most women (54%–60%) reported they did not want to become pregnant ever or for at least 3 years.

Of women who had been pregnant at some time since 1986, less than one fourth (range: 0–24%) reported that their most recent pregnancy was planned (Table 2). From 26% to 38% of women used contraceptives consistently during their most recent 4-week period of sexual activity; however, 37%–49% of the women reported never having used contraceptives.§

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*Women were defined as being at high risk because of their past or current drug use (including trading sex for drugs or money) or because a sex partner was at high risk. For this study, a high-risk partner was defined as a man who was HIV-antibody–positive, had ever used injecting drugs, had ever had sex with another man, or had ever been incarcerated.

†Respondents indicated whether they considered any particular sex partner a primary sex partner.

§When women who reported they were sterilized or practiced abstinence were included in the analysis (as everytime users of contraceptives) the percentage of inconsistent use of contraceptives remained substantial; 48%–62% of women who did not want to become pregnant within the next 3 years and 21%–26% of women who did not ever want to become pregnant used contraceptives inconsistently.

Contraceptive-Use Plans — Continued

Most women (55%–81%) indicated that for pregnancy prevention during the next 12-month period they planned to use contraceptives; however, substantial percentages of women in methadone-maintenance clinics (21%–31%) and detention facilities (25%) reported they did not plan to actively prevent pregnancy in the next year. From 41% to 64% of women reported that they wanted a child sometime in the future, although fewer women (11%–28%) wanted one within the next year.

Reported by: M Fordyce, MPH, M Jones, PhD, RS Hopkins, MD, State Epidemiologist, Florida Dept of Health and Rehabilitative Svcs. G Halpin, MD, A Kline, PhD, K McNally, KC Spitalny, MD,

TABLE 1. Demographic characteristics, HIV risk factors, and childbearing plans among women* in three different settings — perinatal HIV-prevention programs, Florida, New Jersey, New York, and Pennsylvania, 1989–1991

	Methadone-maintenance clinic		Drug-free outpatient clinic		Detention facility	
Category	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Age group (yrs)						
18–24	10	(3)	40	(23)	70	(32)
25–34	172	(50)	112	(65)	128	(58)
35–44	161	(47)	21	(12)	22	(10)
Total	**343**	**(100)**	**173**	**(100)**	**220**	**(100)**
Race/Ethnicity						
White	113	(33)	28	(16)	88	(40)
Black	165	(48)	135	(78)	86	(39)
Hispanic	58	(17)	7	(4)	42	(19)
Other	7	(2)	3	(2)	4	(2)
Total	**343**	**(100)**	**173**	**(100)**	**220**	**(100)**
Ever used injected drugs	285	(83)	40	(23)	66	(30)
Ever traded sex for money or drugs	117	(34)	130	(75)	121	(55)
History of sexually transmitted disease†	130	(38)	111	(64)	132	(60)
Has a primary sex partner	305	(89)	114	(66)	174	(79)
Primary sex partner at high risk for HIV infection§	213	(62)	47	(27)	84	(38)
Wants a/another child						
Within 1 year	58	(17)	19	(11)	61	(28)
Within 1–3 years	41	(12)	36	(21)	31	(14)
After ≥3 years	41	(12)	47	(27)	49	(22)
No (more) children	165	(48)	47	(27)	51	(23)
Don't know/Not sure	38	(11)	24	(14)	28	(13)
Total	**343**	**(100)**	**173**	**(100)**	**220**	**(100)**

*Who were sexually active within the 8 weeks before the enrollment interviews, not pregnant, and not surgically sterilized.

†Have been told by a doctor or nurse that they had gonorrhea, syphilis, or chlamydia.

§Defined as a man who was HIV-antibody–positive, had ever used injecting drugs, had ever had sex with another man, or had ever been incarcerated.

TABLE 2. Pregnancy history and pregnancy-prevention plans among women* who do not want to become pregnant within the next 3 years or ever — perinatal HIV-prevention programs, Florida, New Jersey, New York, and Pennsylvania, 1989–1991

Childbearing intention	Want children after >3 years						Want no (more) children					
	MMC† (n=42)		DFOC§ (n=47)		DF¶ (n=49)		MMC (n=164)		DFOC (n=46)		DF (n=51)	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Pregnancy since 1986	39	(93)	36	(77)	25	(51)	162	(99)	44	(96)	35	(69)
Last pregnancy intended**	10	(24)	6	(13)	11	(22)	16	(10)	3	(7)	8	(16)
Contraceptive use during sexual intercourse (within last 8 weeks)												
Every time	16	(38)	13	(28)	14	(29)	62	(38)	12	(26)	19	(37)
Sometimes	7	(17)	12	(26)	17	(35)	21	(13)	13	(28)	11	(22)
Never	19	(45)	22	(47)	18	(37)	81	(49)	21	(46)	21	(41)
Immediate plans for pregnancy prevention††												
Use contraception	25	(60)	38	(81)	31	(63)	93	(57)	28	(61)	28	(55)
Sterilization§§	0		1	(2)	0		16	(10)	11	(24)	3	(6)
Modify sexual behavior¶¶	1	(2)	9	(19)	7	(14)	20	(12)	7	(15)	8	(16)
Take other precautions	4	(10)	2	(4)	4	(8)	15	(9)	1	(2)	6	(12)
Do nothing	13	(31)	5	(11)	12	(25)	34	(21)	6	(13)	13	(25)

*Who reported sexual activity within the 8 weeks before the enrollment interviews, were not pregnant, and were not surgically sterilized.
†Methadone-maintenance clinic.
§Drug-free outpatient clinic.
¶Detention facility.
**Of those pregnant at some time since 1986.
††Women may plan to prevent pregnancy by more than one means and columns may add to more than 100%.
§§Self and/or partner.
¶¶Reduce number of sex partners, abstain, or change sexual behavior.

Contraceptive-Use Plans — Continued

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Editorial Note: In this assessment, pregnancy history, contraceptive use, plans for childbearing, and plans for pregnancy prevention were similar for women at increased risk for HIV infection in each of the three settings. Contraceptive use, specifically condom use, and sexual behavior changes (e.g., abstinence and nonpenetrative sex) are effective for preventing both HIV infection and pregnancy and may be acceptable prevention strategies for many women at risk. Therefore, women who wish to delay childbearing should be encouraged to use contraceptives consistently and should be informed that condoms are a contraceptive method that will preserve their capacity for future childbearing by reducing their risk for sexually transmitted diseases.

The findings in this report have at least two limitations. First, because data were obtained from women who volunteered to participate in programs in four locations, the findings cannot be readily generalized to women in other settings and locations. Second, the findings may not be helpful in tailoring HIV-prevention and reproductive-service programs for women aged <25 years because of the limited representation of such women in the survey.

Despite these limitations, these findings and results from a recent study of three federally funded community-health centers (*3*) underscore the opportunities for providing women (primarily aged >25 years) at high risk for HIV infection with services for HIV prevention, reproductive health, and family planning. Special efforts to reach minority women, who are disproportionately affected by the AIDS epidemic, may be especially effective in these settings (*1*). Through increased understanding of decisions regarding childbearing and contraceptive use among women at risk for HIV infection, public health agencies may improve HIV-prevention programs and identify additional settings where women at risk for both HIV infection and perinatal transmission can be offered prevention services. To improve access to these women, HIV-prevention and family-planning services may be extended—through outreach and through the provision of on-site services—to drug-treatment centers, sexually transmitted disease clinics, detention facilities, and shelters.

References

1. CDC. HIV/AIDS surveillance report. Atlanta: US Department of Health and Human Services, Public Health Service, September 1991:8.
2. CDC. Division of STD/HIV Prevention annual report, 1990. Atlanta: US Department of Health and Human Services, Public Health Service, 1991:159–64.
3. Salomon P, O'Neill J, Holloway J, et al. Reaching high risk women by placing HIV services at customary sites of primary care [Abstract]. Vol I. VII International AIDS Conference. Florence, Italy, June 16–21, 1991:452.

Surveillance Summaries

Publication of *CDC Surveillance Summaries*

Since 1983, CDC has published the *CDC Surveillance Summaries* under separate cover as part of the *MMWR* series. Each report published in the *CDC Surveillance Summaries* focuses on public health surveillance; surveillance findings are reported for a broad range of risk factors and health conditions.

Summaries for each of the reports published in the most recent (December 1991) issue of the *CDC Surveillance Summaries* (*1*) are provided below. All subscribers to *MMWR* receive the *CDC Surveillance Summaries*, as well as the *MMWR Recommendations and Reports*, as part of their subscriptions.

BEHAVIORAL RISK FACTOR SURVEILLANCE, 1986–1990

Since 1984, an increasing number of states (including the District of Columbia) have participated in the Behavioral Risk Factor Surveillance System (BRFSS). This report provides state-specific estimates of the prevalence of selected health-risk behaviors for the years 1986 through 1990. Apparent trends and progress toward several of the year 2000 national health objectives are discussed, both for the entire adult population (persons ages ≥18 years) and selected high-risk demographic subgroups. Now that BRFSS includes 45 states and covers over 90% of the nation's adult population, it can be used both as a measure of state-specific risk factor prevalence and an indicator of national trends.

Authors: *Paul Z. Siegel, M.D., M.P.H., Robert M. Brackbill, Ph.D., M.P.H., Emma L. Frazier, Ph.D., Peter Mariolis, Ph.D., Lee M. Sanderson, Ph.D., Michael N. Waller, State BRFSS Coordinators, Behavioral Risk Factor Surveillance Branch, Office of Surveillance and Analysis, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

RESULTS OF TESTING FOR INTESTINAL PARASITES BY STATE DIAGNOSTIC LABORATORIES, UNITED STATES, 1987

Results of 216,275 stool specimens examined by the state diagnostic laboratories in 1987 were analyzed; parasites were found in 20.0%. Percentages were highest for protozoans *Giardia lamblia* (7.2%), *Entamoeba coli* and *Endolinax nana* (4.2% each), *Blastocystis hominis* (2.6%), *Entamoeba histolytica* (0.9%), and *Cryptosporidium* species (0.2%). Identifications of *G. lamblia* increased broadly from the 4.0% average found in 1979, with 40 states reporting increases and seven decreases. Most states that identified *Giardia* in more than 9% of specimens were located around the Great Lakes or in the Northwest. Seasonally, *Giardia* identifications increased in the summer and fall, especially in northern states.

The most commonly identified helminths were nematodes: hookworm (1.5%), *Trichuris trichiura* (1.2%), and *Ascaris lumbricoides* (0.8%). Other less commonly identified helminths include *Clonorchis* and *Opisthorchis* species (0.6%), *Strongyloides stercoralis* (0.4%), *Hymenolepis nana* (0.4%), *Enterobius vermicularis* (0.4%), and *Taenia* species (0.1%). Tape tests for *Enterobius*, reported for 35 states, were positive for 11.4% of 9597 specimens. Nine states (California, Colorado, Hawaii, Idaho, New Jersey, Oregon, Rhode Island, Washington, Wisconsin) reported hookworms in more than 2% of specimens; none were states traditionally associated with indigenous transmission.

Cryptosporidium diagnoses, reported by 25 of 49 states, were recorded for the first time in a national survey and showed no significant regional clustering. The

Surveillance Summaries — *Continued*

Giardia data revealed changes in rates of identification and in geographic patterns compared with state laboratory data collected a decade earlier (1976–1978).

Authors: *Karl K. Kappus, Ph.D., Dennis D. Juranek, D.V.M., M.Sc., Jacqueline M. Roberts, M.Sc., Parasitic Diseases Branch, Division of Parasitic Diseases, National Center for Infectious Diseases, CDC.*

Reference

1. CDC. CDC surveillance summaries. MMWR 1991;40(no. SS-4).

Notices to Readers

International Congress on Health Effects of Hazardous Wastes

The Agency for Toxic Substances and Disease Registry (ATSDR), in collaboration with the Emory University School of Public Health and the Association of Occupational and Environmental Clinics, will hold the first International Congress on the Health Effects of Hazardous Waste. The congress, which will be cosponsored by the National Institute of Environmental Health Sciences and the Environmental Protection Agency, will be held May 3–6, 1993, in Atlanta.

This congress will provide an opportunity for biomedical and environmental scientists, epidemiologists, physicians, risk assessors, and toxicologists to evaluate and disseminate state-of-the-art information about the human health effects associated with exposure to hazardous waste. Topics will include populations at risk, exposure assessment (including environmental measurements, modeling, and use of biologic markers), health effects resulting from exposure to toxic substances (including toxicologic studies, health-effects studies, diagnostic strategies, and risk analysis), mitigation strategies, risk communication, technology and information transfer, health implications of emerging technologies, gaps in data, and research needs.

Additional information is available from the Associate Administrator for Science, ATSDR, Mailstop E-28, 1600 Clifton Road, NE, Atlanta, GA 30333; telephone (404) 639-0708, FTS 236-0708.

NIOSH Alert: Preventing Electrocutions During Work With Scaffolds Near Overhead Power Lines

CDC's National Institute for Occupational Safety and Health (NIOSH) periodically issues alerts on workplace hazards that have caused death or serious injury to workers. One such alert, *Preventing Electrocutions During Work with Scaffolds Near Overhead Power Lines* (*1*), was recently released and is now available to the public.* This alert describes 13 deaths that occurred in six separate incidents when workers erected or moved scaffolds that came into contact with energized, overhead power lines or when they contacted overhead power lines with conductive tools or materials while working on scaffolds.

*Single copies of this document are available without charge from the Information Dissemination Section, Division of Standards Development and Technology Transfer, NIOSH, 4676 Columbia Parkway, Cincinnati, OH 45226; telephone (513) 533-8287.

Notices to Readers — Continued

At least 6500 traumatic work-related deaths occur each year in the United States (*2*). An estimated 7% of these fatalities are electrocutions. From 1980 through 1986, at least 25 deaths resulted when workers contacted overhead power lines while erecting or moving scaffolds or while using conductive tools on scaffolds. Many occupational groups (e.g., brickmasons, carpenters, painters, construction laborers, and plasterers) are at risk for electrocution because their jobs involve working from scaffolds near overhead power lines (*2*).

To prevent such electrocutions, NIOSH included recommendations in the alert to be followed by employers, managers, supervisors, and workers where scaffolds and conductive tools or materials are used near overhead power lines. These recommendations include requirements mandated in current and proposed Occupational Safety and Health Administration regulations for the construction industry.

References

1. NIOSH. NIOSH alert: request for assistance in preventing electrocutions during work with scaffolds near overhead power lines. Cincinnati: US Department of Health and Human Services, Public Health Service, CDC, NIOSH, 1991; DHHS publication no. (NIOSH)91-110.
2. NIOSH. National Traumatic Occupational Fatality (NTOF) database. Morgantown, West Virginia: US Department of Health and Human Services, Public Health Service, CDC, NIOSH, Division of Safety Research, 1991.

The *Morbidity and Mortality Weekly Report* (*MMWR*) Series is prepared by the Centers for Disease Control and is available on a paid subscription basis from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 783-3238.

The data in the weekly *MMWR* 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. Inquiries about the *MMWR* Series, including material to be considered for publication, should be directed to: Editor, *MMWR* Series, Mailstop C-08, Centers for Disease Control, Atlanta, GA 30333; telephone (404) 332-4555.

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