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Laboratory-Acquired Meningococcal Disease — United States, 2000

Neisseria meningitidis is a leading cause of bacterial meningitis and sepsis among older children and young adults in the United States. *N. meningitidis* usually is transmitted through close contact with aerosols or secretions from the human nasopharynx. Although *N. meningitidis* is regularly isolated in clinical laboratories, it has infrequently been reported as a cause of laboratory-acquired infection. This report describes two probable cases of fatal laboratory-acquired meningococcal disease and the results of an inquiry to identify previously unreported cases. The findings indicate that *N. meningitidis* isolates pose a risk for microbiologists and should be handled in a manner that minimizes risk for exposure to aerosols or droplets.

Case Reports

Case 1. On July 15, 2000, an Alabama microbiologist aged 35 years presented to the emergency department of hospital A with acute onset of generalized malaise, fever, and diffuse myalgias. The patient was given a prescription for oral antibiotics and released. On July 16, the patient returned to hospital A, became tachycardic and hypotensive, and died 3 hours later. Blood cultures were positive for *N. meningitidis* serogroup C. Three days before the onset of symptoms, the patient had prepared a Gram's stain from the blood culture of a patient who was subsequently shown to have meningococcal disease; the microbiologist also had handled and subcultured agar plates containing cerebrospinal fluid (CSF) cultures of *N. meningitidis* serogroup C from the same patient. Co-workers reported that in the laboratory, aspiration of materials from blood culture bottles was performed at the open laboratory bench; biosafety cabinets, eye protection, or masks were not used routinely for this procedure. Results of pulsed-field gel electrophoresis (PFGE) and multilocus enzyme electrophoresis (MEE) testing at CDC indicated that the two isolates were indistinguishable. The laboratory at hospital A infrequently processed isolates of *N. meningitidis* and had not processed another meningococcal isolate during the previous 4 years.

Case 2. On December 24, 2000, a Michigan microbiologist aged 52 years had acute onset of sore throat, vomiting, headache, and fever; by December 25, the patient had developed a petechial rash on both legs, which quickly evolved to widespread purpura. The patient presented to the emergency department of hospital B and died later that day of overwhelming sepsis. Blood cultures were positive for *N. meningitidis* serogroup C. The patient was a microbiologist in the state public health laboratory and had worked on several *N. meningitidis* serogroup C isolates during the 2 weeks before becoming ill. That laboratory had handled a median of four meningococcal isolates per month (range: 0–11) during the previous 4 years. Co-workers reported that the patient had performed slide agglutination testing and recorded colonial morphology using typical biosafety level 2 (BSL 2) precautions; this did not entail the use of a biosafety cabinet. PFGE was performed at the state public health laboratory and at CDC on all four specimens handled by the microbiologist; results of this testing indicated that the isolates from the patient and from one of the recently handled laboratory samples were indistinguishable.

INSIDE

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To detect additional cases, on November 11, 2000, a request for information was posted on selected electronic mail discussion groups (i.e., listservs) to members of several infectious disease, microbiology, and infection control professional organizations. A probable case of laboratory-acquired meningococcal disease was defined as confirmed or probable meningococcal disease (*1*) in a laboratory scientist who had had occupational exposure to a *N. meningitidis* isolate during the 14 days before onset of illness and who had illness with a serogroup that matched the source isolate. In addition to the two cases described in this report, CDC received an additional 14 reports of probable laboratory-acquired meningococcal disease worldwide during the preceding 15 years; six cases occurred in the United States during 1996–2001. The source isolates from five of these six U.S. cases were from either blood or CSF; the source of the sixth isolate could not be definitively determined but was most likely CSF or middle ear fluid. Of these 16 previously unreported cases, nine (56%) were caused by *N. meningitidis* serogroup B, and seven (44%) were caused by serogroup C; eight cases (50%) were fatal (three from serogroup B and five from serogroup C). Case-fatality rates did not differ significantly by serogroups (serogroup C: 71%; serogroup B: 33%; p=0.16). In the 10 cases for which data were available, a median of 4 days (range: 2–10 days) passed between handling the source isolate and symptom onset. Procedures performed on the 16 source isolates included reading plates (50%), making subcultures on agar plates (50%), and performing serogroup identification at the bench (38%). In 15 of the 16 cases, the laboratory reportedly did not perform procedures within a biosafety cabinet. All 16 cases occurred among workers in the microbiology section of the laboratory; no cases were reported among workers in hematology, chemistry, or pathology.

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Editorial Note: Although the risk for disease remains low (*2*), laboratory-acquired meningococcal disease represents an occupational hazard to microbiologists. The findings in this report were self-reported and required respondents to have access to electronic media. However, the identification of 14 previously unreported cases and the additional two cases reported to CDC in 2001 suggest that either cases of laboratory-acquired meningococcal disease are underreported or the incidence of laboratory-acquired meningococcal disease has increased. The case-fatality rate of 50% in this report is substantially higher than that observed among community-acquired cases; this might reflect underreporting of mild cases or might be a result of the highly virulent strains and high concentration of organisms encountered in the laboratory setting.

Each year in the United States, approximately 3,000 isolates of invasive *N. meningitidis* are cultured (*3*); on the basis of standard practices used for isolation and identification of *N. meningitidis*, each of the clinical samples and isolates is handled by an average of three microbiologists during the course of a laboratory investigation, resulting in an estimated 9,000 microbiologists exposed per year. During 1996–2000 in the United States, six cases of probable laboratory-acquired meningococcal disease were detected, for an attack rate of 13 per 100,000 population (95% confidence interval [CI]= 5–29) at risk per year, compared with approximately 0.2 per 100,000 population among adults aged 30–59 in the United States (CDC, unpublished data, 2001), the age group of most laboratory scientists. If the three cases from 2000 are excluded from this estimate, the attack rate is seven (95% CI=1–19).

N. meningitidis is classified as a biosafety level 2 organism (*4*). Guidelines recommend the use of a biosafety cabinet for mechanical manipulations of samples that have a substantial risk for droplet formation or aerosolization such as centrifuging, grinding, and blending procedures (*4,5*). Less is known about the risk associated with routine isolate manipulation.

The exclusive occurrence of probable laboratory-acquired cases in microbiologists suggests that exposure to isolates of *N. meningitidis*, and not patient samples, increases the risk for infection. Nearly all the microbiologists in this report were manipulating isolates and performing subplating with an inoculation loop on an open laboratory bench. A recent study indicated that manipulating suspensions of *N. meningitidis* outside a biosafety cabinet is associated with a high risk for contracting disease (*3*). Isolates obtained from a respiratory source are in general less pathogenic and represent a lower risk for microbiologists.

Although the exact mechanism of transmission in the laboratory setting is unclear, use of a biosafety cabinet during manipulation of sterile site isolates of *N. meningitidis* would ensure protection. Alternative methods of protection (e.g., splash guards and masks) from droplets and aerosols require additional assessment. If a biosafety cabinet or other means of protection is unavailable, manipulation of these isolates should be minimized, and workers should consider sending specimens to laboratories possessing this equipment. Education of microbiologists and strict adherence to these safety precautions when manipulating meningococcal isolates should further minimize the risk for infection. To address these safety issues, the governing bodies of organizations responsible for setting policy for laboratory safety will be reassessing current guidelines about the handling of *N. meningitidis.*

Although primary prevention should focus on laboratory safety, laboratory workers also should make informed decisions about vaccination. The quadrivalent meningococcal polysaccharide vaccine, which includes serogroups A, C, Y, and W-135, will decrease but not eliminate the risk for infection (*6*). Research and industrial laboratory scientists who are exposed routinely to *N. meningitidis* in solutions that might be aerosolized also should consider vaccination (*6–8*). In addition, vaccination might be used as an adjunctive measure by microbiologists in clinical laboratories.

Laboratory scientists with percutaneous exposure to an invasive *N. meningitidis* isolate from a sterile site should receive treatment with penicillin; those with known mucosal exposure should receive antimicrobial chemoprophylaxis (*6*) (Table 1). Microbiologists who manipulate invasive *N. meningitidis* isolates in a manner that could induce aerosolization or droplet formation (including plating,

TABLE 1. Schedule for administering chemoprophylaxis against meningococcal disease

Drug	Age group	Dosage	Duration and route of administration*
Rifampin†	<1 month	5 mg/kg every 12 hours	2 days
	≥1 month	10 mg/kg every 12 hours	2 days
	Adults	600 mg every 12 hours	2 days
Ciprofloxacin§	Adults	500 mg	Single dose
Ceftriaxone	<15 years	125 mg	Single intramuscular dose
Ceftriaxone	Adults	250 mg	Single intramuscular dose

* Oral administration unless otherwise indicated.
† Not recommended for pregnant women because the drug is teratogenic in laboratory animals. Because the reliability of oral contraceptives may be affected by rifampin therapy, consideration should be given to using alternative contraceptive measures while rifampin is being administered.
§ Not generally recommended for persons aged <18 years or for pregnant and lactating women because the drug causes cartilage damage in immature laboratory animals. However, ciprofloxacin can be used for chemoprophylaxis of children when no acceptable alternative therapy is available.

subculturing, and serogrouping) on an open bench top and in the absence of effective protection from droplets or aerosols also should consider antimicrobial chemoprophylaxis.

CDC has instituted prospective surveillance for laboratory-acquired meningococcal disease. Hospitals, laboratories, and public health departments that are aware of suspected cases should report these cases through their state public health department to CDC, telephone 404-639-3158.

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Populations Receiving Optimally Fluoridated Public Drinking Water — United States, 2000

Dental caries (i.e., tooth decay) is a transmissible, multifactor disease that affects 50% of children aged 5–9 years, 67% of adolescents aged 12–17 years (*1*), and 94% of adults aged ≥18 years (*2*) in the United States. During the second half of the 20th century (*3*), a major decline in the prevalence and severity of dental caries resulted from the identification of fluoride as an effective method of preventing caries. Fluoridation of the public water supply is the most equitable, cost-effective, and cost-saving method of delivering fluoride to the community (*4,5*). In the United States during 2000, approximately 162 million persons (65.8% of the population served by public water systems) received optimally fluoridated water compared with 144 million (62.1%) in 1992 (*6*). This report presents state-specific data on the status of water fluoridation in the United States and describes a new surveillance system designed to routinely produce state and national data to monitor fluoridation in the public water supply. The results of this report indicate slow progress toward increasing access to optimally fluoridated water for persons using public water systems. Data from the new surveillance system can heighten public awareness of this effective caries prevention measure and can be used to identify areas where additional health promotion efforts are needed.

The 2000 and 2010 national health goals include objectives (13.9 and 21.9, respectively) (*7,8*) to increase the 1989 and 1992 national baseline fluoridation levels (61% and 62%, respectively) (*6,9*) to 75% of the U.S. population served by community water systems that receive water with optimal levels of fluoride (0.7–1.2 ppm depending on the average maximum daily air temperature of the area). The U.S. Environmental Protection Agency (EPA) does not regulate the addition of fluoride to water, and EPA's Safe Drinking Water Information System (SDWIS) actively tracks fluoride concentrations only in water systems with naturally occurring fluoride levels above the established regulatory limits (≥2.0 ppm).

During 1998–2000, CDC developed the Water Fluoridation Reporting System (WFRS), a surveillance database that included CDC's 1992 water fluoridation census (*6*) and EPA's SDWIS. To ensure that initial data were accurate and complete, in 2000, CDC sent state-specific reports generated from WFRS to the oral health contact at each state health agency for review; updated information was returned, and nonrespondents were contacted through telephone calls and electronic messages. In July 2001, each state received its preliminary public water system data and was asked to submit corrections. Alabama, California, Kansas, Louisiana, Montana, Rhode Island, Texas, and Wyoming had not updated their data by September 1, 2001; therefore, existing WFRS data were used in this report.

Fluoridation percentages were determined by dividing the number of persons using public water systems with fluoride levels considered optimal (naturally occurring and adjusted) for the state by the total population of the state served by public water systems. When the population served by public water systems exceeded the 2000 population census for that state, the state census was used as the population using the public water supplies. This might occur as a result of the methods used by water systems to estimate the population served. These states were Alabama, Hawaii, Louisiana, Massachusetts, Missouri, Utah, and Wyoming.

In the United States during 2000, approximately 162 million persons (65.8% of the population served by public water systems) received optimally fluoridated water compared with 144 million (62.1%) in 1992 (*6*); state-specific percentages (Table 1) ranged from 2% (Utah) to 100% (District of Columbia) (median: 76.7%). In 27 states during 1992–2000, the proportion increased (range: 0.8%–63.8% [Georgia and Nevada, respectively]; median: 4.9%), and in 23 states, the proportion decreased (range: from –0.1% to –6.0% [Iowa and Alaska, respectively]; median: 2.9%); the District of Columbia remained 100% fluoridated. Delaware, Maine, Missouri, Nebraska, and Virginia reached 75% in 2000 and Oklahoma reached 74.6%. The national objective has been met by 26 states, and the small increase from 1992 to 2000 of 3.7 percentage points has left a gap of 9.2 percentage points from the overall target.

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Editorial Note: WFRS data indicate that during the 1990s, the estimated proportion of the U.S. population using public water supplies that maintained optimally fluoridated water increased from 62.1% to 65.8%. This modest progress occurred as the result of substantial increases in coverage in a few states and, in some instances, because several large metropolitan areas commenced fluoridation (e.g., Clark County [Las Vegas], Nevada; Los Angeles and Sacramento, California; and Manchester, New Hampshire).

The findings in this report are subject to at least three limitations. First, nonresponses might have affected the accuracy of some states' final water fluoridation percentages by not accounting for changes in status. Second, use of the 2000 U.S. census data as the denominator for calculating water fluoridation percentages in seven states might have resulted in the percentages being underestimated because, in most states, the number of persons using public water systems was probably less than the 2000 U.S. census population. Finally, three states (Kentucky, Rhode Island, and South Dakota) reported their 1992 fluoridation rates as 100%; in these states, the apparent decrease from 1992 to 2000 in the percentage of persons using public water supplies receiving optimally fluoridated water represents an error correction in reporting methods rather than a true decrease.

WFRS will become an increasingly valuable tool for monitoring state and annually updating national water fluoridation data as more users register and routinely participate in entering data and receiving reports. WFRS updates and reports will assist states in monitoring the extent and consistency of water fluoridation. During 2002, CDC will provide online information on water fluoridation for states that update their data electronically.

Although the new WFRS online site might facilitate public knowledge about optimally fluoridated water, efforts to convince jurisdictions to provide such water must address 1) the perception by some scientists, policymakers, and members of the public that dental caries is no longer a public health problem or that fluoridation is no longer necessary or effective; 2) the often complex political process involved in adopting water fluoridation; and 3) unsubstantiated claims by opponents of water fluoridation about its alleged adverse health effects (*10*). To reach the goal of 75% of the public water drinking population supplied with optimally fluoridated water, policymakers and public health officials at the federal, state, and local levels will need to devise new promotion and funding approaches to gain support for this prevention measure.

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TABLE 1. Number of persons and percentage of the population receiving optimally fluoridated water through public water systems (PWS), by state — United States, 1992 and 2000

State	2000 fluoridated population	2000 total PWS population	2000 percentage fluoridated	1992 percentage fluoridated (*9*)	Change in percentage 1992–2000
Alabama*	3,967,059	4,447,100	89.2%	82.6%	6.6
Alaska	270,099	489,371	55.2%	61.2%	–6.0
Arizona	2,700,354	4,869,065	55.5%	49.9%	5.6
Arkansas†	1,455,767	2,431,477	59.9%	58.7%	1.2
California	9,551,961	33,238,057	28.7%	15.7%	13.0
Colorado†	2,852,386	3,708,061	76.9%	81.7%	–4.8
Connecticut	2,398,227	2,701,178	88.8%	85.9%	2.9
Delaware	505,747	624,923	80.9%	67.4%	13.5
District of Columbia	595,000	595,000	100.0%	100.0%	0.0
Florida	9,407,494	15,033,574	62.6%	58.3%	4.3
Georgia	6,161,139	6,634,635	92.9%	92.1%	0.8
Hawaii*	109,147	1,211,537	9.0%	13.0%	–4.0
Idaho	383,720	845,780	45.4%	48.3%	–2.9
Illinois	10,453,837	11,192,286	93.4%	95.2%	–1.8
Indiana	4,232,907	4,441,502	95.3%	98.6%	–3.3
Iowa	2,181,649	2,390,661	91.3%	91.4%	–0.1
Kansas	1,513,306	2,421,274	62.5%	58.4%	4.1
Kentucky	3,235,053	3,367,812	96.1%	100.0%	–3.9
Louisiana*	2,375,702	4,468,976	53.2%	55.7%	–2.5
Maine	466,208	618,033	75.4%	55.8%	19.6
Maryland†	4,124,953	4,547,908	90.7%	85.8%	4.9
Massachusetts†*	3,546,099	6,349,097	55.8%	57.0%	–1.2
Michigan	6,568,151	7,242,531	90.7%	88.5%	2.2
Minnesota	3,714,465	3,780,942	98.2%	93.4%	4.8
Mississippi	1,227,268	2,665,075	46.0%	48.4%	–2.4
Missouri*	4,502,722	5,595,211	80.5%	71.4%	9.1
Montana	143,092	645,452	22.2%	25.9%	–3.7
Nebraska†	966,262	1,243,713	77.7%	62.1%	15.6
Nevada†	1,078,479	1,637,105	65.9%	2.1%	63.8
New Hampshire	347,007	807,438	43.0%	24.0%	19.0
New Jersey	1,120,410	7,208,514	15.5%	16.2%	–0.7
New Mexico	1,187,404	1,548,084	76.7%	66.2%	10.5
New York†	12,000,000	17,690,198	67.8%	69.7%	–1.9
North Carolina	4,862,220	5,837,936	83.3%	78.5%	4.8
North Dakota	531,738	557,595	95.4%	96.4%	–1.0
Ohio	8,355,002	9,535,188	87.6%	87.9%	–0.3
Oklahoma†	2,164,330	2,900,000	74.6%	58.0%	16.6
Oregon†	612,485	2,700,000	22.7%	24.8%	–2.1
Pennsylvania	5,825,328	10,750,095	54.2%	50.9%	3.3
Rhode Island	842,797	989,786	85.1%	100.0%	–14.9
South Carolina	3,086,974	3,383,434	91.2%	90.0%	1.2
South Dakota†	553,503	626,221	88.4%	100.0%	–11.6
Tennessee	4,749,493	5,025,998	94.5%	92.0%	2.5
Texas	11,868,046	18,072,680	65.7%	64.0%	1.7
Utah†*	43,816	2,233,169	2.0%	3.1%	–1.1
Vermont	240,579	443,901	54.2%	57.4%	–3.2
Virginia	5,677,551	6,085,436	93.3%	72.1%	21.2
Washington†	2,844,893	4,925,540	57.8%	53.2%	4.6
West Virginia†	1,207,000	1,387,000	87.0%	82.1%	4.9
Wisconsin	3,108,738	3,481,285	89.3%	93.0%	–3.7
Wyoming*	149,774	493,782	30.3%	35.7%	–5.4
Total	**162,067,341**	**246,120,616**	**65.8%**	**62.1%**	**3.7**

* Reported PWS population exceeded total state population; PWS population was set to the 2000 U.S. census of state populations.
† Complete data were not available from Water Fluoridation Reporting System; additional information was obtained from states.

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Socioeconomic Status of Women with Diabetes — United States, 2000

Persons whose socioeconomic status is low have poorer health than other persons (*1,2*) and are less likely to have adequate access to care or to receive high-quality clinical and prevention care services (*3*). In the United States, diabetes is a potentially debilitating disease that is increasing in prevalence (*4*); however, little is known about the socioeconomic status of persons with diabetes (*5–7*). Women account for approximately 52% of all persons aged ≥20 years with diabetes (*4*). To assess the socioeconomic status of women with diabetes, CDC analyzed data from the Behavioral Risk Factor Surveillance System (BRFSS), which indicated that the socioeconomic status of women with diabetes in 2000 was markedly lower than that of women without diabetes. Efforts should be focused to understand the impact of socioeconomic conditions on the health and quality of care of women with diabetes.

BRFSS is a state-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. population aged ≥18 years. In 2000, the median state-specific response rate was 48.9% (range: 28.8%–71.8%) (CDC, unpublished data, 2001). Persons with diabetes were identified if they answered "yes" to the question, "Have you ever been told by a doctor that you have diabetes?" Women who answered "no" and those who had been told they had diabetes only during pregnancy were considered not to have diabetes. Data on level of education and annual household income were used to assess socioeconomic status; marital status, size of household, and employment status were used as indicators of living arrangements; and household size was derived by adding the number of adults and number of children aged ≤17 years. A woman was classified as having low socioeconomic status if she did not complete high school or resided in a household with an annual income of <$25,000.

State-specific data were aggregated and weighted to reflect age, sex, and racial/ethnic distribution, and chi-square tests were used to test all univariate associations. Because many persons aged 18–24 years have not completed their education, socioeconomic status was evaluated only for women aged ≥25 years. Multivariate logistic regression analysis was used to examine the relation between having diabetes and not completing high school or living in a low-income household, with control made for age, race/ethnicity, and living arrangements. The models then were used to calculate adjusted percentages using the distributions of female respondents aged ≥25 years in the total population. All analyses were conducted using SASv8 software with SUDAAN to estimate standard errors.

Of the 109,680 women who participated in the 2000 BRFSS survey, 6,835 (6.3%) had been told by a doctor that they had diabetes (mean age at diagnosis: 48.8 years). Women with diabetes were more likely than women without diabetes to be aged ≥45 years; nonwhite; divorced, separated, or widowed; living alone; retired; or unable to work (Table 1).

Among women aged ≥25 years, the percentage with diabetes who had not completed high school (27.7%; 95% confidence interval [CI]=25.7%–29.7%) was more than twice that of women without diabetes who had not completed high school (12.2%; 95% CI=11.8%–12.6%) (Table 2). Among women with diabetes, 20.5% (95% CI=18.0%–25.3%) of those aged 25–44 years had not completed high school, compared with 34.3% (95% CI=31.4%–37.2%) of those aged ≥65 years. Among women without diabetes, 9.8% (95% CI=9.2%–10.3%) of those aged 25–44 years had not completed high school, compared with 20.5% (95% CI=19.5%–21.5%) of those aged ≥65 years. After multivariate adjustment, a low level of formal education remained significantly more common among women with diabetes than among those without diabetes.

TABLE 1. Percentage of women aged ≥18 years with and without diabetes, by selected characteristics — Behavioral Risk Factor Surveillance System, United States, 2000

Characteristic	Diabetes* %	Diabetes* (95% CI†)	No diabetes* %	No diabetes* (95% CI)
Age (yrs)				
18–24	1.4	(0.9 – 1.9)	12.6	(12.2 –13.0)
25–44	14.7	(13.2 –16.2)	39.6	(39.1 –40.1)
45–64	42.1	(40.0 –44.2)	29.1	(28.6 –29.6)
≥65	41.9	(39.8 –44.0)	18.7	(18.3 –19.1)
Race/Ethnicity				
Non-Hispanic white	64.8	(62.6 –67.0)	73.8	(73.2 –74.3)
Non-Hispanic black	17.9	(16.3 –19.5)	9.9	(9.6 –10.2)
Hispanic	13.5	(11.6 –15.4)	12.3	(11.9 –12.7)
Non-Hispanic other	3.9	(2.7 – 5.1)	4.0	(3.7 – 4.3)
Marital status				
Married/Unwed couple	48.9	(46.7 –51.0)	60.1	(59.6 –60.6)
Divorced/Separated	16.6	(15.2 –18.0)	13.4	(13.1 –13.7)
Widowed	26.5	(24.6 –28.4)	10.3	(10.0 –10.6)
Never married	8.0	(6.8 – 9.2)	16.3	(15.9 –16.7)
Household size				
1	25.9	(25.2 –26.6)	15.6	(15.3 –15.9)
2	37.9	(35.9 –39.9)	32.7	(32.2 –33.2)
3	15.7	(14.0 –17.4)	18.6	(18.4 –18.8)
≥4	20.5	(18.3 –22.7)	33.1	(32.6 –33.6)
Employment status				
Employed	31.8	(29.8 –33.8)	57.5	(56.7 –58.0)
Unemployed	4.4	(3.5 – 5.3)	8.2	(7.9 – 8.5)
Homemaker	13.2	(11.6 –14.8)	14.1	(13.7 –14.5)
Retired	35.5	(33.5 –37.5)	16.6	(16.2 –17.0)
Unable to work	15.1	(13.5 –16.7)	3.6	(3.4 – 3.8)

* Diabetes = 6,835 persons; no diabetes = 100,927.
† Confidence interval.

Overall, women with diabetes (40.4% [95%CI=38.1%–42.6%]) were approximately twice as likely as women without diabetes (22% [95% CI=21.5%–22.5%]) to have an annual household income <$25,000. Among women with diabetes, the percentages with incomes <$25,000 were highest for women aged ≥65 years (47.8% [95% CI=44.4%–51.1%]) and those aged ≤44 years (41.3% [95% CI=35.4%–47.2%]) and lowest (33% [95% CI=29.5%–36.6%) for women aged 45–64 years (Table 2). In each age group, percentages were lower for women without diabetes (32.9%, 19.7%, and 18.6%, respectively). After multivariate adjustment, the difference between women with and without diabetes remained significant.

Reported by: *GLA Beckles, MD, PE Thompson-Reid, MPH, Div of Diabetes Translation, National Center for Chronic Disease and Health Promotion, CDC.*

Editorial Note: The findings in this report indicate that the socioeconomic status of women with diabetes is lower than that of women without diabetes and confirm the findings of the 1989 National Health Interview Survey (NHIS) (*5*). In 2000, at least one in four women with diabetes aged ≥25 years had a low level of formal education, and 40% lived in low-income households. Women with diabetes were more likely to have a low socioeconomic status independent of living arrangements (i.e., marital status, size of household, and employment status). Attaining a higher educational level might influence decision-making, and persons with a higher income might have better access to health care, higher living standards, and other material benefits that have a positive impact on health. Although socioeconomic status might be influenced adversely by factors related to having diabetes (e.g., being unemployed or retiring early), most women with diabetes in this survey were diagnosed long after they had completed their education. BRFSS estimates suggest that the low socioeconomic status of many women with diabetes might compromise their ability to benefit from treatments that might reduce their risks for complications and premature death. Programs designed to meet the needs of women with diabetes should take socioeconomic status into account to assure that women benefit from the interventions. Performance should be carefully evaluated to assess program effectiveness and identify areas for improvement.

The findings in this report are subject to at least three limitations. First, the low median response rate suggests the potential for participation bias. Second, all data were self-reported and might be subject to recall bias. Finally, the level of low socioeconomic status (i.e., household income <$25,000) among women with diabetes might be underestimated because 21% of women with diabetes declined to

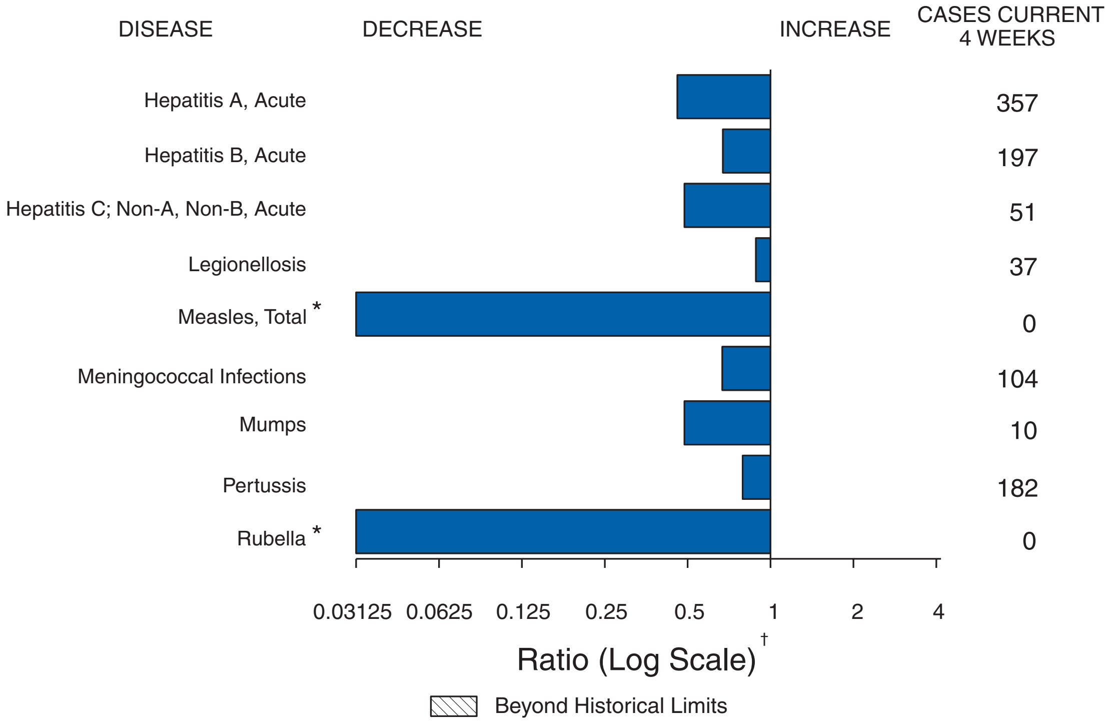
TABLE 2. Percentage of women with low socioeconomic status with and without diabetes, by age group — Behavioral Risk Factor Surveillance System, United States, 2000

	No high school diploma				Annual household income <$25,000			
	Diabetes		No diabetes		Diabetes		No diabetes	
Age group (yrs)	%	(95% CI*)	%	(95% CI)	%	(95% CI)	%	(95% CI)
25–44	20.5	(18.0–25.3)	9.8	(9.2–10.3)	41.3	(35.4–47.2)	19.7	(19.1–20.4)
45–64	23.7	(20.5–26.8)	10.4	(9.7–11.0)	33.0	(29.5–36.6)	18.6	(17.8–19.3)
≥65	34.3	(31.4–37.2)	20.5	(19.5–21.5)	47.8	(44.4–51.1)	32.9	(31.7–34.0)
Unadjusted total	**27.7**	**(25.7–29.7)**	**12.2**	**(11.8–12.6)**	**40.4**	**(38.1–42.6)**	**22.0**	**(21.5–22.5)**
Adjusted total†	**18.0**	**(16.7–19.4)**	**13.0**	**(12.6–13.4)**	**37.0**	**(34.7–39.3)**	**27.0**	**(26.4–27.5)**

* Confidence interval.
† Adjusted for age, race/ethnicity, marital status, size of household, and employment status.

(Continued on page 159)

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending February 16, 2002, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 7 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending February 16, 2002 (7th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		-	-	Encephalitis: West Nile†	4	-
Botulism:	foodborne	5	5	Hansen disease (leprosy)†	3	9
	infant	5	7	Hantavirus pulmonary syndrome†	-	1
	other (wound & unspecified)	1	-	Hemolytic uremic syndrome, postdiarrheal†	8	16
Brucellosis†		7	5	HIV infection, pediatric †§	4	10
Chancroid		3	7	Plague	-	-
Cholera		-	-	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		11	21	Psittacosis†	6	1
Diphtheria		-	-	Q fever†	3	-
Ehrlichiosis:	human granulocytic (HGE)†	5	4	Rabies, human	-	-
	human monocytic (HME)†	1	3	Streptococcal toxic-shock syndrome†	6	13
	other and unspecified	-	-	Tetanus	-	5
Encephalitis:	California serogroup viral†	7	1	Toxic-shock syndrome	13	15
	eastern equine†	-	-	Trichinosis	2	5
	Powassan†	-	-	Tularemia†	4	1
	St. Louis†	-	-	Yellow fever	-	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update January 27, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 16, 2002, and February 17, 2001 (7th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	3,550	4,178	71,342	95,443	211	195	132	126	6	4
NEW ENGLAND	119	87	2,659	2,994	7	4	6	9	-	-
Maine	1	3	174	162	-	-	-	-	-	-
N.H.	2	5	183	160	2	-	-	1	-	-
Vt.	2	5	96	89	-	2	-	-	-	-
Mass.	83	50	1,170	1,147	2	1	4	8	-	-
R.I.	6	9	358	431	3	1	2	-	-	-
Conn.	25	15	678	1,005	-	-	-	-	-	-
MID. ATLANTIC	874	2,021	6,185	8,254	16	30	7	13	-	-
Upstate N.Y.	52	489	900	1,079	3	4	7	9	-	-
N.Y. City	600	1,371	3,313	3,441	8	18	-	-	-	-
N.J.	163	131	263	993	-	2	-	4	-	-
Pa.	59	30	1,709	2,741	5	6	N	N	-	-
E.N. CENTRAL	375	217	10,418	18,793	58	73	41	28	-	-
Ohio	106	37	481	5,356	18	16	11	11	-	-
Ind.	53	26	1,667	1,927	8	8	3	4	-	-
Ill.	175	123	3,253	5,564	3	7	9	7	-	-
Mich.	31	23	3,880	3,592	14	11	8	1	-	-
Wis.	10	8	1,137	2,354	15	31	10	5	-	-
W.N. CENTRAL	47	46	2,743	5,160	16	5	21	11	3	-
Minn.	9	7	746	1,155	7	-	8	6	3	-
Iowa	15	9	-	426	2	2	7	-	-	-
Mo.	22	6	1,030	1,840	5	1	3	2	-	-
N. Dak.	-	-	37	133	-	-	-	-	-	-
S. Dak.	-	-	286	258	-	-	-	1	-	-
Nebr.	-	15	-	488	-	2	-	-	-	-
Kans.	1	9	644	860	2	-	3	2	-	-
S. ATLANTIC	1,156	709	14,748	18,234	52	30	23	14	1	2
Del.	23	14	181	391	-	-	1	-	-	-
Md.	143	39	1,905	1,997	1	2	-	-	-	-
D.C.	19	61	379	401	1	2	-	-	-	-
Va.	113	88	1,978	2,120	-	2	1	2	-	1
W. Va.	8	4	313	310	-	-	-	-	-	-
N.C.	64	33	2,558	2,080	7	4	4	6	-	-
S.C.	112	50	1,702	3,017	-	-	-	1	-	-
Ga.	377	104	1,936	4,116	38	9	16	3	1	1
Fla.	297	316	3,796	3,802	5	11	1	2	-	-
E.S. CENTRAL	158	126	6,213	6,509	11	3	1	4	-	-
Ky.	16	18	972	1,104	1	-	-	-	-	-
Tenn.	86	58	2,093	2,089	1	-	1	2	-	-
Ala.	20	25	2,197	1,620	8	2	-	2	-	-
Miss.	36	25	951	1,696	1	1	-	-	-	-
W.S. CENTRAL	401	385	12,165	14,507	4	4	-	15	-	-
Ark.	14	19	409	1,271	2	1	-	-	-	-
La.	75	117	2,329	2,435	1	1	-	-	-	-
Okla.	7	20	992	1,471	1	1	-	2	-	-
Tex.	305	229	8,435	9,330	-	1	-	13	-	-
MOUNTAIN	121	144	4,865	4,865	10	12	12	7	1	1
Mont.	3	1	364	159	-	-	1	-	-	-
Idaho	1	-	236	249	2	2	1	2	-	-
Wyo.	1	-	99	111	-	-	-	-	1	-
Colo.	21	51	644	1,346	4	5	2	2	-	1
N. Mex.	6	10	755	798	-	3	2	-	-	-
Ariz.	52	37	1,254	1,437	1	1	1	3	-	-
Utah	7	9	880	67	2	1	3	-	-	-
Nev.	30	36	633	698	1	-	2	-	-	-
PACIFIC	299	443	11,346	16,127	37	34	21	25	1	1
Wash.	-	28	1,842	1,871	10	U	4	3	-	-
Oreg.	76	18	-	858	7	3	7	-	1	1
Calif.	220	396	8,680	12,527	20	31	10	18	-	-
Alaska	-	1	434	313	-	-	-	-	-	-
Hawaii	3	-	390	558	-	-	-	4	-	-
Guam	1	1	-	-	-	-	N	N	-	-
P.R.	68	48	-	367	-	-	-	-	-	-
V.I.	33	1	-	24	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	20	U	-	U	-	U	-	U

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

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update January 27, 2002.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 16, 2002, and February 17, 2001 (7th Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive All Ages, All Serotypes		*Haemophilus influenzae*, Invasive Age <5 Years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1	1	1,293	33,495	45,972	182	198	-	2
NEW ENGLAND	-	-	141	847	830	7	7	-	1
Maine	-	-	23	13	23	1	-	-	-
N.H.	-	-	9	11	13	1	-	-	-
Vt.	-	-	16	13	14	-	-	-	-
Mass.	-	-	45	450	354	5	7	-	1
R.I.	-	-	18	119	109	-	-	-	-
Conn.	-	-	30	241	317	-	-	-	-
MID. ATLANTIC	-	-	240	2,996	4,141	31	33	-	-
Upstate N.Y.	-	-	60	501	604	16	7	-	-
N.Y. City	-	-	99	1,452	1,566	10	11	-	-
N.J.	-	-	-	225	584	2	12	-	-
Pa.	-	-	81	818	1,387	3	3	-	-
E.N. CENTRAL	1	-	273	5,490	9,728	26	39	-	-
Ohio	1	-	119	340	2,898	21	16	-	-
Ind.	-	-	-	771	912	3	3	-	-
Ill.	-	-	31	1,906	2,937	-	13	-	-
Mich.	-	-	100	2,078	2,124	1	3	-	-
Wis.	-	-	23	395	857	1	4	-	-
W.N. CENTRAL	-	-	127	1,448	2,278	2	3	-	-
Minn.	-	-	37	262	372	-	-	-	-
Iowa	-	-	34	-	113	1	-	-	-
Mo.	-	-	31	844	1,158	1	3	-	-
N. Dak.	-	-	-	-	4	-	-	-	-
S. Dak.	-	-	8	38	30	-	-	-	-
Nebr.	-	-	-	-	187	-	-	-	-
Kans.	-	-	17	304	414	-	-	-	-
S. ATLANTIC	-	-	222	9,328	11,997	55	58	-	1
Del.	-	-	10	141	217	-	-	-	-
Md.	-	-	17	1,075	1,156	16	12	-	-
D.C.	-	-	8	335	420	-	-	-	-
Va.	-	-	9	1,258	1,219	2	3	-	-
W. Va.	-	-	2	127	59	-	2	-	1
N.C.	-	-	-	2,087	1,733	5	6	-	-
S.C.	-	-	1	995	2,714	-	1	-	-
Ga.	-	-	103	1,236	2,283	22	19	-	-
Fla.	-	-	72	2,074	2,196	10	15	-	-
E.S. CENTRAL	-	1	34	3,825	4,410	3	4	-	-
Ky.	-	1	-	407	466	-	-	-	-
Tenn.	-	-	11	1,289	1,494	2	2	-	-
Ala.	-	-	23	1,477	1,359	1	2	-	-
Miss.	-	-	-	652	1,091	-	-	-	-
W.S. CENTRAL	-	-	9	5,726	7,472	9	2	-	-
Ark.	-	-	9	253	874	-	-	-	-
La.	-	-	-	1,574	1,699	-	-	-	-
Okla.	-	-	-	436	731	9	2	-	-
Tex.	-	-	-	3,463	4,168	-	-	-	-
MOUNTAIN	-	-	126	1,243	1,296	31	35	-	-
Mont.	-	-	5	24	6	-	-	-	-
Idaho	-	-	3	13	17	-	1	-	-
Wyo.	-	-	1	8	12	-	-	-	-
Colo.	-	-	50	433	474	7	7	-	-
N. Mex.	-	-	8	146	141	7	6	-	-
Ariz.	-	-	12	354	392	13	20	-	-
Utah	-	-	25	67	9	3	-	-	-
Nev.	-	-	22	198	245	1	1	-	-
PACIFIC	-	-	121	2,592	3,820	18	17	-	-
Wash.	-	-	22	407	420	-	-	-	-
Oreg.	-	-	76	-	151	13	-	-	-
Calif.	-	-	-	2,038	3,119	-	12	-	-
Alaska	-	-	10	95	37	-	1	-	-
Hawaii	-	-	13	52	93	5	4	-	-
Guam	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	128	-	-	-	-
V.I.	-	-	-	-	3	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	1	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 16, 2002, and February 17, 2001 (7th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive				Hepatitis (Viral, Acute), By Type					
	Age <5 Years									
	Non-Serotype B		Unknown Serotype		A		B		C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	27	37	-	3	830	1,872	394	737	130	691
NEW ENGLAND	1	3	-	-	48	68	14	18	3	9
Maine	-	-	-	-	1	1	-	1	-	-
N.H.	-	-	-	-	3	2	3	1	-	-
Vt.	-	-	-	-	-	1	1	1	3	2
Mass.	1	3	-	-	23	29	9	4	-	7
R.I.	-	-	-	-	4	2	1	-	-	-
Conn.	-	-	-	-	17	33	-	11	-	-
MID. ATLANTIC	2	4	-	-	66	172	63	185	24	313
Upstate N.Y.	2	-	-	-	14	16	4	6	4	6
N.Y. City	-	2	-	-	12	59	31	85	-	-
N.J.	-	-	-	-	1	75	8	71	18	298
Pa.	-	2	-	-	39	22	20	23	2	9
E.N. CENTRAL	4	7	-	-	81	602	57	71	10	46
Ohio	3	2	-	-	29	35	9	15	1	1
Ind.	1	-	-	-	2	5	2	2	-	-
Ill.	-	4	-	-	21	483	2	2	1	19
Mich.	-	-	-	-	26	68	44	52	8	26
Wis.	-	1	-	-	3	11	-	-	-	-
W.N. CENTRAL	-	-	-	1	44	77	17	28	36	161
Minn.	-	-	-	-	1	1	2	1	-	-
Iowa	-	-	-	-	13	5	5	4	-	-
Mo.	-	-	-	1	8	24	7	17	36	159
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	2	-	-	1	-	-
Nebr.	-	-	-	-	-	17	-	4	-	1
Kans.	-	-	-	-	20	30	3	1	-	1
S. ATLANTIC	7	8	-	-	249	192	118	143	10	6
Del.	-	-	-	-	-	1	1	3	3	1
Md.	-	-	-	-	67	38	14	16	2	1
D.C.	-	-	-	-	12	3	2	2	-	-
Va.	1	-	-	-	3	19	13	9	-	-
W. Va.	-	-	-	-	1	-	2	1	-	-
N.C.	-	-	-	-	42	5	34	26	3	1
S.C.	-	-	-	-	8	9	3	-	1	-
Ga.	3	5	-	-	39	70	21	64	-	1
Fla.	3	3	-	-	77	47	28	22	1	2
E.S. CENTRAL	1	-	-	1	28	38	11	50	19	10
Ky.	-	-	-	-	8	5	3	8	1	-
Tenn.	-	-	-	-	-	15	-	15	3	7
Ala.	1	-	-	1	5	17	8	14	2	-
Miss.	-	-	-	-	15	1	-	13	13	3
W.S. CENTRAL	4	1	-	-	13	338	14	45	-	125
Ark.	-	-	-	-	5	13	12	14	-	1
La.	-	-	-	-	-	14	-	19	-	52
Okla.	4	1	-	-	7	20	1	11	-	-
Tex.	-	-	-	-	1	291	1	1	-	72
MOUNTAIN	6	5	-	1	66	120	29	54	12	8
Mont.	-	-	-	-	2	2	-	-	-	-
Idaho	-	-	-	-	-	17	-	2	-	1
Wyo.	-	-	-	-	2	1	2	-	4	2
Colo.	1	-	-	-	15	17	11	13	6	1
N. Mex.	2	2	-	1	3	3	1	16	-	4
Ariz.	2	3	-	-	24	54	7	15	-	-
Utah	-	-	-	-	8	7	3	-	-	-
Nev.	1	-	-	-	12	19	5	8	2	-
PACIFIC	2	9	-	-	235	265	71	143	16	13
Wash.	-	-	-	-	7	5	2	5	-	-
Oreg.	2	-	-	-	20	1	17	3	6	1
Calif.	-	8	-	-	208	248	52	131	10	12
Alaska	-	-	-	-	-	10	-	1	-	-
Hawaii	-	1	-	-	-	1	-	3	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	1	-	6	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	4	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 16, 2002, and February 17, 2001 (7th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	76	98	30	45	361	582	104	153	-	23†
NEW ENGLAND	3	2	1	4	16	80	8	15	-	4
Maine	-	-	1	-	-	-	1	-	-	-
N.H.	1	-	-	-	7	2	4	-	-	-
Vt.	-	1	-	-	-	-	-	-	-	1
Mass.	-	1	-	4	6	29	-	8	-	3
R.I.	-	-	-	-	3	-	-	-	-	-
Conn.	2	-	-	-	-	49	3	7	-	-
MID. ATLANTIC	12	20	5	5	264	407	12	36	-	-
Upstate N.Y.	3	1	3	1	166	111	3	1	-	-
N.Y. City	-	2	1	1	-	4	5	19	-	-
N.J.	-	4	-	2	16	86	2	10	-	-
Pa.	9	13	1	1	82	206	2	6	-	-
E.N. CENTRAL	35	37	5	7	7	23	10	30	-	-
Ohio	25	14	4	1	7	8	7	4	-	-
Ind.	1	2	-	-	-	-	-	6	-	-
Ill.	-	6	-	1	-	2	-	9	-	-
Mich.	9	9	1	3	-	-	3	11	-	-
Wis.	-	6	-	2	U	13	-	-	-	-
W.N. CENTRAL	1	6	-	1	6	3	6	4	-	-
Minn.	-	-	-	-	2	3	-	1	-	-
Iowa	-	1	-	-	2	-	2	-	-	-
Mo.	1	3	-	-	2	-	2	3	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-
Nebr.	-	1	-	-	-	-	-	-	-	-
Kans.	-	1	-	1	-	-	2	-	-	-
S. ATLANTIC	14	9	6	3	52	47	40	30	-	3
Del.	3	-	-	-	5	4	-	1	-	-
Md.	4	5	1	1	37	40	15	12	-	3
D.C.	-	-	-	-	3	1	2	2	-	-
Va.	-	2	-	1	-	1	-	8	-	-
W. Va.	N	N	-	-	-	-	-	-	-	-
N.C.	1	-	-	-	-	1	4	1	-	-
S.C.	-	-	2	-	1	-	2	-	-	-
Ga.	3	1	2	1	-	-	11	4	-	-
Fla.	3	1	1	-	6	-	6	2	-	-
E.S. CENTRAL	-	6	2	4	-	2	2	1	-	-
Ky.	-	2	-	1	-	2	-	-	-	-
Tenn.	-	-	1	2	-	-	1	1	-	-
Ala.	-	2	1	1	-	-	1	-	-	-
Miss.	-	2	-	-	-	-	-	-	-	-
W.S. CENTRAL	-	2	-	3	1	11	-	2	-	-
Ark.	-	-	-	-	-	-	-	-	-	-
La.	-	1	-	-	-	-	-	1	-	-
Okla.	-	-	-	-	-	-	-	-	-	-
Tex.	-	1	-	3	1	11	-	1	-	-
MOUNTAIN	4	4	3	3	2	-	3	8	-	1
Mont.	-	-	-	-	-	-	-	1	-	-
Idaho	-	-	-	-	-	-	-	1	-	1
Wyo.	-	-	-	-	-	-	-	-	-	-
Colo.	1	3	1	1	1	-	2	3	-	-
N. Mex.	1	-	-	-	1	-	-	-	-	-
Ariz.	-	1	2	1	-	-	-	1	-	-
Utah	2	-	-	-	-	-	-	1	-	-
Nev.	-	-	-	1	-	-	1	1	-	-
PACIFIC	7	12	8	15	13	9	23	27	-	15
Wash.	-	1	-	-	-	-	-	-	-	11
Oreg.	N	N	1	1	1	1	-	2	-	2
Calif.	7	11	7	14	12	8	20	22	-	1
Alaska	-	-	-	-	-	-	1	1	-	-
Hawaii	-	-	-	-	N	N	2	2	-	1
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	-	-	N	N	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

† Of 23 cases reported, 19 were indigenous and four were imported from another country.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 16, 2002, and February 17, 2001 (7th Week)*

	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
Reporting Area	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	192	471	18	20	448	637	388	706
NEW ENGLAND	16	29	1	-	126	105	64	59
Maine	2	-	-	-	3	-	4	10
N.H.	1	1	1	-	1	6	1	-
Vt.	2	-	-	-	17	17	17	11
Mass.	8	20	-	-	105	80	19	16
R.I.	2	-	-	-	-	-	4	8
Conn.	1	8	-	-	-	2	19	14
MID. ATLANTIC	19	66	3	2	26	27	71	104
Upstate N.Y.	4	13	1	1	22	22	54	60
N.Y. City	4	12	-	1	-	4	4	-
N.J.	1	28	-	-	-	-	-	16
Pa.	10	13	2	-	4	1	13	28
E.N. CENTRAL	31	49	-	1	65	83	2	6
Ohio	17	13	-	1	43	57	1	-
Ind.	6	-	-	-	2	1	1	1
Ill.	-	11	-	-	10	1	-	-
Mich.	6	17	-	-	9	10	-	2
Wis.	2	8	-	-	1	14	-	3
W.N. CENTRAL	8	27	1	1	61	29	21	45
Minn.	-	-	-	-	1	-	3	11
Iowa	1	8	-	-	26	5	4	9
Mo.	4	12	-	-	22	15	1	2
N. Dak.	-	-	-	-	-	-	-	8
S. Dak.	2	-	-	-	2	2	-	7
Nebr.	-	2	-	-	-	-	-	-
Kans.	1	5	1	1	10	7	13	8
S. ATLANTIC	34	72	3	1	41	27	165	177
Del.	1	-	-	-	1	-	3	-
Md.	1	12	1	1	10	7	38	36
D.C.	-	-	-	-	-	-	-	-
Va.	2	7	1	-	12	-	54	41
W. Va.	-	-	-	-	-	-	10	13
N.C.	5	17	-	-	7	10	54	45
S.C.	2	4	1	-	10	4	6	7
Ga.	8	14	-	-	-	6	-	15
Fla.	15	18	-	-	1	-	-	20
E.S. CENTRAL	10	28	2	-	15	16	12	110
Ky.	-	3	-	-	4	3	1	2
Tenn.	1	9	-	-	9	8	7	106
Ala.	8	10	1	-	2	2	4	2
Miss.	1	6	1	-	-	3	-	-
W.S. CENTRAL	11	110	-	-	18	3	16	129
Ark.	5	6	-	-	5	2	-	-
La.	1	17	-	-	-	-	-	2
Okla.	4	6	-	-	1	1	16	10
Tex.	1	81	-	-	12	-	-	117
MOUNTAIN	22	22	-	2	76	282	15	33
Mont.	-	-	-	-	2	-	-	4
Idaho	-	3	-	-	5	45	-	-
Wyo.	-	-	-	1	1	-	1	10
Colo.	7	8	-	-	41	92	-	-
N. Mex.	-	4	-	1	12	8	-	-
Ariz.	7	3	-	-	9	133	14	19
Utah	4	2	-	-	5	4	-	-
Nev.	4	2	-	-	1	-	-	-
PACIFIC	41	68	8	13	20	65	22	43
Wash.	7	6	-	-	4	7	-	-
Oreg.	11	1	N	N	11	2	-	-
Calif.	21	57	8	7	3	49	8	21
Alaska	1	-	-	-	2	-	14	22
Hawaii	1	4	-	6	-	7	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	11	16
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U

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

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 16, 2002, and February 17, 2001 (7th Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella: Rubella		Rubella: Congenital Rubella		Salmonellosis	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	31	9	-	-	-	-	2,554	3,118
NEW ENGLAND	-	-	-	-	-	-	150	162
Maine	-	-	-	-	-	-	28	8
N.H.	-	-	-	-	-	-	4	11
Vt.	-	-	-	-	-	-	6	9
Mass.	-	-	-	-	-	-	76	121
R.I.	-	-	-	-	-	-	5	9
Conn.	-	-	-	-	-	-	31	4
MID. ATLANTIC	4	1	-	-	-	-	206	535
Upstate N.Y.	-	-	-	-	-	-	42	63
N.Y. City	-	-	-	-	-	-	80	133
N.J.	-	-	-	-	-	-	2	199
Pa.	4	1	-	-	-	-	82	140
E.N. CENTRAL	2	2	-	-	-	-	399	450
Ohio	2	-	-	-	-	-	108	140
Ind.	-	1	-	-	-	-	33	24
Ill.	-	1	-	-	-	-	140	139
Mich.	-	-	-	-	-	-	83	76
Wis.	-	-	-	-	-	-	35	71
W.N. CENTRAL	-	1	-	-	-	-	187	175
Minn.	-	-	-	-	-	-	43	56
Iowa	-	-	-	-	-	-	36	18
Mo.	-	1	-	-	-	-	76	47
N. Dak.	-	-	-	-	-	-	-	1
S. Dak.	-	-	-	-	-	-	11	13
Nebr.	-	-	-	-	-	-	-	13
Kans.	-	-	-	-	-	-	21	27
S. ATLANTIC	23	4	-	-	-	-	775	681
Del.	-	-	-	-	-	-	6	8
Md.	5	1	-	-	-	-	74	76
D.C.	-	-	-	-	-	-	9	13
Va.	-	-	-	-	-	-	70	73
W. Va.	-	-	-	-	-	-	3	1
N.C.	18	3	-	-	-	-	118	134
S.C.	-	-	-	-	-	-	31	49
Ga.	-	-	-	-	-	-	294	199
Fla.	-	-	-	-	-	-	170	128
E.S. CENTRAL	2	1	-	-	-	-	160	178
Ky.	-	-	-	-	-	-	18	31
Tenn.	2	1	-	-	-	-	46	34
Ala.	-	-	-	-	-	-	60	76
Miss.	-	-	-	-	-	-	36	37
W.S. CENTRAL	-	-	-	-	-	-	55	346
Ark.	-	-	-	-	-	-	27	25
La.	-	-	-	-	-	-	-	59
Okla.	-	-	-	-	-	-	26	12
Tex.	-	-	-	-	-	-	2	250
MOUNTAIN	-	-	-	-	-	-	190	162
Mont.	-	-	-	-	-	-	3	7
Idaho	-	-	-	-	-	-	10	6
Wyo.	-	-	-	-	-	-	4	8
Colo.	-	-	-	-	-	-	65	45
N. Mex.	-	-	-	-	-	-	26	26
Ariz.	-	-	-	-	-	-	34	44
Utah	-	-	-	-	-	-	17	15
Nev.	-	-	-	-	-	-	31	11
PACIFIC	-	-	-	-	-	-	432	429
Wash.	-	-	-	-	-	-	12	14
Oreg.	-	-	-	-	-	-	39	5
Calif.	-	-	-	-	-	-	348	360
Alaska	-	-	-	-	-	-	9	5
Hawaii	-	-	-	-	-	-	24	45
Guam	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	3	79
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	1	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 16, 2002, and February 17, 2001 (7th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1,453	1,659	410	528	213	368	12	12
NEW ENGLAND	28	19	15	18	1	2	6	-
Maine	2	-	4	5	-	-	-	-
N.H.	1	-	4	3	-	-	-	-
Vt.	-	-	1	3	1	2	6	-
Mass.	22	17	6	7	-	-	-	-
R.I.	-	-	-	-	-	-	-	-
Conn.	3	2	-	-	-	-	-	-
MID. ATLANTIC	49	224	61	111	10	18	2	8
Upstate N.Y.	6	66	26	27	10	17	2	8
N.Y. City	27	60	22	45	-	-	-	-
N.J.	-	59	6	36	-	-	-	-
Pa.	16	39	7	3	-	1	-	-
E.N. CENTRAL	202	252	76	139	13	22	2	4
Ohio	133	60	30	35	-	-	2	-
Ind.	7	32	1	-	13	22	-	4
Ill.	37	90	1	47	-	-	-	-
Mich.	20	51	44	50	-	-	-	-
Wis.	5	19	-	7	-	-	-	-
W.N. CENTRAL	150	205	17	36	22	4	-	-
Minn.	20	97	-	-	-	-	-	-
Iowa	7	19	-	-	-	-	-	-
Mo.	17	49	10	19	1	-	-	-
N. Dak.	-	8	-	2	-	1	-	-
S. Dak.	91	2	-	2	1	-	-	-
Nebr.	-	10	-	2	-	1	-	-
Kans.	15	20	7	11	20	2	-	-
S. ATLANTIC	629	200	96	66	134	245	2	-
Del.	2	2	-	-	3	-	-	-
Md.	52	15	15	8	-	-	-	-
D.C.	3	8	2	-	2	1	2	-
Va.	154	11	5	21	-	-	-	-
W. Va.	1	1	-	-	3	6	-	-
N.C.	37	45	23	13	-	-	-	-
S.C.	7	12	2	1	21	40	-	-
Ga.	313	45	37	12	45	90	-	-
Fla.	60	61	12	11	60	108	-	-
E.S. CENTRAL	96	112	13	11	23	45	-	-
Ky.	18	41	1	4	1	5	-	-
Tenn.	9	12	12	7	22	39	-	-
Ala.	36	23	-	-	-	1	-	-
Miss.	33	36	-	-	-	-	-	-
W.S. CENTRAL	45	295	7	73	2	22	-	-
Ark.	16	29	-	-	2	6	-	-
La.	-	30	-	-	-	16	-	-
Okla.	28	1	6	6	-	-	-	-
Tex.	1	235	1	67	-	-	-	-
MOUNTAIN	45	82	61	57	8	10	-	-
Mont.	-	-	-	-	-	-	-	-
Idaho	2	4	1	1	-	-	-	-
Wyo.	-	-	1	-	5	-	-	-
Colo.	15	16	41	35	-	-	-	-
N. Mex.	3	19	18	15	3	10	-	-
Ariz.	13	36	-	5	-	-	-	-
Utah	5	2	-	1	-	-	-	-
Nev.	7	5	-	-	-	-	-	-
PACIFIC	209	270	64	17	-	-	-	-
Wash.	2	24	16	-	-	-	-	-
Oreg.	20	-	-	-	-	-	-	-
Calif.	179	243	39	10	-	-	-	-
Alaska	1	-	-	-	-	-	-	-
Hawaii	7	3	9	7	-	-	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	2	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	-	U	-	U	-	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
*Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 16, 2002, and February 17, 2001 (7th Week)*

	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital†					
Reporting Area	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	600	630	-	62	511	990	19	30
NEW ENGLAND	7	2	-	-	17	32	3	4
Maine	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	1	1	-	-
Vt.	-	-	-	-	-	1	-	-
Mass.	6	-	-	-	5	21	2	4
R.I.	-	-	-	-	5	-	-	-
Conn.	1	2	-	-	6	9	1	-
MID. ATLANTIC	51	57	-	11	114	152	2	13
Upstate N.Y.	4	1	-	6	2	20	-	3
N.Y. City	34	34	-	-	77	67	2	1
N.J.	11	7	-	5	-	45	-	9
Pa.	2	15	-	-	35	20	-	-
E.N. CENTRAL	123	88	-	10	94	101	4	3
Ohio	19	6	-	-	21	17	2	1
Ind.	7	14	-	-	12	11	-	-
Ill.	29	40	-	9	44	57	-	1
Mich.	65	25	-	1	11	9	1	1
Wis.	3	3	-	-	6	7	1	-
W.N. CENTRAL	1	14	-	1	43	24	-	1
Minn.	-	11	-	-	22	16	-	-
Iowa	-	-	-	-	-	-	-	-
Mo.	1	3	-	-	21	5	-	1
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	1	-	-
Nebr.	-	-	-	-	-	2	-	-
Kans.	-	-	-	1	-	-	-	-
S. ATLANTIC	144	220	-	16	36	175	5	4
Del.	1	1	-	-	-	-	-	-
Md.	11	37	-	1	10	8	-	2
D.C.	7	3	-	-	-	16	-	-
Va.	5	15	-	-	7	21	-	-
W. Va.	-	-	-	-	5	6	-	-
N.C.	48	55	-	2	10	10	-	-
S.C.	17	34	-	5	2	16	-	-
Ga.	17	28	-	4	2	37	4	2
Fla.	38	47	-	4	-	61	1	-
E.S. CENTRAL	87	74	-	2	33	55	-	-
Ky.	2	7	-	-	13	7	-	-
Tenn.	30	37	-	1	-	8	-	-
Ala.	48	16	-	1	16	29	-	-
Miss.	7	14	-	-	4	11	-	-
W.S. CENTRAL	88	93	-	12	6	189	-	2
Ark.	-	9	-	2	3	13	-	-
La.	19	18	-	-	-	-	-	-
Okla.	8	13	-	1	3	2	-	-
Tex.	61	53	-	9	-	174	-	2
MOUNTAIN	41	24	-	2	22	37	1	1
Mont.	-	-	-	-	-	-	-	-
Idaho	1	-	-	-	-	-	-	-
Wyo.	-	-	-	-	1	-	-	-
Colo.	-	2	-	-	2	12	1	-
N. Mex.	6	2	-	-	4	3	-	-
Ariz.	32	14	-	2	11	12	-	-
Utah	2	4	-	-	2	-	-	-
Nev.	-	2	-	-	2	10	-	1
PACIFIC	58	58	-	8	146	225	4	2
Wash.	6	13	-	-	16	23	-	-
Oreg.	-	2	-	-	6	10	1	-
Calif.	51	41	-	8	96	162	3	2
Alaska	-	-	-	-	12	8	-	-
Hawaii	1	2	-	-	16	22	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	41	-	1	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	1	U	-	U	8	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE III. Deaths in 122 U.S. cities,* week ending February 16, 2002 (7th Week)

Reporting Area	All Causes, By Age (Years)						P&I†
	All Ages	>65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	369	285	57	19	6	2	44
Boston, Mass.	U	U	U	U	U	U	U
Bridgeport, Conn.	43	31	7	5	-	-	5
Cambridge, Mass.	24	22	1	1	-	-	6
Fall River, Mass.	U	U	U	U	U	U	U
Hartford, Conn.	36	25	9	-	-	2	2
Lowell, Mass.	35	28	4	3	-	-	7
Lynn, Mass.	9	7	1	1	-	-	2
New Bedford, Mass.	27	26	-	1	-	-	4
New Haven, Conn.	54	38	11	2	3	-	4
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	5	4	1	-	-	-	1
Springfield, Mass.	42	32	5	3	2	-	3
Waterbury, Conn.	25	20	4	-	1	-	6
Worcester, Mass.	69	52	14	3	-	-	4
MID. ATLANTIC	2,321	1,677	435	153	21	34	161
Albany, N.Y.	51	36	10	3	1	1	8
Allentown, Pa.	28	27	1	-	-	-	4
Buffalo, N.Y.	98	77	15	4	1	1	6
Camden, N.J.	29	17	6	4	1	1	2
Elizabeth, N.J.	14	12	2	-	-	-	-
Erie, Pa.	42	30	7	3	1	1	1
Jersey City, N.J.	30	18	10	2	-	-	-
New York City, N.Y.	1,330	949	252	97	11	21	78
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	21	12	6	2	-	1	1
Philadelphia, Pa.	270	174	66	21	3	5	14
Pittsburgh, Pa.§	26	19	2	3	1	1	4
Reading, Pa.	29	24	4	1	-	-	5
Rochester, N.Y.	140	114	23	3	-	-	16
Schenectady, N.Y.	29	19	6	2	1	1	4
Scranton, Pa.	29	23	3	3	-	-	1
Syracuse, N.Y.	101	81	15	5	-	-	12
Trenton, N.J.	20	17	2	-	-	1	2
Utica, N.Y.	34	28	5	-	1	-	3
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,791	1,274	348	95	36	38	134
Akron, Ohio	65	53	10	1	-	1	10
Canton, Ohio	42	37	3	1	-	1	7
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	76	49	18	3	3	3	14
Cleveland, Ohio	142	90	35	7	6	4	10
Columbus, Ohio	227	172	44	6	1	4	10
Dayton, Ohio	152	111	29	9	1	2	9
Detroit, Mich.	158	83	48	18	3	6	9
Evansville, Ind.	62	57	5	-	-	-	5
Fort Wayne, Ind.	71	50	13	4	3	1	4
Gary, Ind.	18	11	5	-	2	-	1
Grand Rapids, Mich.	45	36	7	1	-	1	3
Indianapolis, Ind.	214	146	43	11	7	7	19
Lansing, Mich.	39	29	5	4	1	-	2
Milwaukee, Wis.	126	85	24	13	2	2	13
Peoria, Ill.	55	41	7	1	4	2	1
Rockford, Ill.	66	43	17	5	-	1	7
South Bend, Ind.	49	40	7	1	1	-	1
Toledo, Ohio	114	87	18	4	2	3	9
Youngstown, Ohio	70	54	10	6	-	-	-
W.N. CENTRAL	745	523	148	39	16	19	63
Des Moines, Iowa	98	74	16	4	-	4	13
Duluth, Minn.	U	U	U	U	U	U	U
Kansas City, Kans.	14	6	3	2	1	2	1
Kansas City, Mo.	98	65	20	6	4	3	8
Lincoln, Nebr.	54	39	10	2	1	2	2
Minneapolis, Minn.	5	3	2	-	-	-	-
Omaha, Nebr.	126	91	22	9	1	3	16
St. Louis, Mo.	86	52	25	5	2	2	5
St. Paul, Minn.	111	87	19	2	3	-	10
Wichita, Kans.	153	106	31	9	4	3	8
S. ATLANTIC	1,394	895	314	115	40	29	104
Atlanta, Ga.	169	103	43	18	1	4	7
Baltimore, Md.	157	93	43	14	5	2	20
Charlotte, N.C.	114	78	20	11	1	4	16
Jacksonville, Fla.	132	90	27	8	3	4	11
Miami, Fla.	93	56	16	13	5	3	4
Norfolk, Va.	62	46	15	1	-	-	-
Richmond, Va.	49	25	17	4	1	2	2
Savannah, Ga.	51	31	15	3	1	1	4
St. Petersburg, Fla.	62	48	6	6	2	-	8
Tampa, Fla.	202	147	38	8	5	4	26
Washington, D.C.	303	178	74	29	16	5	6
Wilmington, Del.	U	U	U	U	U	U	U
E.S. CENTRAL	930	622	198	59	22	27	89
Birmingham, Ala.	221	137	57	12	6	7	21
Chattanooga, Tenn.	97	75	15	5	1	1	8
Knoxville, Tenn.	83	56	20	5	1	1	5
Lexington, Ky.	58	40	12	1	2	3	9
Memphis, Tenn.	195	128	45	9	6	7	17
Mobile, Ala.	68	54	6	7	1	-	7
Montgomery, Ala.	42	24	12	5	1	-	6
Nashville, Tenn.	166	108	31	15	4	8	16
W.S. CENTRAL	990	693	207	51	18	21	95
Austin, Tex.	107	72	21	10	1	3	13
Baton Rouge, La.	47	38	6	1	-	2	3
Corpus Christi, Tex.	67	46	17	2	2	-	11
Dallas, Tex.	U	U	U	U	U	U	U
El Paso, Tex.	60	40	9	4	3	4	5
Ft. Worth, Tex.	166	114	31	13	3	5	19
Houston, Tex.	U	U	U	U	U	U	U
Little Rock, Ark.	75	53	15	4	-	3	3
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	314	218	73	13	7	3	21
Shreveport, La.	20	15	4	-	1	-	5
Tulsa, Okla.	134	97	31	4	1	1	15
MOUNTAIN	1,058	750	182	84	20	17	91
Albuquerque, N.M.	112	72	24	10	4	1	13
Boise, Idaho	62	51	5	4	-	2	5
Colo. Springs, Colo.	80	60	11	7	-	2	5
Denver, Colo.	U	U	U	U	U	U	U
Las Vegas, Nev.	248	178	47	16	4	3	16
Ogden, Utah	31	28	1	2	-	-	3
Phoenix, Ariz.	201	131	32	25	5	4	11
Pueblo, Colo.	36	29	5	1	1	-	6
Salt Lake City, Utah	105	70	21	6	5	3	18
Tucson, Ariz.	183	131	36	13	1	2	14
PACIFIC	2,180	1,581	395	119	49	36	182
Berkeley, Calif.	12	9	2	-	-	1	3
Fresno, Calif.	187	144	29	9	2	3	15
Glendale, Calif.	32	28	3	1	-	-	1
Honolulu, Hawaii	103	80	17	4	-	2	7
Long Beach, Calif.	77	55	13	3	4	2	14
Los Angeles, Calif.	737	530	123	56	22	6	45
Pasadena, Calif.	28	18	4	3	2	1	4
Portland, Oreg.	88	58	14	11	3	2	6
Sacramento, Calif.	162	118	32	6	4	2	16
San Diego, Calif.	193	132	46	7	5	3	21
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	199	143	42	8	1	5	18
Santa Cruz, Calif.	36	30	5	-	1	-	3
Seattle, Wash.	143	102	27	7	3	4	9
Spokane, Wash.	74	55	14	2	1	2	12
Tacoma, Wash.	109	79	24	2	1	3	8
TOTAL	11,778¶	8,300	2,284	734	228	223	963

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

(Continued from page 148)

state their income; these nonrespondents were more likely to be elderly, Hispanic, widowed, retired, or not to have completed high school (i.e., to belong to groups that are frequently low income).

CDC has initiated activities that focus on the needs of women with diabetes. CDC's "*Diabetes and Women's Health Across the Life Stages: A Public Health Perspective*" analyzes the epidemiologic, social, and environmental dimensions of women and diabetes and discusses public health implications (*8*). CDC, the American Diabetes Association, the American Public Health Association, and the Association of State and Territorial Health Officials are developing a National Public Health Action Plan for Diabetes and Women. CDC is sponsoring Translating Research into Action for Diabetes (TRIAD), a 5-year prospective study of the quality of diabetes care, costs, and outcomes in managed-care settings that will examine the effects of socioeconomic status on health and quality of care. Finally, CDC is encouraging increased focus on women with diabetes through the National Diabetes Education Program, a collaborative effort with the National Institutes of Health to promote early diagnosis and improvement of the treatment and outcomes for persons with diabetes (available at http://www.cdc.gov/diabetes/projects/ndeps.htm); Racial and Ethnic Approaches to Community Health (REACH) 2010, a program aimed at eliminating disparities in the health status of ethnic minorities (available at http://www.cdc.gov/reach2010), and state-based diabetes control programs.

The low socioeconomic status of many women with diabetes poses challenges to public health practitioners. As the prevalence of diabetes continues to increase, continued and creative efforts will be needed to gain greater understanding of how socioeconomic status affects the health of women with diabetes.

Acknowledgement

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