MMWR™
Morbidity and Mortality Weekly Report
Weekly October 7, 2005 / Vol. 54 / No. 39

National Breast Cancer Awareness Month — October 2005

October is National Breast Cancer Awareness Month. Breast cancer is the most common cancer and the second leading cause of cancer-related deaths among women in the United States (*1*). Mammography can detect breast cancer at its earliest, most treatable stage, as early as 3 years before lumps are detected during breast self-exams or clinical breast examinations.

According to *United States Cancer Statistics: 2002 Incidence and Mortality*, which includes cancer incidence data for approximately 93% of the U.S. population and cancer mortality data for the entire population, approximately 180,000 cases of breast cancer were diagnosed among women in 2002, and approximately 41,000 women died from the disease. Among men, approximately 1,600 cases of breast cancer were diagnosed, and 369 men died from the disease (*2*).

The National Breast and Cervical Cancer Early Detection Program, administered by CDC, helps low-income, uninsured, and underserved women gain access to breast and cervical cancer screening services. The program has served approximately 2.5 million women, provided approximately 5.8 million screening examinations, and diagnosed approximately 22,000 cases of breast cancer since 1991. Additional information about CDC programs that promote early detection and treatment of breast and cervical cancer is available at http://www.cdc.gov/cancer/nbccedp/index.htm.

References

1 American Cancer Society. Cancer facts and figures. Atlanta, GA: American Cancer Society; 2005.
2. US Cancer Statistics Working Group. United States cancer statistics: 2002 incidence and mortality. Atlanta, GA: National Cancer Institute, US Department of Health and Human Services, CDC; 2005. In press.

Breast Cancer Screening and Socioeconomic Status — 35 Metropolitan Areas, 2000 and 2002

Studies have suggested that women with low incomes residing in metropolitan areas might be less likely to be screened for breast cancer than more affluent women residing in the same areas (*1,2*). However, few studies have examined the associations between breast cancer screening and both individual and area-based measures of socioeconomic status (SES) among women in metropolitan areas (*3,4*). To examine these associations, CDC analyzed the percentage of women who had a mammogram by using individual data (i.e., household income and education level) from the 2000 and 2002 Behavioral Risk Factor Surveillance System (BRFSS) surveys and area-based data (i.e., percentages classified as living in poverty* or at a low education level†) from the 2000 U.S. Census. This report summarizes the results of those analyses, which

* Annual family income below the federally defined poverty line.
† Less than a high school education.

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2005;54:[inclusive page numbers].

suggested that, among women in 35 metropolitan statistical areas (MSAs),[§] those with annual household incomes of <$15,000 were less likely to have had a mammogram than more affluent women (especially in areas where a greater proportion of women were affluent) and those without a high school education were less likely to have had a mammogram than women with more education (especially in areas where a greater proportion of women had higher education levels). Studies are needed to determine how to increase the percentage of women having mammograms among women in low-income and low-education populations.

BRFSS is a state-based, random-digit–dialed telephone survey of the noninstitutionalized, U.S. civilian population aged ≥18 years (*5*). During 2000 and 2002, BRFSS interviews were conducted with 251,269 women. Data from 2000 and 2002 were used to provide the best match between individual-level information and MSA data from the 2000 U.S. Census. Weights were used to adjust for differences in probability of selection, nonresponse, and noncoverage. The CASRO–estimated median response rates among reporting states in 2000 and 2002 were 48.9% and 58.3%, respectively (*5*). Questions were asked regarding general health status, demographic and socioeconomic characteristics, and breast cancer screenings. Female respondents were asked, "Have you ever had a mammogram?" Those who said "yes" were then asked, "How long has it been since you had your last mammogram?"

Self-reported county of residence was used to classify respondents as residents of MSAs using Office of Management and Budget definitions for MSAs (*6*). To reduce the heterogeneity of the MSAs and ensure a sufficient number of respondents in each, only BRFSS respondents who resided in MSAs with populations of ≥1.5 million in 2000 were included in this analysis. The 35 MSAs included in this analysis ranged in population from

[§] The 35 MSAs are as follows: Atlanta-Sandy Springs-Marietta (Georgia), Baltimore-Towson (Maryland), Boston-Cambridge-Quincy (Massachusetts, New Hampshire), Chicago-Naperville-Joliet (Illinois, Indiana, Wisconsin), Cincinnati-Middletown (Ohio, Kentucky, Indiana), Cleveland-Elyria-Mentor (Ohio), Columbus (Ohio), Dallas-Fort Worth-Arlington (Texas), Denver-Aurora (Colorado), Detroit-Warren-Livonia (Michigan), Houston-Sugar Land-Baytown (Texas), Indianapolis (Indiana), Kansas City (Missouri, Kansas), Los Angeles-Long Beach-Santa Ana (California), Miami-Fort Lauderdale-Miami Beach (Florida), Milwaukee-Waukesha-West Allis (Wisconsin), Minneapolis-St. Paul-Bloomington (Minnesota, Wisconsin), New York-Northern New Jersey-Long Island (New York, New Jersey, Pennsylvania), Orlando-Kissimmee (Florida), Philadelphia-Camden-Wilmington (Pennsylvania, New Jersey, Delaware, Maryland), Phoenix-Mesa-Scottsdale (Arizona), Pittsburgh (Pennsylvania), Portland-Vancouver-Beaverton (Oregon, Washington), Providence-New Bedford-Fall River (Rhode Island, Massachusetts), Riverside-San Bernardino-Ontario (California), Sacramento-Arden-Arcade-Roseville (California), San Antonio (Texas), San Diego-Carlsbad-San Marcos (California), San Francisco-Oakland-Fremont (California), San Jose-Sunnyvale-Santa Clara (California), Seattle-Tacoma-Bellevue (Washington), St. Louis (Missouri, Illinois), Tampa-St. Petersburg-Clearwater (Florida), Virginia Beach-Norfolk-Newport News (Virginia, North Carolina), Washington-Arlington-Alexandria (District of Columbia, Virginia, Maryland, West Virginia).

1,500,741 to 18,323,002. Analyses were limited to 38,117 women aged ≥40 years with no missing information about recent mammography. Area-based data regarding SES (i.e., percentage of residents in an MSA classified as living in poverty or having a low education level) were obtained from the 2000 U.S. Census and categorized using previously described cutpoints (*7*). Percentage of residents living below the poverty level was based on the 1999 federal definition of a poverty area. Rates for having a mammogram during the preceding 2 years were calculated with combined data from 2000 and 2002. In examining the bivariate associations between screening and both demographic and health factors, the levels of statistical significance were obtained using Pearson's chi-square tests; 95% confidence intervals (CIs) and p-values were calculated. Multivariate analyses of the associations between individual-level and area-based data and breast cancer screening were conducted using logistic regression analyses that employed the following variables: year (2000 versus 2002), age, race, ethnicity, marital status, health insurance, and physician checkup during the preceding year.

Approximately 9.6% of the women aged ≥40 years who responded had household incomes of <$15,000 per year, a level just above that identified by 1999 federal poverty level guidelines as 100% of poverty ($13,410) for a family of three with one member aged <18 years (*8*); 23.7% had household incomes of $15,000–$34,999 per year, or approximately $1,500 above 250% of the 1999 federal poverty level for a family of three with one member aged <18 years. Among the participants, 11.8% had less than a high school education, 8.0% had never been married, and 9.1% had no health insurance.

Overall, 78.5% of women aged ≥40 years reported having a mammogram during the preceding 2 years (Table 1). Among women who reported annual household incomes of <$15,000, 68.4% (95% confidence interval [CI] = 65.5%–71.3%) received a mammogram in the preceding 2 years; 75.3% (CI = 73.9%–76.8%) of women with household incomes of $15,000–$34,999 and 82.5% of women with household incomes of ≥$50,000 (CI = 81.4%–83.6%) had received a mammogram in the preceding 2 years. Women with less than a high school education, those who were never married, and those who had no health insurance also had lower mammography rates than those who were college graduates, married, or had health insurance. The percentages of residents in MSAs who were living in poverty or who had a low education level were both inversely associated with breast cancer screening.

Women with annual household incomes of <$15,000 per year were less likely to have received a breast cancer screening during the preceding 2 years than more affluent women, especially women with incomes in more affluent areas (Table 2). Similarly, women without a high school education were less likely to receive breast cancer screening than women with more education, especially in areas where a larger proportion of women had more education. These findings were confirmed by multivariate analysis (p<0.0001).

Reported by: *SS Coughlin, PhD, J King, MPH, TB Richards, MD, DU Ekwueme, PhD, Div of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings in this report confirm those from previous studies (*1,2*) that suggested women with lower incomes in metropolitan areas of the United States are less likely to have mammograms than more affluent women in those metropolitan areas. Moreover, these findings suggest that women with low incomes in more affluent areas are less likely to have mammograms than women with low incomes in less affluent areas. Reasons for this disparity are uncertain. The areas in which persons live might affect screening use because of varying living costs, education and employment opportunities, access to health care, and other factors (e.g., cost, proximity, and acceptance of medical services, and availability of public transportation or public clinics) (*8,9*).

Studies are needed to examine the extent to which breast cancer screening is being provided to priority populations (e.g., women not routinely screened for breast cancer) at the community level. Addressing this question might require development of improved methods for obtaining subcounty estimates for the locations of priority populations and comparing these locations with the locations where screening tests currently are being provided (i.e., gap analysis).

The findings in this report are subject to at least four limitations. First, the ability to identify combinations of factors influencing screening utilization was limited by the variables included in the analytic dataset and by the large geographic units involved in MSA analysis. Future analyses might include additional variables related to utilization of cancer screening services and neighborhood characteristics at the census-tract or block-group level. Second, women in households without telephones were excluded, and only approximately half of potential respondents agreed to participate. Third, self-reported information regarding breast cancer screening might differ from information obtained from records of health-care providers. Validation studies have suggested that patients tend to overreport their use of screening and underreport the time lapse since their last screening (*10*). Finally, results of this study might not be generalizable to smaller metropolitan areas.

Results from this study indicate that women with low incomes in metropolitan areas with ≥1.5 million population are less likely to have a mammogram than more affluent women. Many women with annual household incomes of <$15,000 are eligible for Medicaid; however, Medicaid providers and clients are likely to have urgent needs that take precedence over breast cancer

screening. Women not eligible for Medicaid who do not have employer-sponsored health care can receive breast and cervical cancer screening through CDC's National Breast and Cervical Cancer Early Detection Program (available at http://www.cdc.gov/cancer/nbccedp), which funds all 50 state health agencies, the District of Columbia, 13 tribal organizations, and four territories. Analyses of cancer screening by measures of SES and other factors might help direct resources to areas of greatest need so that resources can be most effective and beneficial.

References

1. Mickey RM, Durski J, Worden JK, Danigelis NL. Breast cancer screening and associated factors for low-income African-American women. Prev Med 1995;24:467–76.
2. Garbers S, Jessop DJ, Foti H, Uribelarrea M, Chiasson MA. Barriers to breast cancer screening for low-income Mexican and Dominican women in New York City. J Urban Health 2003;80:81–91.
3. Rakowski W, Pearlman D, Rimer BK, Ehrich B. Correlates of mammography among women with low and high socioeconomic resources. Prev Med 1995;24:149–58.
4. Nelson DE, Bolen J, Marcus S, Wells HE, Meissner H. Cancer screening estimates for U.S. metropolitan areas. Am J Prev Med 2003;24:301–9.
5. CDC. Behavioral Risk Factor Surveillance System: BRFSS. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at http://www.cdc.gov/brfss.
6. US Census Bureau. Metropolitan statistical areas and components, November 2004. Washington DC: US Census Bureau; 2005. Available at http://www.census.gov/population/estimates/metro-city/List4.txt.
7. Krieger N, Chen JT, Waterman PD, Soobader MJ, Subramanian SV, Carson R. Geocoding and monitoring of US socioeconomic inequalities in mortality and cancer incidence: does the choice of area-based measure and geographic level matter? The Public Health Disparities Geocoding Project. Am J Epidemiol 2002;156:471–82.
8. Berk ML, Cunningham P, Beauregard K. The health care of poor persons living in wealthy areas. Soc Sci Med 1991;32:1097–103.
9. Benjamins MR, Kirby JB, Bond Huie SA. County characteristics and racial and ethnic disparities in the use of preventive services. Prev Med 2004;39:704–12.
10. Caplan LS, McQueen DV, Qualters JR, Leff M, Garrett C, Calonge N. Validity of women's self-reports of cancer screening test utilization in a managed care population. Cancer Epidemiol Biomarkers Prev 2003;12:1182–7.

TABLE 1. Number and percentage of women aged ≥40 years who reported having a mammogram during the preceding 2 years, by selected characteristics — 2000 and 2002 Behavioral Risk Factor Surveillance System (BRFSS) and 2000 U.S. Census,* 35 metropolitan statistical areas (MSAs)†

Characteristic	No.	(%)	(95% CI§)
Age group (yrs)			
40–49	13,065	(71.6)	(70.3–72.9)
50–64	3,415	(85.0)	(83.1–86.9)
65–74	6,220	(83.8)	(82.1–85.5)
≥75	5,296	(76.6)	(74.8–78.3)
Race			
White	31,799	(79.0)	(78.3–79.8)
Black	4,302	(80.2)	(78.2–82.1)
Asian/Pacific Islander	585	(65.2)	(58.2–72.1)
American Indian/Alaska Native	241	(67.0)	(58.0–76.1)
Other	897	(75.8)	(71.7–80.0)
Ethnicity			
Hispanic	2,136	(75.6)	(72.6–78.6)
Non-Hispanic	35,824	(78.9)	(78.2–79.6)
Marital status			
Currently married or living as unmarried couple	18,832	(80.4)	(79.4–81.3)
Divorced or separated	8,157	(75.5)	(73.9–77.2)
Widowed	7,633	(77.6)	(75.9–79.2)
Never married	3,376	(72.7)	(70.2–75.3)
Education level			
Less than high school education	3,571	(70.2)	(67.4–73.0)
High school graduate/General equivalency diploma	11,508	(77.6)	(76.3–78.8)
Technical school/Some college	10,128	(79.8)	(78.6–81.0)
College graduate	12,837	(81.6)	(80.4–82.8)
Household income			
<$15,000	3,678	(68.4)	(65.5–71.3)
$15,000–$34,999	9,738	(75.3)	(73.9–76.8)
$35,000–$49,999	5,215	(79.1)	(77.3–80.9)
≥$50,000	13,029	(82.5)	(81.4–83.6)
Not provided	6,457	(81.0)	(79.4–82.6)
Visited physician during the preceding year			
Yes	14,352	(85.5)	(84.6–86.4)
No	2,788	(51.3)	(48.4–54.1)
Health insurance			
Yes	35,486	(80.7)	(80.0–81.4)
No	2,582	(54.0)	(50.7–57.2)
Residents of MSA living in poverty (%)¶			
0–4.9	3,885	(80.2)	(78.1–82.4)
5–9.9	26,698	(78.5)	(77.7–79.3)
10–19.9	6,689	(77.7)	(76.1–79.4)
≥20	845	(76.3)	(69.5–83.0)
Residents of MSA with low education levels (%)**			
0–14.9	16,189	(78.9)	(78.0–79.9)
15–24.9	16,054	(79.5)	(78.5–80.6)
≥25	5,874	(75.7)	(73.7–77.7)
Year			
2000	15,558	(79.2)	(78.2–80.2)
2002	22,559	(77.8)	(76.8–78.8)
Total	**38,117**	**(78.5)**	**(77.8–79.2)**

* 2000 U.S. Census variables are linked at the county level to the 2000 and 2002 BRFSS datasets.
† All MSAs in the United States with 2000 U.S. Census population ≥1.5 million.
§ Confidence interval.
¶ Household income below the federally defined poverty line.
** Less than a high school education.

TABLE 2. Percentage* of women aged ≥40 years who reported having a mammogram during the preceding 2 years, by household income and percentage of residents in metropolitan statistical area (MSA) living in poverty, and by education level and percentage of residents in MSA with low education levels — 2000 and 2002 Behavioral Risk Factor Surveillance System (BRFSS) and 2000 U.S. Census,† 35 MSAs§

	Percentage of residents of MSA living in poverty¶					
	<5%		5%–19.9%		≥20%	
Household income	%	(95% CI**)	%	(95% CI)	%	(95% CI)
<$15,000	58.5	(52.6–64.2)	70.9	(66.4–74.9)	78.1	(69.6–84.8)
$15,000–$34,999	74.4	(71.7–76.8)	73.7	(71.0–76.2)	73.0	(64.7–80.0)
≥$35,000	83.1	(81.6–84.6)	82.7	(80.5–84.7)	81.9	(75.8–86.7)
	Percentage of residents of MSA with low education levels††					
	<14.9%		15%–24.9%		≥25%	
Education level	%	(95% CI)	%	(95% CI)	%	(95% CI)
Less than high school education	62.0	(55.8–67.9)	72.6	(67.4–77.3)	70.4	(63.5–76.6)
High school graduate/General equivalency diploma	77.2	(74.9–79.3)	77.8	(75.5–80.0)	75.8	(70.8–80.2)
Technical school/Some college/College graduate	82.3	(80.9–83.6)	81.7	(80.0–83.3)	80.2	(77.3–82.8)

* Based on logistic regression analyses, including the following variables: year (2000 versus 2002), age, race, ethnicity, marital status, health insurance, and physician checkup.
† 2000 U.S. Census variables are linked at the county level to the 2000 and 2002 BRFSS datasets.
§ All MSAs in the United States with 2000 U.S. Census population ≥1.5 million.
¶ Household income below the federally defined poverty line.
** Confidence interval.
†† Less than a high school education.

Mental Health in the United States

Health Care and Well Being of Children with Chronic Emotional, Behavioral, or Developmental Problems — United States, 2001

The needs of children with emotional, behavioral, and developmental (EBD) problems are a national concern. To assess the health care and well being of children who have chronic EBD problems requiring treatment or counseling, researchers from Oregon Health and Science University and CDC analyzed parent-reported data from the 2001 National Survey of Children with Special Health Care Needs. This report summarizes the findings of that analysis, which indicated that, compared with children with special health-care needs (CSHCN) who do not have chronic EBD problems, children with chronic EBD problems were more likely to experience diminished health and quality of life and to have problems accessing and receiving needed care. These children were more likely to have health conditions that affect their daily activities and cause them to miss school. In addition, their health-care needs were more likely to affect their families. The results of this analysis reinforce existing recommendations that encourage expansions in screening and early detection of mental health problems, as well as improvements in access, coordination, and quality of health-care services for children with EBD problems.

During October 2000–April 2002, CDC conducted the National Survey of Children with Special Health Care Needs as part of the State and Local Area Integrated Telephone Survey (*1*). This random-digit–dialed telephone survey was sponsored by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration. Parents or guardians of 373,055 children aged 0–17 years responded to a set of screening questions that permit identification of CSHCN (*2*). Screening questions were completed by 76.2% of parents contacted.

CSHCN were defined as children who have "a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (*3*). Children with chronic EBD problems that require treatment or counseling (hereafter abbreviated as EBD problems) were considered to be a subset of CSHCN. A child was considered to be in this subgroup if the parent reported that the child needed or received treatment or counseling for an emotional, behavioral, or developmental problem and also reported that this problem had lasted or was expected to last ≥12 months (*2*). A child with EBD problems might also have chronic medical or other health problems.

When a household with CSHCN was identified, one child with special health-care needs was randomly selected to be the focus of an interview about health status, types of services needed or used, access to care and characteristics of that care, health insurance coverage, and effect of the child's health on the family. Interviews were completed for 38,866 CSHCN, a 97.6% participation rate.

Logistic regression analyses were used to compare the health care and well being of children with EBD problems with the

health care and well being of other CSHCN without EBD problems. Children were included in this latter comparison group if their parents did not report EBD problems but did report that the children experienced at least one of four health or health-care consequences attributable to a medical, behavioral, or other health condition that had lasted or was expected to last ≥12 months. These consequences included 1) ongoing limitations in the child's ability to perform activities other children the same age can perform, 2) ongoing need for prescription medications, 3) ongoing need for special therapies, and 4) ongoing need for more medical, mental health, or educational services than is usual for most children the same age (*2*). This comparison group was not necessarily restricted to children with chronic physical conditions; the group might also have included children with chronic emotional, behavioral, or developmental problems not yet diagnosed or for which parents did not report that treatment or counseling were required. Data were weighted to reflect the noninstitutionalized population of children in each state and nationally (*1*).

Among all children, 3.7% (95% confidence interval [CI] = 3.5%–3.8%; range among states: 2.8%–5.4%) had parent-reported EBD problems (Table 1). These children represented 28.7% of all CSHCN nationally (CI = 27.9%–29.6%; range among states: 23.8%–35.3%). Bivariate analyses indicated that the prevalence of EBD problems was greatest among children living in poverty (5.5%), adolescents aged 12–17 years (5.0%), and boys (4.7%) (Table 2).

Compared with children with other special health-care needs, children with EBD problems were more likely to have 1) health conditions that affected their daily activities, 2) missed ≥11 days of school during the past year, 3) no health insurance or inadequate insurance, 4) unmet needs for health-care services, 5) difficulty obtaining referrals, and 6) $1,000 or more in annual out-of-pocket medical expenses (Table 3). Children with EBD problems were also more likely not to have a personal doctor or nurse and not to receive family-centered care. In addition, children with EBD problems were more likely to have family members who 1) experienced financial problems related to the child's health, 2) reduced work hours or stopped working to care for the child, and 3) spent ≥11 hours per week providing or coordinating health care for the child.

Reported by: *CD Bethell, PhD, D Read, MPH, Oregon Health and Science Univ, Portland. SJ Blumberg, Div of Health Interview Statistics, National Center for Health Statistics, CDC.*

Editorial Note: Nationally, 12.8% of children have special health-care needs (*4*). Title V of the Social Security Act calls for community-based systems of services to meet the needs of these CSHCN (*5*). This analysis of data from the 2001

TABLE 1. Prevalence of children with chronic emotional, behavioral, or developmental problems that require treatment or counseling, by state/area — National Survey of Children with Special Health Care Needs, United States, 2001

State/Area	Total screened sample size	Among all children		Among CSHCN*	
		%†	(95% CI§)	%	(95% CI)
Alabama	6,904	3.6	(±0.6)	26.4	(±3.9)
Alaska	8,548	3.6	(±0.5)	33.2	(±3.9)
Arizona	8,542	3.4	(±0.6)	31.2	(±4.3)
Arkansas	6,616	4.6	(±0.6)	32.8	(±3.9)
California	9,662	3.4	(±0.7)	33.4	(±5.0)
Colorado	7,864	3.3	(±0.5)	29.0	(±3.8)
Connecticut	6,411	3.7	(±0.5)	26.7	(±3.3)
Delaware	6,181	4.6	(±0.7)	29.9	(±3.8)
District of Columbia	7,400	4.6	(±0.8)	33.4	(±4.6)
Florida	7,572	4.1	(±0.7)	31.3	(±4.3)
Georgia	7,479	3.2	(±0.5)	24.8	(±3.7)
Hawaii	9,382	3.2	(±0.5)	28.8	(±3.9)
Idaho	8,366	4.1	(±0.6)	35.3	(±4.1)
Illinois	7,761	2.8	(±0.5)	24.1	(±3.7)
Indiana	6,744	3.7	(±0.6)	26.2	(±3.8)
Iowa	7,766	3.7	(±0.5)	29.8	(±3.7)
Kansas	6,517	4.0	(±0.7)	27.5	(±3.8)
Kentucky	6,032	3.8	(±0.6)	24.1	(±3.4)
Louisiana	5,964	4.4	(±0.7)	27.5	(±3.6)
Maine	5,646	4.4	(±0.7)	28.1	(±3.6)
Maryland	6,161	4.3	(±0.7)	28.1	(±3.7)
Massachusetts	6,411	5.1	(±0.8)	34.6	(±4.5)
Michigan	6,637	3.7	(±0.6)	26.8	(±3.6)
Minnesota	6,946	3.6	(±0.6)	29.1	(±4.0)
Mississippi	7,374	3.9	(±0.6)	30.2	(±4.1)
Missouri	12,824	4.3	(±0.5)	28.8	(±2.7)
Montana	7,652	3.7	(±0.5)	31.8	(±3.7)
Nebraska	7,420	3.7	(±0.6)	28.9	(±3.9)
Nevada	8,911	2.8	(±0.5)	26.4	(±3.8)
New Hampshire	6,127	4.8	(±0.7)	31.8	(±3.9)
New Jersey	7,506	3.4	(±0.6)	26.9	(±3.8)
New Mexico	8,110	3.2	(±0.5)	28.4	(±4.1)
New York	8,030	3.6	(±0.5)	30.2	(±3.5)
North Carolina	6,432	3.4	(±0.5)	24.3	(±3.5)
North Dakota	7,527	3.6	(±0.6)	29.2	(±4.0)
Ohio	6,844	3.6	(±0.5)	25.5	(±3.4)
Oklahoma	6,684	3.8	(±0.6)	26.2	(±3.8)
Oregon	6,905	4.4	(±0.6)	33.2	(±3.8)
Pennsylvania	7,322	3.5	(±0.5)	27.0	(±3.6)
Rhode Island	6,134	4.0	(±0.6)	28.5	(±3.6)
South Carolina	6,662	3.8	(±0.6)	28.6	(±3.8)
South Dakota	8,213	3.3	(±0.5)	29.2	(±4.0)
Tennessee	6,338	3.3	(±0.6)	23.8	(±3.6)
Texas	7,848	3.4	(±0.6)	28.1	(±3.9)
Utah	8,850	3.6	(±0.5)	32.6	(±3.8)
Vermont	6,064	5.4	(±0.8)	34.5	(±4.0)
Virginia	5,826	4.1	(±0.6)	27.0	(±3.5)
Washington	6,629	4.6	(±0.6)	33.6	(±3.7)
West Virginia	6,034	4.7	(±0.9)	28.1	(±4.4)
Wisconsin	6,948	4.1	(±0.6)	30.7	(±3.6)
Wyoming	7,448	3.7	(±0.5)	29.5	(±3.6)

* Children with special health-care needs. Children with chronic emotional, behavioral, or developmental problems that require treatment or counseling are considered to be a subset of CSHCN.
† Weighted percentage.
§ Confidence interval.

TABLE 2. Prevalence of children with chronic emotional, behavioral, or developmental (EBD) problems that require treatment or counseling, by selected characteristics — National Survey of Children with Special Health Care Needs, United States, 2001

Characteristic	Total screened sample size	Among all children %†	(95% CI§)	Among CSHCN* %	(95% CI)
Sex					
Male	190,584	4.7	(±0.2)	31.5	(±1.1)
Female	180,970	2.6	(±0.1)	24.5	(±1.2)
Age group (yrs)					
0–5	115,511	1.3	(±0.1)	16.5	(±1.4)
6–11	130,063	4.6	(±0.2)	31.5	(±1.3)
12–17	126,263	5.0	(±0.2)	31.9	(±1.2)
Household poverty level¶					
<100%	48,063	5.5	(±0.4)	40.2	(±2.2)
100%–<200%	76,308	4.5	(±0.4)	33.4	(±2.4)
200%–<400%	116,317	3.4	(±0.2)	26.9	(±1.4)
≥400%	77,373	3.1	(±0.2)	22.8	(±1.4)
Race/Ethnicity					
Hispanic**	47,371	2.6	(±0.3)	30.0	(±2.6)
White, non-Hispanic	256,381	4.0	(±0.2)	28.1	(±0.9)
Black, non-Hispanic	38,395	3.8	(±0.4)	29.1	(±2.3)
Other single race, non-Hispanic††	18,154	2.7	(±1.5)	34.3	(±13.0)
Multiple race, non-Hispanic	10,105	4.6	(±0.7)	30.1	(±4.1)
Total	**372,174**	**3.7**	**(±0.1)**	**28.7**	**(±0.8)**

* Children with special health-care needs. Children with chronic EBD problems that require treatment or counseling are considered to be a subset of all CSHCN.
† Weighted percentage.
§ Confidence interval.
¶ Calculated on the basis of U.S. Department of Health and Human Services poverty guidelines.
** Hispanic might include any race.
†† Includes Asians, American Indians/Alaska Natives, and Native Hawaiians or other Pacific Islanders.

National Survey of Children with Special Health Care Needs suggests that children with EBD problems constitute a substantial subgroup of CSHCN and are at increased risk for not receiving the services and support they and their families need.

This increased risk might be attributable to multiple factors. EBD problems often are not diagnosed early, and children with these problems often require treatment and counseling that is more difficult to access than other types of health-care services (*6,7*). EBD problems usually do not have well-defined, evidence-based treatments (*7*). In addition, compared with other CSHCN, children with EBD problems can have multiple identifiable conditions (e.g., depression, anxiety, attention deficit hyperactivity disorder, and obsessive-compulsive disorder) that require multidisciplinary care, which is often poorly coordinated and not consistently available.

Data on specific diagnoses are not available from the 2001 National Survey of Children with Special Health Care Needs, but estimates from the 2003 National Survey of Children's Health (NSCH) (*8*) indicate several conditions common to children with EBD problems. According to parent reports of what doctors have told them, 53.5% of children with EBD problems have or have had attention deficit disorder or attention deficit hyperactivity disorder, 51.7% have or have had a learning disability, 43.5% have or have had depression or anxiety problems, 6.8% have or have had autism, and 55.7% have or have had a behavioral or conduct problem (*9*). Other EBD-related conditions were not addressed by NSCH, but EBD problems as defined in this report also presumably include complex conditions such as Down syndrome and pervasive developmental delay.

Many children with EBD problems also have comorbid chronic physical conditions. Parents participating in the NSCH reported that two thirds of children with EBD problems have or have had conditions such as asthma, allergies, diabetes, frequent headaches, hearing or vision problems, or bone, joint, or muscle problems (*9*). For children with EBD problems, these comorbid conditions might be related to their decreased likelihood of receiving needed services and support. Alternatively, the consequences of chronic physical conditions might be exacerbated by comorbid EBD problems. The next National Survey of Children with Special Health Care Needs (being conducted in 2005 and 2006) will include questions on functional status and chronic conditions, which might be useful for researchers interested in studying the effects of EBD problems on physical conditions among CSHCN.

The findings in this report are subject to at least three limitations. First, the prevalence estimates of children with EBD problems (Table 1 and Table 2) are lower than certain other estimates of the prevalence of mental and behavioral health problems (*6,10*). This lower rate was expected, given that this report limits the prevalence estimate to children whose parents report an EBD problem that is expected to last ≥12 months and for which the child currently needs or receives treatment or counseling. Other prevalence estimates do not necessarily apply such restrictive criteria. Moreover, because a delay between the onset of symptoms and diagnosis is common for EBD problems, prevalence estimates for EBD problems might be higher if those estimates are based on reports of symptoms or behaviors rather than reports of conditions for which children require treatment or counseling. Second, these estimates were derived from parent evaluations of their children's health-care needs. Biases in parent reporting might exist, and parents might not recognize certain problems or consider certain problems to be EBD in nature, might not consider various EBD problems to be sufficiently serious to warrant treatment or counseling, or might not be aware of available resources and services for their children. Finally, the

TABLE 3. Comparison of health and well being concerns among children with special health-care needs (CSHCN) with and without chronic emotional, behavioral, or developmental (EBD) problems that require treatment or counseling, by key indicator — National Survey of Children with Special Health Care Needs, United States, 2001

	CSHCN with chronic EBD problems† that require treatment or counseling		CSHCN without chronic EBD problems that require treatment or counseling			
Key indicator*	%§	(95% CI¶)	%	(95% CI)	OR**	(95% CI)
Condition affected activities usually, always, or a great deal during the past year	45.4	(±1.9)	14.4	(±0.8)	4.95	(4.49–5.47)
Missed ≥11 days of school during the past year because of illness or injury	20.0	(±1.7)	14.0	(±0.9)	1.54	(1.36–1.75)
Without health insurance at some time during the past year	14.3	(±1.5)	10.6	(±0.7)	1.41	(1.22–1.62)
Uninsured at time of survey	6.6	(±0.9)	4.7	(±0.4)	1.45	(1.21–1.75)
Insured with health insurance that was not adequate††	41.5	(±2.0)	30.4	(±1.0)	1.62	(1.48–1.78)
Had any unmet need during the past year for specific health-care services§§	29.8	(±1.9)	12.8	(±0.8)	2.90	(2.59–3.25)
Had any unmet need during the past year for family support services¶¶	12.5	(±1.2)	2.1	(±0.3)	6.53	(5.40–7.89)
Needed specialty care but had difficulty getting a referral during the past year	32.6	(±2.3)	16.7	(±1.2)	2.41	(2.11–2.76)
Without a usual place for care when ill, or relies on the emergency department as a usual place for such care	9.4	(±0.9)	9.2	(±0.6)	1.02	(0.90–1.17)
Without a personal doctor or nurse	14.0	(±1.5)	9.7	(±0.6)	1.51	(1.31–1.75)
Without family-centered care***	46.0	(±2.0)	28.2	(±1.0)	2.17	(1.98–2.39)
Family paid >$1,000 in medical expenses during the past year for the child	15.3	(±1.3)	9.5	(±0.6)	1.72	(1.52–1.95)
Condition caused financial problems for the family	32.0	(±1.8)	16.4	(±0.8)	2.40	(2.17–2.66)
Family spent ≥11 hours per week providing or coordinating care	18.4	(±1.6)	11.6	(±0.7)	1.72	(1.51–1.96)
Condition affected the employment of family members	42.7	(±1.9)	24.8	(±0.9)	2.26	(2.06–2.48)

* Operational definitions of these key indicators have been published elsewhere (see US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs chartbook 2001. Rockville, MD: US Department of Health and Human Services; 2004; and Child and Adolescent Health Measurement Initiative. Data Resource Center on Child and Adolescent Health. Portland, OR: Oregon Health and Science University. Available at http://www.childhealthdata.org).
† Children with EBD problems might also have chronic medical or other health problems.
§ Weighted percentage.
¶ Confidence interval.
** Odds ratio; reflects the odds for children with EBD problems relative to the odds for children with other special health-care needs but without EBD problems.
†† Assessment of insurance adequacy was based on three questions assessing whether the insurance offered needed benefits, whether the insurance allowed the child to see needed providers, and whether the costs not covered by insurance were reasonable.
§§ Specific health-care services included the following: routine preventive care; specialty care; dental care; prescription medicine; physical, occupational, or speech therapy; mental health care; substance abuse treatment; home health care; eyeglasses or vision care; hearing aids or hearing care; mobility aids; communication aids; medical supplies; and other medical equipment.
¶¶ Family support services included respite care, genetic counseling, and mental health care.
*** Assessment of family-centered care was based on five questions assessing whether doctors usually or always spend enough time with the child, listen carefully to the parent, are sensitive to the family's values and customs, provide needed information, and help the parent feel like a partner in the child's care.

data were restricted to the noninstitutionalized population of children living in households with telephones, although weighted estimates reflect the population of noninstitutionalized children living in households with and without telephones.

The results of this analysis support conclusions of national reports that recommend national, state, and local action to improve care and reduce disparities among children with EBD problems (*6,10*). To promote emotional, behavioral, and cognitive development through early recognition and effective intervention, CDC, MCHB, and other public health agencies have launched such initiatives as the "Learn the Signs. Act Early." campaign (http://www.cdc.gov/ncbddd/autism/ActEarly) and the *Bright Futures in Practice: Mental Health* guidelines (http://www.brightfutures.org/mentalhealth/index.html). Barriers to early detection and care for children with EBD problems must be removed to ensure good health care for children and families.

References

1. Blumberg SJ, Olson L, Frankel M, et al. Design and operation of the National Survey of Children with Special Health Care Needs, 2001. Vital Health Stat 2003;1(41). Available at http://www.cdc.gov/nchs/data/series/sr_01/sr01_041.pdf.

2. Bethell CD, Read D, Stein REK, Blumberg SJ, Wells N, Newacheck PW. Identifying children with special health care needs: development and evaluation of a short screening instrument. Ambul Pediatrics 2002;2:38–48.
3. McPherson M, Arango P, Fox H, et al. A new definition of children with special health care needs. Pediatrics 1998;102:137–140.
4. US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs chartbook 2001. Rockville, MD: US Department of Health and Human Services; 2004.
5. Hutchins VL, McPherson M. National agenda for children with special health needs: social policy for the 1990s through the 21st century. Am Psychol 1991;46:141–3.
6. US Department of Health and Human Services. Mental health: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services; 1999.
7. Hoagwood K, Burns BJ, Kiser L, Ringeisen H, Schoenwald SK. Evidence-based practice in child and adolescent mental health services. Psychiatr Serv 2001;52:1179–89.
8. Blumberg SJ, Olson L, Frankel MR, Osborn L, Srinath KP, Giambo P. Design and operation of the National Survey of Children's Health, 2003. Vital Health Stat 2005;1(43). Available at http://www.cdc.gov/nchs/data/series/sr_01/sr01_043.pdf.
9. Child and Adolescent Health Measurement Initiative. Data Resource Center on Child and Adolescent Health. Portland, OR: Oregon Health and Science University. Available at http://www.childhealthdata.org.
10. New Freedom Commission on Mental Health. Achieving the promise: transforming mental health care in America. Final report. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2003.

Mental Health in the United States

Health Risk Behaviors and Conditions Among Persons with Depression — New Mexico, 2003

Studies have demonstrated relationships between physical health and mental health (*1,2*). Chronic disease has been associated with depression, which, in the absence of intervention, also can assume a chronic course (*3*). To determine the prevalence of depression among adults in New Mexico and examine the association between depression and selected health risk behaviors and health conditions, the New Mexico Department of Health and CDC analyzed data from the 2003 New Mexico Behavioral Risk Factor Surveillance System (BRFSS) survey. This report describes the results of that analysis, which determined that 3.8% of adults in New Mexico had current symptoms of depression and that these adults were significantly more likely to have engaged in certain health risk behaviors (e.g., smoking and binge drinking) and to have certain health conditions (e.g., high blood pressure, high blood cholesterol, arthritis, and asthma) than persons without depression. Public health programs that promote mental health and timely diagnosis and treatment of depression might also help reduce morbidity and risk behaviors related to chronic diseases.

New Mexico BRFSS is a state-based component of the CDC BRFSS, through which states conduct random-digit–dialed telephone surveys of their noninstitutionalized, civilian population aged ≥18 years. In 2003, a total of 5,494 adults participated in the New Mexico survey; the CASRO response rate was 56.4%.

The New Mexico survey included six questions adapted from the Primary Care Evaluation of Mental Disorders (PRIME-MD) to assess the prevalence of depression among adults in the state. Two screening questions were asked: "During the past 30 days, have you often been bothered by feeling down, depressed, or hopeless?" and "During the past 30 days, have you often been bothered by little interest or pleasure in doing things?" (*4*). Respondents who answered "yes" to either screening question were then asked the other four core depressive symptom questions. Respondents were asked how often during the preceding 14 days they had been "bothered by little interest or pleasure in doing things," "bothered by trouble falling or staying asleep, or sleeping too much," "bothered by poor appetite or overeating," and "bothered by feeling bad about yourself, or that you are a failure or have let yourself or your family down" (*5*). Participants chose from the following four responses: "not at all," "several days," "more than half of the days," and "nearly every day." Respondents were considered depressed if they answered "yes" to either of the two PRIME-MD screening questions and "nearly every day" to two or more of the four questions regarding depressive symptoms (*4*). Data were weighted to reflect the demographic profile of the noninstitutionalized civilian population of New Mexico. Differences in point estimates were considered not significant if their 95% confidence intervals (CIs) overlapped.

The overall prevalence of depression among adults in New Mexico was 3.8% (CI = 3.2%–4.5%) and varied significantly by age, race/ethnicity, income, and education but not by sex. Results of age-group analysis indicated that persons aged 45–54 years (4.9%; CI = 3.4%–6.8%) were most likely to be depressed and that those aged ≥75 years (1.7%; CI = 0.9%–3.2%) were least likely to be depressed. Among racial/ethnic groups, prevalence of depression ranged from 4.9% (CI = 3.8%–6.1%) among Hispanics to 1.8% (CI = 0.6%–5.2%) among American Indians/Alaska Natives. By income, persons with annual household incomes of <$10,000 had the highest prevalence of depression (12.7%; CI = 8.6%–18.4%), and those with incomes of >$50,000 had the lowest prevalence (1.4%; CI = 0.9%–2.2%). By education level, adults who had not graduated from high school had the highest prevalence of depression (7.8%; CI = 5.6%–11.0%), and those who had graduated from college had the lowest prevalence (1.7%; CI = 1.1%–2.5%).

Adults with depression were significantly more likely than those without depression to report the following health risk

behaviors or health conditions*: fair or poor general health (53.8% versus 15.2%), no moderate or vigorous physical activity (26.2% versus 7.8%), current smoking (54.4% versus 20.7%), binge drinking (24.9% versus 14.5%), obesity (29.9% versus 20.1%), high blood pressure (30.9% versus 20.9%), and high blood cholesterol (40.7% versus 26.9%). However, no significant difference was determined for those with or without diabetes (Table).

Reported by: *J Daniel, MPH, W Honey, MPH, M Landen, MD, New Mexico Dept of Health. S Marshall-Williams, PhD, D Chapman, PhD, J Lando, MD, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings in this report indicate that, in New Mexico, certain adverse health risk behaviors and health conditions are more common among persons with depression than among persons without depression, underscoring the importance of considering mental health in the prevention and treatment of chronic illnesses. Among the risk behaviors and conditions considered, the findings from this study did not indicate a significant relationship between diabetes and depression, which is consistent with the results of a previous study (*6*) but inconsistent with the results of another (*7*). In addition, the overall estimated 3.8% prevalence of depression is lower than the 6.7% prevalence estimated by the U.S. National Comorbidity Survey Replication. However, the prevalence in this report was based on telephone interviews with participants regarding depressive symptoms that occurred during the preceding 14 days; the national comorbidity survey prevalence came from symptoms that occurred during a 12-month period, based on face-to-face interviews conducted during 2001–2003 (*8*).

The findings in this report are subject to at least four limitations. First, the data on which they were based were self-reported by telephone survey and might have been different had they been obtained by physical and psychiatric examination. Second, data were collected only from noninstitutionalized adult residents with landline telephones; these data might not be generalizable to persons in younger age groups, who might be more likely to use cellular phones exclusively. Third, only residents of New Mexico were surveyed, and results might not be generalizable to persons residing in other regions of the United States. Finally, because these data are cross-sectional, they do not permit any inference of a causal pathway between depression and the physical health risk behaviors and health conditions investigated. Nonetheless, the findings in this report corroborate the correlation between depression and chronic diseases and conditions determined by previous studies (*3*) and thus suggest that the assessment and treatment of depression can help to improve the overall health of a population.

Although depressive disorders can be treated successfully, data ranging from the Epidemiologic Catchment Area program in the early 1980s to those collected by the 2002 National Health Interview Survey indicated that most persons needing treatment for mental illness did not receive treatment (*9*). Barriers to treatment include the stigma associated with depression, lack of knowledge about depression, and lack

TABLE. Prevalence of selected health risk behaviors and health conditions among adults with and without depression — New Mexico, 2003

Characteristic	With depression %	With depression (95% CI*)	Without depression %	Without depression (95% CI)
Health risk behavior				
No moderate or vigorous physical activity†	26.2	(19.4–34.4)	7.8	(7.0–8.8)
Current smoking§	54.4	(46.1–62.4)	20.7	(19.3–22.1)
Binge drinking¶	24.9	(17.7–33.8)	14.5	(13.3–15.8)
Obesity**	29.9	(22.9–38.1)	20.1	(18.7–21.5)
Health condition				
General health fair or poor††	53.8	(45.4–62.0)	15.2	(14.1–16.4)
High blood pressure§§	30.9	(24.2–38.5)	20.9	(16.7–22.2)
High blood cholesterol§§	40.7	(31.8–50.4)	26.9	(25.3–28.5)
Diabetes§§	8.6	(5.2–13.9)	5.5	(4.9–6.2)
Arthritis§§	39.7	(32.2–47.8)	25.3	(23.9–26.7)
Asthma§§	12.2	(7.9–18.2)	6.6	(5.8–7.5)
Disabillity¶¶	57.9	(49.3–66.1)	18.1	(16.9–19.3)

* Confidence interval.
† Respondents said they did not participate in nonoccupational physical activities of moderate intensity (e.g., brisk walking, bicycling, vacuuming, gardening, or anything else that causes small increases in breathing or heart rate) or vigorous intensity (e.g., running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate) for >10 minutes at a time in a usual week.
§ Smoking >100 cigarettes during a lifetime and currently smoking every day or some days.
¶ Having five or more drinks on one or more occasions during the 30 days preceding the survey.
** Self-reported weight and height were used to calculate body mass index (BMI) (weight [kg]/height [m^2]). Participants with BMI of ≥30 were classified as obese.
†† Self-rated by respondents.
§§ Persons who reported ever having been told by a health professional that they had this condition.
¶¶ Based on a qualifying response to one of two questions: "Are you limited in any way in any activities because of an impairment or health problem?" or "If you use special equipment or help from others to get around, what type do you use?"

* Fair or poor general health: Self-rated by respondents. No moderate or vigorous physical activity: Respondents said they did not participate in nonoccupational physical activities of moderate intensity (e.g., brisk walking, bicycling, vacuuming, gardening, or anything else that causes small increases in breathing or heart rate) or vigorous intensity (e.g., running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate) for >10 minutes at a time in a usual week. Current smoking: >100 cigarettes during a lifetime and currently smoking every day or some days. Binge drinking: Having five or more drinks on one or more occasions during the 30 days preceding the survey. Obesity: Self-reported weight and height were used to calculate body mass index (BMI) (weight [kg]/height [m^2]). Participants were classified as obese if their BMI was ≥30. High blood pressure and high blood cholesterol: Persons reported ever having been told by a health professional that they had these conditions.

of adequate insurance coverage (*2*). Persons with depression, particularly those who also have a physical health condition, might seek treatment from various types of health-care professionals (e.g., general practitioners) other than psychiatrists, psychologists, or psychiatric social workers.

The U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression in clinical practices if systems exist to ensure accurate diagnosis, effective treatment, and follow-up. USPSTF determined that screening increases the accurate identification of depressed patients in primary-care settings and that treatment of depressed adults in primary-care settings decreases their level of clinical morbidity (*10*). CDC can help increase understanding of depression and its public health burden by conducting mental health surveillance and working with national partners, such as the National Mental Health Association, Substance Abuse and Mental Health Services Administration, and National Institute of Mental Health to address the prevention and treatment of mental illnesses. New Mexico plans to continue its population-based surveillance for depression through BRFSS.

References

1. American Psychiatric Association. Coexisting severe mental disorders and physical illness. Statement of July 7, 2003. Arlington, VA: American Psychiatric Association; 2003. Available at http://www.psych.org/news_room/press_releases/severementalillness0331.pdf.
2. US Department of Health and Human Services. Mental health: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; National Institutes of Health; National Institute of Mental Health; 1999.
3. Chapman DP, Perry G, Strine TW. The vital link between depression and chronic disease. Prev Chronic Dis 2005;2:A14.
4. Brody DS, Hahn SR, Spitzer RL, et al. Identifying patients with depression in the primary care setting: a more efficient method. Arch Intern Med 1998;158:2469–75.
5. Spitzer RL, Williams JB, Kroenke K, et al. Utility of a new procedure for diagnosing mental disorders in primary care: the PRIME-MD 1000 study. JAMA 1994;272:1749–56.
6. Zhang X, Norris SL, Gregg EW, Change YJ, Beckles G, Kahn HS. Depressive symptoms and mortality among persons with and without diabetes. Am J Epidemiol 2005;161:652–60.
7. Anderson RJ, Freedland KE, Clouse RE, Lustman PJ. The prevalence of comorbid depression among adults: a meta-analysis. Diabetes Care 2001;24:1069–78.
8. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005;62:617–27.
9. Kessler RC, Demler O, Frank RG, et al. Prevalence and treatment of mental disorders, 1990 to 2003. N Engl J Med 2005;352:2515–23.
10. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psych 2005;62:593–602.

Trends in Leisure-Time Physical Inactivity by Age, Sex, and Race/Ethnicity — United States, 1994–2004

Physical inactivity is associated with increased risk for certain chronic diseases, including cardiovascular disease, diabetes, and osteoporosis (*1*). Despite the benefits of physical activity, more than half of adults in the United States are not regularly active at the recommended levels (*2*). Trends in the proportion of adults who achieve the recommended levels of leisure-time physical activity have remained relatively stable over time (*3,4*). However, the proportion of adults from 35 states and the District of Columbia who reported that they did not engage in any leisure-time physical activity declined from 1996 to 2002 (*5*). To further examine trends in no leisure-time physical activity by population subgroup, CDC analyzed data from the Behavioral Risk Factor Surveillance System (BRFSS) for the period 1994–2004. This report is the first analysis of BRFSS physical-inactivity trends that includes all 50 states and the District of Columbia (DC). State and local health departments should continue to create programs that encourage adults to be physically active during leisure time.

BRFSS is a state-based telephone survey of the noninstitutionalized, U.S. civilian, population aged ≥18 years. Data on leisure-time physical activity were collected every other year from 1994 to 2000; data were collected annually beginning in 2000. Rhode Island did not ask the survey question in 1994. The survey sample sizes ranged from 105,853 in 1994 to 296,971 in 2004 for 50 states and DC.

Leisure-time physical inactivity was defined as a "no" response to the survey question, "During the past month, other than your regular job, did you participate in any physical activities or exercise, such as running, calisthenics, golf, gardening, or walking for exercise?" The reference time frame for the wording of this survey question was revised in 2001 to "During the past 30 days" and was changed back to "During the past month" in 2002. Also, in 2001, the phrase "other than your regular job" was added.

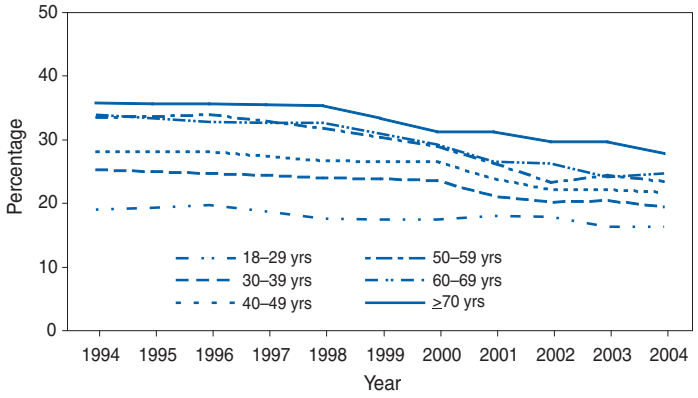
Prevalence estimates by sex, age, and race/ethnicity for 50 states and DC were weighted to account for nonresponse and to represent the populations of states/areas included in the study. Sex and race/ethnicity estimates were age-adjusted to the 2000 U.S. population, and testing for trend was conducted for men and women for each age category. Statistical analysis software was used to account for the complex sampling design. The median CASRO response rate was 69.9% in 1994 and 52.8% in 2004.

Overall, the prevalence of leisure-time physical inactivity declined significantly, from 29.8% in 1994 to 23.7% in 2004 (p<0.001). The proportions of physical inactivity among men and women were highest in 1994 (men, 27.9%; women, 31.5%) and decreased through 2004 (men, 21.4%; women, 25.9%) (Table). The largest decline was among men aged 50–59 years (from 33.5% to 23.5%) and among women aged 60–69 years (from 37.8% to 28.5%). Among racial/ethnic groups, during 1994–2004, prevalence of leisure-time physical inactivity was lowest among non-Hispanic white men and decreased from 26.4% to 18.4%. Among non-Hispanic black men, the prevalence of physical inactivity decreased from 34.2% in 1994 to 27.0% in 2004. Among Hispanic men, the prevalence of leisure-time inactivity decreased from 37.5% in 1994 to 32.5% in 2004. Non-Hispanic black women (45.7% in 1994 to 33.9% in 2004) and Hispanic women (44.8% in 1994 to 39.6% in 2004) had higher prevalences than non-Hispanic white women (28.3% in 1994 to 21.6% in 2004).

Among men, the prevalence of leisure-time physical inactivity declined significantly for each age group (test for trend [p<0.001]) (Figure 1). In 2004, the highest prevalence of physical inactivity among men was among those aged ≥70 years (27.9%), and the lowest was among those aged 18–29 years (16.4%). For women in every age group, the prevalence of leisure-time physical inactivity also declined significantly (test for trend p<0.001) (Figure 2) from 1996 to 2004. Women aged ≥70 years had the highest prevalence of physical inactivity.

Reported by: *J Kruger, PhD, SA Ham, MS, HW Kohl III, PhD, Div of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

FIGURE 1. Prevalence of leisure-time physical inactivity among men, by age group and survey year — Behavioral Risk Factor Surveillance System, United States,* 1994–2004



* The survey question regarding leisure-time physical activity was not asked in Rhode Island in 1994.

Editorial Note: This report summarizes the first prevalence estimates for leisure-time physical inactivity for all 50 states and DC using 11 years of state-based data. Reducing the percentage of adults who engage in no leisure-time physical activity to 20% is a *Healthy People 2010* objective (no. 22.1). The findings in this report demonstrate that the nationwide prevalence of leisure-time physical inactivity for U.S. adults has declined an average of 0.6% per year during an 11-year period. In 2004, approximately 21% of men and 26% of women reported no leisure-time physical activity, which is the lowest reported prevalence in the past decade. In 2004, men aged 18–29 years and men aged 30–39 years were the only groups for which the national health objective was achieved.

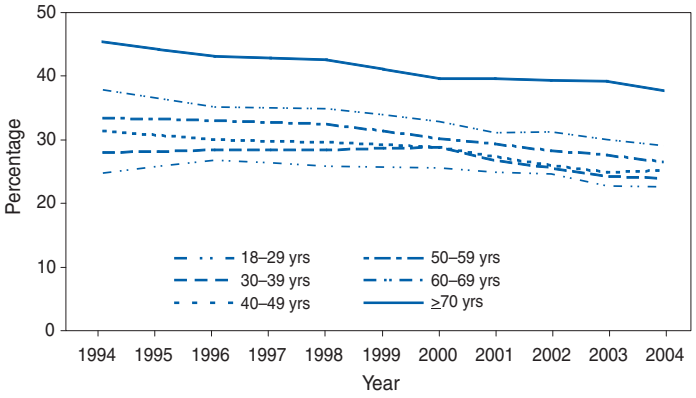
The results are consistent with reports indicating that inactivity in adults declined from 1997 to 2002 (*3*). Findings from

TABLE. Prevalence* of leisure-time physical inactivity among adults aged ≥18 years, by sex and race/ethnicity — Behavioral Risk Factor Surveillance System, United States,† 1994–2004

	1994		1996		1998		2000		2001		2002		2003		2004	
Sex/Race/Ethnicity	%	(95% CI§)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Male	27.9	(±0.7)	27.7	(±0.6)	26.5	(±0.6)	25.1	(±0.6)	23.5	(±0.5)	22.3	(±0.5)	22.0	(±0.5)	21.4	(±0.5)
White, non-Hispanic	26.4	(±0.7)	26.2	(±0.6)	24.9	(±0.6)	22.2	(±0.5)	20.5	(±0.5)	19.2	(±0.4)	19.2	(±0.5)	18.4	(±0.4)
Black, non-Hispanic	34.2	(±2.3)	34.7	(±2.3)	28.4	(±2.0)	28.7	(±2.1)	29.4	(±1.9)	28.8	(±1.8)	28.9	(±1.9)	27.0	(±1.7)
Hispanic	37.5	(±3.3)	36.8	(±3.0)	37.0	(±2.7)	38.7	(±3.0)	34.7	(±2.8)	35.1	(±2.6)	32.8	(±2.5)	32.5	(±2.4)
Asian/Pacific Islander	25.0	(±4.3)	24.0	(±4.6)	26.8	(±5.1)	26.3	(±5.7)	25.0	(±4.7)	21.3	(±4.7)	23.4	(±4.1)	20.4	(±3.6)
American Indian/ Alaska Native	34.4	(±7.0)	26.5	(±6.2)	35.8	(±7.0)	30.9	(±4.9)	31.7	(±5.1)	26.1	(±4.0)	27.1	(±4.3)	23.8	(±3.7)
Other¶	34.4	(±7.9)	22.1	(±5.7)	21.2	(±5.8)	28.4	(±5.9)	27.7	(±4.6)	26.3	(±4.4)	18.5	(±3.7)	22.7	(±4.6)
Female	31.5	(±0.6)	31.1	(±0.5)	30.6	(±0.5)	29.5	(±0.5)	28.3	(±0.5)	27.5	(±0.4)	26.4	(±0.4)	25.9	(±0.4)
White, non-Hispanic	28.3	(±0.6)	28.0	(±0.5)	27.1	(±0.5)	25.6	(±0.5)	24.2	(±0.4)	23.2	(±0.4)	22.3	(±0.4)	21.6	(±0.4)
Black, non-Hispanic	45.7	(±1.9)	43.2	(±1.7)	40.4	(±1.7)	38.3	(±1.6)	39.2	(±1.5)	37.1	(±1.4)	35.7	(±1.4)	33.9	(±1.2)
Hispanic	44.8	(±2.9)	41.6	(±2.5)	44.0	(±2.3)	42.4	(±2.2)	42.1	(±2.2)	39.9	(±2.2)	39.1	(±2.0)	39.6	(±1.9)
Asian/Pacific Islander	31.5	(±4.5)	31.8	(±5.2)	33.0	(±5.2)	34.1	(±5.2)	23.9	(±3.4)	29.0	(±4.1)	27.1	(±3.8)	24.0	(±4.4)
American Indian/ Alaska Native	36.3	(±6.4)	31.9	(±6.1)	31.8	(±5.4)	31.1	(±4.2)	33.3	(±4.6)	31.1	(±4.1)	30.1	(±3.5)	31.8	(±3.7)
Other¶	32.0	(±8.0)	32.0	(±7.2)	29.3	(±7.1)	26.4	(±5.4)	32.6	(±4.8)	30.1	(±5.0)	26.8	(±4.3)	26.6	(±4.3)
Total	**29.8**	**(±0.4)**	**29.5**	**(±0.4)**	**28.7**	**(±0.4)**	**27.4**	**(±0.4)**	**26.0**	**(±0.3)**	**25.0**	**(±0.3)**	**24.3**	**(±0.3)**	**23.7**	**(±0.3)**

* Weighted by state population estimates and age-adjusted to the 2000 U.S. standard population.
† The survey question regarding leisure-time physical activity was not asked in Rhode Island in 1994.
§ Confidence interval.
¶ Other race or multiracial.

FIGURE 2. Prevalence of leisure-time physical inactivity among women, by age group and survey year — Behavioral Risk Factor Surveillance System, United States,* 1994–2004



* The survey question regarding leisure-time physical activity was not asked in Rhode Island in 1994.

this report also update previous analyses that used BRFSS data from 1990–1998 for 43 states and DC (*4*) and from 1996–2002 for 35 states and DC (*5*). No other measure of physical activity (e.g., regular moderate or vigorous physical activity) has exhibited such improvements (*3*).

These findings provide evidence that leisure-time physical inactivity is declining in every age group and among both men and women. Although the trends indicate improvement, more than 30% of older adults aged ≥70 years are inactive. Because inactive older adults are at increased risk for disability, loss of muscle mass, flexibility, and balance and suffer more serious consequences from falling (*6*), public health messages should continue to focus on older adults to heighten awareness of physical activity opportunities.

Trends in leisure-time physical inactivity for racial/ethnic groups indicated improvements among both non-Hispanic whites and non-Hispanic blacks during the 11 years examined in the study. Asians/Pacific Islanders, American Indians/Alaska Natives, and other multiracial groups did not have sufficient sample sizes to assess trends. An overarching goal of *Healthy People 2010* is to reduce health disparities between racial/ethnic groups. Efforts to address racial/ethnic disparities can be bolstered by studies of correlates of physical inactivity behaviors in disparate groups. Community programs that provide accessible facilities, transportation options, culturally sensitive activities, and a multilingual staff might encourage physical activity in certain racial/ethnic populations. Further investigation into attitudes toward and barriers to physical activity might enhance programs for promoting physical activity among racial/ethnic minority populations.

The *Community Guide to Preventive Services* recommends six evidence-based strategies to increase physical activity: communitywide campaigns, signage to encourage stair use near elevators and escalators, individually adapted health-behavior change programs, school physical education, social support interventions in community settings, and creation of or enhanced access to places for physical activity combined with informational outreach activities (*7*). This report identifies segments of the U.S population for whom those recommended interventions might be targeted, including Hispanics and older adults.

The findings of this report are subject to at least four limitations. First, BRFSS is a telephone survey and, as such, the data are self-reported, subject to both recall and social desirability bias, and are provided only by those with landline telephones. Second, small sample sizes and ethnic heterogeneity among the majority of racial/ethnic minority populations might lead to substantial variability in estimates and imprecise trends in these populations. Third, Rhode Island did not ask the physical activity survey question in 1994 and therefore was not included in this study for that year. However, exclusion of Rhode Island from all years did not change the prevalences. Finally, these data are limited by potential nonresponse-related errors, particularly because the response rate declined over time.

Although the decline in leisure-time physical inactivity is a positive trend, 11-year–trend data also indicate that a substantial proportion of U.S. adults remain physically inactive; nearly one in four adults reported no leisure-time physical activity in 2004. CDC and the American College of Sports Medicine recommend that every adult participate in at least 30 minutes of moderate-intensity physical activity (e.g., brisk walking) on most, and preferably all, days of the week (*8*). Regular physical activity can provide important health benefits, even when initiated later in life (*9*). CDC coordinates multiple initiatives at state and local levels to promote physical activity, including Steps to a HealthierUS and various programs focusing on obesity prevention. Public health agencies should continue to encourage adults to meet physical activity recommendations by increasing opportunities and motivation for physical activity.

References

1. US Department of Health and Human Services. Physical activity and health: a report of the Surgeon General. Atlanta, GA: CDC; 1996.
2. CDC. Prevalence of physical activity, including lifestyle activities among adults—United States, 2000–2001. MMWR 2003;52:764–8.
3. US Department of Health and Human Services, CDC. DATA2010: the Healthy People 2010 database; 2004. Available at http://wonder.cdc.gov/data2010.
4. CDC. Physical activity trends—United States, 1990–1998. MMWR 2001;50:166–9.
5. CDC. Prevalence of no leisure-time physical activity—35 states and the District of Columbia, 1988–2002. MMWR 2004;53:82–6.

6. Carlson JE, Ostir GV, Black SA, Markides KS, Rudkin L, Goodwin JS. Disability in older adults: physical activity as prevention. Behav Med 1999;24:157–68.
7. Task Force on Community Preventive Services. Guide to community preventive services. Physical activity. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at http://www.thecommunityguide.org/pa/default.htm.
8. Pate R, Pratt M, Blair SN, et al. Physical activity and public health: a recommendation from the Centers for Disease Control and Prevention and the American College of Sport Medicine. JAMA 1995;273:402–7.
9. King AC. Interventions to promote physical activity by older adults. J Gerontology Series A 2001;56:36–46.

Distribution of Insecticide-Treated Bednets During an Integrated Nationwide Immunization Campaign — Togo, West Africa, December 2004

During December 13–19, 2004, Togo, a West African nation with a population of approximately 5 million, conducted the first-ever nationwide distribution of insecticide-treated bednets (ITNs) for prevention of malaria. A supplemental immunization activity (SIA), conducted as part of Togo's measles mortality reduction strategy and targeting all children aged 9–59 months, was used as an opportunity to distribute ITNs, oral poliovirus vaccine (OPV), and the anti-helminthic medication, mebendazole. The campaign aimed to achieve >95% coverage among the 866,725 children aged 9–59 months with measles vaccine, OPV, one ITN, and one tablet of mebendazole. This report describes the planning, implementation, and results of this campaign, with emphasis on ITN distribution. The findings demonstrate the feasibility of integrating delivery of these services in a campaign setting.

During 1995–2001, Togo experienced an annual average of 2,648 reported measles cases and 15 reported measles deaths; after the 2001 nationwide measles SIA that initiated Togo's measles mortality reduction activities, reported measles cases declined to 358 in 2002 and to 296 in 2003, while reported measles deaths declined to one and zero, respectively (unpublished data, Ministry of Health [MOH] of Togo, 2004). Malaria, endemic throughout Togo, accounted for approximately one quarter to one third of all deaths in Togolese children aged <5 years in 2003 (unpublished data, MOH, 2005); however, a morbidity survey in September 2004 revealed that only 0.4% of children in this age group slept under an ITN during the previous night (unpublished data, MOH, 2005). Although Togo's most recent wild poliovirus (WPV) case occurred in 2003, WPV circulation remains endemic in two West African countries, Niger and Nigeria (*1*). Soil-transmitted helminth infection is prevalent in West Africa, with children aged 2–5 years among those at greatest risk (*2*).

An Interagency Coordination Committee (ICC) for the MOH Expanded Program for Immunization (EPI) approved the campaign plan, mobilized resources, monitored campaign preparations, and disbursed funds. A National Steering Committee under ICC oversaw three groups: 1) the Technical Working Group, which prepared guidelines, reporting forms, and evaluation tools; 2) the Logistics Working Group, which prepared the plan for procuring and distributing vaccines, injection materials, ITNs, and mebendazole tablets and developed the waste-management plan; and 3) the Social Mobilization Working Group, which developed the communications and social mobilization plan and materials.

International partner organizations under the Measles Initiative* and local agencies, such as the Togolese Red Cross, provided funding and consultants to support campaign planning, implementation, and evaluation. Donor campaign contributions came to nearly USD $6 million, with approximately $5.3 million covering vaccine, mebendazole, ITNs, and supplies; $0.7 million covered operational costs, and these costs did not include MOH inputs, such as staff and vehicles. This translates to approximately USD $6.92 per child.

The government established 565 fixed posts and 628 outreach posts and 146 mobile teams. Each fixed post, serving at least 300 children daily and staffed by two vaccinators and two volunteers, was organized as follows: 1) a volunteer tallied eligible children and distributed campaign cards; 2) a vaccinator administered the measles injection; 3) a second vaccinator administered OPV and mebendazole; and 4) a volunteer provided an ITN for each child and documented services provided on each child's card. Outreach teams included one vaccinator and two volunteers, and mobile teams included one vaccinator and one volunteer. Supervisors used checklists to monitor the quality of services. Thirty-two incinerators for destruction of used injection equipment were rehabilitated to

*The Measles Initiative is a long-term commitment to control measles deaths in Africa by vaccinating 200 million children through both mass and follow-up campaigns in up to 36 sub-Saharan African countries by 2006. Partner agencies leading the initiative are the American Red Cross, Canadian International Development Agency, CDC, United Nations Children's Fund (UNICEF), United Nations Foundation, and the World Health Organization. Other partners contributing to the Togo campaign under MOH guidance included Becton Dickinson; Canadian Red Cross; Church of Jesus Christ of Latter-Day Saints; DHL; Freedom from Hunger; Geneva University; Global Fund for AIDS, Tuberculosis, and Malaria; International Federation of Red Cross and Red Crescent Societies; Joint United Nations Program on HIV/AIDS; Nestlé; Liverpool School of Tropical Medicine; London School of Hygiene and Tropical Medicine; New Zealand Red Cross Society; Norwegian Agency for Development Cooperation; Norwegian Red Cross; Plan Togo; Population Services International; Reliance Industries; Right to Play; Roll Back Malaria; Rotary International; Sanofi-Synthelab; Togolese Red Cross; Unilever; United Nations Development Program; U.S. Agency for International Development; U.S. Peace Corps; and Vestergaard Frandsen.

supplement the 140 existing ones; 99% of filled safety boxes were incinerated, and the rest were burned in pits. No severe adverse events were reported.

One month after the campaign, a probability-based survey of 2,599 children aged 9–59 months from 142 enumeration areas[†] and six districts was conducted. The results indicated that coverage for eligible children was 93.1% (95% confidence interval [CI] = 90.8%–95.4%) for measles vaccine, 93.7% (CI = 91.4%–96.1%) for OPV, 90.8% (CI = 88.1%–93.4%) for an ITN, and 92.7% (CI = 90.3%–95.1%) for mebendazole (Figure).

Household ownership of ITNs increased from 8.0% (CI = 5.7%–10.2%) to 62.5% (CI = 58.3%–66.6%) before and after the campaign, respectively; however, only 43.5% (CI = 38.4%–48.7%) of children aged <5 years had slept under an ITN on the night before the survey (unpublished data, MOH, 2005).

Reported by: *V Takpa, MD, K Morgah, MD, Togo Ministry of Health; P Gbedonou, MD, Togo Country Office, World Health Organization, Lome, Togo. Regional Office for Africa, World Health Organization, Harare, Zimbabwe. Div of Parasitic Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program; M Eliades, MD, EIS Officer, CDC.*

Editorial Note: The December 2004 National Integrated Child Health campaign in Togo was the first of its kind to distribute free ITNs nationwide in conjunction with a national immunization campaign. To reach Roll Back Malaria (RBM)[§] goals in Africa and achieve national expansion of malaria prevention interventions, the World Health Organization and UNICEF recommend free distribution of ITNs to children and pregnant women (*3*). Previously, rapid district-level expansion of ITN distribution was achieved during an SIA in one district of Ghana (*4*) and five districts of Zambia (*5*). Similar to previous efforts, the campaign in Togo achieved a substantial increase in ITN ownership without compromising delivery of the other child health interventions provided during the campaign, specifically measles and polio vaccination and anti-helminth treatment. Successful national expansion of malaria prevention activities is crucial if control efforts are to succeed in reducing the burden of disease in Africa. The Togo campaign increased household ownership of at least one ITN from 8.0% to 62.5%. Coverage for all four interventions was >90% for eligible children in the campaign, and levels were similar among households at all economic levels (*6*).

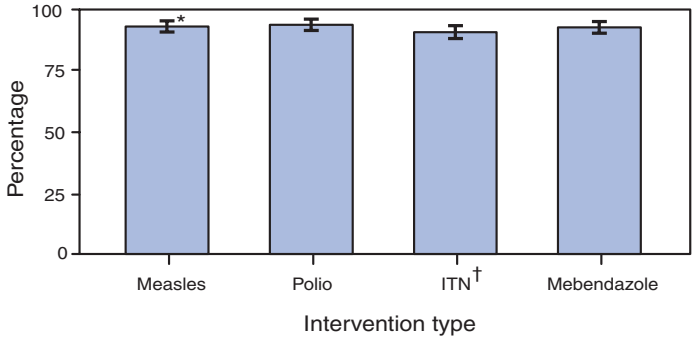
The overall goal of the campaign was to reduce morbidity and mortality in young children in Togo by achieving high coverage for all services provided in the campaign. Community-based trials in Western Kenya demonstrated that two of the key determinants of ITN effectiveness were level of coverage and percentage of persons properly using the bednet each night. When high coverage and appropriate ITN use were achieved in Kenya, a country similar to Togo with intense perennial malaria transmission, both malaria morbidity in children aged <3 years (*7*) and all-cause mortality in children aged 1–11 months (*8*) were reduced. Although ITN coverage increased substantially in all regions after the Togo campaign, a coverage survey conducted 1 month after the campaign demonstrated considerable regional variation in ITN use (30.9%–72.9%) (unpublished data, MOH, 2005). This result is not unexpected, given that the survey was conducted in the hot and dry low-transmission season and use of ITNs tends to be lower when temperatures are high and mosquito populations are low (*9*). Nevertheless, the variable usage rate underscores the need for postcampaign efforts in Togo to encourage proper nighttime use of ITNs because these variable rates of use occurred despite precampaign social mobilization efforts by MOH and the Togolese Red Cross. A multidisciplinary evaluation of the impact of the campaign is being conducted, including pre- and postcampaign morbidity studies during the high malaria-transmission season and health-facility–based surveillance.

Although successful, the campaign faced some challenges. First, a unified message was not communicated clearly to the health posts regarding a one-net-per-household or one-net-per-child strategy. Fear of shortages prompted health posts in one region to switch from the MOH-recommended one-net-per-child policy to a one-net-per-household policy.

[†] Sampling areas defined by the Togo Ministry of Statistics for census purposes.

[§] The RBM partnership was launched in 1998 by the World Health Organization, UNICEF, the United Nations Development Programme, and the World Bank to provide a coordinated global approach to fighting malaria. The overall goal of the partnership is to halve malaria mortality by 2010 and again by 2015. Since its launch, the RBM partnership has grown rapidly and now consists of various partners, including malaria-endemic countries, their bilateral and multilateral development partners, nongovernmental and community-based organizations, foundations, and research and academic institutions.

FIGURE. Percentage of eligible children receiving interventions during the National Integrated Child Health Campaign, by type of intervention — Togo, West Africa, December 2004



* 95% confidence interval.
† Insecticide-treated bednets.

Second, the age group targeted for the campaign was optimal for a follow-up measles SIA but not for the other health interventions provided. Children aged <9 months are especially vulnerable to malaria, and a recent study in Togo revealed that the burden of malaria-related anemia and parasitemia was substantial in this age group (unpublished data, MOH, 2005). Polio vaccinations also are administered to children aged <9 months; however this age group was not targeted in the campaign. Finally, administration of mebendazole tablets was problematic; children aged <2 years, in particular, had difficulty swallowing or chewing the tablets, and efforts to break up tablets in water and administer directly were time-consuming (*10*).

Because ITNs are bulky and have intrinsic commercial value, skepticism persists about the ability of African nations to incorporate the distribution of free bednets into immunization campaigns. Nonetheless, the Togo campaign was successful at increasing both ownership and use of ITNs, even with approximately 130,000 ITNs arriving in port only days before the campaign began. Several factors contributed to the success of the campaign, including a committed MOH, strong support from a global partnership and nongovernmental entities such as the Togolese Red Cross, effective coordination of the global partnership's inputs through ICC, and use of an ICC-approved campaign plan to mobilize resources and oversee campaign implementation. The Togolese experience illustrates how using a mass immunization campaign as a platform to deliver other health services can achieve high (>90%) coverage for all interventions and attract donors in resource-poor countries at the national level. The Togo national campaign and the district-level campaigns in Ghana and Zambia have demonstrated that integrating ITN distribution with an immunization campaign enables quick and equitable distribution of ITNs, a key malaria-control tool, to populations at high risk. The Measles Initiative anticipates that as many as 12 African countries will incorporate ITN distribution into their measles immunization campaigns at the national or subnational levels during 2005 and 2006. Nonetheless, continued efforts are needed to encourage use of ITNs.

References

1. CDC. Progress toward interruption of wild poliovirus transmission—worldwide, January 2004–March 2005. MMWR 2005;54:408–12.
2. World Health Organization, United Nations Children's Fund. Prevention and control of schistosomiasis and soil-transmitted helminthiasis. Geneva, Switzerland: World Health Organization; 2004.
3. World Health Organization, United Nations Children's Fund. Joint statement: malaria control and immunization: a sound partnership with great potential. Geneva, Switzerland: World Health Organization; 2004.
4. Grabowsky M, Nobiya T, Ahun M, et al. Distributing insecticide-treated bednets during measles vaccination: a low-cost means of achieving high and equitable coverage. Bull WHO 2005;83:195–201.
5. Grabowsky M, Farrell N, Hawley W, et al. Distribution of insecticide-treated bednets during a measles vaccination campaign achieves high, rapid, and equitable coverage at low cost. Trop Med Int Health 2005;10:1–10 (in press).
6. Gwatkin D, Johnson K, Wagstaff A, et al. Socio-economic differences in health, nutrition, and population in Togo. Washington, DC: World Bank; 2000. Available at http://www1.worldbank.org/prem/poverty/health/data/togo/togo.pdf.
7. Hawley W, Phillips-Howard P, ter Kuile F, et al. Community-wide effects of permethrin-treated bed nets on child mortality and malaria morbidity in Western Kenya. Am J Trop Med Hyg 2003;68:121–7.
8. Eisele T, Lindblade K, Wannemuehler K, et al. Effect of sustained insecticide-treated bed net use on all-cause child mortality in and area of intense perennial malaria transmission in Western Kenya. Am J Trop Med Hyg 2005;73:149–56.
9. Alaii J, Hawley W, Kolczak M, et al. Factors affecting use of permethrin-treated bed nets during a randomized controlled trial in Western Kenya. Am J Trop Med Hyg 2003;68:137–41.
10. World Health Organization. Report of the Third Global Meeting of the Partners for Parasite Control. Deworming for health and development. Geneva, Switzerland: World Health Organization; 2005. Available at http://whqlibdoc.who.int/hq/2005/who_cds_cpe_pvc_2005.14.pdf.

Carbon Monoxide Poisoning After Hurricane Katrina — Alabama, Louisiana, and Mississippi, August–September 2005

On September 30, this report was posted as an MMWR Early Release *on the* MMWR *website* (http://www.cdc.gov/mmwr).

Hurricane Katrina made landfall on August 29, 2005, on the Gulf Coast of the United States, causing loss of life, widespread property damage, and power outages. After hurricanes, some residents use portable generators and other gasoline-powered appliances for electrical power and cleanup. These devices produce carbon monoxide (CO), and improper use can cause CO poisoning (*1,2*). During August 29–September 24, a total of 51 cases of CO poisoning were reported by hyperbaric oxygen (HBO_2) facilities in Alabama, Louisiana, and Mississippi. This report describes these cases and the rapidly implemented reporting system that identified them. CO poisoning can be prevented by reducing exposure to CO through appropriate placement and ventilation of gasoline-powered engines.

Investigations into CO poisonings in Florida after hurricanes in 2004 revealed that approximately 40% of patients had received HBO_2 treatment. To monitor cases of CO poisoning from HBO_2 facilities in the three affected states, CDC collaborated with the Undersea and Hyperbaric Medicine Society (UHMS) to initiate reporting after Hurricane Katrina. Members of UHMS were asked to report cases, which were compiled and submitted to CDC and shared with each affected state on a daily basis.

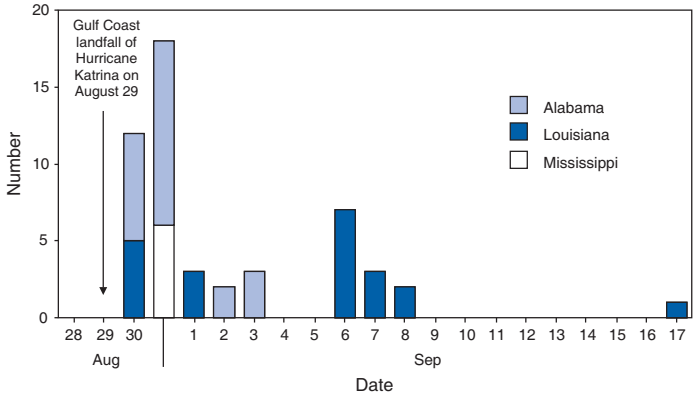
HBO_2 facilities were asked to report information on individual cases and incidents in which multiple persons were poisoned by the same exposure, the date of presentation to the HBO_2 facility, state of residence, source of exposure, and the source of HBO_2 treatment. Of the 35 HBO_2 facilities (Alabama: five, Mississippi: 10, and Louisiana: 20), four (one, two, and one, respectively) reported treating patients. The extent of underreporting of treated patients is unknown.

These reports were sent daily to CDC. A case of post-hurricane CO poisoning was defined as one occurring in a patient with a clinical diagnosis of CO poisoning who had resided in a hurricane-affected state (i.e., Alabama, Louisiana, or Mississippi) and whose exposure was reported by an HBO_2 facility. Cases of CO poisoning caused by intentional exposures or fire- or smoke-related exposures were excluded.

During August 29–September 24, a total of 51 cases of CO poisoning among residents of Alabama, Louisiana, and Mississippi were reported by the HBO_2 facilities. These cases included 46 nonfatal CO poisoning cases and five deaths. Among the nonfatal cases, 16 occurred in residents of Louisiana, 24 in residents of Alabama, and six in residents of Mississippi. Among the 46 nonfatal CO poisoning cases, 37 occurred in patients who were treated with HBO_2, and nine in patients who received high flow oxygen. None of the patients treated with HBO_2 died. All five decedents were Louisiana residents. One exposure incident accounted for four of the deaths and one nonfatal case. Another incident accounted for one death and two nonfatal exposures. Two incidents each involved seven nonfatal cases. A total of 38 (74.5%) of the cases occurred within the first week after the hurricane; the other 13 (25.5%) occurred during September 6–24 (Figure).

The source of exposure for all but one of the nonfatal cases was exhaust from a portable generator. One nonfatal case was associated with use of a gasoline-powered pressure washer. The incident in which four deaths and one nonfatal CO poisoning occurred involved use of a generator in a house. The single death with two nonfatal CO poisoning cases involved use of a generator in a garage. The locations of the generators for the other cases were: under a deck (28.6%), near a window (26.2%), in a shed (16.7%), in a garage (11.9%), in a carport (9.5%), and in a basement (7.1%).

FIGURE. Number of carbon monoxide poisoning cases reported by hyperbaric oxygen facilities after Hurricane Katrina — Alabama, Louisiana, and Mississippi, August 29–September 24, 2005



Since March 15, 2003, CDC and the American Association of Poison Control Centers (AAPCC) have collaborated to facilitate the early detection of chemical exposures of public health importance. Carbon monoxide is one of several exposures monitored. During August 29–September 24, AAPCC reported a total of 58 calls regarding CO exposure: eight in Mississippi, 21 in Alabama, and 29 in Louisiana. No deaths were reported from these exposures.

Reported by: *NB Hampson, MD, Center for Hyperbaric Medicine, Virginia Mason Medical Center, Seattle, Washington. MW Lai, MD, American Assoc of Poison Control Centers. M McNeil, MD, PhD, P Byers, MD, Mississippi Dept of Health. R Ratard, MD, Louisiana Office of Public Health. M Patel, MD, M Belson, MD, A Stock, PhD, J Ferdinands, PhD, R Funk, DVM, P Meyer, PhD, C Pertowski, MD, National Center for Environmental Health; D Crocker, MD, EIS officer, CDC.*

Editorial Note: CO poisoning can be difficult to diagnose because the common symptoms are nonspecific (e.g., headache, dizziness, weakness, nausea, vomiting, chest pain, and confusion). Many persons with CO poisoning mistake their symptoms for influenza. CO poisoning can result in loss of consciousness and death. Health-care providers should consider CO poisoning when evaluating patients who have these symptoms, especially after power outages.

The reporting system described in this report rapidly identified severe cases of CO poisoning in the wake of Hurricane Katrina and was implemented before Hurricane Rita struck the Texas-Louisiana border on September 24. All nonfatal and fatal CO poisonings in this report were attributed to improper use and ventilation of gasoline-powered equipment and tools. Improper placement of portable generators accounted for 98% of the CO poisonings reported by the HBO_2 facilities. The extent of generator use in Alabama, Louisiana, and Mississippi is not known. However, an assessment of generator use in Florida after the 2004 hurricanes indicated that 17.5% of residents used portable generators. Of that group, 5% reported operating the generators indoors (*5*). The HBO_2 facility reports described in this report identified one CO poisoning associated with use of a pressure washer. Pressure washer–associated CO poisonings after a hurricane have not been previously reported but have been documented in certain work settings (*6*). As the cleanup continues after Hurricane Katrina and Hurricane Rita, monitoring of CO poisoning reports from HBO_2 facilities and other sources and education about

CO-poisoning prevention will continue in collaboration with state and local health departments and partners.

CO poisoning is easily preventable by reducing exposure to CO (Box). CO detectors can alert users when dangerous levels of CO are present. Educating the public on proper placement and operation of portable generators and pressure washers will reduce exposure to CO. In anticipation of CO poisonings after the hurricane, CDC developed CO-poisoning prevention information sheets and collaborated with the New Orleans mayor's office to distribute them. In addition, CDC collaborated with local organizations to work with retailers and rental companies of generators and gasoline-powered tools to alert buyers and renters of the risk for CO poisoning with improper use of this equipment. In Mississippi, community and faith-based organizations distributed educational information about CO in severely affected communities. Additional information about CO poisoning and approaches to prevention is available at http://www.bt.cdc.gov/disasters/carbonmonoxide.asp.

The findings in this report are subject to at least four limitations. First, many patients with CO poisoning might not seek medical care. Among those who seek medical care, the diagnosis of CO poisoning might be missed. An estimated 6% of persons with CO poisoning who visit emergency departments are treated with HBO_2 (*7*). HBO_2 therapy can benefit patients with a history of obvious CO exposure and moderate-to-severe symptoms of CO toxicity (*3,4*); however the primary treatment for CO toxicity is the administration of high-flow oxygen by non-rebreather mask, which can be accomplished during the initial patient evaluation and transport (*8*). Therefore, HBO_2 reports also likely underestimate the number of persons with nonfatal CO poisoning. Second, the HBO_2 reports likely underestimate the number of fatal CO poisonings because they report only deaths associated with referred cases. Third, because AAPCC members provide consultation to treatment providers and the public, the AAPCC reports do not necessarily represent persons who have CO poisoning diagnosed. Finally, HBO_2 and AAPCC reports might report some of the same persons. Because the HBO_2 and AAPCC reports did not include personal identifiers, duplicate reports might have occurred.

Despite these limitations, reporting from HBO_2 facilities and AAPCC members was rapidly coordinated through their respective organizations. These reports provided timely information when data from hospitals, emergency departments, and clinics were not available. Local and state public health infrastructure for disease surveillance and control was disrupted, shifting initial emphasis toward nonstandard mechanisms for disease reporting. HBO_2 and AAPCC reports can expedite tracking of CO poisonings when disasters disrupt public health and medical infrastructure.

BOX. Safety messages to prevent carbon monoxide (CO) poisoning

- Never use portable generators, pressure washer engines, or other gasoline-powered tools inside the home.
- Place gasoline-powered equipment outside and away from doors, windows, or air intakes.
- Do not use gasoline-powered equipment in garages, carports, basements, or other enclosed spaces.
- Opening windows and doors, and operating fans are not sufficient to prevent buildup of CO in a home.
- Get out of the house and seek medical help immediately if you or a family member has symptoms of CO poisoning. Symptoms include headache, fatigue, dizziness, nausea or vomiting, and loss of consciousness.

Acknowledgments

The findings in this report are based, in part, on contributions by members of the Undersea and Hyperbaric Medical Society, including J Garcia, Springhill Medical Center; C Witz, Terrebone General Medical Center; B Chamberlain, C Wiggins, West Jefferson Medical Center; J Gleaves, MD, Rush Foundation Hospital; and members of the American Association of Poison Control Centers (AAPCC), including AC Bronstein, MD, MP Hughes, MCS, Mississippi Regional PCC; G Smith, Louisiana PCC; JG Fisher III, PharmD, Alabama (Tuscaloosa) PCC; WD King, DrPH, Alabama (Birmingham Regional) PCC; JP Lofgren, MD, Alabama Dept of Public Health.

References

1. CDC. Carbon monoxide poisoning from hurricane-associated use of portable generators—Florida, 2004. MMWR 2005;54:697–700.
2. Hampson NB, Zmaeff JL. Carbon monoxide poisoning from portable electric generators. Am J Prev Med 2005;28:123–5.
3. Weaver LK, Hopkins RO, Chan KJ, et al. Hyperbaric oxygen for acute carbon monoxide poisoning. N Engl J Med 2002;347:1057–67.
4. Hampson NB, Mathieu D, Piantadosi CA, Thom SR, Weaver L. Carbon monoxide poisoning: interpretation of randomized clinical trials and unresolved treatment issues. Undersea Hyperb Med 2001;28:157–64.
5. CDC. Epidemiologic assessment of the impact of four hurricanes—Florida, 2004. MMWR 2005;54:693–7.
6. National Institute of Occupational Safety and Health. Preventing carbon monoxide poisoning from small gasoline-powered engines and tools. Cincinnati, OH: National Institute for Occupational Safety and Health; 1996. DHHS (NIOSH) publication no. 96-118. Available at http://www.cdc.gov/niosh/carbon2.html.
7. Hampson NB. Emergency department visits for carbon monoxide poisoning in the Pacific Northwest. J Emerg Med 1998;16:695–8.
8. Colomb-Lippa D. Acute carbon monoxide exposure: diagnosis, evaluation, treatment. JAAPA 2005;18:41–6.

Update: West Nile Virus Activity — United States, 2005

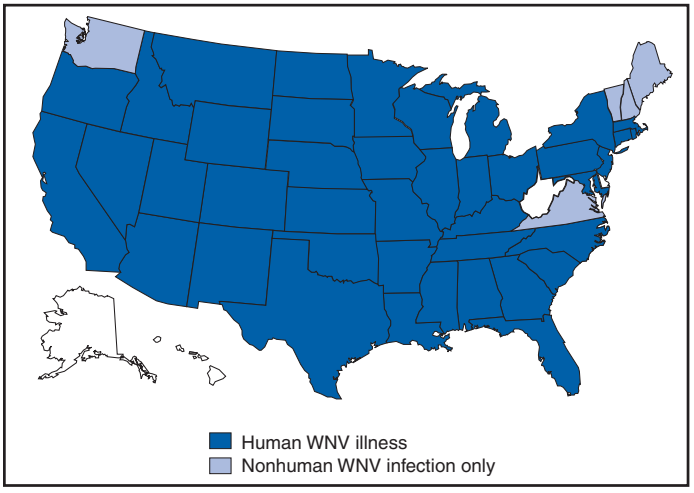
This report summarizes West Nile virus (WNV) surveillance data reported to CDC through Arbo-NET as of 3 a.m. Mountain Daylight Time, October 4, 2005.

Forty-one states have reported 2,016 cases of human WNV illness in 2005 (Figure and Table 1). By comparison, in 2004, a total of 1,865 WNV cases had been reported as of October 5, 2004 (Table 2). A total of 1,058 (57%) of the 1,865 cases for which such data were available in 2005 occurred in males; the median age of patients was 51 years (range: 3 months–98 years). Date of illness onset ranged from January 2 to September 29; a total of 55 cases were fatal.

A total of 345 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET during 2005. Of these, 92 were reported from California; 52 from Nebraska; 50 from Texas; 22 each from Arizona and Louisiana; 19 from Kansas; 16 from South Dakota; 11 from Iowa; 10 from Minnesota; nine from Illinois; seven from Oklahoma; five from New Mexico; four each from Alabama, Pennsylvania, and Utah; three from Michigan; two each from Colorado, Mississippi, Nevada, and Wisconsin; and one each from Idaho, Montana, New York, North Carolina, North Dakota, Ohio, and Oregon. Of the 345 PVDs, three persons aged 53, 56, and 72 years subsequently had neuroinvasive illness; seven persons (median age: 25 years) subsequently had other illnesses; and 76 persons (median age: 46 years [range: 17–78 years]) subsequently had West Nile fever.

Additional information about national WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and at http://westnilemaps.usgs.gov.

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2005*



* As of October 4, 2005.

TABLE 1. Number of human cases of West Nile virus (WNV) illness reported, by state — United States, 2005*

State	Neuroinvasive disease†	West Nile fever§	Other clinical/ unspecified¶	Total**	Deaths
Alabama	5	2	0	**7**	1
Arizona	19	29	15	**63**	2
Arkansas	8	13	0	**21**	0
California	239	429	74	**742**	16
Colorado	14	61	0	**75**	1
Connecticut	2	0	0	**2**	0
Florida	6	12	1	**19**	0
Georgia	5	3	3	**11**	0
Idaho	2	6	4	**12**	0
Illinois	105	72	19	**196**	3
Indiana	5	0	4	**9**	1
Iowa	6	10	7	**23**	2
Kansas	5	2	0	**7**	0
Kentucky	3	0	0	**3**	0
Louisiana	58	23	0	**81**	6
Maryland	4	0	0	**4**	0
Massachusetts	2	2	0	**4**	0
Michigan	17	3	3	**23**	3
Minnesota	14	20	0	**34**	1
Mississippi	33	26	0	**59**	4
Missouri	6	7	1	**14**	1
Montana	7	16	0	**23**	0
Nebraska	19	49	0	**68**	1
Nevada	8	14	0	**22**	0
New Jersey	2	0	0	**2**	0
New Mexico	15	11	0	**26**	1
New York	3	2	0	**5**	0
North Carolina	1	1	1	**3**	0
North Dakota	2	14	0	**16**	0
Ohio	41	8	0	**49**	1
Oklahoma	1	2	0	**3**	0
Oregon	0	5	0	**5**	0
Pennsylvania	13	8	0	**21**	0
Rhode Island	1	0	0	**1**	0
South Carolina	3	0	0	**3**	1
South Dakota	33	187	1	**221**	2
Tennessee	8	1	0	**9**	1
Texas	52	24	0	**76**	5
Utah	17	24	0	**41**	1
Wisconsin	4	3	0	**7**	1
Wyoming	2	4	0	**6**	0
Total	**790**	**1,093**	**133**	**2,016**	**55**

* As of October 4, 2005.
† Cases with neurologic manifestations (i.e., West Nile meningitis, West Nile encephalitis, and West Nile myelitis).
§ Cases with no evidence of neuroinvasion.
¶ Illnesses for which sufficient clinical information was not provided.
** Total number of human cases of WNV illness reported to ArboNET by state and local health departments.

TABLE 2. Comparison of human cases and deaths from West Nile virus — United States, 2002–2005

Year	Human cases	Deaths
2002*	2,530	116
2003†	5,861	115
2004§	1,865	59
2005¶	2,016	55

* As of October 2, 2002.
† As of October 1, 2003.
§ As of October 5, 2004.
¶ As of October 4, 2005.

Notice to Readers

World Mental Health Day — October 10, 2005

World Mental Health Day, observed October 10, 2005, begins a year-long, global awareness campaign devoted to mental health promotion and mental illness prevention. In any given year, one in five persons in the United States has a mental disorder, and 450 million persons worldwide have mental or behavioral disorders. Growing research indicates that mental health and physical well-being are interdependent; one often has a substantial effect on the development of the other.

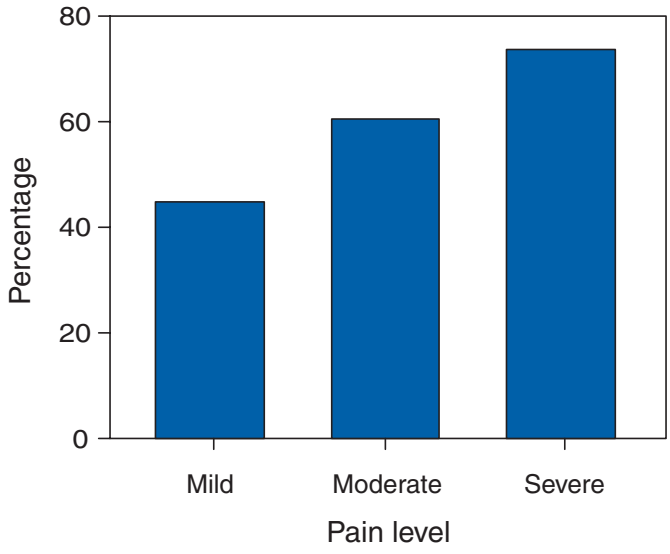
The theme for this year's Mental Health Day is "Mental and Physical Health Across the Life Span." The World Federation of Mental Health (WFMH) initiated Mental Health Day in 1992 to highlight the importance of mental illness as a worldwide concern. This year's campaign stresses that all health-care professionals need a greater understanding of how mental health problems affect persons, mentally and physically, at all stages of life.

WFMH is an international, nongovernmental organization founded in 1948 to advance, among all persons and nations, the prevention of mental and emotional disorders, advocating appropriate treatment and care for those with such disorders and the promotion of mental health. Campaign materials for World Mental Health Day can be accessed and downloaded at http://www.wmhday.net. Other mental health observations occurring during the month of October are National Depression Screening Day, October 6, and Mental Illness Awareness Week, October 2–8.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

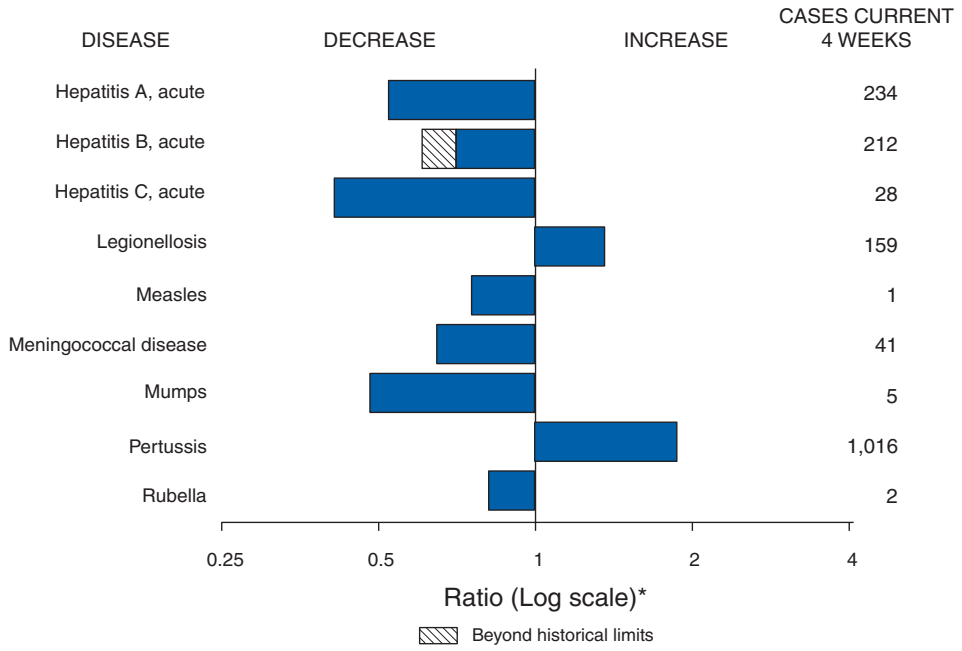
Percentage of Emergency Department Visits During Which Pain Medication Was Prescribed, by Pain Level — United States, 2003



The percentage of emergency department visits during which pain medication was prescribed increased with pain severity as assessed on the patient's arrival. However, pain medication was prescribed for only 74% of visits during which the patient's pain was described as severe.

Source: National Center for Health Statistics. 2003 National Hospital Ambulatory Medical Care Survey, emergency department public-use data file. Available at http://www.cdc.gov/nchs/nhamcs.htm.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals October 1, 2005, with historical data



* 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 October 1, 2005 (39th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	128	132
Botulism:			HIV infection, pediatric†¶	181	294
foodborne	9	8	Influenza-associated pediatric mortality†**	44	—
infant	57	63	Measles	60††	25§§
other (wound & unspecified)	21	13	Mumps	214	158
Brucellosis	75	74	Plague	3	1
Chancroid	21	19	Poliomyelitis, paralytic	1	—
Cholera	4	4	Psittacosis†	16	11
Cyclosporiasis†	679	195	Q fever†	92	51
Diphtheria	—	—	Rabies, human	1	4
Domestic arboviral diseases			Rubella	8	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	36	104	SARS†**	—	—
eastern equine†§	12	3	Smallpox†	—	—
Powassan†§	—	1	*Staphylococcus aureus*:		
St. Louis†§	6	12	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	92	107
human granulocytic (HGE)†	396	310	Tetanus	16	16
human monocytic (HME)†	315	227	Toxic-shock syndrome	77	68
human, other and unspecified †	63	56	Trichinellosis¶¶	15	1
Hansen disease†	57	74	Tularemia†	111	87
Hantavirus pulmonary syndrome†	17	18	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update June 26, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 60 cases reported, 49 were indigenous and 11 were imported from another country.
§§ Of 25 cases reported, eight were indigenous and 17 were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending October 1, 2005, and October 2, 2004 (39th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	20,405	30,659	682,254	689,085	3,455	4,289	4,900	2,726
NEW ENGLAND	778	974	24,208	22,768	—	—	227	143
Maine	11	20	1,588	1,539	N	N	16	17
N.H.	20	36	1,381	1,283	—	—	25	27
Vt.¶	4	14	691	849	—	—	32	21
Mass.	368	337	11,010	10,074	—	—	89	52
R.I.	68	109	2,470	2,568	—	—	7	4
Conn.	307	458	7,068	6,455	N	N	58	22
MID. ATLANTIC	4,352	6,898	85,085	84,705	—	—	2,112	394
Upstate N.Y.	800	772	16,924	16,972	N	N	1,796	92
N.Y. City	2,327	3,892	26,766	26,316	—	—	82	103
N.J.	574	1,143	13,658	13,304	N	N	40	39
Pa.	651	1,091	27,737	28,113	N	N	194	160
E.N. CENTRAL	1,938	2,673	106,026	121,901	7	11	1,038	851
Ohio	312	504	25,449	30,523	N	N	567	185
Ind.	236	285	14,717	13,800	N	N	48	65
Ill.	983	1,267	32,842	35,719	—	—	73	134
Mich.	322	485	18,976	27,695	7	11	75	125
Wis.	85	132	14,042	14,164	N	N	275	342
W.N. CENTRAL	463	626	42,140	42,369	5	6	449	318
Minn.	123	148	8,236	8,862	3	N	95	106
Iowa	50	50	5,263	5,187	N	N	88	63
Mo.	198	267	16,752	15,594	1	3	212	59
N. Dak.	5	15	837	1,380	N	N	1	10
S. Dak.	10	8	2,050	1,866	—	—	16	33
Nebr.¶	18	44	3,767	3,883	1	3	6	24
Kans.	59	94	5,235	5,597	N	N	31	23
S. ATLANTIC	6,473	9,345	133,637	129,334	1	—	504	408
Del.	100	118	2,498	2,159	N	N	3	—
Md.	812	1,251	13,922	14,310	1	—	29	16
D.C.	467	621	2,944	2,652	—	—	9	13
Va.¶	307	506	15,986	16,744	—	—	48	44
W. Va.	36	63	1,991	2,112	N	N	12	5
N.C.	531	471	24,468	21,769	N	N	67	64
S.C.¶	386	534	16,653	14,134	—	—	14	18
Ga.	1,103	1,298	22,885	24,173	—	—	87	143
Fla.	2,731	4,483	32,290	31,281	N	N	235	105
E.S. CENTRAL	1,093	1,515	51,048	45,030	—	5	141	114
Ky.	135	183	6,707	4,192	N	N	94	36
Tenn.¶	434	617	17,600	16,819	N	N	29	31
Ala.¶	295	350	11,132	10,258	—	—	16	21
Miss.	229	365	15,609	13,761	—	5	2	26
W.S. CENTRAL	2,206	3,548	80,022	84,554	1	3	93	81
Ark.	72	175	6,507	6,037	—	1	4	13
La.**	436	704	12,572	16,936	1	2	3	3
Okla.	167	147	8,325	8,273	N	N	34	17
Tex.¶	1,531	2,522	52,618	53,308	N	N	52	48
MOUNTAIN	789	1,126	39,912	42,053	2,387	2,665	100	141
Mont.	4	5	1,474	1,871	N	N	16	34
Idaho¶	9	16	1,826	2,125	N	N	9	21
Wyo.	2	14	837	795	3	2	2	3
Colo.	163	247	10,023	10,706	N	N	36	48
N. Mex.	72	148	4,171	6,776	9	19	3	14
Ariz.	329	403	13,431	12,051	2,339	2,583	10	15
Utah	33	51	3,249	2,784	5	16	15	4
Nev.¶	177	242	4,901	4,945	31	45	9	2
PACIFIC	2,313	3,954	120,176	116,371	1,054	1,599	236	276
Wash.	229	309	13,936	13,217	N	N	38	33
Oreg.¶	136	236	6,100	6,193	—	—	57	29
Calif.	1,874	3,283	94,431	89,962	1,054	1,599	137	212
Alaska	14	32	3,000	2,875	—	—	3	—
Hawaii	60	94	2,709	4,124	—	—	1	2
Guam	1	1	—	801	—	—	—	—
P.R.	537	594	2,759	2,629	N	N	N	N
V.I.	10	10	119	272	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

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

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update June 26, 2005.

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

** Because of Hurricane Katrina, weekly reporting has been disrupted.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 1, 2005, and October 2, 2004 (39th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,661	1,890	221	202	224	143	12,764	14,278	234,290	243,308
NEW ENGLAND	128	120	43	40	23	13	1,195	1,335	4,436	5,259
Maine	13	11	8	—	—	—	156	108	99	168
N.H.	11	15	2	5	—	—	40	31	127	93
Vt.	12	11	3	—	—	—	139	129	39	68
Mass.	48	52	6	13	23	13	494	587	1,958	2,360
R.I.	5	6	—	1	—	—	86	92	333	648
Conn.	39	25	24	21	—	—	280	388	1,880	1,922
MID. ATLANTIC	219	220	23	31	30	33	2,335	3,023	24,600	27,492
Upstate N.Y.	100	96	14	12	9	17	870	1,008	5,024	5,503
N.Y. City	11	34	—	—	—	—	574	843	7,155	8,514
N.J.	36	38	2	6	6	6	272	398	4,156	5,146
Pa.	72	52	7	13	15	10	619	774	8,265	8,329
E.N. CENTRAL	336	367	20	43	10	25	2,018	2,281	42,731	51,166
Ohio	107	78	6	9	5	16	595	606	11,834	15,920
Ind.	43	41	—	—	—	—	N	N	5,896	4,970
Ill.	45	82	1	7	1	6	381	632	13,178	15,593
Mich.	66	65	1	9	4	3	569	527	7,817	11,013
Wis.	75	101	12	18	—	—	473	516	4,006	3,670
W.N. CENTRAL	275	404	23	29	42	20	1,473	1,546	13,539	12,838
Minn.	79	96	7	11	27	4	652	547	2,317	2,209
Iowa	58	108	—	—	—	—	195	226	1,189	921
Mo.	64	69	10	15	7	6	342	429	6,991	6,706
N. Dak.	5	12	—	—	—	6	10	20	55	89
S. Dak.	18	29	3	—	—	—	65	42	263	209
Nebr.	22	60	3	3	4	—	79	114	850	796
Kans.	29	30	—	—	4	4	130	168	1,874	1,908
S. ATLANTIC	154	133	57	23	86	34	1,859	2,192	58,165	58,625
Del.	5	2	N	N	N	N	42	40	642	669
Md.	27	20	22	3	9	3	140	94	5,276	6,116
D.C.	—	1	—	—	—	—	41	54	1,651	1,969
Va.	27	26	22	11	20	—	412	375	5,739	6,731
W. Va.	1	2	—	—	1	—	32	31	548	690
N.C.	—	—	—	—	43	24	N	N	11,681	11,477
S.C.	6	11	—	—	1	—	76	92	7,360	6,968
Ga.	24	16	9	6	—	—	395	669	10,581	10,658
Fla.	64	55	4	3	12	7	721	837	14,687	13,347
E.S. CENTRAL	102	82	2	3	18	14	308	313	20,202	19,738
Ky.	34	21	—	1	13	8	N	N	2,273	1,886
Tenn.	39	35	2	—	5	6	166	170	6,424	6,288
Ala.	24	16	—	—	—	—	142	143	6,447	6,251
Miss.	5	10	—	2	—	—	—	—	5,058	5,313
W.S. CENTRAL	41	66	5	3	7	4	216	243	32,406	32,739
Ark.	6	12	—	—	—	—	64	98	3,451	3,191
La.	3	3	3	1	2	—	27	39	6,950	7,906
Okla.	19	15	1	—	1	—	125	106	3,344	3,514
Tex.	13	36	1	2	4	4	N	N	18,661	18,128
MOUNTAIN	144	184	42	29	8	—	1,014	1,142	8,663	8,900
Mont.	14	13	—	—	—	—	56	52	83	62
Idaho	16	42	8	9	5	—	64	140	76	68
Wyo.	5	7	2	1	—	—	19	19	56	45
Colo.	31	45	1	1	1	—	394	401	2,307	2,266
N. Mex.	8	10	5	5	—	—	48	57	791	908
Ariz.	28	18	N	N	N	N	102	134	2,958	2,859
Utah	32	34	24	12	—	—	282	242	507	435
Nev.	10	15	2	1	2	—	49	97	1,885	2,257
PACIFIC	262	314	6	1	—	—	2,346	2,203	29,548	26,551
Wash.	75	116	—	—	—	—	266	265	2,712	2,043
Oreg.	63	52	6	1	—	—	288	341	1,067	889
Calif.	102	137	—	—	—	—	1,670	1,473	24,857	22,203
Alaska	12	1	—	—	—	—	74	62	418	450
Hawaii	10	8	—	—	—	—	48	62	494	966
Guam	N	N	—	—	—	—	—	2	—	124
P.R.	1	1	—	—	—	—	113	195	262	192
V.I.	—	—	—	—	—	—	—	—	35	80
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 1, 2005, and October 2, 2004 (39th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,608	1,496	4	9	88	84	164	141
NEW ENGLAND	128	138	—	1	10	8	5	1
Maine	6	12	—	—	—	—	1	—
N.H.	6	15	—	—	—	2	—	—
Vt.	8	6	—	—	—	—	2	1
Mass.	61	65	—	1	3	3	1	—
R.I.	7	3	—	—	2	—	—	—
Conn.	40	37	—	—	5	3	1	—
MID. ATLANTIC	321	306	—	1	—	4	37	32
Upstate N.Y.	95	102	—	1	—	4	8	5
N.Y. City	58	68	—	—	—	—	10	12
N.J.	63	58	—	—	—	—	9	2
Pa.	105	78	—	—	—	—	10	13
E.N. CENTRAL	222	286	1	—	4	8	16	42
Ohio	94	80	—	—	—	2	10	14
Ind.	54	40	—	—	4	4	—	1
Ill.	35	101	—	—	—	—	3	20
Mich.	18	18	1	—	—	2	2	4
Wis.	21	47	—	—	—	—	1	3
W.N. CENTRAL	86	83	—	2	3	3	9	8
Minn.	37	37	—	1	3	3	2	—
Iowa	1	1	—	1	—	—	—	—
Mo.	30	32	—	—	—	—	5	6
N. Dak.	1	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	8	4	—	—	—	—	1	1
Kans.	9	6	—	—	—	—	—	1
S. ATLANTIC	383	338	1	—	23	23	24	25
Del.	—	—	—	—	—	—	—	—
Md.	57	53	—	—	5	5	1	—
D.C.	—	2	—	—	—	—	—	1
Va.	38	32	—	—	—	—	2	5
W. Va.	23	15	—	—	1	4	4	—
N.C.	67	45	1	—	8	6	—	1
S.C.	23	10	—	—	—	—	2	1
Ga.	74	91	—	—	—	—	10	16
Fla.	101	90	—	—	9	8	5	1
E.S. CENTRAL	91	58	—	1	1	—	17	7
Ky.	8	5	—	—	1	—	2	—
Tenn.	65	39	—	—	—	—	11	5
Ala.	18	12	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	85	59	1	1	7	6	6	1
Ark.	4	1	—	—	1	—	—	—
La.	28	12	1	—	2	—	6	1
Okla.	51	45	—	—	4	6	—	—
Tex.	2	1	—	1	—	—	—	—
MOUNTAIN	180	153	—	3	13	22	36	18
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	4	1	—	—	—	1	1	—
Colo.	35	39	—	—	—	—	9	5
N. Mex.	16	32	—	—	4	7	2	6
Ariz.	96	53	—	—	7	9	15	2
Utah	13	12	—	2	—	2	6	2
Nev.	13	11	—	1	2	3	2	1
PACIFIC	112	75	1	—	27	10	14	7
Wash.	3	1	—	—	—	—	2	1
Oreg.	29	36	—	—	—	—	5	3
Calif.	47	25	1	—	27	10	2	1
Alaska	25	5	—	—	—	—	5	1
Hawaii	8	8	—	—	—	—	—	1
Guam	—	—	—	—	—	—	—	—
P.R.	3	2	—	—	—	—	1	2
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 1, 2005, and October 2, 2004 (39th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,989	4,474	4,056	4,354	519	592
NEW ENGLAND	399	770	209	275	13	13
Maine	2	11	13	4	—	—
N.H.	69	16	16	26	—	—
Vt.	6	8	4	5	10	5
Mass.	271	653	147	148	—	7
R.I.	10	19	1	5	—	—
Conn.	41	63	28	87	3	1
MID. ATLANTIC	506	583	809	578	80	109
Upstate N.Y.	81	72	68	58	13	6
N.Y. City	228	246	90	118	—	—
N.J.	115	139	484	170	—	—
Pa.	82	126	167	232	67	103
E.N. CENTRAL	262	376	358	414	103	84
Ohio	39	39	103	89	5	4
Ind.	40	49	43	35	22	7
Ill.	58	124	84	63	—	13
Mich.	108	117	128	196	76	60
Wis.	17	47	—	31	—	—
W.N. CENTRAL	70	123	214	255	30	18
Minn.	3	30	27	37	5	15
Iowa	16	35	21	14	—	—
Mo.	33	26	121	158	23	3
N. Dak.	—	1	—	4	1	—
S. Dak.	—	3	3	1	—	—
Nebr.	4	10	21	28	1	—
Kans.	14	18	21	13	—	—
S. ATLANTIC	528	815	1,037	1,368	105	143
Del.	4	6	38	38	7	20
Md.	52	88	112	121	20	3
D.C.	3	5	10	15	—	2
Va.	61	96	115	193	10	13
W. Va.	4	5	27	34	13	19
N.C.	65	74	128	138	15	10
S.C.	31	39	112	109	2	14
Ga.	88	278	127	352	7	12
Fla.	220	224	368	368	31	50
E.S. CENTRAL	209	130	260	369	68	75
Ky.	22	29	46	49	9	23
Tenn.	136	81	108	174	14	26
Ala.	34	7	57	60	10	4
Miss.	17	13	49	86	35	22
W.S. CENTRAL	198	540	302	264	51	76
Ark.	8	60	29	94	—	2
La.	44	39	31	48	9	3
Okla.	4	19	26	55	3	3
Tex.	142	422	216	67	39	68
MOUNTAIN	257	339	428	341	37	36
Mont.	7	5	3	1	1	2
Idaho	16	17	8	10	1	1
Wyo.	—	5	1	7	—	2
Colo.	35	40	38	47	18	10
N. Mex.	19	21	6	16	—	U
Ariz.	152	203	309	176	—	5
Utah	18	33	36	27	8	4
Nev.	10	15	27	57	9	12
PACIFIC	560	798	439	490	32	38
Wash.	34	47	56	40	U	U
Oreg.	35	56	79	87	13	15
Calif.	466	669	292	344	19	22
Alaska	4	4	7	10	—	—
Hawaii	21	22	5	9	—	1
Guam	—	1	—	12	—	9
P.R.	52	33	33	62	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 1, 2005, and October 2, 2004 (39th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,362	1,509	547	541	15,160	14,092	924	1,091
NEW ENGLAND	78	69	42	35	1,692	2,430	54	77
Maine	4	1	1	5	134	29	5	6
N.H.	6	7	5	2	142	165	5	5
Vt.	5	3	2	1	30	42	1	4
Mass.	25	33	12	12	820	1,331	29	46
R.I.	16	10	6	1	27	170	2	3
Conn.	22	15	16	14	539	693	12	13
MID. ATLANTIC	477	411	145	133	10,091	8,719	251	291
Upstate N.Y.	131	81	44	39	2,937	2,874	39	35
N.Y. City	60	58	26	22	—	310	124	155
N.J.	82	63	31	27	2,872	2,262	60	61
Pa.	204	209	44	45	4,282	3,273	28	40
E.N. CENTRAL	252	378	56	95	899	1,168	70	100
Ohio	137	178	25	35	59	44	18	25
Ind.	13	38	4	16	22	22	1	13
Ill.	15	37	1	19	—	82	26	33
Mich.	74	107	19	22	41	20	18	17
Wis.	13	18	7	3	777	1,000	7	12
W.N. CENTRAL	59	46	29	11	636	379	38	52
Minn.	16	7	8	2	535	303	11	18
Iowa	3	4	8	1	71	41	7	3
Mo.	25	22	4	5	20	23	15	17
N. Dak.	2	2	3	—	—	—	—	3
S. Dak.	10	3	—	—	—	1	—	1
Nebr.	1	3	3	3	2	8	1	3
Kans.	2	5	3	—	8	3	4	7
S. ATLANTIC	285	300	111	86	1,656	1,227	216	256
Del.	12	11	N	N	531	223	3	6
Md.	82	61	15	11	815	694	82	55
D.C.	9	10	—	4	8	9	8	11
Va.	33	39	11	14	163	120	20	35
W. Va.	14	9	3	3	10	22	1	1
N.C.	23	29	20	16	42	92	24	17
S.C.	10	8	9	7	18	18	6	10
Ga.	19	36	18	14	4	12	33	52
Fla.	83	97	35	17	65	37	39	69
E.S. CENTRAL	57	80	26	20	29	37	21	29
Ky.	18	30	4	4	5	14	6	4
Tenn.	26	35	11	10	24	18	11	9
Ala.	10	12	8	4	—	5	4	11
Miss.	3	3	3	2	—	—	—	5
W.S. CENTRAL	28	108	25	34	50	49	73	111
Ark.	4	—	1	3	4	8	5	7
La.	4	7	7	3	4	2	2	5
Okla.	7	4	3	—	—	—	9	7
Tex.	13	97	14	28	42	39	57	92
MOUNTAIN	67	67	13	21	21	17	40	40
Mont.	5	2	—	—	—	—	—	—
Idaho	3	7	—	1	2	6	—	1
Wyo.	3	5	—	—	3	3	2	—
Colo.	17	17	4	10	4	—	18	16
N. Mex.	2	4	4	1	1	1	2	2
Ariz.	17	11	—	—	7	6	10	10
Utah	12	17	3	1	2	1	6	6
Nev.	8	4	2	8	2	—	2	5
PACIFIC	59	50	100	106	86	66	161	135
Wash.	—	9	7	8	7	9	12	15
Oreg.	N	N	7	5	15	23	7	15
Calif.	57	41	85	89	61	32	123	101
Alaska	—	—	—	—	3	2	5	1
Hawaii	2	—	1	4	N	N	14	3
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	2	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 1, 2005, and October 2, 2004 (39th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	909	931	73	72	45	37	—	1	791	821
NEW ENGLAND	62	52	1	5	—	6	—	1	61	40
Maine	2	9	—	—	—	1	—	—	2	8
N.H.	12	4	—	—	—	—	—	—	12	4
Vt.	6	2	—	—	—	—	—	—	6	2
Mass.	28	30	—	5	—	5	—	—	28	20
R.I.	2	1	—	—	—	—	—	—	2	1
Conn.	12	6	1	—	—	—	—	1	11	5
MID. ATLANTIC	118	131	33	35	6	5	—	—	79	91
Upstate N.Y.	29	34	4	5	3	3	—	—	22	26
N.Y. City	17	23	—	—	—	—	—	—	17	23
N.J.	30	29	—	—	—	—	—	—	30	29
Pa.	42	45	29	30	3	2	—	—	10	13
E.N. CENTRAL	94	103	23	23	9	6	—	—	62	74
Ohio	31	52	—	3	5	5	—	—	26	44
Ind.	18	16	—	1	4	1	—	—	14	14
Ill.	12	1	—	—	—	—	—	—	12	1
Mich.	23	19	23	19	—	—	—	—	—	—
Wis.	10	15	—	—	—	—	—	—	10	15
W.N. CENTRAL	59	64	3	—	1	4	—	—	55	60
Minn.	11	21	1	—	—	—	—	—	10	21
Iowa	15	13	—	—	1	2	—	—	14	11
Mo.	19	17	1	—	—	1	—	—	18	16
N. Dak.	—	2	—	—	—	—	—	—	—	2
S. Dak.	3	2	1	—	—	1	—	—	2	1
Nebr.	4	4	—	—	—	—	—	—	4	4
Kans.	7	5	—	—	—	—	—	—	7	5
S. ATLANTIC	176	179	5	2	9	2	—	—	162	175
Del.	4	4	—	—	—	—	—	—	4	4
Md.	18	10	2	—	2	—	—	—	14	10
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	23	15	—	—	—	—	—	—	23	15
W. Va.	6	5	1	—	—	—	—	—	5	5
N.C.	28	26	2	—	7	2	—	—	19	24
S.C.	14	14	—	—	—	—	—	—	14	14
Ga.	15	12	—	—	—	—	—	—	15	12
Fla.	68	88	—	—	—	—	—	—	68	88
E.S. CENTRAL	44	50	1	1	3	1	—	—	40	48
Ky.	14	9	—	1	3	1	—	—	11	7
Tenn.	20	15	—	—	—	—	—	—	20	15
Ala.	6	14	1	—	—	—	—	—	5	14
Miss.	4	12	—	—	—	—	—	—	4	12
W.S. CENTRAL	74	53	1	2	5	1	—	—	68	50
Ark.	12	14	—	—	—	—	—	—	12	14
La.	25	28	—	1	2	—	—	—	23	27
Okla.	13	8	1	1	3	1	—	—	9	6
Tex.	24	3	—	—	—	—	—	—	24	3
MOUNTAIN	75	54	5	1	5	5	—	—	65	48
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	2	6	—	—	—	—	—	—	2	6
Wyo.	—	4	—	—	—	—	—	—	—	4
Colo.	17	12	4	—	—	—	—	—	13	12
N. Mex.	2	7	—	1	—	3	—	—	2	3
Ariz.	37	11	—	—	2	1	—	—	35	10
Utah	9	4	1	—	2	—	—	—	6	4
Nev.	8	7	—	—	1	1	—	—	7	6
PACIFIC	207	245	1	3	7	7	—	—	199	235
Wash.	41	24	1	3	4	7	—	—	36	14
Oreg.	28	48	—	—	—	—	—	—	28	48
Calif.	125	163	—	—	—	—	—	—	125	163
Alaska	2	4	—	—	—	—	—	—	2	4
Hawaii	11	6	—	—	3	—	—	—	8	6
Guam	—	1	—	—	—	—	—	—	—	1
P.R.	6	13	—	—	—	—	—	—	6	13
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	1	1	—	—	—	—	—	—	1	1
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 1, 2005, and October 2, 2004 (39th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	14,948	14,009	4,207	5,090	1,259	1,139	29,886	31,386	9,736	9,847
NEW ENGLAND	847	1,368	558	507	3	16	1,679	1,643	239	236
Maine	20	7	43	45	N	N	113	85	8	5
N.H.	47	55	12	23	1	—	131	112	7	7
Vt.	75	61	45	24	—	—	86	44	16	2
Mass.	640	1,173	284	212	1	12	886	947	148	154
R.I.	29	22	18	34	1	1	82	91	14	13
Conn.	36	50	156	169	—	3	381	364	46	55
MID. ATLANTIC	1,037	2,163	718	753	77	61	3,633	4,562	950	947
Upstate N.Y.	403	1,526	422	412	3	1	949	949	219	360
N.Y. City	71	154	21	11	5	20	768	1,045	285	317
N.J.	177	149	N	N	25	12	634	868	237	187
Pa.	386	334	275	330	44	28	1,282	1,700	209	83
E.N. CENTRAL	2,717	5,059	174	161	30	33	3,944	4,056	657	898
Ohio	887	433	64	64	23	9	1,038	975	82	130
Ind.	243	103	11	10	2	6	453	385	116	169
Ill.	519	981	42	42	1	14	1,120	1,312	169	332
Mich.	215	187	33	39	4	2	691	662	172	94
Wis.	853	3,355	24	6	—	2	642	722	118	173
W.N. CENTRAL	2,340	1,449	356	512	148	106	1,864	1,870	1,161	328
Minn.	934	231	59	68	2	—	432	465	68	53
Iowa	443	141	94	86	4	1	283	371	62	59
Mo.	332	282	65	48	124	88	610	502	780	128
N. Dak.	103	669	24	50	—	—	28	36	2	3
S. Dak.	54	27	48	85	5	4	119	80	26	9
Nebr.	166	23	—	88	4	13	116	123	54	19
Kans.	308	76	66	87	9	—	276	293	169	57
S. ATLANTIC	1,021	546	1,242	1,781	618	560	8,596	8,313	1,549	2,257
Del.	5	1	—	9	3	5	91	90	10	6
Md.	128	99	229	256	70	54	632	668	67	115
D.C.	7	7	—	—	2	—	45	47	9	30
Va.	277	152	399	376	67	22	871	902	100	120
W. Va.	37	18	44	52	5	5	124	189	1	6
N.C.	77	67	380	485	356	332	1,168	1,187	149	242
S.C.	300	90	5	131	44	53	1,020	792	74	468
Ga.	27	19	182	267	56	74	1,255	1,494	365	491
Fla.	163	93	3	205	15	15	3,390	2,944	774	779
E.S. CENTRAL	395	237	109	120	227	165	2,041	2,057	972	626
Ky.	110	55	11	20	2	2	369	269	242	53
Tenn.	178	141	36	38	171	88	581	548	471	321
Ala.	69	27	60	52	50	49	537	543	193	205
Miss.	38	14	2	10	4	26	554	697	66	47
W.S. CENTRAL	1,293	607	720	911	119	174	2,478	3,018	2,105	2,580
Ark.	217	58	29	44	92	95	554	425	50	56
La.	30	13	—	3	5	5	458	692	83	235
Okla.	—	33	66	92	7	70	316	311	513	361
Tex.	1,046	503	625	772	15	4	1,150	1,590	1,459	1,928
MOUNTAIN	3,063	1,100	193	182	29	20	1,731	1,787	590	611
Mont.	522	38	15	21	1	3	68	172	5	4
Idaho	118	30	—	7	3	4	80	128	5	12
Wyo.	36	26	15	5	2	4	70	43	4	4
Colo.	993	560	14	44	5	4	484	436	103	125
N. Mex.	110	128	7	4	1	2	179	214	69	106
Ariz.	821	169	115	92	13	2	503	498	341	289
Utah	431	133	14	6	4	1	262	168	35	30
Nev.	32	16	13	3	—	—	85	128	28	41
PACIFIC	2,235	1,480	137	163	8	4	3,920	4,080	1,513	1,364
Wash.	631	536	U	U	—	—	405	404	84	85
Oreg.	539	345	5	6	1	2	290	354	99	59
Calif.	872	568	131	146	7	2	2,954	3,005	1,296	1,171
Alaska	84	11	1	11	—	—	44	42	7	6
Hawaii	109	20	—	—	—	—	227	275	27	43
Guam	—	—	—	—	—	—	—	49	—	41
P.R.	5	3	52	45	N	N	341	316	2	24
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 1, 2005, and October 2, 2004 (39th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	3,331	3,505	1,680	1,688	642	587	5,840	5,812	183	300
NEW ENGLAND	129	231	90	111	47	79	153	154	1	4
Maine	9	10	N	N	—	4	1	2	—	—
N.H.	13	16	—	—	4	N	13	4	—	3
Vt.	9	8	10	6	4	1	1	—	—	—
Mass.	89	105	64	29	38	43	100	95	—	—
R.I.	9	17	16	18	1	6	8	22	—	1
Conn.	U	75	U	58	U	25	30	31	1	—
MID. ATLANTIC	720	593	159	116	111	84	733	740	21	28
Upstate N.Y.	216	193	62	49	49	58	69	71	5	2
N.Y. City	132	98	U	U	20	U	450	451	5	12
N.J.	149	126	N	N	19	8	100	119	11	13
Pa.	223	176	97	67	23	18	114	99	—	1
E.N. CENTRAL	642	802	451	375	163	139	609	670	26	45
Ohio	160	189	281	262	63	61	161	174	1	2
Ind.	82	82	159	113	43	30	45	45	1	2
Ill.	116	212	11	—	50	2	317	283	10	13
Mich.	255	246	—	N	—	N	62	141	12	28
Wis.	29	73	N	N	7	46	24	27	2	—
W.N. CENTRAL	217	252	36	17	68	78	174	130	3	5
Minn.	82	122	—	—	41	50	48	19	1	1
Iowa	N	N	N	N	—	N	2	5	—	—
Mo.	56	55	29	12	7	12	103	78	2	2
N. Dak.	9	11	2	—	2	2	—	—	—	—
S. Dak.	19	12	3	5	—	—	1	—	—	—
Nebr.	17	18	2	—	7	6	4	6	—	—
Kans.	34	34	N	N	11	8	16	22	—	2
S. ATLANTIC	707	697	665	874	67	44	1,457	1,442	33	47
Del.	5	3	1	4	—	N	9	7	—	1
Md.	157	107	—	—	44	30	244	272	12	7
D.C.	7	8	15	8	2	4	83	46	—	1
Va.	68	61	N	N	—	N	100	78	3	2
W. Va.	22	23	96	96	21	10	3	3	—	—
N.C.	103	100	N	N	U	U	206	139	8	8
S.C.	26	50	—	82	—	N	50	94	4	11
Ga.	135	169	112	216	—	N	229	263	1	3
Fla.	184	176	441	468	—	N	533	540	5	14
E.S. CENTRAL	136	179	134	119	8	12	330	314	17	20
Ky.	27	52	25	24	N	N	34	34	—	1
Tenn.	109	127	109	93	—	N	160	98	12	8
Ala.	—	—	—	—	—	N	107	135	4	9
Miss.	—	—	—	2	8	12	29	47	1	2
W.S. CENTRAL	209	277	94	52	128	120	927	908	53	60
Ark.	14	16	12	7	14	8	38	41	—	3
La.	6	2	82	45	22	26	176	223	6	4
Okla.	92	54	N	N	22	35	30	19	1	2
Tex.	97	205	N	N	70	51	683	625	46	51
MOUNTAIN	495	383	51	23	41	31	301	306	15	38
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	2	8	N	N	—	N	20	15	1	2
Wyo.	3	7	21	9	—	—	—	1	—	—
Colo.	185	82	N	N	40	31	31	51	—	—
N. Mex.	38	81	—	N	—	—	37	70	2	2
Ariz.	202	170	N	N	—	N	127	130	12	33
Utah	64	33	28	12	1	—	6	9	—	1
Nev.	1	2	2	2	—	—	75	29	—	—
PACIFIC	76	91	—	1	9	—	1,156	1,148	14	53
Wash.	N	N	N	N	N	N	107	104	—	—
Oreg.	N	N	N	N	6	N	21	24	—	—
Calif.	—	—	N	N	N	N	1,018	1,014	14	53
Alaska	—	—	—	—	—	N	6	1	—	—
Hawaii	76	91	—	1	3	—	4	5	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	147	111	8	5
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 1, 2005, and October 2, 2004 (39th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	7,923	9,834	189	257	17,577	20,585	776	1,095	1,082
NEW ENGLAND	262	333	21	20	1,011	2,209	5	—	2
Maine	14	15	1	—	213	181	—	—	—
N.H.	5	12	—	—	209	—	—	—	—
Vt.	4	2	—	—	51	413	—	—	—
Mass.	164	194	12	14	538	252	2	—	2
R.I.	24	42	1	1	—	—	1	—	—
Conn.	51	68	7	5	U	1,363	2	—	—
MID. ATLANTIC	1,484	1,535	33	65	3,418	74	18	15	10
Upstate N.Y.	185	200	5	9	—	—	—	3	—
N.Y. City	713	771	10	25	—	—	3	2	2
N.J.	363	339	10	16	—	—	2	1	—
Pa.	223	225	8	15	3,418	74	13	9	8
E.N. CENTRAL	940	868	18	32	4,675	8,764	160	64	78
Ohio	176	149	2	6	1,053	1,086	34	11	6
Ind.	102	91	1	—	482	N	5	7	—
Ill.	451	379	5	15	66	4,408	100	28	67
Mich.	152	184	5	9	2,747	2,752	17	13	3
Wis.	59	65	5	2	327	518	4	5	2
W.N. CENTRAL	328	345	3	7	335	144	84	85	288
Minn.	143	134	3	3	—	—	13	13	19
Iowa	32	30	—	—	N	N	6	12	10
Mo.	70	89	—	2	237	5	6	27	7
N. Dak.	2	3	—	—	20	81	2	2	14
S. Dak.	11	8	—	—	78	58	33	6	186
Nebr.	28	26	—	2	—	—	19	7	49
Kans.	42	55	—	—	—	—	5	18	3
S. ATLANTIC	1,820	2,060	33	36	1,531	1,887	19	63	16
Del.	12	17	1	—	22	5	—	—	—
Md.	209	205	9	11	—	—	4	9	—
D.C.	42	71	—	—	24	20	—	1	—
Va.	228	184	8	5	328	474	—	4	—
W. Va.	19	16	—	—	763	1,050	—	—	N
N.C.	203	241	3	6	—	N	1	3	1
S.C.	164	145	—	—	394	338	3	—	—
Ga.	291	435	2	4	—	—	5	13	3
Fla.	652	746	10	10	—	—	6	33	12
E.S. CENTRAL	378	474	5	8	—	37	49	60	29
Ky.	81	84	2	3	N	N	3	1	—
Tenn.	161	158	—	5	—	—	8	13	1
Ala.	136	142	1	—	—	37	5	15	2
Miss.	—	90	2	—	—	—	33	31	26
W.S. CENTRAL	852	1,463	12	20	4,684	5,693	119	206	62
Ark.	79	87	—	—	—	—	8	13	13
La.	—	—	—	—	107	48	58	70	23
Okla.	99	125	—	1	—	—	1	15	2
Tex.	674	1,251	12	19	4,577	5,645	52	108	24
MOUNTAIN	275	393	9	7	1,923	1,777	83	320	163
Mont.	8	4	—	—	—	—	7	2	16
Idaho	—	3	—	—	—	—	2	1	6
Wyo.	—	2	—	—	46	27	1	2	2
Colo.	46	97	4	2	1,373	1,424	14	41	61
N. Mex.	14	22	—	—	124	U	15	30	11
Ariz.	166	162	3	2	—	—	19	213	29
Utah	23	29	1	1	380	326	17	6	24
Nev.	18	74	1	2	—	—	8	25	14
PACIFIC	1,584	2,363	55	62	—	—	239	282	434
Wash.	186	165	5	6	N	N	—	—	—
Oreg.	54	77	3	1	—	—	—	—	5
Calif.	1,227	2,003	37	49	—	—	239	282	429
Alaska	28	28	—	—	—	—	—	—	—
Hawaii	89	90	10	6	—	—	—	—	—
Guam	—	44	—	—	—	131	—	—	—
P.R.	—	83	—	—	512	310	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

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

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending October 1, 2005 (39th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	509	354	105	36	10	4	60
Boston, Mass.	133	84	30	13	4	2	14
Bridgeport, Conn.	27	23	4	—	—	—	2
Cambridge, Mass.	17	13	4	—	—	—	1
Fall River, Mass.	25	19	4	2	—	—	3
Hartford, Conn.	53	31	16	3	2	1	9
Lowell, Mass.	26	20	4	2	—	—	6
Lynn, Mass.	9	8	1	—	—	—	—
New Bedford, Mass.	24	18	3	3	—	—	1
New Haven, Conn.	23	13	6	3	1	—	4
Providence, R.I.	43	32	6	4	1	—	10
Somerville, Mass.	1	1	—	—	—	—	—
Springfield, Mass.	52	36	10	3	2	1	4
Waterbury, Conn.	20	17	3	—	—	—	2
Worcester, Mass.	56	39	14	3	—	—	4
MID. ATLANTIC	2,140	1,430	475	136	49	50	104
Albany, N.Y.	49	35	9	2	—	3	6
Allentown, Pa.	27	22	4	1	—	—	—
Buffalo, N.Y.	104	77	19	3	3	2	10
Camden, N.J.	43	24	10	3	1	5	2
Elizabeth, N.J.	14	11	1	2	—	—	3
Erie, Pa.	42	32	7	3	—	—	2
Jersey City, N.J.	31	16	7	6	2	—	—
New York City, N.Y.	1,025	682	244	64	20	15	36
Newark, N.J.	57	33	16	2	2	4	3
Paterson, N.J.	9	6	1	2	—	—	—
Philadelphia, Pa.	382	225	95	32	16	14	13
Pittsburgh, Pa.§	29	18	6	3	1	1	1
Reading, Pa.	16	11	3	1	1	—	—
Rochester, N.Y.	131	101	22	5	2	1	16
Schenectady, N.Y.	18	17	—	—	1	—	1
Scranton, Pa.	24	20	3	1	—	—	1
Syracuse, N.Y.	94	67	20	2	—	5	7
Trenton, N.J.	19	11	5	3	—	—	—
Utica, N.Y.	11	10	1	—	—	—	2
Yonkers, N.Y.	15	12	2	1	—	—	1
E.N. CENTRAL	1,868	1,215	453	113	41	45	125
Akron, Ohio	50	37	10	1	1	1	3
Canton, Ohio	40	28	9	1	2	—	4
Chicago, Ill.	283	162	81	22	4	13	21
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	213	147	49	8	3	6	17
Columbus, Ohio	205	131	46	18	8	2	9
Dayton, Ohio	116	85	26	4	1	—	10
Detroit, Mich.	158	84	51	12	6	5	10
Evansville, Ind.	43	29	11	—	2	1	5
Fort Wayne, Ind.	58	39	13	3	2	1	3
Gary, Ind.	10	6	1	3	—	—	—
Grand Rapids, Mich.	64	39	16	6	1	2	9
Indianapolis, Ind.	213	146	44	12	4	7	14
Lansing, Mich.	26	23	2	1	—	—	—
Milwaukee, Wis.	83	55	23	4	—	1	5
Peoria, Ill.	48	34	10	2	1	1	5
Rockford, Ill.	44	29	13	1	—	1	—
South Bend, Ind.	60	40	14	4	2	—	1
Toledo, Ohio	101	62	25	9	4	1	5
Youngstown, Ohio	53	39	9	2	—	3	4
W.N. CENTRAL	556	357	118	48	17	16	47
Des Moines, Iowa	29	21	5	2	1	—	5
Duluth, Minn.	28	20	6	1	—	1	4
Kansas City, Kans.	27	15	6	3	1	2	3
Kansas City, Mo.	72	37	20	9	5	1	5
Lincoln, Nebr.	37	22	11	4	—	—	6
Minneapolis, Minn.	54	31	16	1	2	4	4
Omaha, Nebr.	72	57	11	3	1	—	6
St. Louis, Mo.	91	50	24	9	4	4	4
St. Paul, Minn.	62	43	7	6	3	3	4
Wichita, Kans.	84	61	12	10	—	1	6
S. ATLANTIC	1,164	723	270	102	30	38	51
Atlanta, Ga.	186	104	51	20	8	3	5
Baltimore, Md.	157	93	43	12	4	4	14
Charlotte, N.C.	106	59	22	17	2	6	5
Jacksonville, Fla.	164	112	23	19	7	3	8
Miami, Fla.	104	80	12	6	2	4	6
Norfolk, Va.	43	30	7	4	—	2	1
Richmond, Va.	47	32	13	—	1	1	1
Savannah, Ga.	55	38	12	4	—	1	1
St. Petersburg, Fla.	39	24	9	2	2	2	—
Tampa, Fla.	153	98	43	7	1	4	6
Washington, D.C.	100	47	31	11	3	8	4
Wilmington, Del.	10	6	4	—	—	—	—
E.S. CENTRAL	797	500	206	50	20	21	50
Birmingham, Ala.	133	94	27	6	3	3	4
Chattanooga, Tenn.	56	37	9	5	1	4	2
Knoxville, Tenn.	92	53	29	6	2	2	1
Lexington, Ky.	73	39	22	7	1	4	5
Memphis, Tenn.	185	116	49	13	5	2	12
Mobile, Ala.	74	50	20	2	2	—	9
Montgomery, Ala.	47	30	14	1	—	2	5
Nashville, Tenn.	137	81	36	10	6	4	12
W.S. CENTRAL	1,235	772	287	97	35	36	76
Austin, Tex.	74	47	13	9	2	3	5
Baton Rouge, La.	41	33	6	2	—	—	—
Corpus Christi, Tex.	49	35	12	1	—	1	3
Dallas, Tex.	189	103	50	21	5	10	11
El Paso, Tex.	67	34	21	2	1	1	1
Ft. Worth, Tex.	104	54	32	9	4	5	1
Houston, Tex.	292	184	69	18	16	5	19
Little Rock, Ark.	83	52	18	5	4	4	4
New Orleans, La.¶	U	U	U	U	U	U	U
San Antonio, Tex.	234	161	49	17	3	4	19
Shreveport, La.	23	18	2	3	—	—	2
Tulsa, Okla.	79	51	15	10	—	3	11
MOUNTAIN	1,088	695	251	97	18	27	61
Albuquerque, N.M.	131	81	31	11	4	4	7
Boise, Idaho	49	36	9	2	—	2	3
Colo. Springs, Colo.	76	47	15	11	2	1	1
Denver, Colo.	92	59	19	4	2	8	5
Las Vegas, Nev.	240	150	67	20	2	1	10
Ogden, Utah	12	9	2	1	—	—	—
Phoenix, Ariz.	195	115	50	20	5	5	16
Pueblo, Colo.	28	18	6	4	—	—	5
Salt Lake City, Utah	108	74	21	11	—	2	2
Tucson, Ariz.	157	106	31	13	3	4	12
PACIFIC	1,524	1,005	361	93	37	26	111
Berkeley, Calif.	17	9	7	—	—	1	2
Fresno, Calif.	88	56	18	5	5	4	4
Glendale, Calif.	8	4	3	—	1	—	3
Honolulu, Hawaii	100	74	21	2	2	1	7
Long Beach, Calif.	54	36	17	—	—	1	5
Los Angeles, Calif.	152	85	46	15	3	3	12
Pasadena, Calif.	16	12	3	—	1	—	2
Portland, Oreg.	120	85	24	3	2	6	5
Sacramento, Calif.	225	148	51	17	7	2	8
San Diego, Calif.	154	109	29	12	1	2	8
San Francisco, Calif.	119	69	31	12	6	1	13
San Jose, Calif.	176	125	34	9	3	4	17
Santa Cruz, Calif.	22	12	9	1	—	—	2
Seattle, Wash.	129	78	37	10	3	1	7
Spokane, Wash.	45	30	13	2	—	—	4
Tacoma, Wash.	99	73	18	5	3	—	12
TOTAL	10,881**	7,051	2,526	772	257	263	685

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.

¶ Because of Hurricane Katrina, weekly reporting of deaths has been temporarily disrupted.

** Total includes unknown ages.

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/publications/mmwr*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone 202-512-1800.

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 following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop K-95, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone 888-232-3228.

All *MMWR* references are available on the Internet at http://www.cdc.gov/mmwr. Use the search function to find specific articles.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in *MMWR* were current as of the date of publication.

☆U.S. Government Printing Office: 2006-523-142/00117 Region IV ISSN: 0149-2195