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National HIV Testing Day — June 27, 2007

Initiated in 1995 by the National Association of People with AIDS and supported by CDC, National HIV Testing Day is held each year on June 27. This event increases awareness of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and promotes early diagnosis and testing for HIV.

In 2003, CDC announced a plan to explore new strategies to combat HIV (*1*). Since then, CDC researchers have studied the feasibility and effectiveness of HIV testing in diverse settings, including emergency departments and minority gay pride events, two settings featured in this issue of *MMWR*. In 2006, CDC called for routine, voluntary HIV testing of persons aged 13–64 years in health-care settings (*2*). In 2007, CDC launched a heightened national response to the HIV/AIDS crisis among African Americans, with a goal to increase opportunities for diagnosis and testing (*3*).

Persons who know they are infected with HIV can begin treatment at an early stage of infection and take steps to prevent transmitting HIV to others (*4*). Additional information regarding HIV testing, including a list of testing sites, is available at http://www.hivtest.org.

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Rapid HIV Testing in Emergency Departments — Three U.S. Sites, January 2005–March 2006

Approximately one fourth of the estimated 1 million persons living with human immunodeficiency virus (HIV) in the United States are unaware that they are infected with HIV and at risk for transmitting the virus to others (*1,2*). In April 2003, CDC announced a new initiative, Advancing HIV Prevention: New Strategies for a Changing Epidemic, aimed at reducing barriers to early diagnosis of HIV infection and increasing access of persons infected with HIV to medical care and prevention services (*3*). A priority strategy of this initiative is to make HIV testing a routine part of medical care. In April 2004, HIV testing was implemented in one emergency department (ED) in Los Angeles, California, and one in New York, New York, to determine the feasibility and acceptability of offering rapid HIV testing as a routine part of health care in EDs. In January 2005, an ED in Oakland, California, also began offering HIV testing routinely. This report summarizes the preliminary results of integrating rapid HIV testing into the health-care services routinely offered in the three EDs during January 2005–March 2006. Those results indicated that, of 9,365 persons tested, 97 (1.0%) ED patients had newly diagnosed HIV infection, and 85 (88%) of those 97 were linked after diagnosis to HIV care and treatment. EDs should consider integrating rapid HIV testing into their routine medical services to identify patients who are

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unaware that they are infected with HIV and link them to health and prevention services.

The three demonstration projects sought to evaluate patient acceptance and the feasibility of making rapid HIV testing a routine part of health care offered in EDs and to ensure that patients with confirmed HIV infection received appropriate follow-up health care. Data from January–December 2005 were analyzed from the New York and Los Angeles EDs; data from April 2005–March 2006 were analyzed from the Oakland ED. These two periods were chosen because they provided at least 12 months of data when all three testing programs were operating at full capacity. Testing protocols at the three sites were similar. All sites placed posters and brochures in waiting rooms and registration areas advertising the availability of free rapid HIV screening. Persons who, when asked, told project staff members that they were HIV negative or did not know their HIV status and who met project consent requirements (i.e., aged ≥18 years in New York and Los Angeles or aged ≥12 years in Oakland) were offered testing on an opt-in basis (i.e., patients were offered testing and had tests performed if they agreed to be tested and provided specific written consent). In all three EDs, preliminary testing was conducted using rapid HIV test kits (OraQuick® Advance™ Rapid HIV-1/2 Antibody Tests [OraSure Technologies, Bethlehem, Pennsylvania])* with oral mucosal transudate specimens or finger-stick whole blood specimens. Patients who had positive rapid tests were given risk-reduction counseling and asked to provide a whole blood or oral specimen for confirmatory testing by Western blot.

Testing procedures for the three sites differed by the location within the ED where HIV testing was offered and by the personnel responsible for testing and counseling. At the Los Angeles and New York sites, standard pretest information, HIV testing, and test results were provided exclusively by HIV counselors hired specifically to offer and provide these services in the ED. Counselors usually offered HIV testing (in a private room) to the next available patient in the ED waiting area but sometimes provided counseling and testing to patients referred to them by ED physicians.

At the Oakland ED, a different model was used to increase the number of persons offered testing. At intake in the ED, the triage nurse attempted to offer testing to all

* Information regarding sensitivity (99.3%) and specificity (99.8%) for the OraQuick Advance test is available at http://www.orasure.com/uploaded/398.pdf. The OraQuick Advance rapid test requires 20 minutes to process a specimen. Test results must be read after the 20-minute processing period has elapsed, but not more than 40 minutes after the test was initiated.

eligible patients (i.e., those who, when asked, said they were HIV negative or did not know their HIV status and who met consent requirements). ED staff members (usually treatment nurses), obtained written consents from those who agreed to testing, provided pretest information (i.e., an informational handout), and administered the HIV tests, in addition to their usual responsibilities.

In New York and Los Angeles, both negative and positive rapid test results were provided to patients by HIV counselors; in Oakland, negative rapid test results were provided by nurses, but positive rapid results were provided by HIV counselors (on weekdays) and ED physicians (during nights and on weekends). At all three sites, confirmatory specimens were collected immediately upon receipt of a positive rapid test result; confirmatory results were provided approximately 1 week later by HIV counselors either in the ED (Los Angeles and New York) or at hospital-affiliated clinics (Los Angeles, New York, and Oakland). At all three sites, persons with confirmed positive HIV test results were provided further HIV risk-reduction information, partner counseling and referral services, and medical care appointments. Consent forms, counseling, and other services were made available in English and Spanish. Staff members assisted patients with referrals to providers and services elsewhere if the patients were not local residents or requested services at other facilities. In New York and Los Angeles, project staff members performed chart reviews to collect follow-up data. In Oakland, information was collected through an active follow-up process involving project staff from the ED and a linkage coordinator from an affiliated HIV clinic.

During the study periods, HIV testing was offered to 34,627 (18.6%) of 186,415 persons who sought care at the three participating EDs (Table 1). The proportion of ED patients offered HIV testing varied by site: 47.7% in Oakland, 3.6% in Los Angeles, and 2.1% in New York. Overall, 19,556 (56.5%) of those offered testing agreed to be tested; however, the proportion of persons accepting testing varied by site: 98.3% in Los Angeles, 84.0% in New York, and 52.8% in Oakland. The proportion of patients actually tested during the ED visit among those who agreed to testing also varied by site: 99.8% in Los Angeles, 99.4% in New York, and 38.5% in Oakland. Among the 97 patients with newly diagnosed HIV infection, 85 (88%) were then linked to health-care services, defined as having at least one medical follow-up visit for HIV care and treatment (Table 1).

The proportion of tested patients with newly diagnosed HIV infection varied by site: 0.8% in Los Angeles, 1.0% in Oakland, and 1.5% in New York (Table 1). Patients tested at the three sites differed by sex, age, race/ethnicity, and HIV test result. Overall, by racial/ethnic group, among the 97 with newly diagnosed HIV infection, 50 (52%) were non-Hispanic black, 28 (29%) were Hispanic, 12 (12%) were non-Hispanic white, four (4%) were Asian/Pacific Islander, and the race/ethnicity for three patients was unknown (Table 2). Risk information was available for 95 (98%) of those with newly diagnosed HIV infection; 49 (52%) of those persons reported having at least one of the following risks for HIV transmission during the previous 12 months: male-to-male sexual contact, injection-drug use, commercial sex work, or a sexually transmitted disease (STD) diagnosis.

TABLE 1. Number and percentage of persons tested for human immunodeficiency virus (HIV) at hospital emergency departments, by testing site and selected HIV testing characteristics — three sites, United States, January 2005–March 2006*

Characteristic	Los Angeles, California		New York, New York		Oakland, California		Total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Persons examined at emergency departments	47,736	—	72,948	—	65,731	—	**186,415**	**—**
Offered HIV testing (% of total examined)	1,742	(3.6)	1,543	(2.1)	31,342	(47.7)	**34,627**	**(18.6)**
Accepting HIV testing (% of those offered)	1,713	(98.3)	1,296	(84.0)	16,547	(52.8)	**19,556**	**(56.5)**
Tested for HIV (% of those accepting)	1,709	(99.8)	1,288	(99.4)	6,368	(38.5)	**9,365**	**(47.9)**
Confirmed as newly diagnosed HIV positive (% of those tested)	13	(0.8)	19	(1.5)	65	(1.0)	**97**	**(1.0)**
Linked to care† (% of those confirmed as newly diagnosed HIV positive)	11	(84.6)	15	(78.9)	59	(90.8)	**85**	**(87.6)**

* For the Los Angeles and New York sites, the number of persons aged ≥18 years examined at the emergency departments during 2005; for the Oakland site, the number of persons aged ≥12 years examined at the emergency department during April 2005–March 2006.
† Defined as having at least one medical follow-up visit for HIV care and treatment.

Reported by: *EE Telzak, MD, F Grumm, J Coffey, MD, Bronx Lebanon Hospital Center, New York, New York. DAE White, MD, AN Scribner, MPH, Alameda County Medical Center, Oakland; S Quan, MPH, A Martinez, Rand Schrader Health & Research Center, Los Angeles; M Esquivel, R Merrick, County of Los Angeles Dept of Health Svcs, California. B Boyett, MS, JD Heffelfinger, MD, J Schulden, MD, B Song, MS, PS Sullivan, PhD, Div of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC.*

Editorial Note: The findings in this report suggest that offering HIV testing as an integrated part of routine health-care services in EDs, rather than relying on a clinical- or risk-based approach to testing, is a feasible strategy for identifying persons with previously undiagnosed HIV infection who might not otherwise access HIV-testing services. The majority of patients (56.5%) offered HIV testing at the three sites agreed to be tested, indicating that opt-in testing is acceptable in ED settings. If a risk-based approach to testing (e.g., testing only those persons reporting male-to-male sexual contact, injection-drug use, commercial sex work, or STD diagnoses) had been used in these three ED demonstration projects, 48% of the persons with newly diagnosed HIV infection would not have been offered testing. Overall, 88% of persons with newly diagnosed HIV infection were linked to health-care services after diagnosis, a proportion that compares favorably with previous reports (*4*).

Substantially higher proportions of patients were offered HIV testing and subsequently tested at the Oakland ED than at the Los Angeles and New York EDs. Using a counselor-based approach to testing resulted in >90% of patients accepting testing when offered at the Los Angeles and New York sites; however, the number of persons offered testing (<4%) in these EDs was limited by the number of available HIV counselors. Nonetheless, the use of dedicated counselors in EDs enabled the Los Angeles and New York sites to increase the number of patients tested for HIV infection from 21 in 2003 to 1,709 in 2005 and from 415 in 2003 to 1,288 in 2005, respectively. In Oakland, use of existing staff members to offer testing resulted in approximately half of ED patients offered testing; however, only 52.8% of those offered testing accepted it, and only 38.5% of those who accepted testing were

TABLE 2. Number and percentage of persons tested for human immunodeficiency virus (HIV) in emergency departments, by testing site, HIV test result, and selected characteristics — three sites, United States, January 2005–March 2006*

	Los Angeles, California†				New York, New York†				Oakland, California†				Total			
	HIV positive (n = 13)		HIV negative (n = 1,695)		HIV positive (n = 19)		HIV negative (n = 911)		HIV positive (n = 65)		HIV negative (n = 6,278)		HIV positive (n = 97)		HIV negative (n = 8,884)	
Characteristic	No.	(%)§	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Sex																
Male	10	(76.9)	538	(31.7)	14	(73.7)	287	(31.5)	52	(80.0)	3,499	(55.7)	**76**	**(78.4)**	**4,324**	**(48.7)**
Female	2	(15.4)	1152	(68.0)	5	(26.3)	621	(68.2)	12	(18.5)	2,779	(44.3)	**19**	**(19.6)**	**4,552**	**(51.2)**
Transgender	0	—	0	—	0	—	0	—	1	(1.5)	0	—	**1**	**(1.0)**	**0**	**—**
Unknown	1	(7.7)	5	(0.3)	0	—	3	(0.3)	0	—	0	—	**1**	**(1.0)**	**8**	**(0.1)**
Age (yrs)																
12–24	2	(15.4)	257	(15.2)	2	(10.5)	403	(44.2)	8	(12.3)	1,145	(18.2)	**12**	**(12.4)**	**1,805**	**(20.3)**
25–34	4	(30.8)	497	(29.3)	5	(26.3)	279	(30.6)	16	(24.6)	1,645	(26.2)	**25**	**(25.8)**	**2,421**	**(27.3)**
35–44	5	(38.5)	522	(30.8)	3	(15.8)	128	(14.1)	16	(24.6)	1,334	(21.2)	**24**	**(24.7)**	**1,984**	**(22.3)**
45–54	2	(15.4)	302	(17.8)	8	(42.1)	68	(7.5)	22	(33.8)	1,410	(22.5)	**32**	**(33.0)**	**1,780**	**(20.0)**
55–64	0	—	113	(6.7)	1	(5.3)	16	(1.8)	2	(3.1)	621	(9.9)	**3**	**(3.1)**	**750**	**(8.4)**
≥65	0	—	4	(0.2)	0	—	0	—	0	—	123	(2.0)	**0**	**—**	**127**	**(1.4)**
Unknown	0	—	0	—	0	—	17	(1.9)	1	(1.5)	0	—	**1**	**(1.0)**	**17**	**(0.2)**
Race/Ethnicity																
Hispanic	9	(69.2)	1,601	(94.5)	11	(57.9)	531	(58.3)	8	(12.3)	798	(12.7)	**28**	**(28.9)**	**2,930**	**(33.0)**
Black, non-Hispanic	0	—	28	(1.7)	8	(42.1)	348	(38.2)	42	(64.6)	3,264	(52.0)	**50**	**(51.5)**	**3,640**	**(41.0)**
White, non-Hispanic	2	(15.4)	27	(1.6)	0	—	21	(2.3)	10	(15.4)	1,023	(16.3)	**12**	**(12.4)**	**1,071**	**(12.1)**
Asian/Pacific Islander	1	(7.7)	23	(1.4)	0	—	3	(0.3)	3	(4.6)	213	(3.4)	**4**	**(4.1)**	**239**	**(2.7)**
American Indian/Alaska Native	0	—	3	(0.2)	0	—	1	(0.1)	0	—	16	(0.3)	**0**	**—**	**20**	**(0.2)**
Other	0	—	0	—	0	—	2	(0.2)	0	—	—	—	**0**	**—**	**2**	**—**
Unknown	1	(7.7)	13	(0.8)	0	—	5	(0.5)	2	(3.1)	964	(15.4)	**3**	**(3.1)**	**982**	**(11.1)**

* For the Los Angeles and New York sites, the number of persons aged ≥18 years examined at the emergency departments during 2005; for the Oakland site, the number of persons aged ≥12 years examined at the emergency department during April 2005–March 2006.
† Sex, age, and race/ethnicity were not available for 384 persons: one from Los Angeles, 358 from New York, and 25 from Oakland.
§ Column percentages might not add to 100% because of rounding.

actually tested, largely because of limited staff. Persons who agreed to testing but could not be tested during their ED visit in Oakland were referred to other hospital departments, clinics, or community-based organizations for testing. Despite the low acceptance of testing, the Oakland testing approach was most feasible for maximizing the number of patients tested. The number of ED patients tested for HIV infection increased from 307 in 2004 to 6,368 during April 2005–March 2006.

Revised CDC recommendations for HIV testing in health-care settings were published in September 2006 (*5*), 5 months after the end of the study period described in this report. The revised recommendations call for HIV testing to become a routine part of medical services using a voluntary, opt-out approach to ensure that persons with HIV infection are identified and linked to care and prevention services early in the course of their infection and to foster improved long-term prognosis and reduced transmission to others (*5*). Under the opt-out approach recommended in the revised guidelines, patients are notified that HIV testing is a routine part of services offered to all patients aged 13–64 years and will be performed unless the patient declines to be tested. Such an approach has been accepted and effective among pregnant women (*6*). Several analyses have supported the cost-effectiveness of routine testing in clinical settings, even in communities with a low prevalence of HIV infection (*7,8*). In addition, routine testing might reduce the stigma associated with identifying persons for testing on the basis of actual or perceived risk behaviors (*9,10*). Although this report describes HIV testing offered to patients in EDs on a voluntary opt-in basis, it provides insight into methods that could be used to implement testing using an opt-out approach.

The findings in this report are subject to at least two limitations. First, HIV testing was not offered to all patients or to a statistical sample of patients visiting the participating sites; therefore, those who were tested might not be representative of all persons seeking medical care at these or other EDs. Second, data on linkage to follow-up health care might not include information for some patients who sought care outside of the three EDs described in this report. Additionally, some patients might not have sought care until after data for these projects were collected. Therefore, the reported proportion of persons with newly identified HIV infection who were linked to care is a minimum estimate.

Although the results from these projects are preliminary, they demonstrate that integrating HIV testing into the routine care provided in EDs can identify persons with previously undiagnosed HIV infection. Routine testing might increase the linkage of HIV-positive persons to health and prevention services earlier in the course of infection, which might result in improved long-term prognosis and reduced HIV transmission. The two testing protocols described in this report had advantages and disadvantages. Use of a counselor-based approach to HIV testing (Los Angeles and New York) enabled in-depth assessment of risk behaviors and discussion of prevention strategies with patients but limited the number of patients who could be tested. Use of existing staff members (Oakland) enabled offering HIV testing to more patients but resulted in lower acceptance. A combined approach, using dedicated HIV testing personnel in collaboration with existing staff members, might increase testing capacities in EDs, maintain a high rate of acceptance of HIV testing, and facilitate implementation of the opt-out testing approach outlined in the revised CDC recommendations for HIV testing in health-care settings (*5*).

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Rapid HIV Testing Among Racial/Ethnic Minority Men at Gay Pride Events — Nine U.S. Cities, 2004–2006

In the United States, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) disproportionately affect men from racial/ethnic minority groups (*1*). Approximately half of the HIV/AIDS cases among non-Hispanic black and Hispanic males reported by 33 states using name-based HIV surveillance during 2001–2005 were among men who have sex with men (MSM) (*1*). Each year, approximately 100 gay pride events are held in cities across the United States to celebrate diversity, demonstrate solidarity of the gay community, and heighten awareness of topics of importance to the gay community. These events are attended by several hundred to several hundred thousand MSM. Certain gay pride events are focused on celebrating solidarity in the minority gay community and are attended primarily by MSM from racial/ethnic minority groups. These events offer an opportunity for community-based organizations (CBOs) and health departments to provide HIV-prevention education and outreach. In 2004, CBOs and health departments, with technical assistance from CDC, began conducting rapid behavioral assessments at gay pride events and at minority gay pride events (*2*). This report describes the results of assessments and rapid HIV testing conducted at 11 events in nine U.S. cities during 2004–2006; most of these events were attended primarily by MSM from racial/ethnic minority groups. A total of 543 attendees who participated in the assessments reported at the time of the event that they had not had HIV infection diagnosed previously. Of these, 133 (24%) were tested for HIV during the event, and eight (6%) of those tested during the event had a positive rapid test result. All eight were subsequently confirmed to be HIV positive by Western blot testing. Testing at gay pride events provides an opportunity to identify new HIV infections among MSM outside of health-care settings, particularly those from racial/ethnic minority groups.

As part of an initiative to reduce racial/ethnic disparities in HIV infection, the U.S. Conference of Mayors, through a cooperative agreement with CDC, provided funding to CBOs and health departments to conduct behavioral assessments at gay pride events attended primarily by MSM from racial/ethnic minority groups. CDC provided on-site technical assistance to the CBO and health department staff, including developing assessment questionnaires, training interviewers, and coordinating HIV testing and questionnaire administration. During 2004–2006, CBOs and health departments were funded to conduct assessments and HIV testing at 1) black gay pride events in Detroit, Michigan (2004 and 2005), Baltimore, Maryland (2004), Jackson, Mississippi (2005), Charlotte, North Carolina (2006), St. Louis, Missouri (2006), and the District of Columbia (2005); 2) Hispanic gay pride events in Oakland (2004) and San Francisco, California (2005); and 3) gay pride events in Oakland, California (2004), and Chicago, Illinois (2006).

Both volunteer and paid interviewers were stationed in multiple places at event sites. Interviewers approached and invited adult attendees to participate in a behavioral assessment. At some events, attendees were offered nonmonetary incentives (typically valued at ≤$10) to increase participation. Assessments were conducted using a two-page, self-administered questionnaire in 2004 and a more comprehensive questionnaire administered by local staff using hand-held personal computers during 2005–2006. The assessment questionnaires included questions about demographic characteristics, sexual behavior, illicit drug use, HIV status, history of testing for HIV and other sexually transmitted diseases (STDs), and access to HIV and STD prevention services. After completing the questionnaire, respondents who said they were HIV negative or did not know their HIV status were offered rapid HIV testing using the OraQuick® Advance™ Rapid HIV-1/2 Antibody Test (OraSure Technologies, Inc., Bethlehem, Pennsylvania). Because a positive rapid HIV test is considered to be a preliminary result, persons with preliminary positive results were asked to provide an oral fluid or blood specimen for confirmatory Western blot testing. Rapid HIV testing at the 11 events was performed in diverse settings, including tents, mobile testing units, community centers, churches, bars, and hotel rooms.

Of 627 male respondents aged ≥18 years who self-identified as being from a racial/ethnic minority group and as being either gay or bisexual, 543 reported that they were HIV negative or did not know their HIV status. Of these, 133 (24%) were tested for HIV at an event (Table). Of the 133 respondents who were tested, eight (6%) had preliminary positive test results. All eight were subsequently confirmed to be HIV positive by Western blot testing. The median age of the eight HIV-positive respondents was 36 years (range: 21–43 years), and seven were non-Hispanic blacks. Four of the eight newly identified HIV-positive respondents reported having had a negative HIV test

TABLE. Number and percentage of persons who received rapid human immunodeficiency virus (HIV) testing during gay pride events, by selected characteristics — nine U.S. cities, 2004–2006*

Characteristic	No.	(%)†
Age group (yrs)		
18–24	53	(39.8)
25–29	19	(14.3)
30–39	37	(27.8)
40–49	19	(14.3)
≥50	5	(3.8)
Race/Ethnicity		
Black, non-Hispanic	95	(71.4)
Hispanic	18	(13.5)
Other	20	(15.0)
Sexual identity		
Homosexual	105	(78.9)
Bisexual	28	(21.1)
Year/Location		
2004		
Baltimore, Maryland	5	(3.8)
Detroit, Michigan	14	(10.5)
Oakland, California (first event)	3	(2.3)
Oakland, California (second event)	6	(4.5)
2005		
Detroit, Michigan	14	(10.5)
Jackson, Mississippi	9	(6.8)
San Francisco, California	9	(6.8)
District of Columbia	8	(6.0)
2006		
Charlotte, North Carolina	16	(12.0)
St. Louis, Missouri	9	(6.8)
Chicago, Illinois	40	(30.1)
Received HIV test during the preceding year		
Yes	80	(60.2)
No	53	(39.8)
Total	**133**	**(100.0)**

* All persons tested were men aged ≥18 years who self-identified as being from a racial/ethnic minority group and as being either homosexual or bisexual. All had responded to a behavioral assessment offered at the event, and all had reported that they were HIV negative or did not know their HIV status.
† Column percentages might not add to 100% because of rounding.

result during the preceding year, one had never been tested for HIV, and the testing histories of three were unknown.

Of the 169 persons who were willing to be tested at a 2005 or 2006 event, 105 (62%) were tested; data for 2004 were unavailable. Although the reasons willing respondents were not tested were not collected systematically, anecdotal reports from staff at events suggest that the primary reasons were that respondents did not report to testing locations after completing the behavioral assessment or, if they did report to testing locations, they chose not to wait until staff were available to administer a test.

Data on health-care–seeking behaviors were available from the 2005 assessments only. Of the 229 respondents in 2005 who reported that they were HIV negative or did not know their HIV status, 23 (10%) had received a referral for HIV testing from a health-care provider or outreach worker during the preceding year, and 169 (74%) respondents had visited a health-care provider during the preceding year. Of these 169 respondents, 70 (41%) had been offered an HIV test by their health-care provider.

Reported by: *T Dowling, MA, MPH, O Macias, D Sebesta, PhD, San Francisco Dept of Public Health, E Antonio, Mission Neighborhood Health Center, C Emerson, Tenderloin Health, San Francisco; L Hinojosa, Alameda County Office of AIDS Admin, Oakland, California. P LaKosky, MA, Chicago Dept of Public Health, Chicago, Illinois. C Bolden Calhoun, Community Health Awareness Group, Detroit; L Randall, PhD, Michigan Dept of Community Health. B Tucker, Women Accepting Responsibility, Inc., Baltimore; C Flynn, ScM, Maryland Dept of Health and Mental Hygiene. M Robinson, Pride of Mississippi, Inc., H Mangum, MSSW, Grace House Inc., Jackson; C Thompson, Mississippi Dept of Health. D Wrigley, St. Louis City Health Dept, St. Louis, Missouri. M Buie, MA, D Bost, North Carolina Dept of Health and Human Svcs. A Smith, MA, Whitman-Walker Clinic, District of Columbia. E Begley, MPH, B Boyett, MS, H Clark, MPH, J Heffelfinger, MD, K Jafa-Bhushan, MBBS, J Schulden, MD, B Song, MS, P Thomas, PhD, P Sullivan, DVM, PhD, Div of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; A Voetsch, PhD, EIS Officer, CDC.*

Editorial Note: Of the estimated 1 million persons living with HIV infection in the United States, approximately 25% do not know their HIV status (*3*). In 2003, the CDC initiative Advancing HIV Prevention: New Strategies for a Changing Epidemic called for implementation of new models for diagnosing HIV infections (*4*). Rapid HIV testing can increase the number of persons who are willing to be tested and the proportion of persons tested who receive their results (*5*). The findings in this report suggest that rapid HIV testing of MSM in racial/ethnic minority groups at gay pride events is a useful way to enable HIV-infected persons to learn their HIV status.

Overall, of the persons who reported that they were HIV negative or who did not know their HIV status during the assessment and who were tested at gay pride events, 6% had positive HIV test results. This result is comparable to the 7% of minority MSM with a positive HIV test result in 2004 at CDC-supported testing sites, which included hospitals, public health and STD clinics, prisons and jails, drug treatment centers, and outreach settings (*6*). Four of the eight men who were newly identified as infected with HIV had received negative HIV test results during the preceding year. Men who mistakenly believe that they are HIV negative, even those who have this belief based on a recent negative HIV test, represent an important risk group for HIV transmission. For example, 47 (7%) of the 723 MSM in the Young Men's Survey who had received negative HIV

test results during the preceding year and disclosed that they were HIV negative to their sex partners were unaware that they were HIV positive (*7*). Knowledge of being infected with HIV has been associated with reduction of high-risk behaviors (*8*).

CBOs and health departments face several challenges when conducting rapid HIV testing at gay pride events. The effectiveness of testing depends, in part, on the amount of resources that CBOs and health departments can dedicate to such events. The demand for rapid HIV testing at several of the events described in this report exceeded the capacity of CBO and health department staff to provide testing. Persons who could not be tested during the event were referred for testing at a later date. Effectiveness also depends on proper follow up of persons with newly diagnosed HIV. Two of the eight MSM with newly diagnosed and confirmed HIV infection were not referred to medical care because they could not be located after the event. HIV testing at gay pride events is only one part of a greater strategy to encourage HIV testing among MSM.

HIV testing provided by CBOs and health departments outside of the health-care setting, such as at gay pride events, is an important strategy to reach MSM who might not regularly access health care. Among persons for whom health-care–seeking behavior information was available, 74% had visited a health-care provider during the preceding year; however, only 41% had been offered HIV testing by a provider during the preceding year. To decrease the number of missed opportunities for HIV testing, in 2006, CDC recommended that HIV testing for patients aged 13–64 years become a routine part of medical services using a voluntary, opt-out approach. CDC further recommended that persons likely to be at high risk for HIV infection, including sexually active MSM, be tested at least annually (*9*).

Future analyses of outreach activities such as the ones described in this report can be used to understand barriers to HIV testing among MSM and help determine the cost-effectiveness of such activities for health departments and CBOs. Expansion of HIV testing opportunities for racial/ethnic minorities outside of health-care settings, combined with culturally appropriate behavioral interventions, are important components of ongoing CDC activities to reduce HIV transmission and eliminate disparities in the rates of HIV infection by race and ethnicity.

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Decline in Smoking Prevalence — New York City, 2002–2006

In 2002, after a decade with no decrease in smoking prevalence, New York City began implementation of a five-point tobacco-control program consisting of increased taxation in 2002, establishment of smoke-free workplaces in 2003 (*1*), public and health-care–provider education, cessation services, and rigorous evaluation, including annual cross-sectional, citywide telephone surveys using the same measures as CDC's state-based Behavioral Risk Factor Surveillance System (BRFSS).* During 2002–2004, estimated adult smoking prevalence decreased from 21.5% to 18.4%, representing nearly 200,000 fewer smokers (*2,3*). However, in 2005, no change in adult smoking prevalence occurred, either among New York City residents overall or among demographic subpopulations (*3*). In 2006, to further reduce smoking in New York City, the New York City Department of Health and Mental Hygiene (DOHMH) implemented an extensive, television-based anti-tobacco

* BRFSS is a state-based, random-digit–dialed telephone survey of the U.S. civilian, noninstitutionalized population aged ≥18 years. BRFSS is administered in all 50 states, the District of Columbia, and three U.S. territories (Guam, Puerto Rico, and the U.S. Virgin Islands). BRFSS prevalence data is available at http://apps.nccd.cdc.gov/brfss.

media campaign using graphic imagery of the health effects of smoking; the campaign aired simultaneously with a large New York state anti-tobacco media campaign. This report describes the two campaigns and analyzes citywide survey data before and after the campaigns. In 2006, during the first year of the media campaigns, adult smoking prevalence decreased significantly among men (11.6% decrease) and among Hispanics (15.2% decrease). These findings confirm the importance of comprehensive tobacco-control programs and suggest that this intensive, broad-based media campaign has reduced smoking prevalence among certain subgroups.

The 2006 DOHMH media campaign, the first expanded component of the DOHMH tobacco-control program introduced since 2003, focused on increasing smokers' motivation to quit. Advertisements included testimonials from sick and dying smokers and graphic images of the effects of smoking on the lungs, arteries, and brains of smokers. Advertisements included diverse messages in both English and Spanish. The television campaign broadcast for 23 of 40 weeks during January–October 2006, with 100–600 gross ratings points (GRPs)[†] per week, for a total of approximately 6,500 GRPs.

In 2006, the New York State Department of Health also aired a separate, simultaneous statewide television-based anti-tobacco media campaign that included New York City. The campaign included advertisements featuring graphic images of the effects of smoking and emphasizing the effects of secondhand smoke on children. The broadcasts equated to approximately 4,400 GRPs in New York City from January through December 2006. Thus, in total, New York City adult smokers were exposed to nearly 11,000 GRPs during this 1-year period, equating to the average viewer in NYC seeing an advertisement approximately 110 times over the year; this exposure is similar in magnitude to that of the highest exposure group in the American Legacy Foundation's 2000–2002 "truth" campaign,[§] which equated to approximately 20,000 GRPs for the 2-year campaign period (*4*).

To measure the annual prevalence of health conditions and risk behaviors, including smoking, DOHMH has conducted population-based, random-digit–dialed health surveys of approximately 10,000 adult New York City residents annually since 2002. Trained interviewers use computer-assisted telephone interviews to assess smoking status using the same measures as BRFSS; adult smoking is defined as adults who responded "yes" to the question "Have you smoked at least 100 cigarettes in your entire life?" and responded "every day" or "some days" to the question, "Do you now smoke cigarettes every day, some days, or not at all?" Smoking prevalence data for 1993–2001 were obtained through surveys of New York City residents, excerpted from the annual New York state BRFSS (*5*). Because of small sample sizes specific to New York City for individual years from 1993 to 2001 (range: 794–1,665 respondents annually), BRFSS data for these years were grouped into 3-year datasets (1993–1995, 1996–1998, and 1999–2001) (*2*). For annual New York City survey data, survey weights were calculated by adjusting probability-of-selection weights to match the 2000 New York City census counts in each neighborhood by age/sex and race/ethnicity. Smoking status was not imputed for survey respondents who did not answer the relevant questions. Significant changes between survey years were assessed using pairwise *t* tests to compare prevalence estimates of each group. A value of $p \leq 0.05$ was considered significant.

The smoking prevalence among New York City residents decreased significantly from 21.5% in 2002 to 18.4% in 2004 ($p<0.001$)[¶]; decreases were demonstrated in all major age, race/ethnicity, sex, and education subgroups and by location of birth. From 2004 to 2005, smoking prevalence did not change significantly among New York City residents overall, and no changes occurred within any subgroup. Although in 2006, the year during which television advertisements were aired, smoking prevalence did not change significantly among New York City residents overall (17.5% in 2006 compared with 18.9% in 2005, $p=0.055$) (Table), smoking prevalence decreased significantly among men (from 22.5% to 19.9%, $p=0.021$) and Hispanics (from 20.2% to 17.1%, $p=0.027$).

The 17.5% prevalence among New York City residents in 2006 amounts to a 19% decrease from 2002 (Figure), representing 240,000 fewer adult smokers and an average annual rate of decrease of 5%. Young adults (aged 18–24 years) had the largest 2002–2006 decrease, 35%. Although the prevalence of smoking among men remained static from 2004 to 2005, it decreased 12% from 2005 to 2006

[†] GRPs are an industry-specific standardized measure of the broadcast frequency and audience reach of a campaign. For example, 100 GRPs are equal to one exposure in the given period.

[§] The "truth" campaign is a national antismoking campaign to discourage tobacco use among youths.

[¶] Complete New York City survey data available at http://www.nyc.gov/health/epiquery.

TABLE. Estimated adult smoking prevalence and percentage change, by year and selected characteristics — New York City, 2002, 2005, and 2006

Characteristic	Estimated smoking prevalence 2002 %	2002 (95% CI*)	2002 No.†	2005 %	2005 (95% CI)	2005 No.	2006 %	2006 (95% CI)	2006 No.	% change 2005 to 2006	% change 2002 to 2006	Estimated change in number of smokers 2002 to 2006
New York City overall	**21.6**	**(20.5–22.6)**	**1,305,000**	**18.9**	**(17.9–19.9)**	**1,151,000**	**17.5**	**(16.6–18.5)**	**1,065,000**	**-7.3**	**-19.0§**	**-240,000**
Age group (yrs)												
18–24	23.8	(20.7–27.2)	185,000	18.8	(15.5–22.5)	148,000	15.5	(12.5–19.1)	119,000	-17.4	-34.9§	-66,000
25–44	24.3	(22.6–26.0)	616,000	22.3	(20.7–24.0)	583,000	20.2	(18.5–21.9)	531,000	-9.3	-16.9§	-85,000
45–64	23.4	(21.4–25.6)	390,000	20.0	(18.4–21.7)	338,000	19.2	(17.7–20.8)	323,000	-4.1	-17.9§	-67,000
≥65	10.0	(8.4–11.9)	89,000	8.8	(7.4–10.5)	82,000	9.9	(8.4–11.5)	91,000	12.0	-1.0	2,000
Race/Ethnicity												
Asian/Pacific Islander	15.3	(12.0–19.3)	98,000	13.8	(10.8–17.4)	88,000	10.7	(8.4–13.7)	70,000	-22.3	-30.1§	-28,000
Black, non-Hispanic	20.8	(18.8–22.9)	284,000	19.9	(18.0–21.9)	276,000	17.7	(15.8–19.8)	243,000	-11.1	-14.9§	-41,000
Hispanic	21.5	(19.5–23.5)	327,000	20.2	(18.3–22.2)	318,000	17.1	(15.3–19.0)	265,000	-15.2§	-20.5§	-62,000
White, non-Hispanic	23.9	(22.2–25.7)	568,000	19.1	(17.5–20.9)	425,000	19.8	(18.1–21.6)	450,000	3.6	-17.2§	-118,000
Other	22.8	(15.8–31.7)	29,000	17.7	(13.4–23.0)	45,000	18.3	(13.7–24.0)	37,000	3.3	-19.7	8,000
Sex												
Men	23.4	(21.7–25.1)	675,000	22.5	(20.9–24.2)	645,000	19.9	(18.4–21.5)	571,000	-11.6§	-15.0§	-104,000
Women	19.8	(18.5–21.2)	630,000	15.6	(14.5–16.8)	507,000	15.3	(14.1–16.6)	495,000	-2.0	-22.7§	-135,000
Education												
Less than high school diploma	24.5	(21.7–27.5)	188,000	23.5	(20.9–26.2)	230,000	23.0	(20.2–26.0)	198,000	-1.9	-6.1	10,000
High school graduate	23.9	(21.6–26.3)	318,000	22.7	(20.7–24.9)	321,000	21.5	(19.3–23.9)	256,000	-5.3	-10.0	-62,000
Some college	24.3	(21.8–26.9)	277,000	20.2	(18.2–22.4)	258,000	19.3	(17.2–21.7)	211,000	-4.4	-20.6§	-66,000
College degree or more	16.4	(14.9–18.1)	329,000	14.7	(13.1–16.5)	333,000	13.0	(11.7–14.5)	275,000	-11.7	-20.7§	-54,000
Location of birth												
United States	25.8	(24.5–27.2)	944,000	22.9	(21.6–24.3)	790,000	21.5	(20.1–22.9)	729,000	-6.1	-16.7§	-215,000
Other than United States	15.1	(13.6–16.8)	357,000	13.8	(12.4–15.3)	359,000	12.4	(11.1–13.7)	336,000	-10.2	-17.9§	-21,000

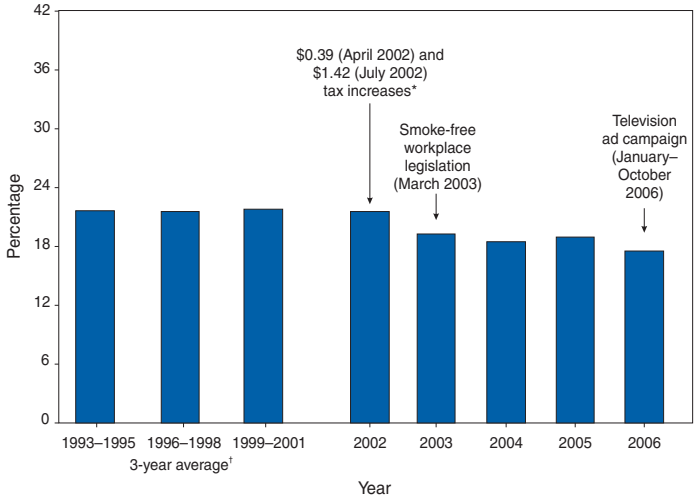
* 95% confidence interval.
† The population counts were calculated as the sum of the survey weights for current smokers. For annual New York City survey data, survey weights were calculated by adjusting probability-of-selection weights to match the 2000 New York City census counts in each neighborhood by age/sex and race/ethnicity. Smoking status is not imputed for survey respondents who did not answer the relevant question, and their weights do not contribute to this table.
§ $p \leq 0.05$. Significant changes between survey years were assessed using pairwise *t* tests to compare prevalence estimates.

(p=0.021), with a statistically significant decrease among Hispanic men (from 24.6% to 19.3%; 22% decrease, p=0.024). Significant decreases occurred among Hispanics, both since 2002 (21% decrease, p=0.002) and since 2005 (15% decrease, p=0.027), after no change in the preceding year. The largest proportional 2002–2006 decrease among racial/ethnic groups was among Asians/Pacific Islanders (30% decrease, p=0.050). Although non-Hispanic whites did not demonstrate a significant decrease in smoking from 2005 to 2006, the smoking rate in this population has decreased 17% since 2002 (p=0.001), representing nearly half of the 2002–2006 decrease in the number of New York City adults who smoke (118,000 fewer non-Hispanic white smokers since 2002). Despite this progress, in 2006, the smoking prevalence among New York City men was significantly higher than among women (p<0.001). The smoking prevalence among those aged 25–44 years was higher than among adults aged 18–24 years (p=0.015); the prevalence among those aged 25–44 years and 45–64 years was higher than among those aged ≥65 years (p<0.001, both comparisons); and the smoking prevalence among those with less than a college education was higher than among those with more education (p<0.001).

Reported by: *JA Ellis, PhD, SB Perl, MPH, TR Frieden, MD, M Huynh, PhD, C Ramaswamy, MBBS, LS Gupta, MPH, BD Kerker, PhD, New York City Dept of Health and Mental Hygiene.*

Editorial Note: Tobacco use remains the leading preventable cause of death in the United States. Several measures are proven to reduce tobacco use. Foremost is taxation (*6*). In July 2002, New York City increased the excise tax on cigarettes from $0.08 to $1.50 per pack, which, combined with an April 2002 New York state excise tax increase from $1.11 to $1.50, resulted in the highest combined city/state tax in the United States at the time. The tax increases resulted in a 32% increase in the retail price of a pack of cigarettes (from $5.20 to $6.85), although an increase in tax-avoidant sales (e.g., purchasing through out-of-state sellers or American Indian reservations) resulted in only a 20% increase in the average actual price paid reported by smokers (from $4.60 to $5.50) (*2*). A second proven way to decrease smoking prevalence is through legislation that makes workplaces and other public areas smoke-free, protecting nonsmokers from secondhand smoke and reducing smoking prevalence among affected smokers (*7*). A comprehensive smoke-free workplace law covering virtually all indoor workplaces, including restaurants and bars, was

FIGURE. Estimated adult smoking prevalence, by year — New York City, 1993–2006



SOURCES: New York State Behavioral Risk Factor Surveillance System (1993–2001); New York City Community Health Survey (2002–2006); New York State Department of Health; New York City Department of Health and Mental Hygiene.

* Specific (rather than percentage) tax, not indexed to inflation, resulted in decreasing real price of tobacco during 2003–2006.

† Because of small sample sizes specific to New York City for individual years from 1993 to 2001 (range: 794–1,665 respondents annually), BRFSS data for these years were grouped into 3-year datasets (1993–1995, 1996–1998, and 1999–2001).

implemented in New York City in 2003 (*1*). After implementation of these components of comprehensive tobacco control, overall smoking prevalence in New York City decreased, after a decade with no change in the smoking rate (*2*). The total decrease associated with New York City's comprehensive program from 2002 to 2006 was 19%, an average annual decrease of 5%. This decrease occurred more quickly than those documented by BRFSS in California (3%–4% annually during 1998–2005), Massachusetts (2% annually during 1995–2005), or the United States as a whole (2% annually during 1965–2004 and 3% annually during 2002–2006)** in any period since data were first collected in 1965.

Although the effectiveness of anti-tobacco media campaigns has been evaluated previously (*8*), few evaluations have assessed the effect of media campaigns independent of other population-based tobacco-control measures in a comprehensive tobacco-control program. The annual survey data collected in New York City do not allow for causal interpretation of the relation between any decreases and any intervention, including the media campaign, and do not account for possible secular trends, but the implementation of the media campaign in New York City was the only major change initiated in the New York City program after 2003. Thus, the New York City data suggest that large-scale, intensive anti-tobacco media campaigns, when implemented in the context of existing comprehensive tobacco-control components such as taxation and smoke-free workplace legislation, can have a contributory effect on reducing smoking prevalence among certain subpopulations (*2*).

Although the 2005–2006 New York City data provide important preliminary information about the potential for large-scale media campaigns to reduce smoking levels among men and Hispanics, additional smoking prevalence data from New York City are needed to confirm the broader effectiveness of such campaigns. In addition, the specific effects of the media campaign on smoking behaviors also might be documented through the use of a cohort or nested case-control study.

The findings in this report are subject to at least three limitations. First, these data rely on self-reported smoking behaviors, which might be affected by social desirability bias. Second, telephone surveys such as the one described in this report exclude certain populations (e.g., military personnel residing on bases, institutionalized populations, and persons without landline telephones). Finally, the decrease in New York City since 2002 might parallel an overall national decrease during the same period; however, certain state decreases likely resulted in large part from more recent tax increases, whereas New York's tobacco tax increase occurred in 2002.

The large decrease in smoking (34.9%) described among young adults (aged 18–24 years) since 2002 is consistent with data from the Youth Risk Behavior Survey in New York City, which indicated decreases among high school students through 2005, the most recent year the survey was administered (*9*). During 2003–2005, youth smoking in New York City decreased substantially from 14.8% to 11.2%, whereas youth smoking in the United States remained unchanged at approximately 23%.†† The aging of a cohort of adolescents with low smoking prevalence into the young adult category accounts for part of the observed decrease in smoking among adults aged 18–24 years.

Although increased tobacco taxation is the most effective way to reduce smoking prevalence (*6*) and was cited in

** California and Massachusetts BRFSS smoking prevalence data are available at http://apps.nccd.cdc.gov/brfss. U.S. smoking prevalence data from the National Health Interview Survey are available at http://www.cdc.gov/tobacco/data_statistics/tables.

†† CDC. Youth risk behavior surveillance—United States, 2005. MMWR 2006;55(No. SS-5).

2003 by New York City smokers as the primary reason for quitting or reducing tobacco use (*2*), this impact likely reaches its maximum effect after 1–2 years, after smokers adjust to the increased price by quitting, reducing quantities smoked, switching to less expensive brands, or purchasing through lower-cost sales channels. This is supported by data from the annual New York City phone survey, which indicates that, after increasing substantially from 2002 to 2003 (from 15.8% to 30.9% of sales), tax-avoidant sales decreased substantially among New York City smokers from 2003 to 2005 (i.e., 1–2 years after implementation, from 30.9% to 22.5%). The $10 billion spent by the tobacco industry annually on discounting the price of cigarettes (http://www.ftc.gov/reports/tobacco/2007cigarette2004-2005.pdf), which is focused in areas that have implemented higher excise taxes (*10*), further erodes the effect of increased taxes. No significant changes in price or place of purchase occurred from 2005 to 2006 in New York City, according to smokers' self-reports. In addition, because New York City's tobacco tax is a specific amount rather than a percentage, the inflation-adjusted price of cigarettes in New York City actually decreased steadily after implementation of the tax in 2002, indicating that the role of media might have been particularly important.

Jurisdictions can make additional progress in reducing tobacco use, particularly by further increasing taxes, expanding smoke-free public places, and airing sustained, graphic, and pervasive anti-tobacco advertising. The most recent data on tobacco industry expenditures indicate that tobacco companies spent approximately $13 billion in the United States on marketing in 2005 (http://www.ftc.gov/reports/tobacco/2007cigarette2004-2005.pdf), which is more than $43 per capita. Funding of anti-tobacco media campaigns in New York City was approximately $2.70 per capita in 2006, with New York City and New York state each contributing approximately half; expenditures were within the range of $1 to $3 per capita as suggested by CDC's *Best Practices for Comprehensive Tobacco Control Programs* (http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/00_pdfs/bpchap6.pdf). The data presented in this report suggest that, in the context of increases in taxation and implementation of smoke-free workplace legislation, additional well-funded media campaigns that have graphic content and are aired with high frequency might further reduce smoking prevalence.

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Errata: Vol. 56, No. 17

In the report, "Projected State-Specific Increases in Self-Reported Doctor-Diagnosed Arthritis and Arthritis-Attributable Activity Limitations — United States, 2005–2030," multiple errors occurred.

On page 423, the fifth sentence of the first paragraph should read: "The results indicate that, among **50** states, the median projected increase in doctor-diagnosed arthritis from 2005 to 2030 will be **34%**; a total of **10** states are projected to have increases of **50% to 99%, and three states are projected to see their numbers more than double.**"

The last paragraph should read: "From 2005 to 2030, the number of adults with doctor-diagnosed arthritis is projected to increase by a median of 34%† in **50** states (range: **10% [West Virginia]** to 134% [Arizona]); in **10** states, the projected increase ranges from **50% to 99%; three states (Arizona, Florida, and Nevada) are projected to see their numbers more than double** (Table). The

median projected increase in the absolute number of persons with doctor-diagnosed arthritis in these same states is **310,000 (range: 21,000 [North Dakota]** to 3,654,000 [Florida]); the comparable median increase in those with arthritis-attributable activity limitations is **103,000 (range: 8,000 [North Dakota]** to 1,336,000 [Florida]) (Table). **Primarily because of an expected population decline, the District of Columbia is projected to have decreases in the numbers of adults with doctor-diagnosed arthritis and arthritis-attributable activity limitations.**"

The footnote at the bottom of the second column should read: "†The number of adults with arthritis-attributable activity limitations is projected to increase similarly."

On page 425, the second sentence of the first paragraph should read: "On the basis of U.S. Census-projected increases in state populations overall and their older age distributions, all **50** states are expected to have an increase in the number of adults reporting doctor-diagnosed arthritis and arthritis-attributable activity limitations by the year 2030, including **10** states with increases of **>50%, and three states that are projected to see their numbers more than double.**"

On page 424, the Table should read:

TABLE. State-specific 2005 estimates and 2030 projections* of the numbers of adults with doctor-diagnosed arthritis and arthritis-attributable activity limitations — Behavioral Risk Factor Surveillance System (BRFSS) and U.S. Census.

State/Area	No. of adults with doctor-diagnosed arthritis			No. of adults with arthritis-attributable activity limitations			% change in doctor-diagnosed arthritis†
	2005 (1,000s)	2030 (1,000s)	Increase (decrease) (1,000s)	2005 (1,000s)	2030 (1,000s)	Increase (decrease) (1,000s)	Increase (decrease) 2030 versus 2005 (%)
Alabama	1,113	1,380	267	469	576	107	24
Alaska	107	156	49	43	61	18	46
Arizona	1,078	2,526	1,448	395	932	537	134
Arkansas	626	827	201	243	319	76	32
California	5,650	9,110	3,460	2,184	3,361	1,177	61
Colorado	792	1,126	334	275	387	112	42
Connecticut	669	823	154	209	258	49	23
Delaware	185	277	92	61	93	32	50
District of Columbia	99	75	-24	36	27	-9	-24
Florida	3,626	7,280	3,654	1,445	2,781	1,336	101
Georgia	1,666	2,595	929	678	1,041	363	56
Hawaii	212	280	68	67	88	21	32
Idaho	256	434	178	105	175	70	70
Illinois	2,347	2,824	477	775	929	154	20
Indiana	1,340	1,625	285	475	562	87	21
Iowa	611	720	109	206	236	30	18
Kansas	546	667	121	185	225	40	22
Kentucky	879	1,115	236	395	476	81	27
Louisiana	757	1,109	352	320	460	140	46
Maine	310	411	101	113	142	29	33
Maryland	1,127	1,577	450	374	512	138	40
Massachusetts	1,256	1,611	355	451	558	107	28
Michigan	2,324	2,837	513	839	1,015	176	22
Minnesota	978	1,376	398	353	495	142	41
Mississippi	674	873	199	296	382	86	30
Missouri	1,384	1,726	342	555	689	134	25
Montana	185	262	77	70	98	28	42
Nebraska	340	409	69	119	143	24	20
Nevada	430	948	518	162	360	198	120
New Hampshire	266	394	128	87	125	38	48
New Jersey	1,562	2,091	529	524	675	151	34
New Mexico	333	510	177	131	197	66	53
New York	3,721	4,433	712	1362	1,592	230	19
North Carolina	1,754	2,761	1,007	681	1,057	376	57
North Dakota	125	146	21	42	50	8	17
Ohio	2,573	2,930	357	857	955	98	14
Oklahoma	797	976	179	351	420	69	22
Oregon	732	1,089	357	310	445	135	49
Pennsylvania	2,989	3,477	488	992	1,135	143	16
Rhode Island	232	289	57	72	86	14	25
South Carolina	967	1,413	446	370	535	165	46
South Dakota	159	196	37	60	76	16	23
Tennessee	1,326	1,814	488	608	809	201	37
Texas	3,560	6,133	2,573	1337	2,254	917	72
Utah	371	622	251	146	242	96	68
Vermont	132	181	49	47	65	18	37
Virginia	1,539	2,310	771	577	850	273	50
Washington	1,222	1,912	690	504	773	269	56
West Virginia	494	545	51	247	267	20	10
Wisconsin	1,142	1,525	383	407	542	135	34
Wyoming	104	139	35	37	50	13	34
Median increase§	—	—	**310**	—	—	**103**	**34**

* Projected state totals were calculated by applying proportions for six sex-specific age groups (i.e., 18–44 years, 45–64 years, and ≥65 years) from the 2005 BRFSS survey to corresponding U.S. Census–projected state populations for the year 2030 and then adding the age groups together.

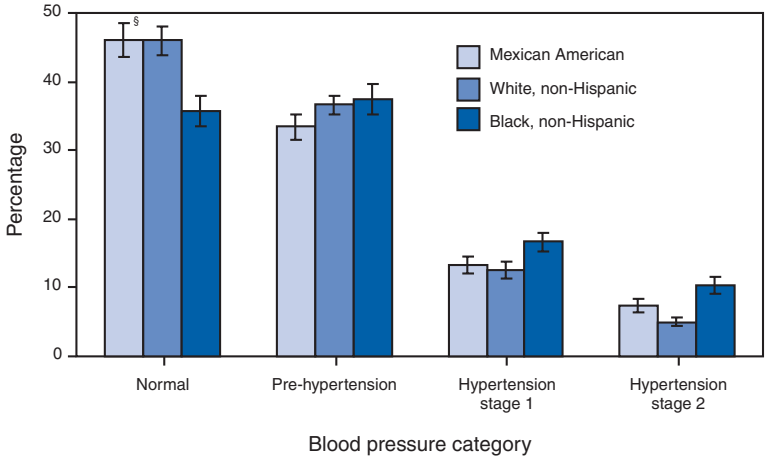
† The number of adults with arthritis-attributable activity limitations is projected to increase similarly.

§ Median increases were calculated using data only from the 50 states that projected increases in prevalences of doctor-diagnosed arthritis and arthritis-attributable activity limitations. The District of Columbia, which showed a decrease, was excluded.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage Distribution* of Blood Pressure Categories† Among Adults Aged ≥18 Years, by Race/Ethnicity — National Health and Nutrition Examination Survey, United States, 1999–2004



* Percentages are age adjusted to the 2000 U.S. standard population.
† Blood pressure categories are based on the classification recommended by the *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure* and are defined as follows: normal (systolic blood pressure <120 mm Hg and a diastolic blood pressure <80 mm Hg); pre-hypertension (systolic blood pressure 120–139 mm Hg or diastolic blood pressure 80–89 mm Hg); hypertension stage 1 (systolic blood pressure 140–159 mm Hg or diastolic blood pressure 90–99 mm Hg); and hypertension stage 2 (systolic blood pressure ≥160 mm Hg or diastolic blood pressure ≥100 mm Hg). Persons are classified into the higher blood pressure group if the systolic and diastolic values fall within more than one category. Categories do not account for blood pressure treatment status.
§ 95% confidence interval.

Blood pressure category varied substantially by race/ethnicity. Mexican Americans and non-Hispanic whites were more likely to have normal blood pressure compared with non-Hispanic blacks. Conversely, higher percentages of non-Hispanic blacks had hypertension stage 1 and hypertension stage 2 compared with non-Hispanic whites and Mexican Americans.

SOURCE: National Health and Nutrition Examination Survey 1999–2004. Available at http://www.cdc.gov/nchs/nhanes.htm.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending June 16, 2007 (24th Week)*

Disease	Current week	Cum 2007	5-year weekly average†	Total cases reported for previous years 2006	2005	2004	2003	2002	States reporting cases during current week (No.)
Anthrax	—	—	—	1	—	—	—	2	
Botulism:									
foodborne	—	2	0	20	19	16	20	28	
infant	—	33	2	97	85	87	76	69	
other (wound & unspecified)	—	8	0	48	31	30	33	21	
Brucellosis	—	49	2	120	120	114	104	125	
Chancroid	—	11	1	33	17	30	54	67	
Cholera	—	—	0	9	8	5	2	2	
Cyclosporiasis§	5	35	11	136	543	171	75	156	KS (1), FL (4)
Diphtheria	—	—	0	—	—	—	1	1	
Domestic arboviral diseases§,¶:									
California serogroup	—	—	1	67	80	112	108	164	
eastern equine	—	—	0	8	21	6	14	10	
Powassan	—	—	0	1	1	1	—	1	
St. Louis	—	—	0	11	13	12	41	28	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	12	51	15	646	786	537	362	511	ME (1), NY (4), MN (6), TN (1)
human monocytic	3	81	9	575	506	338	321	216	MD (1), TN (1), AR (1)
human (other & unspecified)	3	31	5	230	112	59	44	23	MD (2), TN (1)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	5	0	22	9	19	32	34	
nonserotype b	—	45	2	146	135	135	117	144	
unknown serotype	4	120	3	212	217	177	227	153	OH (1), IN (2), FL (1)
Hansen disease§	1	22	2	66	87	105	95	96	CA (1)
Hantavirus pulmonary syndrome§	—	7	1	38	26	24	26	19	
Hemolytic uremic syndrome, postdiarrheal§	4	47	5	284	221	200	178	216	NC (1), FL (1), CA (2)
Hepatitis C viral, acute	8	291	20	821	652	713	1,102	1,835	OH (1), MN (1), OK (6)
HIV infection, pediatric (age <13 yrs)††	—	—	5	52	380	436	504	420	
Influenza-associated pediatric mortality§,§§	—	66	0	41	45	—	N	N	
Listeriosis	5	216	13	871	896	753	696	665	NY (1), GA (1), FL (2), ID (1)
Measles¶¶	—	15	1	56	66	37	56	44	
Meningococcal disease, invasive***:									
A, C, Y, & W-135	2	128	5	308	297	—	—	—	NY (1), GA (1)
serogroup B	—	47	4	188	156	—	—	—	
other serogroup	—	9	0	30	27	—	—	—	
unknown serogroup	4	325	14	647	765	—	—	—	SC (1), FL (2), CA (1)
Mumps	—	431	28	6,575	314	258	231	270	
Novel influenza A virus infections	—	—	—	N	N	N	N	N	
Plague	—	1	0	17	8	3	1	2	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Poliovirus infection, nonparalytic§	—	—	—	N	N	N	N	N	
Psittacosis§	—	3	0	21	16	12	12	18	
Q fever§	6	79	3	170	136	70	71	61	MN (3), NE (1), NC (1), AZ (1)
Rabies, human	—	—	0	3	2	7	2	3	
Rubella†††	—	9	0	10	11	10	7	18	
Rubella, congenital syndrome	—	—	—	1	1	—	1	1	
SARS-CoV§,§§§	—	—	—	—	—	—	8	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	53	3	125	129	132	161	118	
Syphilis, congenital (age <1 yr)	—	106	8	380	329	353	413	412	
Tetanus	—	5	1	40	27	34	20	25	
Toxic-shock syndrome (staphylococcal)§	2	34	2	101	90	95	133	109	OH (1), KY (1)
Trichinellosis	1	2	0	15	16	5	6	14	NY (1)
Tularemia	4	19	4	94	154	134	129	90	OK (4)
Typhoid fever	3	110	6	343	324	322	356	321	PA (1), CA (2)
Vancomycin-intermediate *Staphylococcus aureus*§	—	4	0	6	2	—	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	1	3	1	N	N	
Vibriosis (non-cholera *Vibrio* species infections)§	2	74	1	N	N	N	N	N	FL (2)
Yellow fever	—	—	—	—	—	—	—	1	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting years 2006 and 2007 are provisional, whereas data for 2002, 2003, 2004, and 2005 are finalized.

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf.

§ Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.

¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.

** Data for *H. influenzae* (all ages, all serotypes) are available in Table II.

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Implementation of HIV reporting influences the number of cases reported. Updates of pediatric HIV data have been temporarily suspended until upgrading of the national HIV/AIDS surveillance data management system is completed. Data for HIV/AIDS, when available, are displayed in Table IV, which appears quarterly.

§§ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. A total of 66 cases were reported for the 2006–07 flu season.

¶¶ No measles cases were reported for the current week.

*** Data for meningococcal disease (all serogroups) are available in Table II.

††† No rubella cases were reported for the current week.

§§§ Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 16, 2007, and June 17, 2006 (24th Week)*

Reporting area	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	10,193	20,223	25,287	448,663	461,898	172	152	658	3,803	4,034	27	66	319	1,138	1,262
New England	286	692	1,357	15,783	14,301	—	0	0	—	—	—	5	27	66	100
Connecticut	—	221	829	4,529	3,697	N	0	0	N	N	—	0	11	11	38
Maine§	—	48	73	1,138	975	—	0	0	—	—	—	0	6	11	13
Massachusetts	200	309	600	7,276	6,651	—	0	0	—	—	—	2	19	18	31
New Hampshire	25	40	71	905	828	—	0	0	—	—	—	1	4	12	12
Rhode Island§	50	65	108	1,540	1,571	—	0	0	—	—	—	0	5	5	3
Vermont§	11	20	45	395	579	N	0	0	N	N	—	1	4	9	3
Mid. Atlantic	1,626	2,616	4,284	63,657	56,507	—	0	0	—	—	4	10	37	141	201
New Jersey	—	373	541	6,751	8,885	N	0	0	N	N	—	0	5	—	10
New York (Upstate)	477	501	2,758	11,321	10,564	N	0	0	N	N	2	3	14	48	41
New York City	594	798	1,521	20,800	18,941	N	0	0	N	N	—	2	10	25	60
Pennsylvania	555	816	1,790	24,785	18,117	N	0	0	N	N	2	4	18	68	90
E.N. Central	777	3,163	6,257	75,026	79,268	—	1	3	14	19	7	15	110	259	286
Illinois	—	1,001	1,295	20,410	25,045	—	0	0	—	—	—	2	22	25	39
Indiana	—	378	644	9,090	9,537	—	0	0	—	—	4	1	18	25	24
Michigan	500	740	1,225	16,471	15,077	—	0	3	10	15	—	3	10	59	44
Ohio	112	643	3,650	20,554	19,733	—	0	2	4	4	3	4	33	81	94
Wisconsin	165	371	528	8,501	9,876	N	0	0	N	N	—	5	53	69	85
W.N. Central	609	1,201	1,448	26,483	28,139	—	0	54	3	—	3	12	77	179	192
Iowa	—	165	243	3,642	3,823	N	0	0	N	N	—	2	28	32	19
Kansas	207	147	308	3,667	3,777	N	0	0	N	N	2	1	8	27	27
Minnesota	—	242	314	4,667	5,923	—	0	54	—	—	1	2	25	47	68
Missouri	296	456	628	10,469	10,261	—	0	1	3	—	—	2	21	32	38
Nebraska§	106	105	184	2,399	2,326	N	0	0	N	N	—	1	16	7	14
North Dakota	—	31	69	549	828	N	0	0	N	N	—	0	11	1	3
South Dakota	—	49	84	1,090	1,201	N	0	0	N	N	—	1	7	33	23
S. Atlantic	2,149	3,905	6,760	85,370	87,904	—	0	1	1	2	10	18	70	288	282
Delaware	54	69	115	1,554	1,653	N	0	0	N	N	—	0	3	2	1
District of Columbia	94	82	167	2,556	1,417	—	0	0	—	—	—	0	2	3	8
Florida	1,024	1,043	1,651	23,900	21,993	N	0	0	N	N	7	9	32	143	112
Georgia	—	681	3,822	10,365	15,682	N	0	0	N	N	1	3	17	52	89
Maryland§	414	407	696	8,962	9,289	—	0	1	1	2	—	0	2	12	9
North Carolina	—	631	1,233	13,876	16,201	—	0	0	—	—	2	1	11	35	29
South Carolina§	—	426	2,105	11,440	9,506	N	0	0	N	N	—	1	14	19	15
Virginia§	517	490	685	11,433	10,802	N	0	0	N	N	—	1	5	18	17
West Virginia	46	54	86	1,284	1,361	N	0	0	N	N	—	0	3	4	2
E.S. Central	886	1,414	2,044	29,736	34,909	—	0	0	—	—	—	3	15	52	45
Alabama§	—	346	539	2,787	11,050	N	0	0	N	N	—	0	12	21	16
Kentucky	194	130	691	3,671	4,296	N	0	0	N	N	—	1	3	15	12
Mississippi	206	405	959	10,266	8,214	N	0	0	N	N	—	0	8	8	6
Tennessee§	486	531	697	13,012	11,349	N	0	0	N	N	—	1	5	8	11
W.S. Central	1,174	2,197	3,028	50,270	52,307	—	0	1	—	—	—	5	45	39	71
Arkansas§	164	167	337	3,654	3,635	N	0	0	N	N	—	0	3	3	8
Louisiana	1	328	610	7,142	8,107	—	0	1	—	—	—	1	9	14	13
Oklahoma	198	258	471	5,711	5,540	N	0	0	N	N	—	1	9	16	14
Texas§	811	1,452	1,911	33,763	35,025	N	0	0	N	N	—	1	36	6	36
Mountain	623	1,334	2,026	24,201	29,940	94	98	293	2,457	2,846	2	4	40	84	52
Arizona	36	463	993	6,569	9,173	93	97	293	2,403	2,764	—	0	6	18	6
Colorado	251	299	416	4,527	7,248	N	0	0	N	N	2	1	7	25	14
Idaho§	—	42	253	1,263	1,466	N	0	0	N	N	—	0	5	5	5
Montana§	—	53	144	1,145	1,041	N	0	0	N	N	—	0	26	5	7
Nevada§	189	170	397	4,056	3,541	1	1	3	19	35	—	0	3	4	3
New Mexico§	—	167	396	3,843	4,598	—	0	2	11	11	—	1	6	18	11
Utah	120	98	200	2,236	2,193	—	1	4	24	34	—	0	3	2	6
Wyoming§	27	26	45	562	680	—	0	0	—	2	—	0	11	7	—
Pacific	2,063	3,370	4,362	78,137	78,623	78	53	311	1,328	1,167	1	1	5	30	33
Alaska	54	88	157	1,968	1,937	N	0	0	N	N	—	0	1	—	1
California	1,244	2,674	3,627	61,278	61,250	78	53	311	1,328	1,167	—	0	0	—	—
Hawaii	—	106	130	2,241	2,632	N	0	0	N	N	—	0	1	—	—
Oregon§	152	160	394	4,193	4,364	N	0	0	N	N	1	1	5	30	32
Washington	613	344	621	8,457	8,440	N	0	0	N	N	—	0	0	—	—
American Samoa	U	0	32	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	16	24	—	425	—	0	0	—	—	—	0	0	—	—
Puerto Rico	108	122	234	3,344	2,156	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	U	3	8	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional. Data for HIV/AIDS, AIDS, and TB, when available, are displayed in Table IV, which appears quarterly.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 16, 2007, and June 17, 2006 (24th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes†				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	128	301	1,511	5,730	6,793	3,110	6,921	8,911	144,117	157,552	25	47	180	1,088	1,101
New England	1	23	67	394	501	59	114	259	2,544	2,463	2	3	19	71	74
Connecticut	—	5	25	99	120	—	45	204	944	923	—	0	6	20	19
Maine§	1	4	14	60	40	—	2	8	47	55	—	0	4	6	7
Massachusetts	—	9	26	157	229	48	49	96	1,244	1,130	—	2	5	36	34
New Hampshire	—	0	3	4	11	3	3	8	76	105	—	0	2	6	5
Rhode Island§	—	0	17	25	40	7	9	19	210	224	2	0	10	3	2
Vermont§	—	3	12	49	61	1	1	5	23	26	—	0	1	—	7
Mid. Atlantic	24	62	127	998	1,370	345	707	1,537	16,633	14,837	2	10	27	225	227
New Jersey	—	6	17	36	212	—	102	155	2,126	2,408	—	1	5	22	40
New York (Upstate)	21	25	108	382	442	88	115	1,035	2,527	2,766	1	3	15	64	65
New York City	1	16	32	328	419	127	188	376	4,452	4,577	—	2	6	45	42
Pennsylvania	2	14	34	252	297	130	251	610	7,528	5,086	1	3	10	94	80
E.N. Central	11	44	100	783	1,099	296	1,292	2,602	29,634	31,708	11	7	15	127	193
Illinois	—	10	30	109	275	—	353	485	7,349	9,109	—	2	6	23	59
Indiana	N	0	0	N	N	—	155	293	3,680	4,133	7	1	10	28	34
Michigan	3	14	38	258	295	180	285	880	6,649	5,868	—	0	5	13	18
Ohio	8	15	32	299	315	42	320	1,570	8,995	9,367	4	2	5	56	44
Wisconsin	—	9	27	117	214	74	131	181	2,961	3,231	—	1	4	7	38
W.N. Central	3	21	553	367	723	201	390	515	8,615	8,559	—	3	24	63	57
Iowa	—	5	16	83	107	—	41	63	796	803	—	0	1	1	—
Kansas	2	3	11	57	68	62	43	88	1,054	1,033	—	0	2	7	12
Minnesota	—	0	514	12	279	—	66	87	1,239	1,400	—	1	17	24	24
Missouri	—	9	28	152	190	112	201	268	4,730	4,539	—	1	5	23	17
Nebraska§	1	2	9	37	37	27	28	57	651	570	—	0	2	7	3
North Dakota	—	0	16	5	8	—	3	7	32	54	—	0	2	1	1
South Dakota	—	1	6	21	34	—	6	15	113	160	—	0	0	—	—
S. Atlantic	27	53	106	1,061	1,010	769	1,653	3,209	33,495	38,043	4	11	34	286	279
Delaware	—	1	4	15	11	14	27	44	622	678	—	0	3	5	1
District of Columbia	—	1	7	34	31	39	38	63	1,018	816	—	0	2	3	2
Florida	18	24	44	510	398	439	481	717	10,212	10,677	2	3	8	85	87
Georgia	4	10	27	186	235	—	327	2,068	4,342	7,275	1	2	7	56	66
Maryland§	4	4	12	102	88	137	130	228	2,825	3,282	—	2	5	48	36
North Carolina	—	0	0	—	—	—	317	676	6,529	7,757	—	1	9	36	23
South Carolina§	—	1	8	33	51	—	179	1,026	4,817	4,320	1	1	4	27	22
Virginia§	1	9	28	169	186	131	124	238	2,785	2,871	—	1	6	15	32
West Virginia	—	0	21	12	10	9	18	44	345	367	—	0	6	11	10
E.S. Central	3	9	34	185	171	386	548	879	10,954	13,856	4	2	9	64	61
Alabama§	2	4	22	97	84	—	154	271	1,313	5,080	—	0	3	14	13
Kentucky	N	0	0	N	N	99	51	268	1,373	1,490	—	0	1	2	4
Mississippi	N	0	0	N	N	86	157	434	3,751	3,054	—	0	1	4	6
Tennessee§	1	5	12	88	87	201	194	240	4,517	4,232	4	1	6	44	38
W.S. Central	3	7	55	128	113	449	943	1,490	20,612	22,489	1	1	32	51	49
Arkansas§	2	3	13	55	31	77	79	142	1,739	2,042	—	0	2	3	4
Louisiana	—	1	6	23	38	—	210	366	4,360	4,703	—	0	3	4	11
Oklahoma	1	2	42	50	44	70	91	236	2,195	2,035	1	1	29	41	31
Texas§	N	0	0	N	N	302	561	938	12,318	13,709	—	0	2	3	3
Mountain	24	30	67	581	626	177	277	454	4,552	6,574	1	4	11	139	115
Arizona	—	3	11	78	66	27	103	220	1,381	2,218	—	2	6	59	43
Colorado	8	9	26	186	205	70	67	93	1,089	1,660	1	1	4	30	33
Idaho§	6	3	12	51	69	—	2	20	84	87	—	0	1	4	3
Montana§	—	2	11	36	29	—	3	20	43	73	—	0	0	—	—
Nevada§	4	2	8	50	53	59	48	135	991	1,273	—	0	2	6	7
New Mexico§	—	2	6	45	24	—	30	64	603	797	—	0	4	18	18
Utah	6	7	27	120	173	18	16	28	330	399	—	0	3	20	10
Wyoming§	—	1	4	15	7	3	2	5	31	67	—	0	1	2	1
Pacific	32	57	558	1,233	1,180	428	757	935	17,078	19,023	—	2	16	62	46
Alaska	3	1	17	29	19	6	10	27	193	258	—	0	2	5	4
California	24	43	93	866	963	278	632	804	14,412	15,669	—	0	10	15	12
Hawaii	—	1	4	29	27	—	14	26	288	469	—	0	2	3	9
Oregon§	5	8	14	166	171	14	25	46	479	653	—	1	6	39	21
Washington	—	0	449	143	—	130	72	142	1,706	1,974	—	0	5	—	—
American Samoa	U	0	0	U	U	U	0	4	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	0	0	—	—	—	2	6	—	41	—	0	1	—	3
Puerto Rico	—	6	19	96	62	3	6	16	151	137	—	0	2	1	1
U.S. Virgin Islands	U	0	0	U	U	U	0	3	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for *H. influenzae* (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 16, 2007, and June 17, 2006 (24th Week)*

Reporting area	Hepatitis (viral, acute), by type† A: Current week	A: Previous 52 weeks Med	A: Previous 52 weeks Max	A: Cum 2007	A: Cum 2006	B: Current week	B: Previous 52 weeks Med	B: Previous 52 weeks Max	B: Cum 2007	B: Cum 2006	Legionellosis: Current week	Legionellosis: Previous 52 weeks Med	Legionellosis: Previous 52 weeks Max	Legionellosis: Cum 2007	Legionellosis: Cum 2006
United States	29	56	177	1,146	1,662	35	79	375	1,695	1,934	18	47	113	620	699
New England	—	2	6	29	95	—	2	5	30	62	2	2	13	27	35
Connecticut	—	1	3	8	16	—	0	5	15	27	—	0	9	4	10
Maine§	—	0	2	—	5	—	0	2	2	11	—	0	2	—	3
Massachusetts	—	1	4	8	48	—	0	2	2	12	—	1	8	13	18
New Hampshire	—	0	2	6	17	—	0	1	5	7	—	0	2	—	3
Rhode Island§	—	0	2	5	3	—	0	4	5	4	2	0	6	9	—
Vermont§	—	0	1	2	6	—	0	1	1	1	—	0	2	1	1
Mid. Atlantic	5	7	20	163	175	2	10	21	207	244	6	15	55	162	200
New Jersey	—	2	5	41	57	—	2	6	44	81	—	2	10	19	32
New York (Upstate)	1	1	11	33	38	2	1	13	41	28	4	5	30	52	63
New York City	—	2	10	52	52	—	2	6	40	56	—	3	24	23	34
Pennsylvania	4	1	5	37	28	—	3	7	82	79	2	5	19	68	71
E.N. Central	—	6	17	110	143	4	9	23	195	236	4	10	31	115	143
Illinois	—	2	7	30	32	—	2	6	43	75	—	1	13	1	26
Indiana	—	0	7	7	13	3	0	21	20	18	—	1	6	9	9
Michigan	—	2	8	34	47	—	2	8	52	69	1	3	10	43	31
Ohio	—	1	4	32	35	1	3	10	69	55	3	3	19	58	60
Wisconsin	—	0	4	7	16	—	0	3	11	19	—	0	3	4	17
W.N. Central	7	2	17	75	67	1	2	15	61	62	—	1	16	23	20
Iowa	—	0	4	14	5	—	0	3	10	9	—	0	3	3	2
Kansas	—	0	1	2	20	—	0	1	5	8	—	0	3	1	1
Minnesota	6	0	17	42	6	1	0	13	8	6	—	0	11	5	—
Missouri	—	0	2	8	20	—	1	5	31	34	—	0	2	11	9
Nebraska§	1	0	2	5	9	—	0	3	5	4	—	0	1	2	5
North Dakota	—	0	3	—	—	—	0	1	—	—	—	0	1	—	—
South Dakota	—	0	1	4	7	—	0	1	2	1	—	0	1	1	3
S. Atlantic	8	10	27	201	218	18	21	56	450	551	3	8	25	140	156
Delaware	—	0	1	2	9	—	0	3	6	23	—	0	2	1	3
District of Columbia	—	0	5	14	2	—	0	2	1	4	—	0	5	1	5
Florida	2	3	13	65	78	10	7	14	165	194	2	2	9	61	70
Georgia	2	1	4	30	20	—	3	10	49	92	—	1	3	12	10
Maryland§	3	1	6	32	29	1	2	7	43	74	—	2	8	27	29
North Carolina	—	0	11	7	45	7	0	16	63	84	1	0	5	18	14
South Carolina§	—	0	3	5	10	—	2	5	33	34	—	0	2	6	3
Virginia§	1	1	5	44	24	—	2	7	65	19	—	1	4	11	20
West Virginia	—	0	3	2	1	—	0	23	25	27	—	0	4	3	2
E.S. Central	2	2	7	40	55	3	6	20	127	165	—	2	7	36	41
Alabama§	—	0	2	7	4	—	2	10	46	44	—	0	1	4	7
Kentucky	1	0	2	6	23	—	1	3	11	37	—	1	6	15	12
Mississippi	—	0	4	6	4	—	0	8	10	22	—	0	2	—	1
Tennessee§	1	1	5	21	24	3	3	8	60	62	—	1	3	17	21
W.S. Central	—	6	19	78	151	3	18	142	303	336	1	1	15	30	19
Arkansas§	—	0	2	4	32	—	1	7	10	29	—	0	2	3	1
Louisiana	—	1	4	11	9	—	1	6	19	24	—	0	2	1	6
Oklahoma	—	0	3	3	4	1	1	24	14	12	1	0	6	1	1
Texas§	—	5	15	60	106	2	15	108	260	271	—	1	12	25	11
Mountain	2	5	17	138	142	2	3	9	100	59	2	2	8	38	43
Arizona	—	4	14	110	77	—	0	5	41	—	—	0	4	12	14
Colorado	2	1	3	14	23	—	1	2	16	18	—	0	2	6	5
Idaho§	—	0	1	2	7	1	0	2	5	6	1	0	3	3	6
Montana§	—	0	3	2	5	—	0	0	—	—	—	0	1	1	3
Nevada§	—	0	2	6	8	—	1	5	22	17	—	0	2	3	4
New Mexico§	—	0	2	1	11	—	0	2	4	8	—	0	2	2	1
Utah	—	0	1	2	10	1	0	4	12	10	1	0	2	8	10
Wyoming§	—	0	1	1	1	—	0	1	—	—	—	0	1	3	—
Pacific	5	14	92	312	616	2	10	106	222	219	—	1	11	49	42
Alaska	—	0	1	2	1	—	0	3	4	1	—	0	1	—	—
California	5	13	40	281	587	2	8	31	169	175	—	1	11	39	42
Hawaii	—	0	2	2	6	—	0	1	—	5	—	0	1	1	—
Oregon§	—	1	3	16	22	—	1	5	30	38	—	0	1	2	—
Washington	—	0	52	11	—	—	0	74	19	—	—	0	2	7	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	1	10	25	25	2	1	9	27	24	—	0	2	3	1
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for acute hepatitis C, viral are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 16, 2007, and June 17, 2006 (24th Week)*

Reporting area	Lyme disease					Malaria					Meningococcal disease, invasive† All serogroups				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	207	223	1,177	3,294	3,942	14	23	80	363	548	6	18	84	509	634
New England	42	36	409	292	685	—	1	7	13	26	—	1	3	21	20
Connecticut	37	10	227	150	95	—	0	3	1	4	—	0	2	4	8
Maine§	—	2	38	24	37	—	0	1	3	3	—	0	3	4	2
Massachusetts	—	2	145	2	414	—	0	2	8	15	—	0	2	10	8
New Hampshire	5	6	70	99	126	—	0	3	1	3	—	0	1	—	1
Rhode Island§	—	0	93	—	1	—	0	1	—	—	—	0	1	1	—
Vermont§	—	1	15	17	12	—	0	0	—	1	—	0	1	2	1
Mid. Atlantic	104	108	560	1,706	2,030	4	5	18	90	130	1	2	8	59	105
New Jersey	—	25	192	402	794	—	0	7	—	42	—	0	2	1	11
New York (Upstate)	77	50	426	457	512	3	1	7	24	10	1	1	2	17	21
New York City	—	2	23	6	42	1	3	9	56	65	—	0	4	17	39
Pennsylvania	27	42	223	841	682	—	1	4	10	13	—	0	5	24	34
E.N. Central	1	5	162	59	546	—	2	10	39	62	—	3	9	71	93
Illinois	—	0	16	4	29	—	1	6	10	26	—	0	3	18	25
Indiana	1	0	3	6	3	—	0	2	4	6	—	0	4	14	12
Michigan	—	1	5	9	6	—	0	2	7	8	—	0	3	14	16
Ohio	—	0	5	4	15	—	0	2	11	16	—	1	3	19	27
Wisconsin	—	4	154	36	493	—	0	3	7	6	—	0	2	6	13
W.N. Central	15	5	195	93	101	—	1	12	19	21	—	1	5	32	36
Iowa	—	1	8	17	39	—	0	1	2	1	—	0	3	7	9
Kansas	—	0	2	6	3	—	0	2	1	—	—	0	1	1	1
Minnesota	15	2	188	63	52	—	0	12	11	14	—	0	3	9	8
Missouri	—	0	3	5	—	—	0	1	2	3	—	0	3	9	11
Nebraska§	—	0	2	2	6	—	0	1	2	1	—	0	1	2	5
North Dakota	—	0	7	—	—	—	0	1	—	1	—	0	3	2	1
South Dakota	—	0	0	—	1	—	0	1	1	1	—	0	1	2	1
S. Atlantic	42	45	134	1,051	545	5	5	14	91	150	4	3	11	76	109
Delaware	—	9	28	227	186	—	0	1	2	4	—	0	1	1	4
District of Columbia	—	0	7	13	8	—	0	2	3	—	—	0	1	—	—
Florida	1	1	3	16	8	2	1	4	20	21	2	1	7	28	43
Georgia	—	0	1	1	2	—	1	5	9	48	1	0	3	9	10
Maryland§	9	24	106	577	298	1	1	4	24	39	—	0	2	16	7
North Carolina	6	0	4	14	9	1	0	4	12	11	—	0	6	6	19
South Carolina§	1	0	2	9	4	—	0	2	4	4	1	0	2	8	11
Virginia§	25	9	36	190	30	1	1	4	16	22	—	0	2	8	12
West Virginia	—	0	14	4	—	—	0	1	1	1	—	0	2	—	3
E.S. Central	2	1	4	17	4	—	0	3	15	12	—	1	4	29	21
Alabama§	—	0	3	5	1	—	0	2	3	6	—	0	2	6	4
Kentucky	—	0	2	—	—	—	0	1	3	1	—	0	2	5	5
Mississippi	—	0	1	—	—	—	0	1	1	3	—	0	4	7	3
Tennessee§	2	0	3	12	3	—	0	2	8	2	—	0	2	11	9
W.S. Central	—	1	6	18	5	2	1	7	16	32	—	2	13	50	60
Arkansas§	—	0	0	—	—	—	0	2	—	1	—	0	2	6	6
Louisiana	—	0	1	2	—	—	0	2	12	1	—	0	4	14	27
Oklahoma	—	0	0	—	—	2	0	3	3	2	—	0	4	11	8
Texas§	—	1	6	16	5	—	0	6	1	28	—	0	9	19	19
Mountain	—	0	3	9	4	3	1	6	25	28	—	1	5	42	37
Arizona	—	0	1	—	3	—	0	3	5	9	—	0	3	12	10
Colorado	—	0	0	—	—	—	0	2	9	10	—	0	2	14	14
Idaho§	—	0	2	3	—	—	0	1	—	—	—	0	1	3	1
Montana§	—	0	1	1	—	—	0	1	2	1	—	0	1	1	2
Nevada§	—	0	2	5	—	—	0	1	1	—	—	0	1	3	3
New Mexico§	—	0	1	—	1	—	0	1	—	1	—	0	1	1	1
Utah	—	0	1	—	—	3	0	2	8	7	—	0	2	7	4
Wyoming§	—	0	1	—	—	—	0	0	—	—	—	0	2	1	2
Pacific	1	2	16	49	22	—	3	45	55	87	1	4	48	129	153
Alaska	—	0	1	2	—	—	0	4	2	10	—	0	1	1	2
California	1	2	8	46	22	—	2	6	39	68	1	2	10	93	122
Hawaii	N	0	0	N	N	—	0	1	2	3	—	0	1	2	4
Oregon§	—	0	1	1	—	—	0	3	9	6	—	0	3	19	25
Washington	—	0	8	—	—	—	0	43	3	—	—	0	43	14	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	1	—	—	0	1	5	4
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for meningococcal disease, invasive caused by serogroups A, C, Y, & W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 16, 2007, and June 17, 2006 (24th Week)*

Reporting area	Pertussis					Rabies, animal					Rocky Mountain spotted fever				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	62	249	1,428	3,413	6,075	43	95	168	1,869	2,210	11	31	210	424	578
New England	1	32	77	471	725	5	11	22	237	163	—	0	10	—	6
Connecticut	—	2	10	18	30	5	4	14	81	68	—	0	0	—	—
Maine†	1	2	15	36	23	—	2	8	37	40	N	0	0	N	N
Massachusetts	—	21	46	369	453	—	0	0	—	—	—	0	1	—	5
New Hampshire	—	2	9	27	123	—	1	4	17	11	—	0	0	—	1
Rhode Island†	—	0	31	1	22	—	0	3	18	12	—	0	9	—	—
Vermont†	—	1	9	20	74	—	2	13	84	32	—	0	0	—	—
Mid. Atlantic	18	34	155	540	759	—	13	38	303	189	—	1	6	18	24
New Jersey	—	3	16	60	145	—	0	0	—	—	—	0	4	—	13
New York (Upstate)	17	18	146	293	277	—	—	—	—	—	—	0	0	—	—
New York City	—	2	6	51	42	—	1	5	24	5	—	0	3	8	4
Pennsylvania	1	9	20	136	295	—	11	37	279	184	—	0	3	10	7
E.N. Central	23	41	80	692	873	5	2	18	44	38	—	0	9	6	24
Illinois	—	9	23	68	232	—	0	7	3	9	—	0	4	1	14
Indiana	2	2	45	16	86	—	0	2	5	3	—	0	1	1	2
Michigan	1	10	39	119	162	4	0	5	12	20	—	0	1	1	—
Ohio	20	14	56	379	284	1	0	12	24	6	—	0	4	3	7
Wisconsin	—	3	20	110	109	—	0	0	—	—	—	0	0	—	1
W.N. Central	—	17	151	202	628	6	6	19	105	112	—	3	13	67	55
Iowa	—	4	16	62	165	—	0	7	13	16	—	0	1	1	2
Kansas	—	3	14	71	132	6	2	6	66	34	—	0	1	—	—
Minnesota	—	0	119	—	78	—	0	6	6	12	—	0	2	1	1
Missouri	—	3	10	37	173	—	1	6	8	12	—	3	12	61	46
Nebraska†	—	1	4	12	63	—	0	0	—	—	—	0	5	3	6
North Dakota	—	0	18	4	4	—	0	6	7	13	—	0	0	—	—
South Dakota	—	0	4	16	13	—	0	3	5	25	—	0	1	1	—
S. Atlantic	16	19	163	422	481	22	40	63	907	1,020	4	15	67	216	355
Delaware	—	0	1	3	2	—	0	0	—	—	—	0	3	5	8
District of Columbia	—	0	2	2	3	—	0	0	—	—	—	0	1	1	—
Florida	2	4	18	105	99	—	0	24	61	176	—	0	4	7	8
Georgia	—	1	7	6	37	—	4	9	81	112	—	0	5	5	18
Maryland†	3	2	7	58	79	—	6	12	128	140	1	1	7	20	26
North Carolina	11	1	112	159	87	10	11	21	231	184	—	9	61	131	272
South Carolina†	—	3	11	40	65	—	3	11	46	70	—	1	5	13	5
Virginia†	—	2	17	42	98	12	12	31	323	290	3	2	12	33	17
West Virginia	—	0	19	7	11	—	1	8	37	48	—	0	2	1	1
E.S. Central	1	5	24	89	134	—	3	11	61	120	6	6	27	83	82
Alabama†	—	1	17	28	31	—	0	8	—	36	1	1	9	24	20
Kentucky	—	0	5	2	23	—	0	4	9	7	—	0	1	1	—
Mississippi	—	0	10	12	18	—	0	0	—	4	—	0	1	2	—
Tennessee†	1	3	9	47	62	—	2	8	52	73	5	4	22	56	62
W.S. Central	1	17	186	219	318	—	15	35	56	406	—	1	167	25	20
Arkansas†	1	2	17	59	31	—	0	5	11	17	—	0	53	1	16
Louisiana	—	0	2	6	16	—	0	1	—	2	—	0	1	—	—
Oklahoma	—	0	36	2	10	—	1	22	45	30	—	0	108	20	1
Texas†	—	14	134	152	261	—	10	34	—	357	—	0	6	4	3
Mountain	1	28	63	553	1,488	3	2	28	59	73	1	0	4	8	10
Arizona	—	6	17	139	325	2	2	10	45	58	—	0	2	—	3
Colorado	—	7	18	141	498	—	0	0	—	—	1	0	1	1	1
Idaho†	—	1	7	21	38	—	0	24	—	—	—	0	3	2	—
Montana†	—	1	8	30	58	—	0	2	1	7	—	0	2	—	—
Nevada†	—	0	9	3	41	—	0	1	—	—	—	0	0	—	—
New Mexico†	—	2	8	23	46	—	0	2	4	5	—	0	1	—	3
Utah	1	9	48	182	450	1	0	1	5	2	—	0	0	—	—
Wyoming†	—	1	8	14	32	—	0	2	4	1	—	0	2	5	3
Pacific	1	23	547	225	669	2	4	13	97	89	—	0	1	1	2
Alaska	1	1	8	16	34	—	0	6	35	14	N	0	0	N	N
California	—	18	225	99	506	2	3	12	61	73	—	0	0	—	—
Hawaii	—	0	5	10	56	N	0	0	N	N	N	0	0	N	N
Oregon†	—	1	11	43	73	—	0	4	1	2	—	0	1	1	2
Washington	—	0	377	57	—	—	0	0	—	—	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	1	7	—	14	—	0	0	—	—	N	0	0	N	N
Puerto Rico	—	0	1	—	—	—	1	4	19	51	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 16, 2007, and June 17, 2006 (24th Week)*

Reporting area	Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†					Shigellosis				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006
United States	447	828	1,899	13,642	14,348	36	68	315	1,032	1,007	275	283	879	5,374	4,679
New England	4	34	153	645	1,074	1	3	21	63	120	—	4	16	83	155
Connecticut	—	0	139	139	503	—	0	16	16	75	—	0	13	13	67
Maine§	1	2	14	47	41	1	1	8	16	6	—	0	5	12	2
Massachusetts	—	21	60	335	415	—	1	6	21	30	—	2	11	50	76
New Hampshire	—	3	15	49	64	—	0	3	5	6	—	0	2	3	3
Rhode Island§	3	2	20	48	35	—	0	2	2	1	—	0	3	4	5
Vermont§	—	1	6	27	16	—	0	4	3	2	—	0	2	1	2
Mid. Atlantic	44	96	189	1,771	1,731	2	8	63	105	121	2	12	47	203	421
New Jersey	—	16	50	148	365	—	1	20	9	34	—	2	18	22	180
New York (Upstate)	28	27	112	520	364	1	3	15	45	41	1	3	42	45	90
New York City	4	24	45	463	466	—	0	4	11	19	—	5	12	104	114
Pennsylvania	12	32	66	640	536	1	3	47	40	27	1	1	6	32	37
E.N. Central	61	97	203	1,860	2,092	4	9	63	119	155	71	25	75	429	464
Illinois	—	29	65	478	613	—	1	8	13	18	—	10	53	70	152
Indiana	16	15	55	249	223	1	1	8	13	20	2	2	17	28	61
Michigan	11	18	35	313	392	2	1	6	24	29	—	1	5	16	84
Ohio	34	24	56	491	492	1	3	18	47	46	69	4	22	244	78
Wisconsin	—	17	48	329	372	—	2	41	22	42	—	3	14	71	89
W.N. Central	16	50	109	1,027	897	7	11	45	160	155	6	41	156	921	609
Iowa	—	8	26	154	155	—	2	38	31	34	—	2	14	31	30
Kansas	4	7	20	168	137	3	0	4	16	7	3	1	10	16	41
Minnesota	12	13	60	261	199	4	3	26	65	43	3	5	24	111	39
Missouri	—	15	35	286	263	—	2	13	28	48	—	14	72	732	386
Nebraska§	—	3	11	75	82	—	1	11	19	15	—	1	14	8	37
North Dakota	—	0	23	15	6	—	0	12	—	2	—	0	127	4	3
South Dakota	—	3	11	68	55	—	0	5	1	6	—	5	24	19	73
S. Atlantic	169	225	401	3,512	3,359	10	13	32	227	171	124	77	150	1,971	1,119
Delaware	—	2	10	41	35	—	0	3	7	1	—	0	2	4	—
District of Columbia	—	1	4	16	27	—	0	1	1	—	—	0	5	4	6
Florida	83	93	176	1,507	1,452	6	2	8	63	33	71	41	76	1,215	497
Georgia	33	28	73	498	501	2	2	7	25	28	50	27	63	624	397
Maryland§	12	14	32	263	222	—	3	9	37	28	—	2	10	28	37
North Carolina	28	31	130	538	507	1	2	11	36	31	—	1	14	28	90
South Carolina§	4	19	47	288	297	—	0	3	5	4	1	1	4	31	66
Virginia§	9	20	58	313	280	1	3	11	52	46	2	2	9	36	26
West Virginia	—	1	31	48	38	—	0	5	1	—	—	0	2	1	—
E.S. Central	26	53	140	909	863	—	4	21	53	78	25	17	89	482	304
Alabama§	4	13	78	259	278	—	0	4	10	11	14	6	67	199	80
Kentucky	9	9	23	180	163	—	1	12	14	18	7	2	15	69	142
Mississippi	—	12	101	176	186	—	0	3	1	1	—	2	76	129	33
Tennessee§	13	17	32	294	236	—	2	9	28	48	4	4	14	85	49
W.S. Central	32	84	189	1,016	1,460	1	4	52	63	53	27	38	249	518	655
Arkansas§	16	13	45	178	315	1	1	7	14	10	2	2	10	46	34
Louisiana	—	18	48	143	324	—	0	0	—	—	—	5	25	89	69
Oklahoma	16	10	103	159	137	—	0	17	12	5	7	2	63	41	42
Texas§	—	41	107	536	684	—	2	48	37	38	18	27	174	342	510
Mountain	34	50	88	1,000	1,047	8	8	34	134	121	12	21	84	320	362
Arizona	9	17	44	349	301	1	2	9	45	29	9	10	37	166	193
Colorado	11	11	21	253	312	2	1	8	21	26	—	3	15	46	53
Idaho§	5	3	9	49	59	5	2	8	20	23	—	0	3	4	6
Montana§	—	2	10	36	61	—	0	0	—	—	—	0	13	13	3
Nevada§	2	4	20	81	69	—	0	5	10	11	2	1	20	15	42
New Mexico§	—	5	15	84	88	—	1	5	18	12	—	2	15	44	40
Utah	7	4	14	112	129	—	2	14	20	15	1	1	4	9	22
Wyoming§	—	1	4	36	28	—	0	3	—	5	—	0	19	23	3
Pacific	61	106	890	1,902	1,825	3	4	164	108	33	8	33	256	447	590
Alaska	3	1	5	37	34	N	0	0	N	N	—	0	2	6	4
California	58	90	260	1,466	1,517	3	0	8	64	N	7	28	84	361	504
Hawaii	—	5	16	88	96	—	0	3	6	5	—	0	3	13	19
Oregon§	—	7	17	117	178	—	1	9	14	28	1	1	6	25	63
Washington	—	0	625	194	—	—	0	162	24	—	—	0	170	42	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	0	0	—	—	N	0	0	N	N	—	0	0	—	—
Puerto Rico	2	15	66	270	170	—	0	0	—	—	—	1	6	13	9
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes *E. coli* O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 16, 2007, and June 17, 2006 (24th Week)*

Reporting area	Streptococcal disease, invasive, group A					*Streptococcus pneumoniae*, invasive disease† Age <5 years				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max		
United States	75	86	253	2,627	3,075	25	28	105	785	713
New England	—	5	29	183	195	—	2	11	57	64
Connecticut	—	0	17	35	55	—	0	6	—	21
Maine§	—	0	3	18	9	—	0	1	1	—
Massachusetts	—	3	10	95	99	—	1	6	42	37
New Hampshire	—	0	5	22	21	—	0	2	7	6
Rhode Island§	—	0	12	—	4	—	0	3	5	—
Vermont§	—	0	2	13	7	—	0	1	2	—
Mid. Atlantic	8	15	41	512	580	3	4	20	95	100
New Jersey	—	2	8	69	106	—	1	4	14	40
New York (Upstate)	7	5	27	170	175	3	2	15	58	51
New York City	—	3	11	111	103	—	1	3	23	9
Pennsylvania	1	6	11	162	196	N	0	0	N	N
E.N. Central	14	15	30	475	632	8	5	14	109	191
Illinois	—	5	12	118	196	—	1	6	9	54
Indiana	2	2	12	67	68	4	0	10	13	23
Michigan	2	3	10	115	129	2	1	4	45	47
Ohio	10	4	14	156	166	2	1	7	37	39
Wisconsin	—	1	6	19	73	—	0	2	5	28
W.N. Central	7	5	32	199	192	—	2	8	61	51
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	—	1	3	24	38	—	0	1	1	9
Minnesota	7	0	29	97	83	—	1	6	41	26
Missouri	—	2	6	50	37	—	0	2	13	10
Nebraska§	—	0	3	15	19	—	0	2	5	4
North Dakota	—	0	2	9	8	—	0	2	1	2
South Dakota	—	0	2	4	7	—	0	0	—	—
S. Atlantic	28	20	48	596	661	8	3	14	157	47
Delaware	—	0	2	4	7	—	0	0	—	—
District of Columbia	—	0	3	8	8	—	0	1	—	—
Florida	16	6	16	154	133	2	0	5	35	—
Georgia	4	5	11	111	151	2	0	5	44	—
Maryland§	5	4	8	111	130	2	1	6	39	39
North Carolina	—	0	26	56	93	—	0	0	—	—
South Carolina§	—	1	7	58	43	1	0	3	17	—
Virginia§	3	2	11	78	79	—	0	3	19	—
West Virginia	—	0	3	16	17	1	0	4	3	8
E.S. Central	3	4	9	109	132	1	1	6	50	11
Alabama§	N	0	0	N	N	N	0	0	N	N
Kentucky	—	1	3	28	33	—	0	0	—	—
Mississippi	N	0	0	N	N	—	0	2	2	11
Tennessee§	3	3	6	81	99	1	0	6	48	—
W.S. Central	3	6	82	161	226	4	4	40	122	113
Arkansas§	—	0	2	14	18	—	0	2	7	15
Louisiana	—	0	2	4	10	—	0	4	25	16
Oklahoma	1	2	23	43	61	4	1	13	29	23
Texas§	2	3	56	100	137	—	1	24	61	59
Mountain	10	10	23	327	410	—	4	12	114	123
Arizona	4	5	11	130	213	—	2	7	63	72
Colorado	4	3	9	98	68	—	1	4	33	30
Idaho§	—	0	1	6	6	—	0	1	2	1
Montana§	N	0	0	N	N	N	0	0	N	N
Nevada§	—	0	1	2	2	—	0	1	1	—
New Mexico§	—	1	6	29	78	—	0	4	15	20
Utah	2	1	7	58	40	—	0	0	—	—
Wyoming§	—	0	1	4	3	—	0	0	—	—
Pacific	2	3	9	65	47	1	0	4	20	13
Alaska	2	0	2	17	N	1	0	2	18	—
California	N	0	0	N	N	N	0	0	N	N
Hawaii	—	2	9	48	47	—	0	2	2	13
Oregon§	N	0	0	N	N	N	0	0	N	N
Washington	N	0	0	N	N	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U
Guam	—	0	0	—	—	N	0	0	N	N
Puerto Rico	—	0	0	—	—	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease, in children aged <5 years, caused by *S. pneumoniae*, which is susceptible or for which susceptibility testing is not available (NNDSS event code 11717).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 16, 2007, and June 17, 2006 (24th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease, drug resistant†										Syphilis, primary and secondary				
	All ages					Age <5 years									
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	36	44	254	1,276	1,414	7	8	35	225	217	125	193	310	4,137	4,112
New England	—	1	12	27	81	—	0	3	5	2	3	4	13	98	89
Connecticut	—	0	5	—	62	—	0	0	—	—	—	0	10	12	19
Maine§	—	0	2	6	5	—	0	2	1	1	—	0	1	2	7
Massachusetts	—	0	0	—	—	—	0	0	—	—	2	3	7	60	49
New Hampshire	—	0	0	—	—	—	0	0	—	—	—	0	2	11	5
Rhode Island§	—	0	4	10	6	—	0	1	2	—	1	0	5	12	7
Vermont§	—	0	2	11	8	—	0	1	2	1	—	0	1	1	2
Mid. Atlantic	—	3	9	79	85	1	0	5	19	11	31	24	43	720	532
New Jersey	—	0	0	—	—	—	0	0	—	—	—	3	8	75	81
New York (Upstate)	—	1	5	27	26	—	0	4	7	5	7	2	14	58	73
New York City	—	0	0	—	—	—	0	0	—	—	20	15	34	476	252
Pennsylvania	—	2	6	52	59	1	0	2	12	6	4	5	12	111	126
E.N. Central	13	10	40	329	322	3	1	7	40	51	7	15	32	310	394
Illinois	—	0	2	5	18	—	0	1	1	4	—	6	13	123	217
Indiana	4	2	31	83	76	1	0	5	9	14	—	1	5	18	37
Michigan	—	0	1	1	15	—	0	0	—	2	2	2	10	48	36
Ohio	9	5	38	240	213	2	1	5	30	31	3	4	9	94	85
Wisconsin	N	0	0	N	N	—	0	0	—	—	2	1	4	27	19
W.N. Central	—	1	124	92	25	—	0	15	6	1	10	5	14	134	124
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	4	8
Kansas	—	0	10	48	—	—	0	2	2	—	—	0	3	8	11
Minnesota	—	0	123	—	—	—	0	15	—	—	—	1	5	35	28
Missouri	—	1	5	36	25	—	0	1	—	1	10	3	8	85	74
Nebraska§	—	0	1	2	—	—	0	0	—	—	—	0	2	1	2
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	1
South Dakota	—	0	3	6	—	—	0	1	4	—	—	0	3	1	—
S. Atlantic	18	20	59	566	673	3	4	15	120	103	39	42	180	934	892
Delaware	—	0	1	5	—	—	0	1	1	—	—	0	3	6	12
District of Columbia	—	0	2	5	17	—	0	0	—	2	10	2	11	82	51
Florida	13	11	29	337	346	1	2	8	70	67	16	14	25	352	324
Georgia	5	6	16	182	237	2	1	10	42	34	—	4	153	55	111
Maryland§	—	0	1	1	—	—	0	0	—	—	5	5	15	129	155
North Carolina	—	0	0	—	—	—	0	0	—	—	6	5	23	163	137
South Carolina§	—	0	0	—	—	—	0	0	—	—	—	1	10	46	36
Virginia§	N	0	0	N	N	—	0	0	—	—	1	4	17	97	64
West Virginia	—	1	17	36	73	—	0	1	7	—	1	0	2	4	2
E.S. Central	4	2	9	81	106	—	0	3	16	19	10	15	29	331	268
Alabama§	N	0	0	N	N	—	0	0	—	—	—	5	17	105	110
Kentucky	—	0	2	16	25	—	0	1	2	4	1	1	7	35	33
Mississippi	—	0	0	—	—	—	0	0	—	—	2	2	9	55	26
Tennessee§	4	2	8	65	81	—	0	3	14	15	7	5	12	136	99
W.S. Central	1	1	9	69	60	—	0	2	10	6	16	29	55	689	637
Arkansas§	—	0	3	1	8	—	0	0	—	2	2	1	7	49	36
Louisiana	—	1	3	24	52	—	0	1	2	4	3	6	29	158	92
Oklahoma	1	0	8	44	—	—	0	2	8	—	—	1	5	32	34
Texas§	—	0	0	—	—	—	0	0	—	—	11	21	31	450	475
Mountain	—	1	5	33	62	—	0	5	9	24	1	7	27	119	232
Arizona	—	0	0	—	—	—	0	0	—	—	—	2	16	31	88
Colorado	—	0	0	—	—	—	0	0	—	—	—	1	5	15	39
Idaho§	N	0	0	N	N	—	0	0	—	—	—	0	1	1	2
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	1	1	1
Nevada§	—	0	3	15	15	—	0	2	5	—	1	2	12	39	66
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	1	7	27	32
Utah	—	0	5	9	25	—	0	4	3	16	—	0	2	4	4
Wyoming§	—	0	3	9	22	—	0	1	1	8	—	0	1	1	—
Pacific	—	0	0	—	—	—	0	0	—	—	8	38	57	802	944
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	2	5	5
California	N	0	0	N	N	—	0	0	—	—	4	35	54	731	831
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	1	3	12
Oregon§	N	0	0	N	N	—	0	0	—	—	—	0	6	8	8
Washington	N	0	0	N	N	—	0	0	—	—	4	2	11	55	88
American Samoa	U	0	0	U	U	U	0	1	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	0	—	—	5	3	11	66	71
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease caused by drug-resistant *S. pneumoniae* (DRSP) (NNDSS event code 11720).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 16, 2007, and June 17, 2006 (24th Week)*

Reporting area	Varicella (chickenpox)					West Nile virus disease†									
						Neuroinvasive					Non-neuroinvasive§				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	238	764	2,152	21,901	28,445	—	1	178	3	22	—	1	417	3	17
New England	12	23	151	384	2,808	—	0	3	—	—	—	0	2	—	—
Connecticut	—	7	76	1	1,000	—	0	3	—	—	—	0	1	—	—
Maine¶	—	0	7	—	166	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	63	—	991	—	0	1	—	—	—	0	1	—	—
New Hampshire	4	7	17	157	217	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Vermont¶	8	9	66	226	434	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	30	103	195	2,671	2,972	—	0	11	—	—	—	0	4	—	—
New Jersey	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
New York (Upstate)	N	0	0	N	N	—	0	5	—	—	—	0	1	—	—
New York City	—	0	0	—	—	—	0	4	—	—	—	0	2	—	—
Pennsylvania	30	103	195	2,671	2,972	—	0	2	—	—	—	0	1	—	—
E.N. Central	103	214	568	6,257	9,689	—	0	42	—	2	—	0	33	—	1
Illinois	—	2	11	75	76	—	0	24	—	1	—	0	22	—	—
Indiana	—	0	0	—	—	—	0	5	—	1	—	0	12	—	—
Michigan	39	85	258	2,442	2,883	—	0	10	—	—	—	0	4	—	—
Ohio	64	112	449	3,170	6,017	—	0	11	—	—	—	0	3	—	—
Wisconsin	—	16	57	570	713	—	0	2	—	—	—	0	2	—	1
W.N. Central	—	32	136	1,158	1,158	—	0	37	—	3	—	0	78	2	4
Iowa	N	0	0	N	N	—	0	3	—	1	—	0	4	1	1
Kansas	—	9	52	422	222	—	0	3	—	—	—	0	3	—	—
Minnesota	—	0	0	—	—	—	0	7	—	—	—	0	7	—	—
Missouri	—	17	78	597	879	—	0	14	—	1	—	0	2	—	—
Nebraska¶	N	0	0	N	N	—	0	9	—	1	—	0	38	—	2
North Dakota	—	0	60	84	25	—	0	5	—	—	—	0	28	—	1
South Dakota	—	2	15	55	32	—	0	7	—	—	—	0	22	1	—
S. Atlantic	33	90	239	2,772	2,696	—	0	2	—	—	—	0	7	—	—
Delaware	—	1	6	19	42	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	8	14	19	—	0	0	—	—	—	0	1	—	—
Florida	21	0	90	729	N	—	0	1	—	—	—	0	0	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	4	—	—
Maryland¶	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
North Carolina	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
South Carolina¶	7	18	72	646	754	—	0	1	—	—	—	0	0	—	—
Virginia¶	—	26	190	693	934	—	0	0	—	—	—	0	2	—	—
West Virginia	5	25	50	671	947	—	0	1	—	—	—	0	0	—	—
E.S. Central	1	1	571	292	25	—	0	15	3	3	—	0	17	1	1
Alabama¶	1	1	571	290	25	—	0	2	—	—	—	0	0	—	—
Kentucky	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
Mississippi	—	0	2	2	—	—	0	10	3	3	—	0	16	1	1
Tennessee¶	N	0	0	N	N	—	0	5	—	—	—	0	2	—	—
W.S. Central	45	200	979	6,649	7,334	—	0	59	—	11	—	0	27	—	2
Arkansas¶	3	9	105	221	470	—	0	5	—	—	—	0	2	—	—
Louisiana	—	1	11	49	173	—	0	13	—	—	—	0	10	—	1
Oklahoma	—	0	0	—	—	—	0	6	—	—	—	0	4	—	—
Texas¶	42	172	873	6,379	6,691	—	0	39	—	11	—	0	16	—	1
Mountain	14	56	133	1,694	1,763	—	0	63	—	2	—	0	245	—	6
Arizona	—	0	0	—	—	—	0	10	—	—	—	0	14	—	1
Colorado	12	22	62	631	911	—	0	11	—	2	—	0	51	—	2
Idaho¶	N	0	0	N	N	—	0	32	—	—	—	0	174	—	3
Montana¶	—	2	40	254	N	—	0	3	—	—	—	0	8	—	—
Nevada¶	—	0	1	1	8	—	0	9	—	—	—	0	17	—	—
New Mexico¶	1	5	39	262	291	—	0	1	—	—	—	0	1	—	—
Utah	1	15	73	530	523	—	0	8	—	—	—	0	17	—	—
Wyoming¶	—	0	11	16	30	—	0	7	—	—	—	0	10	—	—
Pacific	—	0	9	24	—	—	0	15	—	1	—	0	51	—	3
Alaska	—	0	9	24	N	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	N	—	0	15	—	1	—	0	37	—	3
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon¶	N	0	0	N	N	—	0	2	—	—	—	0	14	—	—
Washington	N	0	0	N	N	—	0	0	—	—	—	0	2	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	3	14	—	143	—	0	0	—	—	—	0	0	—	—
Puerto Rico	8	12	27	340	292	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending June 16, 2007 (24th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	473	334	100	17	11	11	43
Boston, MA	109	70	24	3	7	5	11
Bridgeport, CT	28	22	5	1	—	—	2
Cambridge, MA	16	14	2	—	—	—	1
Fall River, MA	28	20	3	3	—	2	3
Hartford, CT	39	31	8	—	—	—	1
Lowell, MA	19	16	2	1	—	—	—
Lynn, MA	8	7	1	—	—	—	1
New Bedford, MA	20	17	3	—	—	—	4
New Haven, CT	41	29	6	4	2	—	7
Providence, RI	54	37	13	3	—	1	5
Somerville, MA	U	U	U	U	U	U	U
Springfield, MA	30	16	11	1	1	1	1
Waterbury, CT	19	11	7	—	—	1	2
Worcester, MA	62	44	15	1	1	1	5
Mid. Atlantic	2,183	1,457	493	140	48	45	129
Albany, NY	44	26	13	1	3	1	1
Allentown, PA	23	19	3	1	—	—	1
Buffalo, NY	68	40	19	4	2	3	3
Camden, NJ	16	9	2	1	3	1	—
Elizabeth, NJ	13	9	2	2	—	—	1
Erie, PA	42	34	7	—	1	—	2
Jersey City, NJ	18	6	7	4	1	—	3
New York City, NY	982	677	217	62	13	13	51
Newark, NJ	58	28	12	8	5	5	3
Paterson, NJ	20	10	8	1	—	1	—
Philadelphia, PA	549	337	139	39	19	15	41
Pittsburgh, PA§	U	U	U	U	U	U	U
Reading, PA	34	24	6	4	—	—	—
Rochester, NY	153	121	24	5	1	2	15
Schenectady, NY	21	15	4	2	—	—	3
Scranton, PA	28	22	4	1	—	1	1
Syracuse, NY	67	47	15	2	—	3	2
Trenton, NJ	17	11	4	2	—	—	—
Utica, NY	14	9	5	—	—	—	2
Yonkers, NY	16	13	2	1	—	—	—
E.N. Central	1,956	1,321	425	113	41	55	129
Akron, OH	31	15	13	—	1	2	1
Canton, OH	28	23	5	—	—	—	3
Chicago, IL	312	190	77	29	6	9	25
Cincinnati, OH	123	75	23	9	6	10	13
Cleveland, OH	185	132	36	7	4	6	3
Columbus, OH	213	156	43	6	3	5	22
Dayton, OH	146	100	32	8	2	4	9
Detroit, MI	153	75	49	18	6	5	6
Evansville, IN	43	31	8	3	—	1	4
Fort Wayne, IN	56	47	8	1	—	—	1
Gary, IN	15	4	8	1	2	—	—
Grand Rapids, MI	72	58	8	4	2	—	8
Indianapolis, IN	183	126	34	10	6	7	13
Lansing, MI	40	29	10	1	—	—	1
Milwaukee, WI	88	55	21	9	—	3	4
Peoria, IL	36	23	10	1	1	1	6
Rockford, IL	31	28	2	1	—	—	1
South Bend, IN	43	31	9	1	2	—	3
Toledo, OH	106	79	21	4	—	2	3
Youngstown, OH	52	44	8	—	—	—	3
W.N. Central	742	475	168	52	24	20	53
Des Moines, IA	133	99	22	7	3	1	13
Duluth, MN	23	18	3	—	2	—	3
Kansas City, KS	26	6	12	5	1	2	1
Kansas City, MO	102	70	18	10	2	2	6
Lincoln, NE	34	23	4	1	4	2	2
Minneapolis, MN	42	23	12	1	2	4	4
Omaha, NE	90	73	15	1	—	1	4
St. Louis, MO	160	74	56	18	7	3	7
St. Paul, MN	47	30	10	2	1	4	5
Wichita, KS	85	59	16	7	2	1	8
S. Atlantic	1,195	681	311	121	48	34	43
Atlanta, GA	177	93	45	23	9	7	7
Baltimore, MD	159	87	40	26	3	3	8
Charlotte, NC	95	47	28	12	2	6	9
Jacksonville, FL	162	87	46	13	14	2	—
Miami, FL	68	44	15	4	4	1	1
Norfolk, VA	50	26	12	5	4	3	—
Richmond, VA	52	30	18	2	2	—	3
Savannah, GA	55	38	10	6	—	1	4
St. Petersburg, FL	49	27	11	6	2	3	4
Tampa, FL	189	118	50	15	4	2	3
Washington, D.C.	123	71	33	9	4	6	2
Wilmington, DE	16	13	3	—	—	—	2
E.S. Central	872	572	195	51	32	22	55
Birmingham, AL	157	111	27	7	4	8	9
Chattanooga, TN	72	50	16	3	2	1	9
Knoxville, TN	111	75	26	4	5	1	3
Lexington, KY	78	56	12	6	2	2	6
Memphis, TN	127	77	29	12	7	2	5
Mobile, AL	111	71	24	9	4	3	10
Montgomery, AL	86	53	21	4	5	3	3
Nashville, TN	130	79	40	6	3	2	10
W.S. Central	1,449	902	352	107	44	44	70
Austin, TX	112	79	20	5	7	1	6
Baton Rouge, LA	45	27	10	4	3	1	—
Corpus Christi, TX	59	43	9	3	1	3	6
Dallas, TX	185	103	56	11	5	10	9
El Paso, TX	84	52	18	7	7	—	2
Fort Worth, TX	108	59	33	9	1	6	7
Houston, TX	309	192	84	17	9	7	13
Little Rock, AR	84	56	19	4	4	1	4
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	246	150	57	25	3	11	12
Shreveport, LA	83	52	18	12	—	1	3
Tulsa, OK	134	89	28	10	4	3	8
Mountain	1,023	644	234	83	29	32	55
Albuquerque, NM	108	70	27	6	—	4	10
Boise, ID	35	25	6	2	2	—	4
Colorado Springs, CO	91	65	16	3	4	3	2
Denver, CO	88	45	21	13	1	8	6
Las Vegas, NV	278	174	71	18	10	5	13
Ogden, UT	24	15	6	2	—	1	1
Phoenix, AZ	164	85	43	24	5	7	8
Pueblo, CO	27	20	6	—	1	—	2
Salt Lake City, UT	110	72	18	12	5	3	5
Tucson, AZ	98	73	20	3	1	1	4
Pacific	1,274	890	268	75	27	14	95
Berkeley, CA	14	12	2	—	—	—	1
Fresno, CA	162	103	43	11	4	1	15
Glendale, CA	U	U	U	U	U	U	U
Honolulu, HI	57	44	11	—	2	—	5
Long Beach, CA	57	35	17	3	2	—	4
Los Angeles, CA	U	U	U	U	U	U	U
Pasadena, CA	25	17	5	2	1	—	3
Portland, OR	152	108	27	15	1	1	12
Sacramento, CA	172	114	42	10	4	2	11
San Diego, CA	164	122	31	8	1	2	16
San Francisco, CA	U	U	U	U	U	U	U
San Jose, CA	177	122	33	13	4	5	13
Santa Cruz, CA	U	U	U	U	U	U	U
Seattle, WA	108	72	25	6	3	2	7
Spokane, WA	90	72	13	2	2	1	6
Tacoma, WA	96	69	19	5	3	—	2
Total	11,167**	7,276	2,546	759	304	277	672

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.

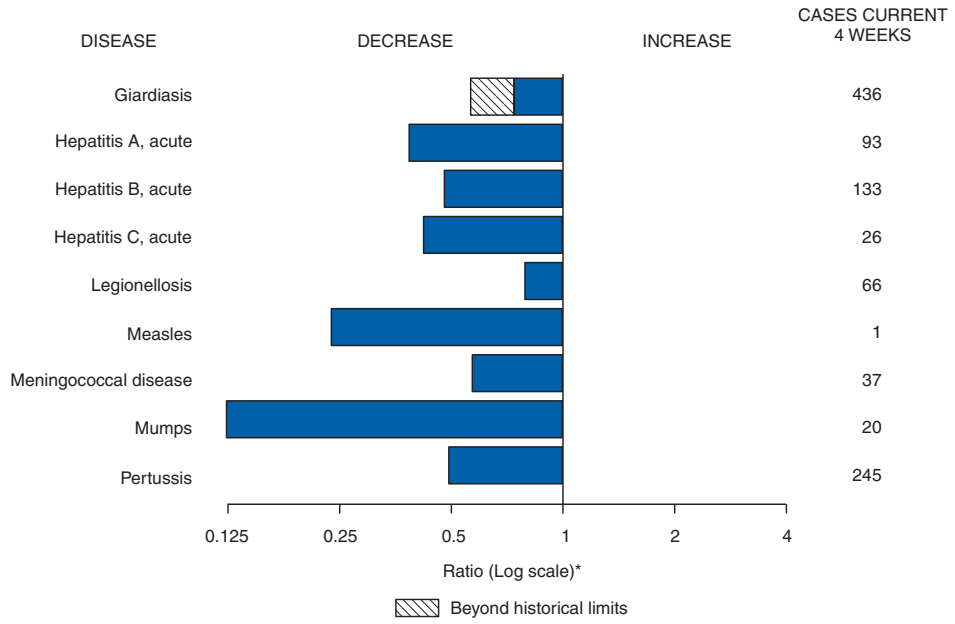
† Pneumonia and influenza.

§ 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.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals June 16, 2007, 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.

Notifiable Disease Data Team and 122 Cities Mortality Data Team

Patsy A. Hall

Deborah A. Adams
Willie J. Anderson
Lenee Blanton
Rosaline Dhara
Vernitta Love
Pearl C. Sharp

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