MMWR
Morbidity and Mortality Weekly Report
www.cdc.gov/mmwr
Weekly October 26, 2007 / Vol. 56 / No. 42

Unregistered Deaths Among Extremely Low Birthweight Infants — Ohio, 2006

In the United States, infants with birthweights <750 g (i.e., extremely low birthweight infants) account for <1% of all births but approximately one third of the total infant mortality rate (*1*). Because these infants often have short life spans, their deaths might be misclassified as fetal deaths, leading to an underestimation of the overall infant mortality rate. Accurate infant mortality rates are important for program planning and evaluation, identification of health disparities and emerging trends, and development of prevention strategies. To assess the extent of unregistered deaths among extremely low birthweight infants born in Ohio during January–June 2006, the Ohio Department of Health analyzed birth and death records from this period for all infants with birthweights <750 g (1.7 lbs) and contacted birth hospitals to follow up on the discharge status of these infants. This report describes the results of that analysis, which indicated that 7% of the extremely low birthweight infants who were born in Ohio during this period, and who subsequently died, had deaths that were unregistered. The findings emphasize the need for routine verification of the discharge status of these infants from their birth hospitals and follow-up to ensure proper registration of deaths.

Birth records for all infants with birthweights <750 g born in Ohio during January 1–June 30, 2006, were identified and matched with death records registered through December 31, 2006, using the Ohio Department of Health's vital statistics database. The birth hospitals of infants with only birth records were contacted by telephone to verify discharge status (i.e., alive to home, alive transferred, or deceased). Deaths among infants that were confirmed (via medical-record review) by the birth hospitals but for which no death records were found were considered unregistered deaths. Selected characteristics of extremely low birthweight infants with unregistered deaths (e.g., birthweight, race, and Medicaid coverage) were compared with those with registered deaths using data from birth records. Categorical variables were analyzed using Fisher's exact test, and continuous variables were analyzed using the Wilcoxon rank sum test.

Among the 325 infants with birthweights <750 g, 192 (59%) had registered deaths, and 129 (40%) had no death records on file. Of the 129 infants with no death records on file, 115 (89%) were confirmed to be alive at the time of discharge from their birth hospitals; 14 (11%) were confirmed by their birth hospitals to have died. Thus, among the 325 extremely low birthweight infants, 206 deaths occurred, of which 192 (93%) were registered and 14 (7%) were unregistered. No statistically significant ($p<0.05$) differences were observed when comparing infants with unregistered deaths to those with registered deaths (Table).

Reported by: *J Paulson, MS, W Ramsini, PhD, Ohio Dept of Health. E Conrey, PhD, R Duffy, DDS, National Center for Chronic Disease Prevention and Health Promotion; MP Cooper, MD, EIS Officer, CDC.*

Editorial Note: Deaths among infants with extremely low birthweights are more likely to be unregistered because of the often short life spans of these infants and the potential for their deaths to be misclassified as fetal deaths. Previous

INSIDE

1103 Reported HIV Status of Tuberculosis Patients — United States, 1993–2005
1106 Trends in Folic Acid Supplement Intake Among Women of Reproductive Age — California, 2002–2006
1109 Baseline Data from the Nyando Integrated Child Health and Education Project — Kenya, 2007
1113 Notices to Readers
1115 QuickStats

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

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

Suggested Citation: Centers for Disease Control and Prevention. [Article title]. MMWR 2007;56:[inclusive page numbers].

studies indicate that numerous infant deaths likely have not been registered (*2–4*). In addition, in 2006, an analysis of CDC's linked birth/infant death data set for 2002–2004 demonstrated that numerous states reported infant mortality rates for infants with birthweights <500 g that were implausibly low (CDC, unpublished data, 2006), leading to concerns that these deaths were not being registered.

CDC recognizes that deaths among low birthweight infants might not be registered and requires that all states follow up on the discharge status of infants with birthweights <750 g. However, not all states currently supply this information to CDC, and the number of deaths that are not registered in many states remains unknown. These practices might indicate that states are underestimating their infant mortality rates, leading to an overall underestimation of the national infant mortality rate, information that is important to agencies for policy planning, program evaluation, research, and identification of health disparities and trends.

The results of this analysis indicate that an estimated 7% of deaths among infants born in Ohio with extremely low birthweights are not being registered. Reasons for the lack of registration of these deaths likely include confusion regarding whether they were fetal deaths or deaths of liveborn infants. Although the resulting adjustment to Ohio's overall infant mortality rate is not substantial, programs that rely on accurate birthweight-specific infant mortality rates likely will observe a more pronounced effect. As a result of these findings, in 2007, the Ohio Department of Health plans to implement routine follow-up of infants with birthweights <750 g to ensure accurate birth and death records. This follow-up will include routine verification of the discharge status of all infants with birthweights <750 g and will ensure that all deceased infants have a registered death certificate. Officials in states that are not performing this follow-up also should consider implementing routine follow-up so that infant mortality rates are accurately reported.

The findings in this report are subject to at least three limitations. First, the analysis was restricted to births that occurred in the first half of 2006. Findings from that period might not reflect the registration of deaths for the entire year. Moreover, a longer study period might have allowed for identification of any seasonal trends in registrations. Second, the small sample size might have prevented this analysis from detecting statistically significant differences between the registered and unregistered groups. Previous studies have indicated that the lack of registration of

TABLE. Number of registered and unregistered deaths* among infants born during January–June with birthweights <750 g, by selected characteristics — Ohio, 2006

	Registered (n = 192)			Unregistered (n = 14)		
Characteristic	Median for characteristic	No. of deaths†	%§	Median for characteristic	No. of deaths†	%§
Birthweight (g)	480.0	192	—	421.0	14	—
Age of mother (yrs)	25.0	191	—	24.5	14	—
Gestational age (wks)	22.0	190	—	21.5	14	—
No. of prenatal visits	5.0	136	—	5.0	9	—
No. of previous live births	0.5	170	—	1.0	12	—
Male	—	108	57	—	8	57
Mother married	—	70	37	—	6	43
Medicaid coverage	—	54	28	—	3	21
Mother with at least a high school diploma	—	142	74	—	9	64
Mother white	—	96	51	—	9	69
Mother black	—	91	49	—	4	31

* No significant differences (p<0.05) were observed between infants with registered and unregistered deaths (Fisher's test for categorical variables and Wilcoxon rank sum test for continuous variables).
† For which information on selected characteristic is available.
§ Denominators for certain selected characteristics vary because of missing data on birth records.

deaths in extremely low birthweight infants has occurred disproportionately for black infants, those born to unmarried mothers, and those born to mothers living in rural areas (*2,3*). Finally, the study design did not allow for identification of live-born infants whose deaths were misclassified as fetal deaths. Such infants would have received fetal death certificates instead of standard birth or death certificates.

In addition to routine follow-up of infants with extremely low birthweights, further research regarding the reasons for the lack of registration of certain infant deaths is needed. Findings from such research might help in targeting interventions to improve the accuracy of infant death reporting.

References

1. Mathews TJ, MacDorman MF. Infant mortality statistics from the 2004 period linked birth/infant death data set. Natl Vital Stat Rep 2007;55(14). Available at http://www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_14.pdf.
2. McCarthy BJ, Terry J, Rochat RW, Quave S, Tyler CW Jr. The underregistration of neonatal deaths: Georgia 1974–77. Am J Public Health 1980;70:977–82.
3. Rogers PB, Council CR, Abernathy JR. Testing death registration completeness in a group of premature infants. Public Health Rep 1961;76:717–24.
4. CDC. Underreporting of neonatal deaths—Georgia, 1974–1977. MMWR 1979;28:253–4.

Reported HIV Status of Tuberculosis Patients — United States, 1993–2005

Knowing the human immunodeficiency virus (HIV) status of tuberculosis (TB) patients is essential to optimal patient management. TB is an acquired immunodeficiency syndrome (AIDS)-defining opportunistic condition. Patients with both TB and HIV infection are five times more likely to die during anti-TB treatment than patients who are not HIV infected (CDC, unpublished data, 2003). HIV infection is the greatest known risk factor for progression from latent TB infection to TB disease (*1*). In the United States, after TB exposure and infection, HIV-infected persons who do not receive appropriate treatment progress to TB disease over 5 years at a rate 10 times greater than that for persons not infected with HIV (*2,3*). In 1989, CDC recommended that all TB patients be offered HIV testing (*4*) and, in 2006, called for routine HIV screening of all TB patients after the patient is notified that testing will be performed, unless the patient declines (opt-out screening) (*5*). In addition to enabling optimal patient management, knowing the HIV status (i.e., positive or negative) of TB patients helps public health agencies to identify HIV-infected contacts of TB patients. Highly active antiretroviral therapy (HAART) can reduce the progression to TB disease (*6*), TB relapse (*7*), and death (*8*). To assess reported HIV status of TB patients and selected characteristics of TB patients with HIV infection, CDC analyzed data from the U.S. National TB Surveillance System for the period 1993–2005. This report summarizes the results of that analysis, which indicated that 1) reporting of HIV status among TB patients increased from 35% in 1993 to 68% in 2003, 2) HIV status of 31% of TB patients was unknown in 2005, 3) 9% of TB patients were HIV positive in 2005, and 4) groups of TB patients at greater risk for HIV infection included injection-drug users (IDUs), noninjection-drug users (NIDUs), homeless persons, non-Hispanic blacks, correctional-facility inmates, and alcohol abusers. Increased promotion of routine HIV testing and rapid HIV tests (*9*) might increase acceptability of testing, which would allow health-care providers to know the HIV status of a greater percentage of TB patients and enable them to provide optimal care.

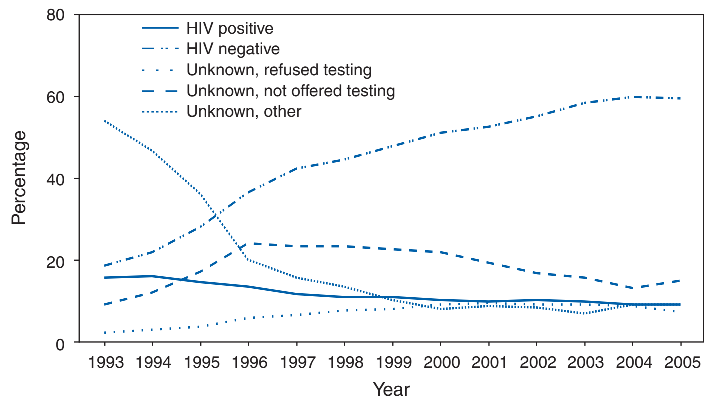
Data on reported HIV status were analyzed for the period 1993–2005 (updated through March 29, 2006) from the National TB Surveillance System for 49 states and the District of Columbia (DC).* This system contains data regarding confirmed cases of TB reported annually to CDC; the data are collected by state and local TB programs from interviews with patients, using a standardized surveillance case report form that includes HIV status. HIV status usually is assessed at the time of TB diagnosis but can be updated throughout the course of treatment for TB. Known HIV status was defined as either HIV positive or HIV negative. Unknown HIV status included the following categories: not offered testing, refused testing, tested with indeterminate results, tested but results unknown, and missing data. Mantel-Haenszel risk ratios (RRs), significant within 95% confidence intervals (CIs), were used to assess significant associations between variables.

Reported HIV status (i.e., positive or negative) among TB patients in the United States increased from 35% in 1993 to 68% in 2003, then leveled during 2004–2005 (Figure). Twenty-five states reported known HIV status for fewer than 75% of TB cases (Table 1). Twenty-six states and DC reported more than five TB patients with HIV-positive status, with the prevalence of positive results ranging from 5% to 32% (average: 13%; median: 11%) of TB patients having known HIV status.

Overall in 2005, a total of 7,689 (69%) of 11,193 TB patients in the United States had known HIV status and 3,504 (31%) had unknown HIV status (including 1,675 [15%] who were not offered testing and 827 [7%] who refused testing). Of the 7,689 with known status, a total of 1,034 (13%) were HIV positive and 6,655 (87%) were HIV negative. A significantly greater percentage (79%) of non-Hispanic black TB patients had known HIV status, compared with all other racial/ethnic groups combined (RR = 1.24, CI = 1.21–1.27) (Table 2). Non-Hispanic, U.S.-born black females were significantly less likely than black males to have known HIV status (RR = 0.91, CI = 0.87–0.95).

* California data were excluded because the state provides CDC only with the results of AIDS and TB registry matches, which likely underestimates TB/HIV prevalence. California does not report to CDC the numbers of TB patients whose HIV test status was negative or indeterminate, who refused testing, who were not offered testing, who were tested but with unknown results, or who were missing HIV data.

FIGURE. Reported human immunodeficiency virus (HIV) infection status of tuberculosis patients — United States,* 1993–2005



* Excludes California.

Groups of TB patients with rates of HIV infection significantly greater than the 9% rate for the United States overall included the following: IDUs (35%), NIDUs (27%), homeless persons (22%), non-Hispanic blacks (17%), correctional-facility inmates (16%), persons aged 25–44 years (16%), alcohol abusers (15%), males (11%), persons aged 45–64 years (11%), and U.S.-born persons (11%) (Table 2). A total of 652 (63%) of the 1,034 TB patients who were HIV positive were non-Hispanic blacks.

Among groups of patients having unknown HIV status, 33% of IDUs, 32% of NIDUs, 38% of homeless persons, 37% of inmates, and 37% of alcohol abusers were not offered HIV testing. In addition, 28% of Asians, 27% of patients aged 15–24 years and 45–64 years, 27% of non-Hispanic whites, and 26% of persons born outside the United States refused testing. Hispanics were significantly less likely to refuse HIV testing than non-Hispanics (RR = 0.64, CI = 0.55–0.75).

Reported by: *S Marks, MPH, MA, E Magee, MPH, MS, V Robison, DDS, PhD, Div of Tuberculosis Elimination, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC.*

Editorial Note: Knowing the HIV status of TB patients is essential for optimal management of patient care, including selection of appropriate TB-treatment regimens and referral to and coordination of care for HIV infection. Once TB disease occurs, provider knowledge of HIV infection can help avoid TB relapse and mortality through increased vigilance and monitoring of TB therapy and providing access to HIV care and support services.

Knowing HIV status also helps public health programs identify HIV-infected contacts of TB patients, who are at increased risk for TB disease. Surveillance data enable CDC

TABLE 1. Reported human immunodeficiency virus (HIV) infection in tuberculosis (TB) patients, by state — United States,* 2005

State	Total no. of TB patients	TB patients with known HIV status† No.	(%)	TB patients with known HIV status reported as HIV positive No.	(%)
Alabama	216	170	(79)	9	(5)
Alaska	59	40	(68)	—§	—
Arizona	281	226	(80)	19	(8)
Arkansas	114	82	(72)	—	—
Colorado	101	81	(80)	—	—
Connecticut	95	65	(68)	12	(18)
Delaware	26	21	(81)	—	—
District of Columbia	56	53	(95)	17	(32)
Florida	1,094	909	(83)	196	(22)
Georgia	505	430	(85)	69	(16)
Hawaii	112	13	(12)	—	—
Idaho	23	8	(35)	—	—
Illinois	596	408	(68)	38	(9)
Indiana	146	80	(55)	7	(9)
Iowa	55	33	(60)	—	—
Kansas	60	55	(92)	7	(13)
Kentucky	124	93	(75)	—	—
Louisiana	257	174	(68)	29	(17)
Maine	17	11	(65)	—	—
Maryland	283	224	(79)	38	(17)
Massachusetts	265	168	(63)	22	(13)
Michigan	246	146	(59)	19	(13)
Minnesota	199	173	(87)	12	(7)
Mississippi	103	93	(90)	8	(9)
Missouri	108	65	(60)	—	—
Montana	10	8	(80)	—	—
Nebraska	35	16	(46)	—	—
Nevada	112	101	(90)	11	(11)
New Hampshire	4	4	(100)	—	—
New Jersey	485	284	(59)	38	(13)
New Mexico	39	24	(62)	—	—
New York	1,289	856	(66)	173	(20)
North Carolina	329	283	(86)	34	(12)
North Dakota	6	5	(83)	—	—
Ohio	260	179	(69)	13	(7)
Oklahoma	144	108	(75)	10	(9)
Oregon	103	95	(92)	—	—
Pennsylvania	325	165	(51)	18	(11)
Rhode Island	47	31	(66)	—	—
South Carolina	261	200	(77)	17	(9)
South Dakota	16	9	(56)	—	—
Tennessee	298	255	(86)	26	(10)
Texas	1,535	726	(47)	124	(17)
Utah	29	28	(97)	—	—
Vermont	8	4	(50)	—	—
Virginia	355	228	(64)	20	(9)
Washington	256	191	(75)	15	(8)
West Virginia	28	8	(29)	—	—
Wisconsin	78	60	(77)	—	—
Wyoming	0	0	—	—	—
Total	**11,193**	**7,689**	**(69)**	**1,034**	**(13)**

* Excludes California.
† Reported as HIV positive or HIV negative.
§ Five or fewer reported as HIV positive.

TABLE 2. Selected characteristics of tuberculosis patients, by reported human immunodeficiency virus (HIV)-infection status — United States,* 2005†

Characteristic	No.	% HIV positive	% HIV negative	% HIV status unknown§
Total	**11,193**	**9**	**59**	**31**
Sex				
Male	6,965	11	61	28
Female	4,228	7	57	36
Age group at diagnosis (yrs)				
0–4	393	1	32	67
5–14	319	2	37	61
15–24	1,264	3	76	20
25–44	3,827	16	65	19
45–64	3,287	11	62	27
>64	2,103	1	45	54
Race/Ethnicity				
Black, non-Hispanic	3,731	17	61	21
Hispanic	2,916	8	60	32
White, non-Hispanic	2,318	5	57	38
American Indian/ Alaska Native	148	2	61	36
Asian	1,956	1	59	40
Native Hawaiian/ Pacific Islander	42	0	50	50
Multiple race/ethnicity	40	5	60	35
Unknown race/ethnicity	42	12	31	57
Birthplace				
United States	5,716	11	57	32
Outside United States	5,464	7	62	30
HIV risk factor				
Injection-drug user	218	35	54	11
Noninjection-drug user	841	27	61	12
Homeless person	622	22	64	14
Correctional-facility inmate	469	16	63	22
Alcohol abuser	1,526	15	68	17

* Excludes California.
† Percentages might not add to 100% because of rounding.
§ Includes the following categories: not offered testing, refused testing, tested with indeterminate results, tested but results unknown, and missing data.

to track trends in TB/HIV accurately so that outbreaks can be identified and prevention measures targeted to areas where TB/HIV coinfection is most common.

However, despite CDC recommendations calling for routine HIV testing of all TB patients, the proportion of TB patients whose HIV status is unknown remained at approximately one third during 2003–2005. Data provided by the U.S. National TB Surveillance System are limited by incomplete reporting, which might result from 1) concerns regarding patient confidentiality or laws and regulations that might limit reporting of HIV status or 2) not offering HIV testing because of insufficient resources, lack of trained staff, or perceptions that patients are not at risk for HIV.

High rates of both HIV infection and TB disease among non-Hispanic blacks emphasize the need in this population to prevent, diagnose early, and provide access to care for both conditions. Substance abuse is a risk factor common to both TB and HIV infection, and homelessness and incarceration are two factors associated with both greater TB incidence and transmission of TB disease (*10*).

The findings in this report are subject to at least one limitation: the exclusion of data from California. In 2004, the latest year for which California reported AIDS-registry data to CDC, the state reported 123 TB patients who had AIDS, which amounted to approximately 10% of all known HIV/TB patients in the United States.

Improvements in HIV testing and reporting are needed. All TB patients should be offered HIV testing where feasible, especially IDUs, NIDUs, homeless persons, non-Hispanic blacks, correctional-facility inmates, and alcohol abusers. Implementation of the 2006 updated CDC HIV-testing recommendations, calling for routine HIV testing of all TB patients, and increased use of rapid HIV tests that can provide results in less than 20 minutes might increase acceptance of HIV testing. These improvements might increase the proportion of TB patients in the United States whose HIV status is known and who can thereby benefit from optimal care.

References

1. CDC. Targeted tuberculin testing and treatment of latent tuberculosis infection. MMWR 2000;49(No. RR-6):8–9.
2. Markowitz N, Hansen NI, Hopewell PC, et al. Incidence of tuberculosis in the United States among HIV-infected persons. Ann Intern Med 1997;126:123–32.
3. Ferebee SH. Controlled chemoprophylaxis trials in tuberculosis: a general review. Bibl Tuberc 1970;26:28–106.
4. CDC. Tuberculosis and human immunodeficiency virus infection: recommendations of the Advisory Committee for the Elimination of Tuberculosis. MMWR 1989;38:236–8.
5. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55(No. RR-14).
6. Girardi E, Sabin CA, d'Arminio-Monforte A, et al. Incidence of tuberculosis among HIV-infected patients receiving highly active antiretroviral therapy in Europe and North America. Clin Infect Dis 2005;41:1772–82.
7. Nahid P, Gonzalez LC, Rudoy I, et al. Treatment outcomes of patients with HIV and tuberculosis. Am J Respir Crit Care Med 2007;175:1199–206.
8. Severe P, Leger P, Charles M, et al. Antiretroviral therapy in a thousand patients with AIDS in Haiti. N Engl J Med 2005;353:2325–33.
9. Bulterys M, Jamieson DJ, O'Sullivan MJ, et al. Rapid HIV-1 testing during labor: a multicenter study. JAMA 2004;292:269–71.
10. Haddad MB, Wilson TW, Ijaz K, Marks SM, Moore M. Tuberculosis and homelessness in the United States, 1994–2003. JAMA 2005;293:2762–6.

Trends in Folic Acid Supplement Intake Among Women of Reproductive Age — California, 2002–2006

Daily intake of 400 μg of folic acid before conception can reduce by approximately 80% the risk for having an infant with a neural tube defect (NTD) such as spina bifida or anencephaly (*1*). Although other risk factors for NTDs exist, such as diabetes, obesity, and family history of NTDs, prevention measures have focused predominantly on promoting folic acid consumption. Women can ensure they are consuming the recommended amount of folic acid by eating one serving of breakfast cereal fortified with 100% of the recommended daily value of folic acid or by taking a supplement with 400 μg folic acid daily (*2*). Annual surveys conducted for the March of Dimes (MOD) Birth Defects Foundation indicate that 40% of all U.S. women of reproductive age (i.e., aged 15–45 years) took supplements containing folic acid in 2007 (MOD, unpublished data, 2007), up from 28% in 1995 (*3*). To analyze trends in folic acid–containing supplement intake among California women aged 18–44 years during 2002–2006, the California Department of Public Health conducted trend analyses of data from the California Women's Health Survey (CWHS). This report summarizes the results of those analyses, which indicated that although the overall prevalence of intake of folic acid–containing supplements remained stable from 2002 (40%) to 2006 (41%) in California, use of such supplements decreased among Hispanic women and women with less education. Downward trends among Hispanic women are of particular concern because 1) Hispanic women are at increased risk for having a fetus or an infant with an NTD compared with women of other races/ethnicities (*4,5*), 2) the number of births to Hispanics in California increased during 1993–2003 (*6*), and 3) Hispanics accounted for nearly 52% of all births in California in 2005 (California Department of Public Health, unpublished data, 2005). Development of additional targeted and evidence-based public health interventions for increasing folic acid intake among these populations is needed.

CWHS is a statewide, random-digit–dialed telephone survey of women aged $\geq$18 years. Data from approximately 4,000 interviews are collected annually, half of which are from respondents aged 18–44 years. Survey cooperation rates (the proportion of eligible households contacted that resulted in a completed interview) for 2002–2006 ranged from 72% to 74%; Council of American Survey Research Organizations (CASRO) response rates ranged from 37% to 42%. The survey is conducted in English and Spanish and contains questions on various women's health topics (e.g., domestic violence, mammography use, body mass index, and physical activity).

Questions on the daily use of supplements containing folic acid were first included in the 2002 survey. In each year since 2002, respondents have been asked, "Are you currently taking a prenatal or multivitamin pill or a pill containing the B vitamin folate or folic acid?" and "Do you take any of these on a daily basis?" Respondents who answered yes to both questions were identified as persons who used folic acid daily. Data were stratified by pregnancy status, race/ethnicity, age, educational attainment, and income. Income was measured as the percentage of household income above or below the federal poverty level in a given year. Prevalence estimates, temporal trends, and risk-adjusted linear trends for daily folic acid intake among respondents aged 18–44 years were examined for each year from 2002 to 2006. Using the 2000 U.S. census, all results were weighted by age and race/ethnicity to reflect the total population of women aged 18–44 years in California and to allow for comparisons of survey years. The Cochran Armitage test for trend was used to determine significance in unadjusted models, and the orthogonal polynomial test for linear trend in logistic regression was used in risk-adjusted models.

The overall prevalence of daily intake of supplements containing folic acid among California women aged 18–44 years did not change significantly from 2002 (40.0%) to 2006 (41.1%), although a decrease occurred in 2005 (36.5%) (2002 versus 2005, p=0.01; 2003 versus 2005, p=0.002; 2004 versus 2005, p<0.001, by chi-square test) (Table). Among Hispanic women, the prevalence of daily intake of supplements containing folic acid declined significantly from 32.8% in 2002 to 30.2% in 2006 (p=0.002, Cochran Armitage two-tailed test for trend). This decrease also was significant in risk-adjusted models controlling for the effects of 1) age and income and 2) age and educational attainment (p<0.001 for both).

Reported by: *AM Herrndorf, MPH, SC Haydu, MPH, ER Takahashi, PhD, Maternal, Child, and Adolescent Health Program, California Dept of Public Health.*

Editorial Note: To reduce the risk for NTDs, the Institute of Medicine (IOM) recommends that all women of reproductive age consume at least 400 *µ*g of synthetic folic acid daily through dietary supplements, fortified foods, or a combination of the two. In addition, IOM recommends that women eat foods rich in naturally occurring folate from a varied diet* (*7*). These recommendations are for all women of reproductive age because 50% of U.S. pregnancies are unplanned (*8*).

Since the mid-1990s, the California Department of Health Services (CDHS)† has partnered with the California MOD to promote folic acid intake by women of reproductive age and participated in the National Folic Acid campaign that occurred during 1999–2001. In 2002, folic acid pamphlets and posters in English and Spanish were revised by CDHS to focus on two options for obtaining 400 *µ*g of folic acid daily: fortified cereals or vitamin supplements. CDHS and MOD have developed and distributed folic acid education guidelines and materials, including a booklet given to couples who are obtaining a marriage license. During 2000–2004, the California Folic Acid Council developed targeted interventions, including informational slides in English and Spanish that were shown in movie theaters. Although folic acid supplements have been available as a benefit of Medi-Cal (California's Medicaid program) for decades, use of 400-*µ*g folic acid supplements among nonpregnant women of reproductive age has been considerably lower than anticipated (Medi-Cal, unpublished data, 2006–2007).

Data from the 2001–2002 National Health and Nutrition Examination Survey indicate that only 8% of nonpregnant women aged 15–49 years consumed ≥400 *µ*g folic acid by eating fortified foods, suggesting that more women need to take a supplement containing folic acid to achieve recommended intake levels (*9*). Since 1995, the Gallup Organization, commissioned by MOD, has conducted surveillance on self-reported intake of folic acid supplements among U.S. women of reproductive age. Findings from the MOD survey indicate that the proportion of U.S. women who use supplements containing folic acid increased from 28% in 1995 to 40% in 2007 (MOD, unpublished data, 2007). The estimated use of daily supplements containing folic acid might be slightly higher in California than in the United States overall, with approximately 37% of California women reporting intake of supplements containing folic

* A well-balanced, varied diet includes foods naturally rich in folate, such as orange juice, strawberries, cantaloupe, asparagus, broccoli, cooked dry peas and beans, and dark green, leafy vegetables.

† On July 1, 2007, CDHS was divided into the California Department of Public Health and the California Department of Health Care Services.

TABLE. Estimated percentage of women of reproductive age (18–44 years) who reported taking a supplement containing folic acid daily, by year and select demographic characteristics — California Women's Health Survey, 2002–2006*

	Year									
	2002 (N = 2,310)		2003 (N = 2,232)		2004 (N = 2,305)		2005 (N = 2,140)		2006 (N = 2,019)	
Characteristic	%	(95% CI†)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
All women aged 18–44 yrs (mean: 40.0%)	**40.0**	**(38.0–41.9)**	**40.7**	**(38.8–42.7)**	**41.7**	**(39.8–43.7)**	**36.5**	**(34.6–38.3)**	**41.1**	**(39.2–43.0)**
Pregnancy status										
Not currently pregnant	37.7	(35.7–39.7)	37.4	(35.4–39.4)	38.9	(37.0–41.0)	34.0	(32.1–35.9)	38.4	(36.5–40.3)
Weight status										
Normal weight (BMI§ <25)	41.1	(38.4–43.8)	43.3	(40.5–46.0)	43.9	(41.2–46.6)	38.6	(35.9–41.2)	43.1	(40.3–45.9)
Overweight (BMI 25–29)	38.6	(34.6–42.5)	38.0	(34.1–41.9)	41.9	(37.9–45.9)	37.5	(33.7–41.3)	39.4	(35.6–43.2)
Obese (BMI ≥30)	41.2	(36.7–45.7)	38.2	(33.8–42.6)	40.4	(36.1–44.8)	33.8	(29.6–38.0)	39.6	(35.6–43.6)
Race/Ethnicity										
White	47.6	(44.5–50.6)	49.0	(46.0–52.1)	51.2	(48.2–54.2)	47.3	(44.3–50.3)	50.6	(47.6–53.5)
Black	38.8	(31.3–46.2)	31.5	(24.4–38.6)	41.8	(34.3–49.3)	41.9	(34.4–49.3)	39.5	(32.2–46.8)
Asian/Other	35.4	(30.5–40.3)	38.3	(33.3–43.3)	41.7	(36.7–46.7)	33.4	(28.7–38.1)	40.0	(35.1–44.9)
Hispanic¶**	32.8	(29.7–36.0)	33.4	(30.2–36.6)	30.2	(27.1–33.2)	23.4	(20.6–26.2)	30.2	(27.2–33.2)
Non-Hispanic	43.8	(41.3–46.3)	44.7	(42.2–47.1)	48.0	(45.5–50.4)	43.5	(41.1–45.9)	46.9	(44.5–49.3)
Age group (yrs)										
18–24	29.3	(25.6–33.1)	30.1	(26.4–33.9)	34.9	(31.0–38.7)	22.5	(19.2–25.9)	29.7	(26.0–33.4)
25–34	41.6	(38.4–44.8)	45.3	(42.1–48.6)	43.9	(40.7–47.1)	39.5	(36.4–42.7)	44.1	(40.9–47.3)
35–44	44.8	(41.6–48.0)	42.7	(39.6–45.9)	43.8	(40.7–46.9)	41.8	(38.7–44.8)	45.0	(41.9–48.1)
Education										
Less than high school	27.5	(23.0–32.0)	23.7	(19.4–28.1)	28.0	(23.9–32.2)	17.7	(14.1–21.4)	24.2	(20.0–28.5)
High school, technical school, or vocational training	35.2	(31.4–38.9)	35.7	(32.0–39.5)	35.7	(31.9–39.6)	31.8	(28.1–35.5)	31.5	(28.1–34.9)
College (any)	45.5	(42.9–48.1)	47.4	(44.8–50.1)	48.4	(45.8–51.0)	43.7	(41.1–46.2)	50.6	(48.0–53.2)
Household income (as % FPL††)										
≤200% FPL	30.2	(27.2–33.1)	32.4	(29.3–35.4)	31.0	(28.1–34.0)	28.4	(25.5–31.2)	29.4	(26.5–32.2)
>200% of FPL	48.0	(45.3–50.7)	46.7	(44.0–49.4)	50.1	(47.4–52.8)	43.4	(40.8–46.0)	49.5	(46.9–52.1)

* Prevalence estimates are weighted to the 2000 U.S. census by age and racial/ethnic characteristics to reflect the total population of California women of reproductive age.
† 95% confidence interval.
§ Body mass index (weight [kg] / height [m^2]).
¶ Statistically significant trend (unadjusted), Cochran Armitage test for trend.
** Statistically significant trend, risk-adjusted test orthogonal polynomial test for linear trend.
†† Federal poverty level.

acid in 2005 compared with 33% of women nationally.[§] According to these estimates, California and all other states likely are far from meeting the *Healthy People 2010* objective for folic acid intake (objective 16-16a), which is to increase to 80% the proportion of all nonpregnant women aged 15–44 years who consume at least 400 *µ*g of folic acid daily. Hispanic respondents to CWHS were less likely than respondents of other racial/ethnic groups to report daily use of supplements containing folic acid. The decline in daily supplement use likely indicates a lower total intake of folic acid among Hispanic women and is of particular concern because NTD rates are nearly two times higher among Hispanic women (0.60 per 1,000 live births during 1999–2003) than among white women (0.36 per 1,000 live births) in California (*5*).

The findings in this report are subject to at least three limitations. First, although the sample size was large, cell sizes were not adequate to include all relevant covariates in the risk-adjusted trend models. Second, the weighting methodology used in CWHS adjusts for age and racial/ethnic discrepancies between the CWHS sample and California's general population but does not adjust for education or income discrepancies. Because U.S. women with higher levels of education are more likely to report vitamin use (*3*), and overall, respondents to CWHS have higher levels of education than California's general population, the results of this study might overestimate folic acid supplement use among California women. Third, CWHS data on folic acid use are derived from self-reported supplement use; questions regarding additional sources of folic acid, such as fortified breakfast cereal or grain products, were

§ The MOD-commissioned Gallup Survey asks women of reproductive age "Do you currently take any vitamin or mineral supplement on a daily basis?" and "What type of vitamin or mineral supplement do you take?" The survey questions are similar to, but not the same as, those asked in CWHS. Response rates from the MOD Gallup Survey range from 24% to 53%.

not included in CWHS, which might have resulted in an underestimation of the number of women consuming folic acid.

Educational materials and provider guidelines on folic acid use have been widely distributed to women participating in CDHS programs and receiving CDHS services. However, not all California women of reproductive age have benefited from or participated in these programs. Evidence-based strategies such as social marketing (*10*) and providing better access to supplements containing folic acid might be needed, especially among certain subgroups of women (e.g., those with less education and Hispanic women).

To reduce disparities in NTD rates between Hispanics and non-Hispanics, Hispanic women of reproductive age should consume 400 μg of folic acid daily through fully fortified sources: either breakfast cereal or vitamin supplements. Supporting evidence-based behavior-change initiatives, such as social marketing campaigns, is an important step toward ensuring that all women of childbearing age consume 400 μg of folic acid every day to prevent serious birth defects.

Acknowledgments

This report is based, in part, on contributions by the Survey Research Group (Sacramento, California), which administers the California Women's Health Survey; A Ratnasiri, MSc, JL Troyan, MPH, KC Ramstrom, DO, L Llewelyn, MPP, Maternal, Child, and Adolescent Health Program, California Dept of Public Health; and CE Prue, PhD, and J Mulinare, MD, Div of Birth Defects and Developmental Disabilities, National Center on Birth Defects and Developmental Disabilities, CDC.

References

1. Berry RJ, Li Z, Erickson JD, et al. Prevention of neural tube defects with folic acid in China. China-U.S. collaborative project for neural tube defect prevention. N Engl J Med 1999;341:1485–90.
2. Burke B, Lyon Daniel K, Latimer A, et al. Preventing neural tube defects: a prevention model and resource guide. Atlanta, GA: CDC; 1998.
3. Green-Raleigh K, Carter H, Mulinare J, Prue C, Petrini J. Trends in folic acid awareness and behavior in the United States: the Gallup Organization for the March of Dimes Foundation Surveys, 1995–2005. Matern Child Health J 2006;10(Suppl 5):S177–82.
4. Williams LJ, Rasmussen SA, Flores A, Kirby RS, Edmonds LD. Decline in the prevalence of spina bifida and anencephaly by race/ethnicity: 1995–2002. Pediatrics 2005;116:580–6.
5. California Birth Defects Monitoring Program. Neural tube defects. Available at http://www.cbdmp.org/bd_neural.htm.
6. California Center for Health Statistics. Selected health indicators concerning live births, California, 1993–2003. Sacramento, CA: State of California Department of Health Services, Center for Health Statistics; 2004. Available at http://www.dhs.ca.gov/hisp/chs/ohir/tables/datafiles/specificcauses/birthindicators.pdf.
7. Institute of Medicine. Dietary reference intake: folate, other B vitamins, and choline. Washington, DC: National Academy Press; 1998.
8. Henshaw SK. Unintended pregnancy in the United States. Fam Plann Perspect 1998;30:24–9,46.
9. Yang QH, Carter HK, Mulinare J, Berry RJ, Friedman JM, Erickson JD. Race-ethnicity differences in folic acid intake in women of childbearing age in the United States after folic acid fortification: findings from the National Health and Nutrition Examination Survey, 2001–2002. Am J Clin Nutr 2007;85:1409–16.
10. Grier S, Bryant C. Social marketing in public health. Annu Rev Public Health 2005;26:319–39.

Baseline Data from the Nyando Integrated Child Health and Education Project — Kenya, 2007

On October 22, this report was posted as an MMWR Early Release *on the* MMWR *website* (http://www.cdc.gov/mmwr).

Approximately 10 million children aged <5 years die each year in developing countries (*1*). The leading infectious causes of these deaths include acute respiratory infections, diarrhea, measles, and malaria; malnutrition contributes to approximately 50% of these deaths (*2*). To address multiple conditions that contribute to mortality, child-survival programs require effective interventions and implementation strategies (*3*). To assess the effectiveness of multiple interventions, CDC has joined with partners to create the Nyando Integrated Child Health and Education (NICHE) project to combine several proven approaches to child survival in an impoverished rural district of western Kenya. During March–April 2007, CDC began the NICHE project with a baseline survey. This report summarizes preliminary data from that survey, which determined that 1) 86.1% of surveyed households were in the poorest Kenya socioeconomic quintile and 2) among children aged 6–35 months, 21.5% had experienced an acute respiratory infection and 9.1% had experienced diarrhea in the preceding 24 hours, 28.0% had chronic malnutrition, 66.2% had anemia, and 19.8% had a positive malaria smear. Comprehensive interventions will be needed

This report is presented in conjunction with the Council of Science Editors 2007 Global Theme Issue on Poverty and Human Development, an international collaboration of 235 publications, all releasing reports on poverty and human development on October 22, 2007. Additional information is available at http://www.councilscienceeditors.org/globalthemeissue.cfm.

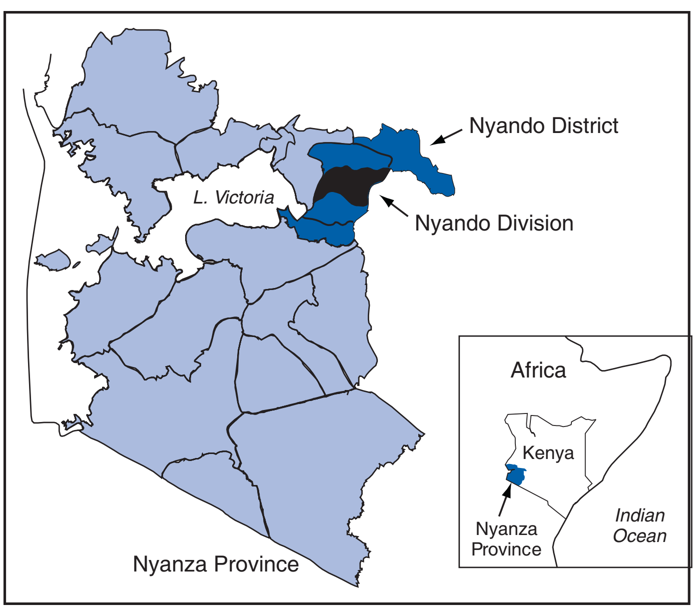
to improve living conditions and reduce the risk for death before age 5 years among children in this population.

NICHE Project Methodology

In the NICHE project, two groups of villages, an intervention group and a comparison group, were selected to compare the effects of child-survival interventions targeted at leading causes of mortality (i.e., respiratory infections, diarrhea, and malaria). Intervention activities were begun initially in the intervention group, and will be expanded to include the comparison group in 2008. A two-stage, modified cluster-sampling strategy was used to select 30 intervention villages and 30 comparison villages from Nyando Division (population 80,000), an impoverished area with poor sanitary facilities located in Nyanza Province in rural western Kenya (Figure). The two clusters of villages were chosen from separate political jurisdictions (i.e., sublocations) to inhibit interventions in one cluster from influencing conditions in the other.

Households and children were numbered in each village. Random samples of children aged 6–35 months, and primary-school children (from grades 4–8; generally aged 9–13 years) in the villages were selected by using random number tables. During March–April 2007, a baseline survey was conducted in enrolled households in all 60 villages to determine the 1) demographic, socioeconomic, and health characteristics and 2) health behaviors of the two populations. Information was collected regarding household drinking water, sanitation, hygiene, dietary practices, and child health. A principal component analysis developed by the World Bank was used to categorize the study households into Kenya socioeconomic quintiles (*4*). NICHE project field workers tested water stored in households for the presence of water chlorination products. Laboratory technicians obtained blood samples from children aged 6–35 months to measure hemoglobin, iron stores, and malaria status. Field workers measured heights and weights of these children, and z-scores were calculated to assess nutritional status; stool samples were collected from primary-school children to test for intestinal parasites.

FIGURE. Nyando Division (population 80,000), in rural Nyando District in Nyanza Province, is the site of the Nyando Integrated Child Health and Education Project — Kenya, 2007



Baseline Survey Results

The baseline survey collected data on samples of 1,049 children aged <3 years and 905 primary-school children from 1,586 sampled households (Table); 86.1% of households were in the poorest Kenya socioeconomic quintile, and 94.8% of respondents were women. Respondent ages ranged from 16 to 90 years (median: 30 years), and 84.4% had a primary-school education or less.

Among households, 47.9% relied on surface sources (e.g., rivers or ponds) for drinking water, and 99.7% of respondents reported storing drinking water in the home. Respondents in 66.6% of households reported treating their drinking water, and 43.0% reported treating water with a Safe Water System (SWS)*chlorine product; however, investigators detected chlorine residuals in 10.7% of stored water samples. Among households, 89.7% were observed to have soap present, and 56.6% had a latrine. Respondents reported that 80.6% of 2,508 children aged <5 years had slept under an insecticide-treated bednet (ITN) the preceding night; ITNs were observed hanging over the sleeping areas of 72.2% of children aged <5 years.

The prevalence of chronic malnutrition† in children aged 6–35 months was 28.0%. Of 974 children aged 6–35 months who were tested, 66.2% were anemic (hemoglobin <11.0 g/dL), and 44.8% were iron deficient (ferritin <12.0 ng/mL); 19.8% had a positive malaria smear. Stool samples from 14.8% of primary-school children exhibited parasites (e.g., schistosomes, trichuris, ascaris, and hookworms). Baseline survey data indicated that 27.7% of children aged 6–35 months were reported to have been ill in

* A household-based intervention that includes water treatment with dilute chlorine bleach, safe water storage, and education aimed at changing hygiene behavior.

† Defined as a z-score of less than -2 for height-for-age, according to the 2005 World Health Organization Child Growth Standards. Available at http://www.who.int/childgrowth/en.

TABLE. Baseline survey data* from the Nyando Integrated Child Health and Education Project, by selected characteristics and village study status of respondents — Kenya, March–April 2007†

Characteristic	Intervention villages	Comparison villages	Total
No. of sampled households	806	780	**1,586**
No. of sampled children aged 6–35 mos	550	499	**1,049**
No. of sampled primary-school children, grades 4–8	456	449	**905**
Respondent age (yrs)			
Mean (standard deviation)	33.3 (12.7)	33.8 (13.2)	**33.5 (13.0)**
Median (range)	30 (16–90)	30 (16–83)	**30 (16–90)**
Female (%)	93.9	95.6	**94.8**
Respondent education level (%)			
No schooling	2.8	3.3	**3.0**
At least some primary school	83.2	85.9	**84.4**
At least some secondary school	14.2	10.6	**12.5**
Kenya household socioeconomic quintile (%)			
Poorest	84.8	87.6	**86.1**
Second poorest	3.4	1.6	**2.5**
Third poorest	2.0	1.2	**1.6**
Fourth poorest	3.3	2.2	**2.8**
Wealthiest	6.5	7.5	**7.0**
Reported water source, storage, and treatment in households (%)			
Rely on surface sources for drinking water	56.5	39.0	**47.9**
Store drinking water at home	99.7	99.7	**99.7**
Treat drinking water	70.8	62.3	**66.6**
Treat drinking water with a Safe Water System§ chlorine product	44.1	41.8	**43.0**
Positive chlorine residual detected in stored water in households	9.2	12.3	**10.7**
Observed soap in households (%)	90.0	89.3	**89.7**
Households with latrines (%)	63.7	49.5	**56.6**
Reported use of insectide-treated bednets (ITNs) the preceding night for 2,508 children aged <5 yrs (%)	84.8	80.2	**80.6**
Observed ITNs hanging over sleeping areas of children aged <5 yrs (%)	73.3	71.2	**72.2**
Reported illness in the preceding 24 hrs in children aged 6–35 months (%)	27.5	28.0	**27.7**
Acute respiratory infection (ARI)	20.9	22.1	**21.5**
Diarrhea	8.4	9.8	**9.1**
Fever not attibutable to ARI or diarrhea	3.5	1.9	**2.7**
Chronic malnutrition in children aged 6–35 mos (%)	30.1	25.7	**28.0**
Laboratory results for 974 children aged 6–35 mos (%)			
Anemia (hemoglobin <11.0 g/dL)	64.9	67.6	**66.2**
Iron deficiency (ferritin <12.0 ng/mL)	44.6	45.1	**44.8**
Positive malaria smear	20.5	19.0	**19.8**
Laboratory results for primary-school children (%)			
Positive for intestinal parasites	18.5	10.5	**14.8**

* Data were collected before any interventions were conducted.
† Percentages might not add to 100.0% because of rounding.
§ A household-based intervention that includes water treatment with dilute chlorine bleach, safe water storage, and education aimed at changing hygiene behavior.

the preceding 24 hours; 21.5% had acute respiratory infection, and 9.1% had diarrhea. Fewer than 1% had been hospitalized.

NICHE Implementation

Implementation activities began in the 30 intervention villages after baseline data collection was completed in April 2007 and will continue through October 2007. Interventions include 1) SWS (*5*); 2) distribution of ITNs (*6*); 3) promotion of handwashing with soap (*7*); 4) distribution of Sprinkles®, single-serve packets of dry powder, containing iron and other micronutrients intended for home fortification of foods consumed by young children who are no longer exclusively breastfeeding (*8*); and 5) deworming of primary-school children (i.e., of geohelminths) with albendazole; this was the only activity that also was extended to children in the 30 comparison villages.

To promote these interventions, project partners have combined several approaches. Population Services International, a social-marketing nongovernmental organization, has an ongoing program to promote purchase and use of SWS bleach solution, ITNs, and reproductive-health products through mass media, peer educators, murals, and billboards. The Safe Water and AIDS Project (SWAP) trains HIV self-help groups in rural villages and urban low-income settings to provide health education and sell health products to their neighbors as an income-generating activity. SWAP trains clinic nurses, school teachers, and religious leaders to teach their clients, students, and congregations about these interventions and installs drinking water and handwashing stations in these settings. Finally, NICHE project staff members enlist the support of local political leaders and the ministries of health and education.

As of May 30, 2007, primary-school children in all 60 villages had been dewormed with albendazole. In June, active surveillance to collect data on all household members through biweekly visits to all study households was initiated to assess product use and health status. In addition, ongoing qualitative research is being conducted in intervention villages to supplement surveillance data. A follow-up evaluation of the NICHE project is planned in March 2008. In April 2008, project staff members will expand implementation of all interventions to the 30 comparison villages, and active surveillance will resume in enrolled households in all 60 study villages for another year.

To motivate village populations to participate more actively in the NICHE project, staff members are analyzing baseline data and will present summary and village-specific findings to each participating village. Study personnel also will analyze surveillance data regarding specific intervention use and health indicators. In November 2007 and again in March 2008, NICHE staff members will present surveillance findings to each participating intervention village so that residents can see how well they are doing in comparison with the entire study population.

Reported by: *A Obure, MA, C Mbakaya, PhD, S Kariuki, PhD, D Karanja, PhD, Kenya Medical Research Institute. PC Juliao, PhD, RE Quick, MD, K Teates, MPH, Div of Foodborne, Bacterial and Mycotic Diseases; S Montgomery, DVM, W Secor, PhD, L Slutsker, MD, M Hamel, MD; Div of Parasitic Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases; PS Suchdev, MD, L Ruth, MPH, ME Jefferds, PhD, B Woodruff, MD, Div of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion; CDC.*

Editorial Note: The families in the NICHE project face problems associated with poverty that are common in the developing world. The majority of respondents in the 60 villages are poor; 86.1% fall into the poorest socioeconomic quintile in a country that ranked 152nd out of 177 countries in the 2006 United Nation's Human Development Index.§ These families have poor access to basic sanitary facilities, and young children have high rates of acute respiratory infection, diarrhea, and malaria, compared with populations in more developed countries. High rates of chronic malnutrition are of particular concern, because malnutrition contributes to approximately half the deaths in children aged <5 years (*2*).

Previous programs in Kenya aimed at increasing child survival and improving public health in this study population have had some success. Free distribution of ITNs has resulted in high observed baseline use rates, and ongoing promotion of water-treatment products has resulted in reported use of SWS products at baseline by 43.0% of households and confirmed use by 10.7% of households.

In recent years, a trend has been observed toward increased funding for high-profile, disease-specific, child-health programs that have had an impact on child survival. Recognition of the need for multiple interventions to address child survival has led to recent initiatives to bundle interventions (*9*). Greater use of interventions available today might make possible the achievement of the United Nations millennium development goal to reduce child mortality by two thirds by the year 2015 (*3*). By integrating services, combining interventions, and engaging local leadership, the NICHE project is attempting to create a model for improved child health.

§ Available at http://hdr.undp.org/hdr2006/statistics.

The findings in this report are subject to at least three limitations. First, results are specific to the study population and geographic area and are not generalizable to the entire population of Kenya. Second, socioeconomic quintiles for Kenya households were derived from 1998 data; recent changes (e.g., more widespread use of cellular telephones) might affect socioeconomic indicators. Finally, illness data were based on unverified reports; therefore, the 21.5% of children reported with acute respiratory infection and other illness data might be subject to recall bias.

The NICHE project will enable CDC and partners to assess the extent to which combining proven child-survival interventions and employing multiple community-based implementation techniques can improve health in impoverished populations. The use of inexpensive, locally available interventions will control program costs and increase the prospects for sustaining the program. If the simultaneous engagement of local populations and institutions, the private sector, and government in program implementation proves successful, this implementation approach might serve as a blueprint for child-survival programs in other regions of Kenya and elsewhere in Africa.

Acknowledgments

This report is based, in part, on contributions by the Kenya Ministry of Health; Safe Water and AIDS Project; Kenya Medical Research Institute; Sprinkles Global Health Initiative; CDC Coordinating Office of Global Health; Bur of Global Health of the U.S. Agency for International Development; Bur of Oceans, Environment, and Science of the U.S. Dept of State; and A Eleveld, C Jalang'o, V Were, C Ochieng, SH Faith, S Kola, I Sadumah, W Abok, R Otieno, L Ogange, M Owuor, B Ondego, P Odonde, T Malachi, U Mandava, I Parvanta, D Feikin, J Vulule, J Kioko, F Diemo, and R Abayo.

References

1. UNICEF. The state of the world's children 2007. Downloadable statistical tables. New York, NY: UNICEF; 2007. Available at http://www.unicef.org/sowc07/statistics/tables.php.
2. Blössner M, de Onis M. Malnutrition: quantifying the health impact at national and local levels. Geneva, Switzerland: World Health Organization; 2005. Available at http://whqlibdoc.who.int/publications/2005/9241591870.pdf.
3. Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS, the Bellagio Study Group on Child Survival. How many child deaths can we prevent this year? Lancet 2003;362:65–71.
4. Gwatkin DR, Rustein S, Johnson K, et al. Socio-economic differences in health, nutrition and population in Kenya. Washington, DC: The World Bank; 2000.
5. CDC. Safe water systems for the developing world: a handbook for implementing household-based water treatment and safe storage projects. Atlanta, GA: CDC; 2000. Available at http://www.cdc.gov/safewater.
6. Lengeler C. Insecticide-treated bed nets and curtains for preventing malaria. Cochrane Database Sys Rev 2004;2:CD000363.
7. Curtis V, Cairncross S. Effect of washing hands with soap on diarrhoea risk in the community: a systematic review. Lancet Infect Dis 2003;3:275–81.
8. Zlotkin SH, Schauer C, Christofides A, Sharieff W, Tondeur MC, Ziauddin Hyder SM. Micronutrient Sprinkles to control childhood anaemia. PLoS Med 2005;2:24–8.
9. CDC. Distribution of insecticide-treated bednets during an integrated nationwide immunization campaign—Togo, West Africa, December 2004. MMWR 2005;54:994–6.

Notice to Readers

National Epilepsy Awareness Month — November 2007

November is National Epilepsy Awareness Month. Epilepsy, which currently affects approximately 3 million persons in the United States, is characterized by recurrent, unprovoked seizures (*1*). Delayed recognition of these seizures and subsequent inadequate treatment increases the risk for additional seizures, brain injury, disability, decreased health-related quality of life, and death from injuries incurred during a seizure (*2–4*).

Although epilepsy can occur at any age, the condition primarily affects children and older adults (*5*). The number of cases among older adults is increasing as the U.S. population ages (*3,6*). The effects of epilepsy also can affect the transition to adult activities (e.g., driving and working).

The Epilepsy Foundation (EF), in partnership with CDC, is continuing a national campaign to use public education and programs that foster community awareness to improve the health care and community support available to persons affected by epilepsy. The theme for the foundation's program through 2008 is "Not another moment lost to seizures."

Campaign activities include school-based health-education programs, community workshops for diverse audiences, and training for older adults and their caregivers. In addition, EF has developed pilot curricula for police and emergency response personnel to increase recognition and appropriate management of persons who are having seizures and to reduce numbers of arrests of persons with epilepsy who are exhibiting seizure-related behaviors that are mistaken as other behaviors (e.g., perceived intoxication or disorderly conduct). To address the impact of head trauma on military veterans, EF is establishing a study group to outline public education programs and training for the Department of Veterans Affairs health-care system. EF also will implement a pilot comprehensive employment program to educate employers about epilepsy in the workplace. Partnerships with other national and local organizations have been established to provide programs in public education and community awareness; these organizations include the National Association of School Nurses, AARP, Community Health Workers/Promotores National Network, National Council of La Raza, National Center for Farmworker Health, and East Coast Community Health Centers Association.

Information regarding epilepsy and the national campaign is available from the Epilepsy Foundation by telephone, 800-332-1000, or online at http://www.epilepsyfoundation.org. Information in Spanish is available at http://www.fundacionparalaepilepsia.org or by telephone, 866-748-8008.

References

1. Epilepsy Foundation; 2007. Available at http://www.epilepsyfoundation.org.
2. Engel JR Jr. A greater role for surgical treatment of epilepsy: why and when? Epilepsy Curr 2003;3:37–40.
3. Begley CE, Famulari M, Annegers JF, et al. The cost of epilepsy in the United States: an estimate from population-based clinical and survey data. Epilepsia 2000;41:342–51.
4. Gilliam F. Optimizing health outcomes in active epilepsy. Neurology 2002;58(Suppl 5):S9–20.
5. Hirtz D, Thurman DJ, Gwinn-Hardy K, Mohamed M, Chaudhuri AR, Zalutsky R. How common are the "common" neurological disorders? Neurology 2007;68:326–37.

Notice to Readers

Application Deadline for The CDC Experience Applied Epidemiology Fellowship — December 3, 2007

The CDC Experience is a 1-year fellowship in applied epidemiology that is tailored for rising third- and fourth-year medical students and aims to develop a pool of physicians with a population-based health perspective. Eight competitively selected fellows spend 10–12 months at CDC in Atlanta, Georgia, where they conduct epidemiologic analyses in areas of public health that interest them. The fellowship provides multiple opportunities to enhance skills in research and analytic thinking, written and oral scientific presentations, and the practices of preventive medicine and public health.

Applicants do not need experience in public health to apply for this program. Through this training, fellows acquire practical tools for approaching population-based health problems, whether in an entire community or among their own community of patients. Graduates of The CDC Experience have an appreciation of the role of epidemiology in medicine and health and are able to apply their knowledge and skills to enhance their clinical acumen.

Information on applying for The CDC Experience is available at http://www.cdcfoundation.org/thecdcexperience. Applications for The CDC Experience fellowship class of 2008–09 must be postmarked by December 3, 2007. Questions can be addressed to Catherine Piper, program coordinator, at e-mail, cpiper@cdc.gov.

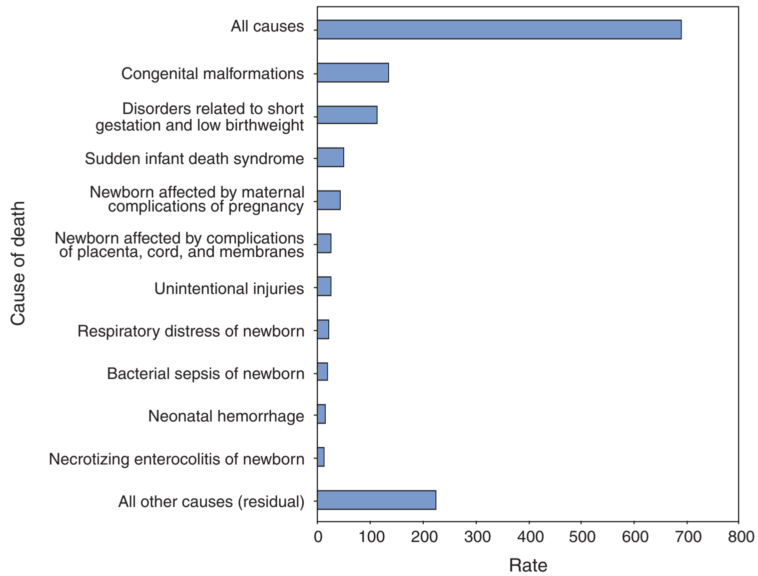
Erratum: Vol. 55, No. RR-16

In the *MMWR Recommendations and Reports*, "A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP), Part II: Immunization of Adults," an error occurred. In Appendix A, page 28, second column, line 10, the sentence should read, "However, long-term protection has been demonstrated only for persons who have completed a licensed vaccination series and have ever had an anti-HBs concentration of ≥10 mIU/mL; persons with an anti-HBs-positive result but who did **not** complete a vaccine schedule might not have long-term protection from HBV infection."

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Infant Mortality Rates* for 10 Leading Causes of Infant Death — United States, 2005†



* Per 100,000 live births.
† Mortality data for 2005 are preliminary; the numbers of deaths attributed to certain causes might be underestimated.

The three leading causes of infant mortality (congenital malformations, disorders related to short gestation and low birthweight, and sudden infant death syndrome) accounted for approximately 43% of all infant deaths in the United States in 2005.

SOURCE: Kung HC, Hoyert DL, Xu JQ, Murphy, SL. E-stat deaths: preliminary data for 2005 health E-stats. Hyattsville, MD: US Department of Health and Human Services, CDC; 2007. Available at http://www.cdc.gov/nchs/products/pubs/pubd/hestats/prelimdeaths05/prelimdeaths05.htm.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending October 20, 2007 (42nd 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	—	15	0	20	19	16	20	28	
infant	—	64	2	97	85	87	76	69	
other (wound & unspecified)	1	18	1	48	31	30	33	21	CA (1)
Brucellosis	3	98	2	121	120	114	104	125	CO (1), CA (2)
Chancroid	1	25	1	33	17	30	54	67	NY (1)
Cholera	—	3	0	9	8	5	2	2	
Cyclosporiasis[§]	—	84	1	136	543	171	75	156	
Diphtheria	—	—	0	—	—	—	1	1	
Domestic arboviral diseases[§,¶]:									
California serogroup	—	24	3	67	80	112	108	164	
eastern equine	—	3	0	8	21	6	14	10	
Powassan	—	1	—	1	1	1	—	1	
St. Louis	—	3	0	10	13	12	41	28	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis[§]:									
human granulocytic	23	408	10	646	786	537	362	511	NY (4), OH (1), MN (16), TN (1), AR (1)
human monocytic	11	508	9	578	506	338	321	216	NY (1), MN (3), MD (1), NC (1), AR (5)
human (other & unspecified)	3	133	1	231	112	59	44	23	VA (1), NC (1), AR (1)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	1	13	0	29	9	19	32	34	TX (1)
nonserotype b	3	111	2	175	135	135	117	144	MN (1), FL (1), OK (1)
unknown serotype	2	169	3	179	217	177	227	153	MD (1), OR (1)
Hansen disease[§]	2	45	1	66	87	105	95	96	OH (1), CA (1)
Hantavirus pulmonary syndrome[§]	—	22	0	40	26	24	26	19	
Hemolytic uremic syndrome, postdiarrheal[§]	2	171	5	288	221	200	178	216	CT (1), CA (1)
Hepatitis C viral, acute	4	529	19	802	652	713	1,102	1,835	VA (1), TN (1), OK (1), TX (1)
HIV infection, pediatric (age <13 yrs)[††]	—	—	5	52	380	436	504	420	
Influenza-associated pediatric mortality[§,§§]	—	73	—	43	45	—	N	N	
Listeriosis	9	537	20	875	896	753	696	665	OH (3), VA (1), NC (1), FL (1), CO (1), WA (1), CA (1)
Measles[¶¶]	—	30	0	55	66	37	56	44	
Meningococcal disease, invasive***:									
A, C, Y, & W-135	—	217	4	318	297	—	—	—	
serogroup B	2	104	2	193	156	—	—	—	IN (2)
other serogroup	1	22	0	32	27	—	—	—	NE (1)
unknown serogroup	5	494	11	651	765	—	—	—	MI (1), MO (1), FL (1), TN (1), CA (1)
Mumps	7	613	11	6,584	314	258	231	270	NC (1), FL (3), CO (1), WA (2)
Novel influenza A virus infections	—	3	—	N	N	N	N	N	
Plague	—	6	0	17	8	3	1	2	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Poliovirus infection, nonparalytic[§]	—	—	—	N	N	N	N	N	
Psittacosis[§]	—	6	0	21	16	12	12	18	
Q fever[§]	1	135	1	169	136	70	71	61	CO (1)
Rabies, human	—	—	0	3	2	7	2	3	
Rubella[†††]	—	11	0	11	11	10	7	18	
Rubella, congenital syndrome	—	—	—	1	1	—	1	1	
SARS-CoV[§,§§§]	—	—	—	—	—	—	8	N	
Smallpox[§]	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome[§]	3	80	1	125	129	132	161	118	CT (3)
Syphilis, congenital (age <1 yr)	2	365	8	380	329	353	413	412	FL (1), LA (1)
Tetanus	—	15	1	41	27	34	20	25	
Toxic-shock syndrome (staphylococcal)[§]	3	65	2	101	90	95	133	109	MN (1), NE (1), CA (1)
Trichinellosis	—	5	0	15	16	5	6	14	
Tularemia	2	102	2	95	154	134	129	90	MO (1), OK (1)
Typhoid fever	3	275	7	353	324	322	356	321	OH (1), FL (1), CO (1)
Vancomycin-intermediate *Staphylococcus aureus*[§]	—	18	0	6	2	—	N	N	
Vancomycin-resistant *Staphylococcus aureus*[§]	—	—	0	1	3	1	N	N	
Vibriosis (noncholera *Vibrio* species infections)[§]	30	291	2	N	N	N	N	N	NY (1), OH (1), MD (1), VA (1), FL (1), WA (22), CA (3)
Yellow fever	—	—	—	—	—	—	—	1	

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

* Incidence data for reporting year 2007 are provisional, whereas data for 2002, 2003, 2004, 2005, and 2006 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 nonneuroinvasive. 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 71 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 October 20, 2007, and October 21, 2006 (42nd Week)*

	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
		Previous 52 weeks					Previous 52 weeks					Previous 52 weeks			
Reporting area	Current week	Med	Max	Cum 2007	Cum 2006	Current week	Med	Max	Cum 2007	Cum 2006	Current week	Med	Max	Cum 2007	Cum 2006
United States	11,374	20,429	25,327	820,847	826,585	53	142	658	5,904	6,432	187	82	951	8,550	4,656
New England	657	713	1,357	28,174	27,014	—	0	1	2	—	—	4	37	248	341
Connecticut	164	229	829	8,524	7,864	N	0	0	N	N	—	0	37	37	38
Maine§	—	50	74	2,021	1,816	—	0	0	—	—	—	1	6	41	39
Massachusetts	391	305	480	12,740	12,155	—	0	0	—	—	—	2	7	80	166
New Hampshire	76	39	70	1,731	1,593	—	0	1	2	—	—	1	5	46	40
Rhode Island§	—	62	106	2,449	2,621	—	0	0	—	—	—	0	3	8	14
Vermont§	26	19	45	709	965	N	0	0	N	N	—	1	3	36	44
Mid. Atlantic	2,226	2,732	4,284	114,896	101,212	—	0	0	—	—	10	10	110	1,121	557
New Jersey	—	401	528	16,034	16,354	N	0	0	N	N	—	0	2	9	41
New York (Upstate)	584	515	2,758	21,582	19,468	N	0	0	N	N	6	3	20	205	139
New York City	1,170	952	1,982	40,442	33,376	N	0	0	N	N	—	1	6	69	128
Pennsylvania	472	754	1,760	36,838	32,014	N	0	0	N	N	4	4	103	838	249
E.N. Central	1,248	3,092	6,206	133,220	139,121	1	1	3	25	36	32	18	122	1,431	1,177
Illinois	552	950	1,367	38,950	43,549	—	0	0	—	—	—	2	10	110	181
Indiana	257	398	646	16,618	16,034	—	0	0	—	—	4	1	12	85	80
Michigan	274	709	1,059	28,274	28,968	—	0	3	16	32	1	2	10	143	125
Ohio	76	705	3,633	34,373	33,827	1	0	2	9	4	22	5	61	498	302
Wisconsin	89	368	443	15,005	16,743	N	0	0	N	N	5	6	56	595	489
W.N. Central	641	1,178	1,429	47,877	50,083	—	0	54	6	1	18	13	120	1,239	734
Iowa	115	162	252	6,991	6,780	N	0	0	N	N	4	2	61	544	158
Kansas	182	151	294	6,545	6,378	N	0	0	N	N	—	1	15	76	74
Minnesota	—	233	314	8,488	10,413	—	0	54	—	—	11	3	34	219	158
Missouri	302	455	565	18,687	18,631	—	0	1	6	1	2	2	13	118	174
Nebraska§	—	103	183	3,956	4,278	N	0	0	N	N	1	1	21	127	85
North Dakota	—	27	61	1,143	1,481	N	0	0	N	N	—	0	11	15	9
South Dakota	42	49	84	2,067	2,122	N	0	0	N	N	—	2	15	140	76
S. Atlantic	3,669	3,999	6,760	161,972	158,322	—	0	1	3	3	59	20	68	972	941
Delaware	64	65	140	2,714	2,880	—	0	0	—	—	—	0	4	18	13
District of Columbia	77	110	166	4,627	2,441	—	0	0	—	—	—	0	2	3	12
Florida	1,348	1,129	1,767	47,064	39,851	N	0	0	N	N	33	11	35	532	413
Georgia	10	652	3,822	19,714	28,609	N	0	0	N	N	7	4	22	179	232
Maryland§	414	393	696	16,223	17,273	—	0	1	3	3	—	0	2	26	16
North Carolina	727	562	1,905	23,375	27,038	—	0	0	—	—	18	1	9	96	81
South Carolina§	553	497	3,030	26,073	18,466	N	0	0	N	N	—	1	5	57	121
Virginia§	474	485	685	19,850	19,424	N	0	0	N	N	1	1	4	51	44
West Virginia	2	57	96	2,332	2,340	N	0	0	N	N	—	0	5	10	9
E.S. Central	820	1,457	2,044	57,534	61,404	—	0	0	—	—	9	3	62	516	148
Alabama§	—	360	560	12,765	19,016	N	0	0	N	N	4	1	13	89	52
Kentucky	269	148	691	6,582	6,575	N	0	0	N	N	4	1	39	233	35
Mississippi	—	355	959	15,786	15,260	N	0	0	N	N	—	0	11	83	24
Tennessee§	551	505	725	22,401	20,553	N	0	0	N	N	1	1	19	111	37
W.S. Central	477	2,287	2,968	96,376	93,779	—	0	1	1	1	5	5	41	281	340
Arkansas§	328	168	320	7,541	6,670	N	0	0	N	N	—	0	8	27	20
Louisiana	149	361	853	15,794	14,715	—	0	1	1	1	—	1	5	39	78
Oklahoma	—	266	467	10,464	9,844	N	0	0	N	N	5	1	11	103	32
Texas§	—	1,480	1,952	62,577	62,550	N	0	0	N	N	—	2	29	112	210
Mountain	124	1,264	1,811	46,912	55,528	16	91	293	3,790	4,423	54	6	570	2,622	343
Arizona	23	460	897	16,165	17,903	16	88	293	3,666	4,303	—	0	6	39	23
Colorado	—	232	369	7,581	13,240	N	0	0	N	N	4	1	25	140	62
Idaho§	—	56	253	2,883	2,331	N	0	0	N	N	49	0	71	385	30
Montana§	—	47	82	1,488	2,084	N	0	0	N	N	—	1	7	56	126
Nevada§	—	178	293	7,279	6,879	—	1	5	50	54	—	0	3	17	10
New Mexico§	—	149	394	6,354	7,903	—	0	2	17	18	—	1	8	89	37
Utah	101	104	209	4,245	3,997	—	1	7	54	46	—	0	497	1,846	15
Wyoming§	—	23	38	917	1,191	—	0	1	3	2	1	0	8	50	40
Pacific	1,512	3,351	4,362	133,886	140,122	36	44	311	2,077	1,968	—	2	19	120	75
Alaska	—	88	157	3,445	3,550	N	0	0	N	N	—	0	2	3	4
California	1,165	2,666	3,627	107,975	110,024	36	44	311	2,077	1,968	—	0	0	—	—
Hawaii	—	104	133	4,223	4,633	N	0	0	N	N	—	0	4	6	4
Oregon§	100	159	394	6,935	7,652	N	0	0	N	N	—	2	15	111	67
Washington	247	309	621	11,308	14,263	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	1	4	207	390	724	—	0	0	—	—	—	0	0	—	—
Puerto Rico	164	120	544	6,170	4,034	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	U	3	7	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 year 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 October 20, 2007, and October 21, 2006 (42nd Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes†				
	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	222	304	1,513	13,114	14,412	3,241	6,701	8,941	266,469	288,631	25	45	184	1,806	1,841
New England	12	25	52	1,136	1,195	106	109	259	4,498	4,543	2	3	19	144	144
Connecticut	1	6	18	290	252	38	45	204	1,730	1,862	2	0	7	42	41
Maine§	—	4	10	157	145	—	2	8	98	107	—	0	2	9	17
Massachusetts	—	10	26	463	522	65	51	96	2,171	1,951	—	2	6	69	64
New Hampshire	—	0	3	23	21	2	3	8	124	159	—	0	2	15	10
Rhode Island§	7	0	15	66	97	—	8	18	329	406	—	0	10	7	4
Vermont§	4	3	9	137	158	1	1	5	46	58	—	0	1	2	8
Mid. Atlantic	32	56	127	2,256	2,844	406	719	1,537	29,831	26,975	2	10	27	366	371
New Jersey	—	5	11	142	397	—	115	159	4,669	4,381	—	1	5	50	64
New York (Upstate)	23	24	108	920	979	105	116	1,035	5,504	5,097	1	3	15	102	117
New York City	2	15	25	633	791	174	204	363	8,456	8,371	—	2	6	81	70
Pennsylvania	7	14	29	561	677	127	244	586	11,202	9,126	1	3	10	133	120
E.N. Central	31	47	77	1,897	2,322	523	1,241	2,575	53,651	57,604	2	6	15	226	306
Illinois	—	12	24	493	580	223	356	498	14,519	16,345	—	1	6	60	92
Indiana	N	0	0	N	N	129	166	307	7,176	7,194	2	1	7	47	65
Michigan	1	12	20	456	587	119	278	747	11,483	12,170	—	0	5	22	23
Ohio	24	15	37	666	666	28	318	1,554	15,234	16,255	—	2	5	83	68
Wisconsin	6	7	15	282	489	24	127	181	5,239	5,640	—	0	2	14	58
W.N. Central	11	20	553	905	1,545	187	374	512	15,173	15,713	2	3	24	108	129
Iowa	1	4	23	240	246	15	39	60	1,535	1,520	—	0	1	1	1
Kansas	—	2	8	108	167	46	42	86	1,855	1,795	—	0	2	9	16
Minnesota	—	0	514	12	476	—	59	86	2,260	2,645	2	1	17	49	67
Missouri	7	7	22	351	463	123	198	266	8,099	8,213	—	1	5	34	32
Nebraska§	3	2	8	104	99	—	27	57	1,140	1,122	—	0	2	13	7
North Dakota	—	0	16	18	17	—	2	7	76	113	—	0	2	2	6
South Dakota	—	1	6	72	77	3	6	11	208	305	—	0	0	—	—
S. Atlantic	37	57	106	2,266	2,215	1,297	1,562	3,209	62,535	71,319	11	11	34	472	453
Delaware	1	1	6	36	35	38	26	43	1,053	1,193	1	0	3	7	1
District of Columbia	—	0	7	34	53	29	47	71	1,906	1,429	—	0	2	3	5
Florida	23	24	47	1,040	889	536	472	717	19,305	19,574	6	3	8	134	135
Georgia	—	10	33	463	531	2	293	2,068	8,112	14,338	1	2	7	95	93
Maryland§	3	4	17	197	192	152	117	227	5,007	5,847	1	1	6	68	66
North Carolina	—	0	0	—	—	166	263	675	10,577	14,144	2	1	9	48	48
South Carolina§	—	2	8	79	87	203	206	1,361	10,957	8,586	—	1	4	40	29
Virginia§	10	9	19	379	402	171	122	221	4,891	5,462	—	1	22	53	57
West Virginia	—	0	21	38	26	—	18	36	727	746	—	0	6	24	19
E.S. Central	4	10	23	429	360	277	570	752	22,325	25,127	—	2	9	98	97
Alabama§	1	4	16	195	167	—	156	242	5,727	8,844	—	0	3	20	20
Kentucky	N	0	0	N	N	101	54	268	2,596	2,377	—	0	1	2	5
Mississippi	N	0	0	N	N	—	141	310	5,981	6,032	—	0	1	7	12
Tennessee§	3	5	16	234	193	176	193	260	8,021	7,874	—	1	6	69	60
W.S. Central	3	7	55	292	285	160	983	1,185	40,024	41,258	4	2	34	85	73
Arkansas§	—	2	13	100	107	87	78	120	3,254	3,502	—	0	2	8	8
Louisiana	—	1	9	74	71	73	222	384	9,127	8,834	—	0	2	6	18
Oklahoma	3	3	42	118	107	—	101	235	4,044	3,685	3	1	29	64	40
Texas§	N	0	0	N	N	—	573	731	23,599	25,237	1	0	3	7	7
Mountain	29	30	63	1,290	1,383	22	246	374	9,463	12,481	1	4	12	202	180
Arizona	1	3	11	153	135	12	103	206	3,449	4,528	1	1	6	77	76
Colorado	15	8	24	383	463	—	51	93	1,945	3,029	—	1	4	45	44
Idaho§	11	3	12	150	154	—	4	20	215	139	—	0	1	5	5
Montana§	2	2	8	90	88	—	1	8	50	166	—	0	1	2	—
Nevada§	—	2	8	89	98	—	45	87	1,781	2,360	—	0	2	9	12
New Mexico§	—	2	6	79	66	—	30	58	1,333	1,459	—	1	4	32	26
Utah	—	7	32	313	348	10	16	34	628	695	—	0	3	29	14
Wyoming§	—	1	4	33	31	—	1	5	62	105	—	0	1	3	3
Pacific	63	61	558	2,643	2,263	263	714	875	28,969	33,611	1	3	16	105	88
Alaska	—	1	9	59	93	—	10	27	387	494	—	0	2	10	10
California	31	45	93	1,764	1,795	215	610	734	25,095	27,752	—	0	10	34	25
Hawaii	—	1	4	54	44	—	11	22	501	784	—	0	2	9	15
Oregon§	11	8	15	359	331	18	23	63	864	1,183	1	1	6	50	38
Washington	21	7	449	407	—	30	55	142	2,122	3,398	—	0	5	2	—
American Samoa	U	0	0	U	U	U	0	2	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	0	0	—	—	—	1	38	74	91	—	0	0	—	1
Puerto Rico	—	5	15	165	203	9	6	23	281	248	—	0	1	2	3
U.S. Virgin Islands	U	0	0	U	U	U	1	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 year 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 October 20, 2007, and October 21, 2006 (42nd Week)*

	Hepatitis (viral, acute), by type†										Legionellosis				
	A					B									
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2007	2006	week	Med	Max	2007	2006	week	Med	Max	2007	2006
United States	26	53	201	2,222	2,859	53	77	405	3,132	3,528	37	43	106	1,806	2,189
New England	3	2	6	100	160	—	2	5	60	99	2	2	12	99	151
Connecticut	3	0	3	20	35	—	0	5	26	41	1	0	5	32	41
Maine§	—	0	1	3	8	—	0	2	9	20	—	0	1	4	8
Massachusetts	—	1	4	46	77	—	0	1	4	18	—	0	3	15	61
New Hampshire	—	0	3	12	21	—	0	1	5	8	—	0	2	7	13
Rhode Island§	—	0	2	11	11	—	0	3	13	9	1	0	6	32	21
Vermont§	—	0	1	8	8	—	0	1	3	3	—	0	2	9	7
Mid. Atlantic	2	8	17	332	330	3	8	21	356	434	15	12	35	577	798
New Jersey	—	2	5	72	95	—	1	8	64	140	—	1	10	66	104
New York (Upstate)	2	1	11	63	75	3	2	13	79	52	13	4	22	181	271
New York City	—	2	7	127	107	—	1	6	76	102	—	2	9	90	155
Pennsylvania	—	2	5	70	53	—	3	8	137	140	2	5	21	240	268
E.N. Central	1	6	13	232	293	5	9	23	355	413	8	9	27	414	487
Illinois	—	2	5	83	90	—	2	6	96	116	—	1	8	66	109
Indiana	—	0	7	26	23	—	0	21	46	44	—	1	7	45	38
Michigan	1	1	8	63	97	—	2	8	89	121	2	2	10	121	119
Ohio	—	1	4	53	46	5	3	7	111	103	6	3	17	174	182
Wisconsin	—	0	3	7	37	—	0	3	13	29	—	0	3	8	39
W.N. Central	—	2	18	133	116	—	2	15	104	116	2	1	9	79	67
Iowa	—	1	4	36	9	—	0	3	18	19	—	0	1	8	10
Kansas	—	0	1	3	25	—	0	2	7	10	—	0	1	2	7
Minnesota	—	0	17	56	17	—	0	13	17	14	2	0	6	23	17
Missouri	—	0	2	21	39	—	1	5	48	53	—	0	3	33	20
Nebraska§	—	0	2	12	17	—	0	3	9	15	—	0	1	9	8
North Dakota	—	0	3	—	—	—	0	1	—	—	—	0	1	—	—
South Dakota	—	0	1	5	9	—	0	1	5	5	—	0	1	4	5
S. Atlantic	9	10	21	424	450	10	19	56	782	981	5	7	25	299	370
Delaware	—	0	1	7	11	—	0	3	15	39	—	0	2	7	10
District of Columbia	—	0	5	14	6	—	0	2	1	5	—	0	4	1	19
Florida	3	3	7	131	177	6	7	14	276	336	1	2	10	123	134
Georgia	1	1	4	59	48	—	2	7	93	169	—	0	2	19	26
Maryland§	3	1	5	67	55	1	2	6	90	129	1	1	6	54	83
North Carolina	—	0	11	49	72	3	0	16	111	129	—	1	4	36	30
South Carolina§	—	0	4	15	22	—	1	5	51	74	—	0	2	14	5
Virginia§	2	1	5	74	53	—	3	8	107	54	3	1	4	37	50
West Virginia	—	0	2	8	6	—	0	23	38	46	—	0	4	8	13
E.S. Central	1	2	5	88	108	3	7	17	285	257	2	2	6	79	84
Alabama§	—	0	3	16	12	—	2	10	99	72	—	0	1	9	9
Kentucky	—	0	2	18	31	2	1	7	58	61	2	1	6	41	32
Mississippi	—	0	4	8	7	—	0	8	22	9	—	0	1	—	3
Tennessee§	1	1	5	46	58	1	3	8	106	115	—	1	4	29	40
W.S. Central	—	5	43	180	302	21	18	169	648	709	—	2	16	88	56
Arkansas§	—	0	2	10	44	—	1	7	52	62	—	0	3	8	4
Louisiana	—	1	3	24	25	—	1	4	62	49	—	0	1	3	10
Oklahoma	—	0	8	11	6	13	1	24	59	54	—	0	6	5	1
Texas§	—	3	39	135	227	8	13	135	475	544	—	2	13	72	41
Mountain	2	4	15	207	226	3	3	7	140	113	—	2	5	75	104
Arizona	1	3	11	147	135	—	1	4	48	—	—	0	3	25	32
Colorado	1	0	3	21	35	3	0	2	24	30	—	0	2	14	23
Idaho§	—	0	1	4	9	—	0	1	11	11	—	0	1	5	11
Montana§	—	0	2	9	9	—	0	3	—	—	—	0	1	3	5
Nevada§	—	0	2	9	11	—	1	3	29	30	—	0	2	7	8
New Mexico§	—	0	2	9	12	—	0	2	10	21	—	0	2	8	5
Utah	—	0	1	5	13	—	0	4	16	21	—	0	2	10	20
Wyoming§	—	0	1	3	2	—	0	1	2	—	—	0	1	3	—
Pacific	8	13	92	526	874	8	10	106	402	406	3	2	11	96	72
Alaska	—	0	1	4	1	—	0	3	5	5	—	0	1	—	—
California	6	10	40	455	829	7	7	31	298	327	—	1	11	67	72
Hawaii	—	0	2	4	10	—	0	2	5	7	—	0	1	1	—
Oregon§	—	1	2	23	34	—	1	5	52	67	1	0	1	9	—
Washington	2	0	52	40	—	1	0	74	42	—	2	0	3	19	—
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	45	51	—	1	9	44	51	—	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 year 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 October 20, 2007, and October 21, 2006 (42nd Week)*

Reporting area	Lyme disease					Malaria					Meningococcal disease, invasive[†] All serogroups				
	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	271	249	1,175	16,115	16,439	15	22	105	869	1,162	8	21	87	837	917
New England	8	38	288	2,863	3,849	—	1	5	38	45	—	1	3	34	40
Connecticut	7	11	214	1,519	1,580	—	0	3	1	10	—	0	1	6	9
Maine[§]	—	3	53	317	213	—	0	2	6	4	—	0	3	6	4
Massachusetts	—	2	14	64	1,379	—	0	3	21	22	—	0	2	18	20
New Hampshire	1	6	79	697	584	—	0	4	8	8	—	0	1	—	4
Rhode Island[§]	—	0	93	151	1	—	0	1	—	—	—	0	1	1	1
Vermont[§]	—	1	13	115	92	—	0	2	2	1	—	0	1	3	2
Mid. Atlantic	57	114	604	8,320	8,456	1	5	14	219	305	—	3	8	115	138
New Jersey	—	26	134	1,725	2,228	—	0	2	—	79	—	0	2	13	18
New York (Upstate)	51	52	426	2,775	3,065	1	1	5	56	36	—	1	3	29	31
New York City	—	1	19	122	277	—	3	7	128	148	—	0	4	26	53
Pennsylvania	6	41	296	3,698	2,886	—	1	4	35	42	—	1	5	47	36
E.N. Central	—	8	131	1,099	1,639	—	2	8	86	144	3	3	9	122	144
Illinois	—	1	12	111	107	—	1	6	36	73	—	1	3	38	38
Indiana	—	0	7	41	20	—	0	2	9	11	2	0	4	24	21
Michigan	—	1	5	52	49	—	0	2	14	17	1	0	3	23	24
Ohio	—	0	3	16	40	—	0	2	18	27	—	1	3	28	42
Wisconsin	—	5	118	879	1,423	—	0	2	9	16	—	0	3	9	19
W.N. Central	109	5	195	456	537	—	0	12	28	33	2	1	5	52	54
Iowa	—	1	11	97	93	—	0	1	3	1	—	0	3	11	15
Kansas	—	0	2	9	4	—	0	1	2	7	—	0	1	1	4
Minnesota	108	1	188	317	424	—	0	12	11	14	—	0	3	16	12
Missouri	—	0	6	25	5	—	0	1	5	6	1	0	3	14	13
Nebraska[§]	1	0	1	6	10	—	0	1	6	3	1	0	2	5	6
North Dakota	—	0	7	2	—	—	0	1	—	1	—	0	3	2	1
South Dakota	—	0	0	—	1	—	0	1	1	1	—	0	1	3	3
S. Atlantic	90	54	173	3,133	1,805	10	4	13	209	289	1	3	11	141	158
Delaware	6	11	34	614	427	—	0	1	4	5	—	0	1	1	4
District of Columbia	—	0	7	13	46	—	0	2	3	3	—	0	1	—	1
Florida	1	1	11	76	19	2	1	7	50	49	1	1	7	54	60
Georgia	—	0	1	2	7	1	0	5	30	79	—	0	5	21	14
Maryland[§]	59	26	109	1,633	1,021	2	1	5	50	66	—	0	2	20	13
North Carolina	2	0	8	42	25	2	0	4	20	27	—	0	6	16	24
South Carolina[§]	—	0	2	22	18	—	0	1	6	9	—	0	2	14	19
Virginia[§]	22	12	60	673	230	3	1	4	44	49	—	0	2	13	16
West Virginia	—	0	14	58	12	—	0	1	2	2	—	0	2	2	7
E.S. Central	—	1	5	45	31	—	0	3	30	23	1	1	4	41	35
Alabama[§]	—	0	3	10	7	—	0	1	5	9	—	0	2	7	5
Kentucky	—	0	2	5	7	—	0	1	7	3	—	0	2	9	8
Mississippi	—	0	0	—	3	—	0	1	2	6	—	0	4	9	4
Tennessee[§]	—	0	4	30	14	—	0	2	16	5	1	0	2	16	18
W.S. Central	—	1	6	53	19	—	1	29	71	87	—	2	15	84	84
Arkansas[§]	—	0	1	1	—	—	0	0	—	4	—	0	2	9	10
Louisiana	—	0	1	2	—	—	0	2	14	6	—	0	4	25	34
Oklahoma	—	0	0	—	—	—	0	3	5	7	—	0	4	15	8
Texas[§]	—	1	6	50	19	—	1	25	52	70	—	0	11	35	32
Mountain	—	0	4	34	25	—	1	6	49	63	—	1	4	52	61
Arizona	—	0	1	2	9	—	0	3	11	21	—	0	2	12	14
Colorado	—	0	1	2	—	—	0	2	16	14	—	0	2	17	20
Idaho[§]	—	0	2	7	5	—	0	2	2	1	—	0	1	3	3
Montana[§]	—	0	2	4	—	—	0	1	3	2	—	0	1	2	4
Nevada[§]	—	0	2	7	3	—	0	1	2	3	—	0	1	4	5
New Mexico[§]	—	0	1	4	3	—	0	1	4	5	—	0	1	2	5
Utah	—	0	2	5	4	—	0	3	11	17	—	0	2	10	6
Wyoming[§]	—	0	1	3	1	—	0	0	—	—	—	0	1	2	4
Pacific	7	2	16	112	78	4	3	45	139	173	1	4	48	196	203
Alaska	—	0	1	5	3	—	0	1	2	23	—	0	1	1	3
California	7	2	9	103	69	3	2	7	99	132	1	3	10	141	156
Hawaii	N	0	0	N	N	—	0	1	2	8	—	0	2	8	8
Oregon[§]	—	0	1	3	6	—	0	3	13	10	—	0	3	28	36
Washington	—	0	8	1	—	1	0	43	23	—	—	0	43	18	—
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	3	1	—	0	1	6	6
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 year 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 October 20, 2007, and October 21, 2006 (42nd Week)*

	Pertussis					Rabies, animal					Rocky Mountain spotted fever				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2007	2006	week	Med	Max	2007	2006	week	Med	Max	2007	2006
United States	106	171	1,479	6,918	11,410	37	96	156	4,109	4,655	17	30	211	1,678	1,821
New England	—	29	77	1,063	1,421	7	12	22	489	390	—	0	10	2	11
Connecticut	—	2	5	59	95	5	4	10	194	172	—	0	0	—	—
Maine†	—	1	13	63	112	—	2	7	72	98	—	0	0	—	—
Massachusetts	—	23	46	845	889	—	0	0	—	—	—	0	1	2	10
New Hampshire	—	1	8	50	183	—	1	4	42	38	—	0	0	—	1
Rhode Island†	—	0	31	17	47	—	0	4	35	27	—	0	9	—	—
Vermont†	—	0	9	29	95	2	3	13	146	55	—	0	0	—	—
Mid. Atlantic	12	23	155	941	1,489	—	14	44	726	450	—	1	6	53	80
New Jersey	—	2	11	116	251	—	0	0	—	—	—	0	2	6	37
New York (Upstate)	9	12	146	486	664	—	—	—	—	—	—	0	1	3	—
New York City	—	2	6	97	79	—	1	5	33	29	—	0	3	22	22
Pennsylvania	3	6	15	242	495	—	13	44	693	421	—	0	3	22	21
E.N. Central	10	29	79	1,186	1,789	2	4	48	358	147	1	1	4	42	60
Illinois	—	3	23	109	446	—	1	15	108	46	—	0	3	23	25
Indiana	4	0	45	51	181	—	0	1	11	11	—	0	2	5	6
Michigan	—	7	29	240	496	1	1	27	169	43	—	0	1	3	4
Ohio	6	15	54	587	484	1	0	11	70	47	1	0	2	11	24
Wisconsin	—	3	24	199	182	—	0	0	—	—	—	0	0	—	1
W.N. Central	—	13	151	500	1,067	2	5	13	225	274	1	4	31	336	185
Iowa	—	3	16	115	259	1	0	3	29	55	—	0	4	13	5
Kansas	—	3	13	104	252	—	2	8	95	67	—	0	1	1	1
Minnesota	—	0	119	111	161	1	0	5	28	37	—	0	1	1	3
Missouri	—	2	9	63	268	—	0	3	39	63	1	3	25	306	153
Nebraska†	—	1	12	51	82	—	0	0	—	—	—	0	2	11	23
North Dakota	—	0	18	4	25	—	0	6	16	16	—	0	0	—	—
South Dakota	—	1	6	52	20	—	0	2	18	36	—	0	1	4	—
S. Atlantic	21	17	163	778	888	22	40	76	1,734	1,940	7	15	111	821	994
Delaware	—	0	2	10	3	—	0	0	—	—	—	0	2	14	21
District of Columbia	—	0	1	2	6	—	0	0	—	—	—	0	1	1	1
Florida	3	4	18	189	176	—	0	29	103	176	1	0	4	20	13
Georgia	—	1	4	25	80	—	4	34	200	224	1	0	5	33	49
Maryland†	—	2	8	90	121	—	7	18	295	359	—	1	7	53	71
North Carolina	18	3	112	273	155	7	9	19	419	435	2	5	96	521	717
South Carolina†	—	2	9	65	148	—	0	11	46	145	—	1	7	60	34
Virginia†	—	2	17	97	158	15	13	31	607	510	3	2	11	114	85
West Virginia	—	0	19	27	41	—	0	10	64	91	—	0	3	5	3
E.S. Central	2	6	31	332	298	—	3	11	133	213	—	4	16	221	339
Alabama†	—	2	18	77	73	—	0	5	—	71	—	1	9	68	81
Kentucky	—	0	1	5	56	—	0	3	18	25	—	0	2	5	3
Mississippi	2	1	29	179	32	—	0	1	1	4	—	0	2	13	6
Tennessee†	—	2	7	71	137	—	3	9	114	113	—	2	10	135	249
W.S. Central	5	21	226	760	698	1	2	32	72	829	7	1	168	165	105
Arkansas†	—	1	17	119	81	1	0	5	27	26	7	0	53	89	46
Louisiana	—	0	1	14	24	—	0	1	—	5	—	0	1	2	4
Oklahoma	—	0	36	6	18	—	0	22	45	58	—	0	108	45	28
Texas†	5	16	174	621	575	—	0	26	—	740	—	0	7	29	27
Mountain	13	22	61	858	2,169	2	3	14	193	193	1	0	4	30	45
Arizona	—	4	13	170	446	—	2	12	135	126	—	0	1	7	11
Colorado	12	6	17	230	648	—	0	0	—	—	1	0	2	4	4
Idaho†	—	1	5	34	80	—	0	0	—	24	—	0	1	4	14
Montana†	1	0	7	35	104	2	0	3	17	14	—	0	1	1	2
Nevada†	—	0	5	11	65	—	0	1	2	5	—	0	0	—	—
New Mexico†	—	1	8	56	107	—	0	2	8	8	—	0	1	4	7
Utah	—	7	47	303	650	—	0	2	14	10	—	0	0	—	—
Wyoming†	—	0	4	19	69	—	0	4	17	6	—	0	2	10	7
Pacific	43	12	547	500	1,591	1	4	10	179	219	—	0	3	8	2
Alaska	—	0	8	41	86	—	0	6	37	16	N	0	0	N	N
California	—	3	167	131	1,328	1	2	8	131	180	—	0	3	6	—
Hawaii	—	0	2	17	84	N	0	0	N	N	N	0	0	N	N
Oregon†	—	2	14	98	93	—	0	3	11	23	—	0	1	2	2
Washington	43	2	377	213	—	—	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	—	0	2	—	61	—	0	0	—	—	N	0	0	N	N
Puerto Rico	—	0	1	—	1	—	0	5	37	70	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 year 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 October 20, 2007, and October 21, 2006 (42nd Week)*

	Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†					Shigellosis				
		Previous 52 weeks					Previous 52 weeks					Previous 52 weeks			
Reporting area	Current week	Med	Max	Cum 2007	Cum 2006	Current week	Med	Max	Cum 2007	Cum 2006	Current week	Med	Max	Cum 2007	Cum 2006
United States	635	862	2,338	34,180	35,561	52	80	336	3,518	3,359	257	346	1,287	12,746	11,023
New England	4	34	377	1,849	1,961	—	3	88	255	251	1	4	37	207	245
Connecticut	—	0	362	362	503	—	0	82	82	75	—	0	34	34	67
Maine§	—	3	14	103	106	—	1	4	33	37	—	0	5	14	4
Massachusetts	—	23	57	1,096	1,021	—	2	10	109	88	—	3	8	136	150
New Hampshire	—	3	10	132	189	—	0	3	15	24	—	0	2	5	6
Rhode Island§	4	1	20	86	82	—	0	2	6	8	1	0	9	15	12
Vermont§	—	2	5	70	60	—	0	1	10	19	—	0	1	3	6
Mid. Atlantic	51	98	176	4,185	4,495	13	7	63	347	403	11	11	47	570	770
New Jersey	—	11	25	321	944	—	1	20	27	102	—	2	9	91	271
New York (Upstate)	31	28	112	1,189	1,056	13	3	15	174	144	7	3	42	123	195
New York City	4	24	50	1,135	1,076	—	0	4	29	42	3	5	10	213	229
Pennsylvania	16	33	69	1,540	1,419	—	3	47	117	115	1	1	21	143	75
E.N. Central	61	103	252	4,680	4,719	8	9	31	514	590	33	33	130	1,773	1,143
Illinois	—	31	186	1,481	1,328	—	1	9	72	99	—	11	32	404	528
Indiana	21	15	54	599	745	4	1	13	81	77	7	2	11	95	124
Michigan	4	18	35	740	851	1	1	6	76	78	2	1	7	57	135
Ohio	29	26	65	1,109	1,033	1	3	11	139	154	24	11	104	1,024	140
Wisconsin	7	17	50	751	762	2	3	8	146	182	—	3	13	193	216
W.N. Central	31	49	101	2,210	2,201	10	12	45	624	567	19	36	156	1,539	1,448
Iowa	—	8	19	378	386	—	2	38	143	114	1	2	14	73	94
Kansas	—	6	20	274	307	—	0	4	37	21	—	0	3	20	124
Minnesota	9	13	44	566	571	5	4	17	213	172	2	5	24	202	165
Missouri	19	15	26	610	627	5	2	12	119	143	16	18	72	1,110	581
Nebraska§	3	4	12	209	162	—	1	6	68	71	—	0	7	20	116
North Dakota	—	0	23	36	24	—	0	12	2	6	—	0	127	5	79
South Dakota	—	3	11	137	124	—	0	5	42	40	—	1	30	109	289
S. Atlantic	288	222	425	9,219	9,194	5	14	37	559	514	70	88	174	3,714	2,550
Delaware	—	2	8	124	135	—	0	3	13	7	—	0	2	10	9
District of Columbia	—	0	4	16	51	—	0	1	1	2	—	0	5	4	14
Florida	162	85	176	3,673	3,739	3	2	8	116	74	36	44	76	1,913	1,185
Georgia	36	33	71	1,588	1,519	—	1	9	77	72	25	30	94	1,336	950
Maryland§	15	15	42	726	638	—	2	5	78	101	2	2	9	89	102
North Carolina	67	29	110	1,310	1,331	2	2	24	119	94	—	0	14	71	129
South Carolina§	2	17	51	818	847	—	0	3	15	11	3	2	20	129	76
Virginia§	6	19	39	811	815	—	3	8	123	141	4	3	11	138	81
West Virginia	—	3	31	153	119	—	0	5	17	12	—	0	10	24	4
E.S. Central	38	56	134	2,543	2,340	1	4	26	261	261	52	27	142	1,761	604
Alabama§	7	15	78	700	643	—	0	19	59	28	9	11	67	508	189
Kentucky	12	10	22	470	372	1	1	11	95	84	7	3	34	388	204
Mississippi	11	13	101	713	689	—	0	1	5	10	34	6	85	702	83
Tennessee§	8	17	34	660	636	—	2	10	102	139	2	3	14	163	128
W.S. Central	37	83	595	3,252	4,190	2	3	73	145	196	42	39	655	1,429	1,562
Arkansas§	10	14	46	622	770	2	1	4	32	42	—	2	10	72	84
Louisiana	—	15	41	573	898	—	0	2	3	14	—	8	22	349	210
Oklahoma	26	8	103	523	411	—	0	17	17	35	5	2	63	104	109
Texas§	1	42	470	1,534	2,111	—	2	68	93	105	37	24	580	904	1,159
Mountain	24	48	90	2,023	2,163	3	8	31	400	465	4	19	58	756	1,141
Arizona	4	17	44	741	716	—	2	8	88	88	—	11	31	446	583
Colorado	9	10	22	438	524	2	1	9	66	97	2	2	9	90	190
Idaho§	9	3	7	114	148	1	1	16	113	86	1	0	2	10	14
Montana§	1	1	6	80	112	—	0	0	—	—	1	1	13	21	28
Nevada§	—	4	10	145	184	—	0	3	18	30	—	0	9	47	103
New Mexico§	—	5	13	211	214	—	1	3	33	41	—	2	6	82	155
Utah	—	4	18	233	228	—	1	9	82	105	—	1	5	29	58
Wyoming§	1	1	4	61	37	—	0	1	—	18	—	0	19	31	10
Pacific	101	103	890	4,219	4,298	10	7	164	413	112	25	27	256	997	1,560
Alaska	—	1	5	65	65	N	0	0	N	N	—	0	2	7	7
California	70	76	260	3,150	3,682	5	3	33	212	N	13	21	84	805	1,398
Hawaii	—	5	16	208	198	—	0	4	18	13	—	0	2	21	43
Oregon§	—	7	15	254	351	—	1	11	72	99	—	1	6	65	112
Washington	31	10	625	542	2	5	1	162	111	—	12	1	170	99	—
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	—	12	66	446	463	—	0	0	—	—	—	0	4	18	34
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 year 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 October 20, 2007, and October 21, 2006 (42nd Week)*

Reporting area	Streptococcal disease, invasive, group A					*Streptococcus pneumoniae*, invasive disease, nondrug resistant† Age <5 years				
	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	37	97	261	4,081	4,385	16	29	108	1,239	1,049
New England	11	5	28	338	296	—	2	11	95	95
Connecticut	10	0	23	109	77	—	0	6	12	28
Maine§	—	0	3	22	16	—	0	1	2	—
Massachusetts	—	3	12	153	151	—	1	6	63	55
New Hampshire	—	0	4	32	34	—	0	2	8	8
Rhode Island§	1	0	12	6	6	—	0	2	8	4
Vermont§	—	0	2	16	12	—	0	1	2	—
Mid. Atlantic	6	17	41	758	791	1	4	37	207	146
New Jersey	—	3	10	107	128	—	1	4	25	54
New York (Upstate)	4	5	27	249	255	1	2	15	87	72
New York City	—	4	13	177	140	—	1	35	95	20
Pennsylvania	2	5	11	225	268	N	0	0	N	N
E.N. Central	2	16	33	680	834	3	5	14	187	273
Illinois	—	5	13	185	254	—	1	6	47	70
Indiana	—	2	12	102	100	1	0	10	16	47
Michigan	1	4	10	167	175	—	1	4	59	63
Ohio	1	4	14	197	206	2	1	7	53	53
Wisconsin	—	0	6	29	99	—	0	2	12	40
W.N. Central	—	5	32	275	293	3	2	8	93	94
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	3	28	48	—	0	1	1	11
Minnesota	—	0	29	137	136	3	1	6	64	58
Missouri	—	2	6	67	63	—	0	2	17	12
Nebraska§	—	0	3	23	26	—	0	2	10	10
North Dakota	—	0	2	13	10	—	0	2	1	3
South Dakota	—	0	2	7	10	—	0	0	—	—
S. Atlantic	8	22	52	1,033	987	4	4	14	226	63
Delaware	—	0	1	10	10	—	0	0	—	—
District of Columbia	—	0	3	8	14	—	0	1	—	1
Florida	3	6	16	256	243	3	1	5	55	—
Georgia	2	5	13	205	205	—	0	5	44	—
Maryland§	1	4	10	175	183	1	1	6	51	51
North Carolina	1	1	22	142	140	—	0	0	—	—
South Carolina§	—	1	7	83	55	—	0	4	38	—
Virginia§	1	2	11	131	112	—	0	4	31	—
West Virginia	—	0	3	23	25	—	0	4	7	11
E.S. Central	4	4	13	175	176	—	1	6	74	16
Alabama§	N	0	0	N	N	N	0	0	N	N
Kentucky	2	1	3	35	39	—	0	0	—	—
Mississippi	N	0	0	N	N	—	0	2	3	16
Tennessee§	2	3	13	140	137	—	1	6	71	—
W.S. Central	4	6	90	258	335	4	4	43	179	178
Arkansas§	—	0	2	17	24	—	0	2	10	19
Louisiana	—	0	4	16	16	—	0	4	27	20
Oklahoma	—	1	23	60	86	2	1	13	43	43
Texas§	4	3	64	165	209	2	2	27	99	96
Mountain	2	9	23	451	573	1	4	12	152	164
Arizona	—	4	11	176	297	1	2	7	90	91
Colorado	1	3	9	128	99	—	1	4	36	43
Idaho§	1	0	2	16	8	—	0	1	2	2
Montana§	N	0	0	N	N	N	0	0	N	N
Nevada§	—	0	1	2	—	—	0	1	1	2
New Mexico§	—	1	4	48	111	—	0	4	19	26
Utah	—	2	7	76	54	—	0	2	4	—
Wyoming§	—	0	1	5	4	—	0	0	—	—
Pacific	—	3	9	113	100	—	0	4	26	20
Alaska	—	0	3	30	N	—	0	2	24	—
California	N	0	0	N	N	N	0	0	N	N
Hawaii	—	2	9	83	100	—	0	2	2	20
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

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 year 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 October 20, 2007, and October 21, 2006 (42nd Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease, drug resistant† All ages Current week	All ages Previous 52 weeks Med	All ages Previous 52 weeks Max	All ages Cum 2007	All ages Cum 2006	Age <5 years Current week	Age <5 years Previous 52 weeks Med	Age <5 years Previous 52 weeks Max	Age <5 years Cum 2007	Age <5 years Cum 2006	Syphilis, primary and secondary Current week	Syphilis Previous 52 weeks Med	Syphilis Previous 52 weeks Max	Syphilis Cum 2007	Syphilis Cum 2006
United States	16	46	256	1,848	1,955	6	9	35	342	317	101	201	310	8,206	7,689
New England	—	2	12	86	102	—	0	3	10	3	3	5	13	207	166
Connecticut	—	2	5	50	77	—	0	2	4	—	—	0	10	25	36
Maine§	—	0	2	9	6	—	0	2	1	1	—	0	2	9	8
Massachusetts	—	0	0	—	—	—	0	0	—	—	3	3	8	127	101
New Hampshire	—	0	0	—	—	—	0	0	—	—	—	0	3	23	10
Rhode Island§	—	0	4	14	9	—	0	1	3	—	—	0	5	21	9
Vermont§	—	0	2	13	10	—	0	1	2	2	—	0	1	2	2
Mid. Atlantic	—	2	9	101	114	—	0	5	21	17	21	28	44	1,227	929
New Jersey	—	0	0	—	—	—	0	0	—	—	—	4	8	160	139
New York (Upstate)	—	1	5	35	36	—	0	4	7	8	1	3	14	112	124
New York City	—	0	0	—	—	—	0	0	—	—	18	17	34	756	443
Pennsylvania	—	2	6	66	78	—	0	2	14	9	2	4	10	199	223
E.N. Central	9	9	40	436	404	4	2	7	64	66	3	15	27	629	715
Illinois	—	0	4	15	21	—	0	1	2	6	1	7	13	290	346
Indiana	5	2	31	118	107	2	0	5	22	17	—	1	6	43	74
Michigan	—	0	1	2	15	—	0	1	1	2	1	2	9	94	93
Ohio	4	5	38	301	261	2	1	5	39	41	1	3	10	156	146
Wisconsin	N	0	0	N	N	—	0	0	—	—	—	1	4	46	56
W.N. Central	—	1	124	116	86	—	0	15	9	13	3	6	14	284	235
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	13	15
Kansas	—	0	11	63	—	—	0	2	5	—	—	0	3	18	21
Minnesota	—	0	123	—	51	—	0	15	—	10	2	1	5	56	41
Missouri	—	1	5	45	33	—	0	0	—	3	1	4	11	188	138
Nebraska§	—	0	1	2	1	—	0	0	—	—	—	0	2	2	7
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	1
South Dakota	—	0	3	6	1	—	0	1	4	—	—	0	3	7	12
S. Atlantic	6	21	59	821	940	2	4	15	174	147	42	47	180	1,929	1,717
Delaware	1	0	1	8	—	—	0	1	2	—	—	0	3	12	16
District of Columbia	—	0	2	5	23	—	0	0	—	2	3	3	12	141	97
Florida	4	11	29	472	502	1	2	8	101	95	22	16	38	719	592
Georgia	1	7	17	286	319	1	1	10	63	50	—	6	153	272	310
Maryland§	—	0	1	1	—	—	0	0	—	—	2	6	15	249	250
North Carolina	—	0	0	—	—	—	0	0	—	—	7	5	23	270	244
South Carolina§	—	0	0	—	—	—	0	0	—	—	1	2	11	83	57
Virginia§	N	0	0	N	N	—	0	0	—	—	7	4	17	178	142
West Virginia	—	1	17	49	96	—	0	1	8	—	—	0	1	5	9
E.S. Central	1	3	9	129	160	—	0	3	28	29	11	17	30	699	579
Alabama§	N	0	0	N	N	—	0	0	—	—	—	6	16	274	266
Kentucky	—	0	2	19	30	—	0	1	2	6	4	1	7	50	58
Mississippi	—	0	2	—	22	—	0	0	—	—	—	2	9	85	53
Tennessee§	1	2	8	110	108	—	0	3	26	23	7	6	15	290	202
W.S. Central	—	2	11	114	69	—	0	3	17	7	6	35	53	1,452	1,254
Arkansas§	—	0	1	1	10	—	0	0	—	2	2	1	10	98	60
Louisiana	—	1	4	52	59	—	0	2	7	5	4	9	23	386	246
Oklahoma	—	0	9	61	—	—	0	2	10	—	—	1	4	44	59
Texas§	—	0	0	—	—	—	0	0	—	—	—	21	39	924	889
Mountain	—	1	5	45	80	—	0	3	16	35	—	7	19	270	403
Arizona	—	0	0	—	—	—	0	0	—	—	—	3	12	104	151
Colorado	—	0	0	—	—	—	0	0	—	—	—	1	5	31	58
Idaho§	N	0	0	N	N	—	0	0	—	—	—	0	1	1	3
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	1	1	1
Nevada§	—	0	3	18	16	—	0	2	5	2	—	2	6	87	114
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	1	7	37	62
Utah	—	0	5	15	33	—	0	3	9	23	—	0	2	6	14
Wyoming§	—	0	2	12	31	—	0	1	2	10	—	0	1	3	—
Pacific	—	0	0	—	—	—	0	1	3	—	12	38	57	1,509	1,691
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	1	6	10
California	N	0	0	N	N	—	0	0	—	—	4	35	54	1,372	1,503
Hawaii	—	0	0	—	—	—	0	1	3	—	—	0	2	7	15
Oregon§	N	0	0	N	N	—	0	0	—	—	—	0	6	14	15
Washington	N	0	0	N	N	—	0	0	—	—	8	2	12	110	148
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	1	3	—
Puerto Rico	N	0	0	N	N	—	0	0	—	—	5	3	10	129	116
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 year 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 October 20, 2007, and October 21, 2006 (42nd Week)*

	Varicella (chickenpox)					West Nile virus disease[†]									
						Neuroinvasive					Nonneuroinvasive[§]				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2007	2006	week	Med	Max	2007	2006	week	Med	Max	2007	2006
United States	272	796	2,813	27,801	35,954	—	1	123	986	1,477	1	2	287	2,121	2,746
New England	9	16	124	573	3,512	—	0	2	7	9	—	0	2	5	3
Connecticut	—	0	76	2	1,300	—	0	2	4	7	—	0	1	1	2
Maine[¶]	—	0	7	—	194	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	—	1,141	—	0	2	3	2	—	0	2	3	1
New Hampshire	4	7	17	270	318	—	0	0	—	—	—	0	0	—	—
Rhode Island[¶]	—	0	0	—	—	—	0	0	—	—	—	0	1	1	—
Vermont[¶]	5	8	66	301	559	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	2	108	195	3,299	3,974	—	0	3	16	26	—	0	1	5	12
New Jersey	N	0	0	N	N	—	0	1	1	2	—	0	0	—	3
New York (Upstate)	N	0	0	N	N	—	0	0	—	8	—	0	0	—	4
New York City	—	0	0	—	—	—	0	3	12	8	—	0	1	2	4
Pennsylvania	2	108	195	3,299	3,974	—	0	1	3	8	—	0	1	3	1
E.N. Central	75	229	568	7,827	11,529	—	0	16	83	244	—	0	7	42	174
Illinois	—	2	11	111	117	—	0	13	51	127	—	0	7	30	88
Indiana	—	0	0	—	—	—	0	2	6	27	—	0	1	4	53
Michigan	29	97	258	3,196	3,548	—	0	5	13	43	—	0	0	—	12
Ohio	46	105	449	3,723	7,040	—	0	4	10	36	—	0	2	5	11
Wisconsin	—	19	80	797	824	—	0	1	3	11	—	0	1	3	10
W.N. Central	7	32	136	1,311	1,412	—	0	40	231	223	—	0	113	695	482
Iowa	N	0	0	N	N	—	0	4	10	22	—	0	3	14	15
Kansas	—	8	52	439	267	—	0	3	11	17	—	0	7	26	13
Minnesota	—	0	0	—	—	—	0	11	42	31	—	0	11	54	34
Missouri	7	15	78	726	1,035	—	0	9	53	51	—	0	2	10	10
Nebraska[¶]	N	0	0	N	N	—	0	5	18	44	—	0	15	122	218
North Dakota	—	0	60	84	44	—	0	11	49	20	—	0	46	311	117
South Dakota	—	1	15	62	66	—	0	9	48	38	—	0	32	158	75
S. Atlantic	41	99	239	4,043	3,605	—	0	11	34	18	—	0	6	30	13
Delaware	—	1	4	37	61	—	0	1	1	—	—	0	0	—	—
District of Columbia	—	0	8	14	34	—	0	0	—	—	—	0	1	—	1
Florida	26	22	76	1,015	N	—	0	1	3	3	—	0	0	—	—
Georgia	N	0	0	N	N	—	0	8	22	2	—	0	4	23	6
Maryland[¶]	N	0	0	N	N	—	0	2	4	10	—	0	2	4	1
North Carolina	—	0	0	—	—	—	0	0	—	1	—	0	0	—	—
South Carolina[¶]	1	21	72	852	925	—	0	2	2	1	—	0	1	2	—
Virginia[¶]	—	27	190	1,201	1,354	—	0	1	2	—	—	0	1	1	5
West Virginia	14	22	50	924	1,231	—	0	0	—	1	—	0	0	—	—
E.S. Central	—	6	571	409	28	—	0	11	61	117	—	0	13	81	97
Alabama[¶]	—	6	571	406	26	—	0	2	14	8	—	0	1	4	—
Kentucky	N	0	0	N	N	—	0	1	3	5	—	0	0	—	1
Mississippi	—	0	2	3	2	—	0	7	40	88	—	0	11	74	90
Tennessee[¶]	N	0	0	N	N	—	0	1	4	16	—	0	1	3	6
W.S. Central	114	154	1,640	8,237	9,647	—	0	23	160	368	—	0	12	67	229
Arkansas[¶]	2	12	105	568	719	—	0	5	13	24	—	0	2	5	5
Louisiana	—	1	11	99	193	—	0	1	1	90	—	0	1	1	85
Oklahoma	—	0	0	—	—	—	0	10	48	27	—	0	7	38	20
Texas[¶]	112	144	1,534	7,570	8,735	—	0	16	98	227	—	0	4	23	119
Mountain	24	55	131	2,072	2,247	—	0	35	245	385	—	1	139	970	1,475
Arizona	—	0	0	—	—	—	0	6	31	60	—	0	10	40	72
Colorado	12	21	62	825	1,206	—	0	17	95	66	—	0	65	449	278
Idaho[¶]	N	0	0	N	N	—	0	2	8	139	—	0	19	101	856
Montana[¶]	11	5	40	317	N	—	0	10	36	12	—	0	30	157	22
Nevada[¶]	—	0	1	1	9	—	0	1	1	34	—	0	3	10	90
New Mexico[¶]	—	5	37	302	321	—	0	8	36	3	—	0	6	21	5
Utah	—	14	73	600	664	—	0	8	23	56	—	0	7	28	102
Wyoming[¶]	1	0	11	27	47	—	0	4	15	15	—	0	34	164	50
Pacific	—	0	9	30	—	—	0	17	149	87	1	0	22	226	261
Alaska	—	0	9	30	N	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	N	—	0	17	145	80	1	0	20	208	196
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon[¶]	N	0	0	N	N	—	0	1	4	7	—	0	4	18	62
Washington	N	0	0	N	N	—	0	0	—	—	—	0	0	—	3
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	—	6	30	168	199	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	11	30	467	473	—	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 year 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 October 20, 2007 (42nd Week)

Reporting Area	All causes, by age (years)						
	All Ages	≥65	45-64	25-44	1-24	<1	P&I† Total
New England	445	309	95	20	8	14	28
Boston, MA	124	85	23	9	5	2	8
Bridgeport, CT	U	U	U	U	U	U	U
Cambridge, MA	7	4	2	1	—	—	1
Fall River, MA	29	25	4	—	—	—	2
Hartford, CT	47	34	9	2	—	2	3
Lowell, MA	16	10	6	—	—	—	2
Lynn, MA	7	4	2	1	—	—	—
New Bedford, MA	18	14	3	—	1	—	1
New Haven, CT	22	11	7	—	—	4	3
Providence, RI	52	32	13	2	2	3	—
Somerville, MA	3	—	3	—	—	—	—
Springfield, MA	37	28	6	1	—	2	5
Waterbury, CT	25	19	4	2	—	—	3
Worcester, MA	58	42	13	2	—	1	—
Mid. Atlantic	1,952	1,335	425	129	29	30	105
Albany, NY	41	31	6	4	—	—	—
Allentown, PA	29	23	5	1	—	—	1
Buffalo, NY	69	51	8	6	1	3	3
Camden, NJ	36	25	9	1	1	—	—
Elizabeth, NJ	16	12	2	2	—	—	3
Erie, PA	42	33	8	—	—	1	3
Jersey City, NJ	17	11	3	2	—	1	3
New York City, NY	1,026	693	230	71	18	11	47
Newark, NJ	26	11	8	5	1	1	2
Paterson, NJ	22	13	3	4	—	2	1
Philadelphia, PA	173	100	52	14	4	3	9
Pittsburgh, PA§	44	29	12	1	1	1	4
Reading, PA	54	33	13	4	1	2	3
Rochester, NY	142	108	26	5	1	2	11
Schenectady, NY	26	18	6	1	1	—	2
Scranton, PA	30	18	8	4	—	—	2
Syracuse, NY	98	79	15	2	—	2	8
Trenton, NJ	28	18	8	1	—	1	—
Utica, NY	18	17	1	—	—	—	2
Yonkers, NY	15	12	2	1	—	—	1
E.N. Central	1,977	1,295	474	112	50	46	137
Akron, OH	45	30	9	2	4	—	—
Canton, OH	33	23	7	—	—	3	5
Chicago, IL	294	192	77	15	6	4	19
Cincinnati, OH	110	63	23	11	7	6	15
Cleveland, OH	170	120	37	9	2	2	9
Columbus, OH	218	136	66	12	3	1	12
Dayton, OH	121	87	28	4	1	1	7
Detroit, MI	165	90	49	12	6	8	13
Evansville, IN	58	43	10	1	1	3	2
Fort Wayne, IN	75	54	18	2	1	—	2
Gary, IN	9	5	1	3	—	—	—
Grand Rapids, MI	53	36	8	5	1	3	6
Indianapolis, IN	190	114	44	16	10	6	16
Lansing, MI	46	30	13	2	—	1	10
Milwaukee, WI	103	66	25	5	5	2	6
Peoria, IL	49	24	18	4	1	2	4
Rockford, IL	53	38	12	—	1	2	2
South Bend, IN	33	27	4	2	—	—	1
Toledo, OH	90	67	17	5	—	1	6
Youngstown, OH	62	50	8	2	1	1	2
W.N. Central	592	384	138	37	17	14	33
Des Moines, IA	55	43	11	1	—	—	7
Duluth, MN	31	24	3	3	1	—	—
Kansas City, KS	22	10	9	3	—	—	1
Kansas City, MO	103	62	29	8	3	1	3
Lincoln, NE	34	22	7	3	—	1	1
Minneapolis, MN	61	41	16	1	2	1	7
Omaha, NE	91	69	16	3	1	2	6
St. Louis, MO	65	24	22	6	5	7	3
St. Paul, MN	63	43	13	2	4	1	4
Wichita, KS	67	46	12	7	1	1	1
S. Atlantic	1,364	839	366	98	34	27	71
Atlanta, GA	93	45	31	11	5	1	6
Baltimore, MD	212	105	74	25	6	2	11
Charlotte, NC	88	54	19	11	2	2	5
Jacksonville, FL	151	94	38	12	2	5	6
Miami, FL	124	83	31	7	2	1	6
Norfolk, VA	55	33	12	3	—	7	4
Richmond, VA	60	37	14	4	5	—	2
Savannah, GA	43	28	12	2	1	—	2
St. Petersburg, FL	226	168	44	5	5	4	8
Tampa, FL	204	126	59	12	2	5	14
Washington, D.C.	97	57	30	6	4	—	7
Wilmington, DE	11	9	2	—	—	—	—
E.S. Central	878	560	211	55	23	29	64
Birmingham, AL	164	105	36	12	5	6	12
Chattanooga, TN	79	58	15	5	1	—	7
Knoxville, TN	80	54	21	1	2	2	7
Lexington, KY	77	41	25	4	1	6	3
Memphis, TN	155	94	42	11	5	3	18
Mobile, AL	119	77	26	8	2	6	4
Montgomery, AL	54	35	9	6	3	1	4
Nashville, TN	150	96	37	8	4	5	9
W.S. Central	1,415	865	363	103	42	42	63
Austin, TX	94	57	27	7	3	—	5
Baton Rouge, LA	U	U	U	U	U	U	U
Corpus Christi, TX	51	32	11	5	1	2	7
Dallas, TX	229	124	66	17	11	11	3
El Paso, TX	67	43	17	5	1	1	1
Fort Worth, TX	115	74	26	8	1	6	9
Houston, TX	396	242	100	38	12	4	13
Little Rock, AR	64	43	12	6	—	3	3
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	214	152	43	8	6	5	12
Shreveport, LA	70	40	23	2	3	2	6
Tulsa, OK	115	58	38	7	4	8	4
Mountain	965	598	237	81	26	17	68
Albuquerque, NM	102	76	22	2	2	—	8
Boise, ID	69	49	12	7	1	—	5
Colorado Springs, CO	79	51	12	12	3	1	5
Denver, CO	80	45	23	5	3	3	4
Las Vegas, NV	186	115	54	12	3	2	13
Ogden, UT	29	18	6	2	2	1	3
Phoenix, AZ	154	74	41	23	6	5	11
Pueblo, CO	24	12	10	2	—	—	2
Salt Lake City, UT	119	75	29	11	2	2	12
Tucson, AZ	123	83	28	5	4	3	5
Pacific	1,326	906	306	68	24	22	96
Berkeley, CA	9	6	1	1	1	—	2
Fresno, CA	169	110	40	13	2	4	11
Glendale, CA	U	U	U	U	U	U	U
Honolulu, HI	50	39	6	4	1	—	10
Long Beach, CA	46	23	13	7	1	2	4
Los Angeles, CA	U	U	U	U	U	U	U
Pasadena, CA	29	21	6	2	—	—	2
Portland, OR	106	60	38	5	1	2	4
Sacramento, CA	188	130	44	6	2	6	17
San Diego, CA	133	98	25	5	5	—	13
San Francisco, CA	99	66	26	6	—	1	5
San Jose, CA	172	120	39	6	4	3	14
Santa Cruz, CA	40	26	10	3	1	—	1
Seattle, WA	117	80	25	7	3	2	4
Spokane, WA	59	50	9	—	—	—	4
Tacoma, WA	109	77	24	3	3	2	5
Total	10,914**	7,091	2,615	703	253	241	665

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.

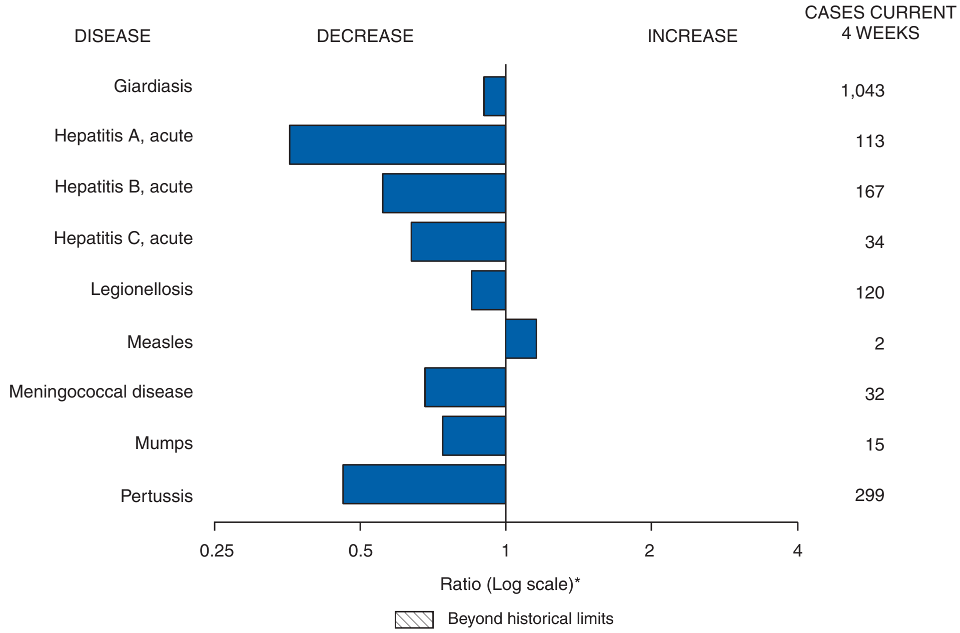
† Pneumonia and influenza.

§ 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 October 20, 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, Carol Worsham, Pearl C. Sharp

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

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Data are compiled in the National Center for Public Health Informatics, Division of Integrated Surveillance Systems and Services. Address all inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop E-90, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333 or to *www.mmwrq@cdc.gov*.

☆U.S. Government Printing Office: 2007-623-038/41056 Region IV ISSN: 0149-2195